Making it Better: The Voice of Social Care Workers

I would like us to be recognised not as a homogenous workforce, but a workforce that is progressive and has different skills and levels that are recognised.

May 2023

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Foreword: message from the Chief Executive

As the Chief Executive of the Social Care Council, I am pleased to present this summary report of research activity undertaken by the Council.

The Northern Ireland Social Care Council was tasked by the Department of Health (OSS) to develop proposals for the introduction of a qualification based social care workforce register; develop and deliver a career structure framework for social care; and develop and deliver a CPD framework for the social care workforce. This work is part of a wider specification for the development and transformation of the social care workforce. In line with the Council's partnership model, the Leaders in Social Care Partnership (LSCP) are working with the executive team and sector partners to lead delivery of social care reform. In taking this work forward we recognised the importance of listening to our stakeholders, including frontline social care staff and managers. We wanted to ensure the voice of frontline social care was included and considered in our reform work. As part of the project workstreams the Social Care Council completed the following:

- In 2020 we undertook a desktop review of health and social care policy drivers in Northern Ireland over a decade (2010-2020). This work was undertaken to summarise the strategic context for investing in the social care workforce.

- In 2021 we invited registered social care workers to participate in an online anonymous survey. We wanted to hear about their views on qualifications and career development in social care. We undertook this work because it is important to understand social care workers' experiences and career goals. This enabled us to take account of the views of social care workers in planning our work and provided opportunities for the workforce to shape and inform the future of social care registration, learning and career pathways.

- In 2022 we undertook a survey of social care managers to explore how learning and development, including career progression opportunities, are facilitated by organisations. The outputs from this work are summarised in this report.

On behalf of the Social Care Council Board Members and staff, we would like to acknowledge the valuable contribution made by each of the social care workers and social care managers who responded to our surveys.

Patricia Higgins
Chief Executive

Section 1: Introduction

This summary report brings together key messages from social care projects completed by the Social Care Council during 2020-2022:

- A review of policy and strategic drivers (2011-2021) that lend support to the development of the social care workforce, with specific reference to qualifications, continuing professional development, and a career framework.
- Key findings from a survey of social care workers' perspectives on qualifications, social care career pathways and progression, and experiences of working in social care.
- Key findings from a survey of social care managers' perspectives on qualifications and social care career pathways/progression (2022).

This report considers the emerging themes and provides an opinion on how these themes can be reflected in the reform work of the Social Care Council (hereafter 'Council'). The information presented here can be used to inform and influence across health and social care sector in a range of contexts. (Further data are available in the original reports).

1.1 Information about the survey of social care workers

The survey was distributed to all registered social care workers (SCW) in 2021 and received 586 responses. While this is not a representative sample of the workforce, the findings do provide a practitioner context that elaborates upon the policy rhetoric. The findings represent voices from the frontline, and it is important that SCW experiences and issues are considered in any reform of social care. Some key facts about the respondents who participated in the survey:

- Age-one third of respondents (33%) were aged 50-59, just over one quarter (28%) were 40-49, just under one-fifth (18%) were 30-39, 10% were 20-29, 10% were 60-69. 1% were over 70 and 1% were under 20 years old
- Gender- most respondents were female (84%).
- Ethnicity- most respondents were white (97%).
- Countries of birth- most respondents were born in the UK and Ireland (92%).
- Over half (52%) of respondents have been employed in social care for more than 10 years. One-quarter (25%) have been working in social care more than 20 years.

- 42% were employed by the private sector and 38% by Health & Social Care (HSC) Trusts.
- Just over half worked full-time (52%), with just under one-third (29%) working part-time. The remainder were bank staff working 'as and when required'.
- Just over one-quarter were domiciliary care workers (29%), 17% were adult residential care workers and 12% supported living workers. The remainder undertook social care jobs with other job titles.
- Just over one-quarter (27%) were 'senior' care workers, 35% had supervisory responsibilities for other staff. 15% were managers.
- Most (90%) had permanent contracts.
- 5% of respondents indicated they also worked as personal assistants.
- Just under half of respondents (47%) said they met with a manager to agree a learning and development plan.
- Three-quarters of respondents (75%) indicated they could access learning and development activities through their work.
- Over half (53%) reported they wouldn't know how to get a promotion in social care.

1.2 Information about the survey of social care managers

In Spring 2022 the Council undertook a survey of social care managers, exploring the delivery of learning and development. The survey focussed on induction support to new employees, and opportunities to undertake further training and qualifications. 59 responses were received, and while the sample is not representative, it does provide information about the types and methods of learning and development activity undertaken across a range of providers. The sample included representation from all sectors:

- 49% were employed in the voluntary and charity sector, 29% in the private sector, and 22% of respondents were from HSC Trusts.
- 37% were from organisations with over 500 employees; 13% from organisations that have 201-500 employees; 22% from organisations with 51-200 employees; and just over a quarter (27%) were employed in small-scale organisations with less than 50 employees.

1.3 The context and importance of social care

Social care employs a diverse workforce that supports people who have additional needs due to age, frailty, disability and mental or physical ill health. Social care workers' roles range from the provision of personal care to more intensive support for people with complex needs. Social care practitioners are primarily located in residential and nursing homes, and domiciliary care, with

most (75%) employed in the independent sector. Practitioners are also employed in Supporting People provision, reablement services, family support and mental health services, or employed by families either privately or via Direct Payments.

It is well documented that the population of Northern Ireland is undergoing significant change, and this is having an impact upon health and social care (HSC) services. Northern Ireland is projected to have a population growth of 5.7% between 2018- 2043 (the second largest in the UK), with those aged over 65 expected to increase by 56%, and the over 85 population by 106%. In less than 10 years, there is projected to be more older people (65+) than children (aged 0-15) in Northern Ireland (NISRA, 2019). This has coincided with an increase in need for social care, due to ill health and complex needs. 80% of carers in NI have problems getting a break from caring responsibilities, and this is highlighted as the single largest factor in contributing to carers' health and well-being (NISCC, 2017). Compared to 2016, over 20,000 more care packages will be needed in 2037 (NISCC, 2017). Changing demographics and increasing ill health has placed demands on an HSC system that has failed to keep pace with increasing expectations of services (Kelly & Kennedy, 2017).

In Northern Ireland 37,104 social care workers were registered with the Council on the 29 March 2023. These staff are employed by 951 registered providers on the 20 December 2020. Social care is the largest HSC workforce, accounting for 5% of the total workforce (DOH, 2016, 2017; ICF Consulting, 2018). Social care is a sector that is crucial for economic growth. It provides 71,400 jobs and makes a contribution of £1 billion to the Northern Ireland economy (ICF Consulting Ltd, 2018). Workforce planning projections indicate that the workforce will need to increase in scale. A study undertaken in 2018 reported that 10% of the SC workforce in Northern Ireland comes from outside the UK (ICF Consulting Limited, 2018). At present, data is available on the ethnicity of 70% of the registered social care workforce (25,936), and the majority (89%) were Caucasian (white). 11% of social care workers were from black and other ethnic minority groups. 3.6% of the Northern Ireland general population are from black and minority ethnic groups (NISRA, 2022), indicating higher representation amongst the social care workforce.

For more than a decade the need for reform of the HSC system and investment in social care has been highlighted. These messages have been restated in successive HSC reviews, such as the Compton Review (Transforming Your Care) (HSC, 2011); the Bengoa Report (2016) and the responding 10-year plan, Health & Wellbeing 2026: Delivering Together

(DOH, 2016); the Domiciliary Care Workforce Review (DOH, 2018), and "Power to People" Review of Adult Social Care (Kelly & Kennedy, 2017).

Policy rhetoric and planning outline the challenges, opportunities and strategic commitments to social care. Drivers to advance the sector also align with wider cross-governmental reform initiatives, such as the Northern Ireland Skills Strategy (OECD, 2020). Despite the need for change, in the past decade there has been limited investment, with implementation of strategies and recommendations curtailed by political stalemate. Continuing budgetary constraints and a focus on value for money have also put a strain on the delivery of social care and its workforce.

The centrality of social care as a key component of the HSC system is particularly illuminated when the provision of hospital care is under pressure. Unmet social care needs are associated with higher response from emergency care, and higher rates of unnecessary admissions/ readmissions to hospital (Bengoa *et al*, 2016). This is acutely evidenced in delays to hospital discharge, due to gaps in social care provision. While social care is fundamental to a transformed HSC system, it also has to compete with healthcare for investment; yet adequate funding of social care contributes to efficiencies in other parts of the HSC system. Recent media has featured health colleagues discussing the lack of social care as a significant factor affecting hospital pressures. Social care could benefit from better recognition as a solution to healthcare pressures, championed by healthcare colleagues.

Section 2: Challenges for social care

There are significant issues currently experienced by the social care workforce. However, the themes explored here are not new; they have been highlighted across successive policy documents and in research. What is significant is that reform work to date has not been able to fully address these issues, and while demand continues to grow, it does so against a backdrop of depleted services and workers.

2.1 Commissioning social care

The commissioning of social care services differs from health care, because most social care services are provided by independent providers (private and voluntary organisations). A prevailing focus on cost-effectiveness means that commissioning is predicated on market competition. Non-statutory providers have to be financially agile, and with the bulk of costs being staff, argue that they need to keep wages low to be competitive. This has resulted in ‘minimum waged social care’ and ‘financially fragile’ providers (Kelly & Kennedy, 2017), which was also reported by independent providers to the Northern Ireland

Affairs Committee in November 2019. It has been questioned whether a model of a competitive market is appropriate for social care. Fees paid by commissioners are not adequate to attract and retain social care staff. Several independent providers in their submission to the Northern Ireland Affairs Committee (2019), highlight that they recruit and train staff, only to lose them to statutory providers. There was also criticism of the commissioning arrangements that enabled:

"The Health and Social Care Trusts in making "superior and inequitable" offerings which, due to the dual role of Trusts in both the commissioning and provision of services were "in effect distorting the social care employment market while failing to support the provider network.""

There has been some evidence of a downturn in the independent sector, with some independent providers withdrawing from the market due to affordability. Kelly & Kennedy (2017: 54,62) report that:

> *We've actually created a commissioning model that forces providers to compete almost exclusively on price. Such that we get a 'race to the bottom'…good professional social care cannot be achieved through a minimum wage workforce afforded little status and built on a business model unsuited to endeavour based on personal relationships."*

It could be argued that the commissioning model has contributed to the negative experiences reported by service users, SCW and providers. Issues with commissioning and HSC policy, was commented on by several respondents to the SCW survey:

> *Poor resourcing. Cost cutting. Privatisation of community care leading to a focus on 'value for money' and profit rather than client outcomes and experience of the service provided. Endless governance for the sake of governance - mostly tick box exercises that make managers feel good but do nothing to protect clients or improve the service.*

2.2 Recruitment & retention

Staff turnover is costly and destabilising to service delivery, with difficulties attracting and keeping staff well documented (DHSSPS, 2013, Bengoa *et al*, 2016 NISCC, 2017, DOH, 2018). This is evidenced by on-going vacancies and a significant 'churn' in the workforce. Salaries in adult social care (£16,600) were found to be significantly lower (approximately 45%) than the average salary in Northern Ireland (£30,200) (ICF Consulting Limited, 2018).

To compound matters, employers are competing with other (low pay) sectors such as retail and hospitality. Independent providers have the added difficulty of competing with their commissioners (HSC Trusts) for staff, recruiting from the same group of people. The literature and survey results highlight a range of contributing factors, which are explored in more detail below.

2.3 Terms and conditions

Social care has 'an increasingly frustrated' workforce, as illustrated by high staff turnover (McMurray, 2020). Prospective employees are attracted to jobs based on their terms and conditions, as such social care 'falls short', as there is little by way of incentives to enter the workforce and even less to remain (NISCC, 2017). We asked SCW what the worst thing was about working in social care.

1. Pay- this was the number one factor commented on, that the pay is not commensurate with the work and responsibilities of social care. Some respondents also highlighted issues such as using their own car, not being paid for travel time and expenses. Essentially, they reported undertaking work without pay, and incurring costs that should be absorbed by their employers. Some discussed the lack of unsocial hours payments; sickness pay and annual leave entitlement. Comparisons were made with tasks and remuneration of other HSC staff groups or sectors:

> *Poor pay because you are classed as unqualified, despite having to utilise many skills, and often work in physically, emotionally and mentally demanding environments.*

> *Times for calls and travelling between calls not taken into consideration. No mileage allowance.*

2. Contracts and hours of work- The number of hours worked was reported by some as the worst thing about working in social care This was expressed more often in terms of having to work long or unsocial hours:

> *Long hours often beyond contracted hours.*

> *Temporary contracts.*

> *Unpaid breaks.*

However, problems with getting enough working hours, particularly for those on zero hours contracts was also of concern. A NISCC employer survey estimates the range of hours worked is 10-60 hours, yet one-fifth of Trust staff and many independent sector workers are on 'as and when required'/bank contracts which provide for no minimum or guaranteed hours (NISCC, 2017).

3. Impact of role on workers' health & life- some respondents wrote about how work affected their emotional, mental and physical health. The responses highlighted the challenging environments and situations that workers deal with. Of note was the distress caused by witnessing service users in pain, bereavement when service users died, or dealing with challenging behaviour, bullying, verbal abuse, and physical attacks. Others talked about the stress and burnout experienced due to excessive workloads, difficult service users, families, or employers:

> *It can be stressful and traumatic when someone dies. It leaves a big gap in your life. It's like losing a family member.*
>
> *Constantly being undermined. Rudeness from families.*
>
> *The negativity - compliments are very rare, people are happier to point out what you are doing wrong than right.*

4. Staffing and teamwork- staffing levels were another 'worst thing' about working in social care. Daily pressures, sick leave, not enough staff on shift, and high turnover of staff created problems for existing staff. So too did working with colleagues who were not good at team working, not suited to social care, or were unreliable:

> *High staff turnover, especially at support worker level. Long-term staffing issues.*
>
> *Lazy co-workers.*
>
> *Other thing that strikes me is that a lot of staff haven't got the right personality and attitude to social care work. That often leads to good people leaving.*

5. Employers and managers- this theme was often considered alongside factors of poor work condition, particularly where management contribute to the challenges faced by staff (or do nothing to alleviate such challenges).

There was some acknowledgement that managers also work in difficult circumstances (and some respondents in this survey were in managerial positions):

> *Over stretched managers, not having enough time to discuss problems/concerns regarding service users or personal issues.*

> *A stagnated senior management who don't like to listen to advice and changes that would help the environment from those who are below them.*

6. Workload- Workload pressures and the time allocated to undertake tasks is a significant challenge for staff. SCW highlighted unrealistic expectations and time pressures, being over worked and the impact this had on service users. They frequently cited not being able to spend enough time with service users in delivering person-centred and relational care:

> *Too little time to talk to service users and learn from them.*

> *We don't really get time to enjoy the company of residents…it just seems to be a regime of assisting to toilet and assisting with meals from 8am to 8pm no quality time with clients which is sad.*

Staff are often under pressure to complete tasks in proscribed and restricted time slots, meaning service users have limited social contact to build relationships with workers (DHSSPS, 2013, DOH, 2018).

7. Problematic work practices- Other aspects of the role that were difficult included the amount of change (too much or too little), excessive administration and bureaucracy, little support from others (particularly statutory services), difficulties accessing resources, and issues for service users (such as quality of care, funding, access to services, standards and outcomes).

> *Being hindered in helping individuals because of the lack of facilities and amenities for people with learning difficulties.*

> *Paperwork, audits, figures seem to have overtaken a lot of the personal care touch.*

8. Opportunities for career development- respondents highlighted limited availability and/or investment in opportunities for SCW, (usually described as

development within current roles, and/or progression into more senior positions). For some the lack of a defined career pathway stymied their professional growth.

> *Lack of development in our role given that this has been highlighted over 10 years ago without success.*
>
> *Little opportunity to progress up the career ladder.*
>
> *We are not viewed as professionals in our areas of expertise. Despite having the qualifications and the experience. When promotion opportunities arise it is usually the professional staff in social care for example nursing who are successful, despite our qualifications and expertise. It is quite demoralizing. Especially for long term staff who are dedicated and loyal to social care.*

2.4 Inequity between sectors

The low status of social care reinforces inequity between health and social care professions, and also between the statutory and non-statutory sectors. The independent sector is often characterised by poorer conditions; job insecurity and limited career progression (HSC & DOH, 2016; DOH, 2018). Public sector jobs have better pay, pensions, occupational sick pay, travel and training provision (DOH, 2018). As most jobs are in the independent sector, less favourable conditions are more prevalent amongst this workforce.

Some respondents made comparisons with other HSC staff groups or sectors. They commented on undertaking tasks that were above their pay band, or those in hospitality and retail being paid more with fewer responsibilities:

> *The money is dire. Better paid to work in Lidl, which is outrageous in the extreme. (Most) of those who work in social care are exceptionally well trained and highly competent in their roles and go above and beyond in their commitment to the people in their care.*
>
> *Less demanding roles in other sectors offer better remuneration.*
>
> *Making less money in social care than someone in McDonald's or someone working in Tesco.*
>
> *Care assistants, support workers etc. in private sector are badly underpaid and undervalued and working conditions are bad too.*

If you don't work for a H&SCT there is a lack of recognition for the hard work of staff working in: charitable/voluntary Organisations.

Kelly & Kennedy (2017) recommend that, as a first step, the workforce should be paid a 'Living Wage' as recognition as a professional workforce, followed by equity in employment conditions between Trusts and the independent sector. This could help foster better retention rates, with savings emerging from the costs of repeated recruitment, induction and use of agency staff. Making social care more competitive by elevating it from minimum wage reduces the competition with other low-pay sectors, such as retail and hospitality. It would promote permanency, and potentially increase uptake from people who are job seekers or economically inactive, helping to provide a more stabilised workforce. There is some evidence that providers who enhanced their pay offer saw a reduction in staff absence (Kelly and Kennedy, 2017).

2.5 The impact of the COVID-19 pandemic

The COVID-19 pandemic put the media spotlight on social care, particularly in care homes. Never before has the workforce received such extensive attention, which illustrated the central role of social care (DOH, 2020c). The pandemic also highlighted inequalities in the HSC workforce, yet these adversities juxtaposed with the public and media narrative of caring as heroic work. The emphasis on NHS health staff reinforced a hierarchal value with social care and the independent sector at the lower end of the scale. This was illustrated in more substantial rewards and gifts made to the NHS workforce than those in the non-statutory sector.

Some survey respondents highlighted the role of SCW during the pandemic. Despite their contributions in care homes and the community, there were problems with PPE, and a lack of recognition for non-statutory workers:

We are part of social care during the Pandemic, but our sector is not recognised for the £500 bonus paid to healthcare workers. It is very demotivating given we too were on the frontline.

Social care workers have been somewhat forgotten about during the covid pandemic, despite the responsibilities faced working on the frontline. Focus has been on NHS, which is important too, but some

NHS staff haven't had to deal with the same risks as social care workers.

The survey results highlighted in this report were not specifically about the impact of the pandemic. In 2020 the Department of Health sought feedback from the domiciliary care workforce to inform the Department's Rapid Learning Review of Domiciliary Care. A subsequent survey was undertaken in 2021, comprising 371 domiciliary care and supported living workers and managers. Despite problems accessing resources (PPE, technology) at the beginning of the pandemic this improved over time, although some respondents were less positive about adequate time to implement infection control procedures. There were also some negative responses about support for staff wellbeing, with over half unable to access counselling and support, and the longer-term impact of dealing with loss of service users or family members due to COVID. Some respondents reflected on good support from management and colleagues, with encouragement to avail of occupational health, counselling services and self-care activities. Work pressures, lack of parity, covering staff shortages, terms and conditions and inadequate sick pay when off due to COVID also featured in the responses. Some staff welcomed working in smaller teams which helped to build relationships at work, access to the vaccine, good communication and information. The lack of recognition of the domiciliary care workforce was highlighted, with examples of inequity in terms and conditions across sectors and locations. Non-statutory workers also highlighted difficulties in accessing the £500 workforce recognition payment.

During the COVID-19 pandemic recruitment of additional social care and social work staff became necessary to support the existing workforce. In April 2020 the Council introduced temporary emergency registration procedures that would enable the recruitment of temporary staff (DOH, 2020b). As of April 2022, nearly half (n=1606, 48%) remained registered in social care or social work roles. Three-quarters (75%) of these were employed in adult residential care or domiciliary care. Reflecting on their experience of working during the challenges presented by the pandemic, over half of those who responded to a survey, said they welcomed the opportunity to undertake such valuable work. Job satisfaction and relationships with service users featured amongst the top motivators for remaining in social care. There was positive engagement with online or digital learning on up to 20 topics relevant to their work, albeit some experienced barriers to learning due to age or limited access at work.

Despite the challenges of the pandemic and Brexit, a study by the Work Foundation and Totaljobs indicated that over half (53%) of the public reported more positive views about social care due to the pandemic. They reported that a third (31%) of UK jobseekers would consider a career in care. Applications for social care jobs have increased by 39%, and one-quarter of

young people (aged 16-25) stated they are likely to pursue a career in social care. In order to benefit from these improved perceptions, the study highlighted those issues contributing to poor retention (e.g., low pay, work pressures and lack of career progression) must be addressed.

Section 3: Perceptions of social care work

3.1 Public attitudes about social care workers

The contribution of social care is not well understood by the public. This may be exacerbated as, compared to health care, the general public has fewer encounters with social care. Yet at an individual level, the benefits of supporting people to live well are evident to those who use social care services. While the practice of social care is varied, caring activity is often 'narrowly defined' (Kelly & Kennedy, 2017). Indeed, it is the flexibility and variation that is social care's success, but it can also be difficult to understand what social care is, thereby perpetuating uninformed or negative views about the value of social care.

Staff reported feeling that their work is not appreciated by society (n=81). Two statements that appeared repeatedly in the findings were 'lack of recognition' and 'devalued'/undervalued'.

> *Many people feel we just clean bums, which couldn't be further from the truth. The myriad of problems and challenges we face day and daily is complex.*

> *Disrespect from society- the assumption that you work in social care because of a lack of intelligence and other options.*

> *Little recognition from the government, in the media, and society in general of the essential work that social care workers do.*

3.2 Attitudes of services users, families and other professionals

Some SCW reported that other professionals, their employers, service users and families do not appreciate them or the work they do. Some documented how they were poorly treated or spoken to:

> *Even district nurses can be guilty of treating us with disdain and make us feel as if we know nothing, often leaving their rubbish for the care worker to clean up. This is unfair and can make care workers feel worthless and their efforts unappreciated.*

> *Abuse from family members or distressed residents.*

None, treated without respect, treated as mules just there for hauling and pulling. Domiciliary care workers are looked down on by everyone that includes nurses and higher management. We don't have the brains to make our own health and safety judgments … I despise my job because I am treated with disdain.

Being treated as second class staff and services by other health care professionals.

Treated like a servant not a human being with feelings.

Some reported that they were not listened to or consulted; their views not sought about the needs of service users or improvements to services:

Seen as the bottom of the pecking order and being talked down to by locality managers. Not having a voice at decision level. Concerns being reported but often very little change occurs

Not being listened to. Feeling as if your views don't matter because your 'only a carer'.

Statutory agencies can undermine social care workers' views / report, in favour of their professional judgement, which can be detrimental to the service user and sometime goes against their wishes.

Lack of recognition was expressed as both attitudes towards social care work and the lack of remuneration for the work they do, issues of equity between sectors and bands, and opportunities for promotion and career development.

3.3 Expectations of social care workers

There are inherent contradictions in the narrative around professional care. On the one hand the policy response is that social care is important to service users, their families, the HSC system, and the wider community and economy. Yet there has been little attention paid to the needs of frontline workers, who are afforded little in the way of recognition and remuneration (Kelly & Kennedy, 2017). These contradictions are also evidenced in high expectations of the workforce, expected to uphold standards, and provide efficient, high quality, person-centred care in predetermined timeslots. While workers are often dedicated and altruistic individuals (particularly those who choose social care as a career), their commitment has not been sufficiently rewarded. The current commissioning arrangements have resulted in

'exploitation', affecting the quality and sustainability of the workforce (Kelly & Kennedy, 2017).

3.4 The gendered politics of caring

It is well documented that caring roles are predominantly undertaken by women. As of March 2023, 85% of registered social care workers are female and 15% are male. The age profile of the registered social care workforce is presented in the table below:

Age range	Number of registrants	Percentage*
Under 20	793	2%
20-29	8856	24%
30-39	8418	23%
40-49	7068	19%
50-59	7358	20%
60-69	4123	11%
Over 70	488	1%

*Percentages have been rounded up to nearest whole number.

While retention issues point to a transient workforce, the Domiciliary Care Review reported that most Trust domiciliary care workers are female (98%), nearly half are older (43% aged over 55), and most (96%) are on the lower pay band 2 (DOH, 2018). The DOH Learning & Development Strategy indicates women represent 87% of the SC workforce, with women over 55 accounting for 19% of staff (DOH, 2017). Care ethics points to how groups of workers can be disadvantaged, because caring is generally viewed as women's work (Raghuram, 2019). Bearing in mind health and social inequalities in low-income households and communities, Kelly & Kennedy (2017:53) caution that:

> "*The risk of colluding in a disingenuous 'group think' …that we can expect the highest of standards whilst simultaneously saying that working in social care has no more value than other minimum wage jobs. Given that the vast majority of care workers are women, and that the majority of care is given to older people, this is a deeply sexist and ageist position to have reached."*

There needs to be a reorienting of how social care is viewed. It needs to shift from the periphery, to be recognised as an essential and valued function of the HSC system, without which other systems cannot effectively operate. Raising the status of social care also requires a move away from the viewpoint of social care as low value work.

Section 4: Positive aspects of working in social care

We also asked SCW to tell us what the best thing was about working in social care. Although a lot of respondents answered the question, many did not. However, there were two dominant and homogenous themes apparent in the findings.

1. The people- 352 social care workers responded to this question. An overwhelming majority (93%, n=327) described working with service users as the best thing about working in social care. This theme was prominent in the descriptions provided. Social care workers value the people they work with, and the opportunities to provide help and support. This is rewarding work that provides job satisfaction, with respondents motivated by altruism to improve outcomes for service users. The responses illustrated values-based practice, with emphasis on improving outcomes, empowerment, promoting independence, and benefits of relationships between staff and service users. There was acknowledgement of vulnerabilities and loneliness for some service users, and the ability of social care workers to make a difference:

2. The role- respondents noted other aspects of the jobs that were positive. These included the flexibility, hours of work, opportunities in social care, and

the variety in tasks and roles that means no two days are the same. Work colleagues were also important, with support, camaraderie, and good relationships in the workplace:

It is notable that respondents focussed on others. There was much less description of self-serving rewards, perhaps because they are not in abundance, (particularly if considering earlier findings about what is the worst thing about working in social care). This suggests that the rewards come from the outcomes of their relationships with service users and their families. It is interesting to note such a unified theme emerging from qualitative data with a large response size (n=352).

> *It is a fulfilling role, and you can actively make a difference to someone's quality of life. Each person you have contact with is unique and the support that you provide to them is very individualised …You get to see people develop and enjoy new opportunities.*

> *I love working with the clients, getting to know their personalities, their life stories and doing my best for them.*

> *The job is hard but it's incredibly rewarding. Social care is an amazing sector to work in.*

> *It is a pleasure to work in a sector that strives to better people's lives, and it is a privilege to work with and alongside people who genuinely care about those they assist. The joy of doing something that is worthwhile and feeds the soul.*

> *The unpredictability of each day, the work is stimulating and enjoyable, the staff team I work with are great and we all work well together; my current Line Manager and the Organisation I work for are excellent.*

> *I do enjoy the freedom of being my own boss. I love working with the clients in the community and seeing places that I never knew that existed, some big roads and some small bendy wee roads and amazing places, and also working with other staff and other teams.*

> *More challenges, stimulating environment, mentors to help you learn your role and progress.*

Section 5: Qualifications framework and career progression opportunities

5.1 Policy context of workforce development

Strategic drivers in Northern Ireland do lend support to developing the social care workforce through qualifications, CPD and a career framework. A recurring message from the literature is that staff are the greatest asset of the HSC. Transformation requires a modern workforce enabled to respond to increasing levels of complex need. Reform in HSC requires investment in staff (HSC, 2011; DHSSPS, 2011; Donaldson *et al*, 2014; DHSSPS, 2015; Bengoa *et al*, 2016; DOH 2016; DOH, 2018), and the need for a social care career framework has been promoted (HSC & DOH, 2016, Kelly and Kennedy, 2017).

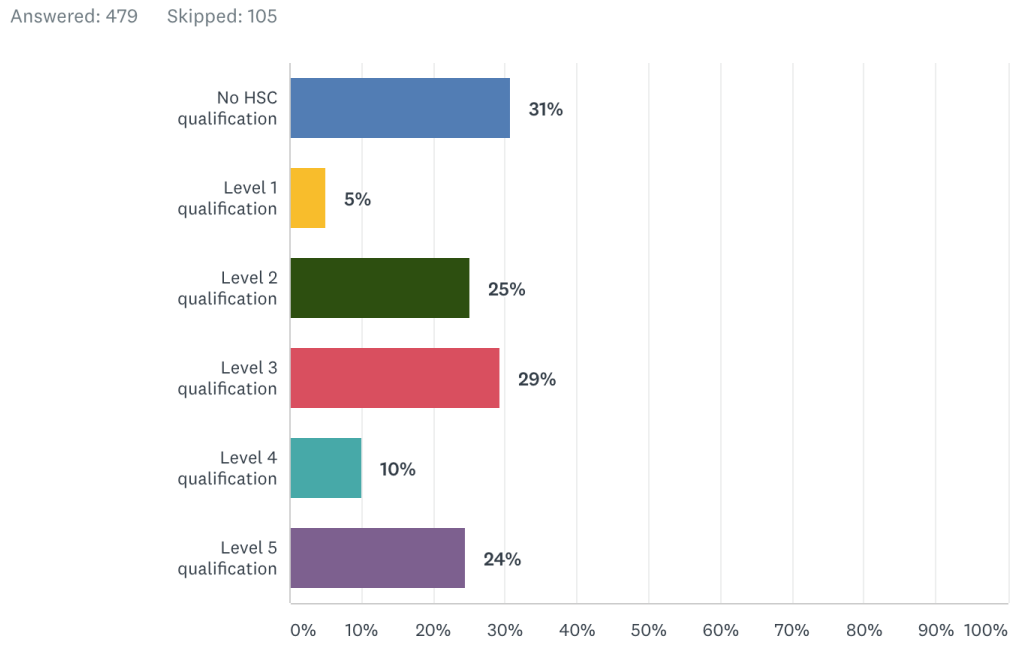
The Domiciliary Care Review provides an action plan for career development and places an onus on employers to create career pathways for staff. The diversity of social care practice provides avenues for advancement into senior or specialist practice roles, management, or into other professions such as social work or nursing (DOH, 2018). The Supporting People Strategic Plan discusses redeveloping supported housing to expand floating support and Housing First places. These initiatives will require staff to engage more autonomously with service users with complex needs, with SCW undertaking risk assessments and managing challenging behaviours (NIHE, 2019). The involvement of SCW in community development work means they will need training, skills development and remuneration appropriate to this type of work (DOH, 2017, 2020a). The proportionality of increased responsibility in delivering theory-informed practice and managing risk should be reflected in rewards and opportunities for staff.

The policy statements and strategic actions outlined in the Department's Learning & Development Strategy 2019-2027(DOH, 2017) are aligned to both social work and social care. This suggests the semi-professionalization of social care. However, there are challenges around recruitment, retention, terms and conditions, and career progression that are unique to social care. This may merit specific and individual attention, as being integrated with social work risks these challenges being overlooked.

The evidence also points to a lack of training opportunities, upskilling, or job roles that are appropriately rewarded and renumerated with salary and personal development. A survey of independent sector staff found that just over half (51%) had relevant vocational qualifications, with staff in domiciliary care and nursing homes less likely to have qualification. Providers indicated a

skills shortage of staff at qualification levels 2 and 3 (NISCC, 2017). Lack of career development can be a deterrent to choosing social care for long-term employment (HSC & DOH, 2016).

5.2 HSC qualifications held (or working towards) by respondents



The survey of SCW found that over two-thirds (69%) held or were working towards an HSC qualification. There were similar levels for HSC qualifications Level 2, level 3 and level 5 qualifications (24%-29%). However nearly one third of respondents (31%) did not have HSC qualifications.

5.3 Motivation for undertaking HSC qualifications

Answer choices	Responses	
To develop my skills & help me in my job	66%	228
To improve the quality of care I provide to service users	53%	185
To get a better job/promotion in social care	37%	130
Advance my career prospects in HSC (e.g., nursing, social work, OT, SLT, dietician)	35%	123
To be a leader/role model for other care workers	32%	110
My employers encourage staff to do qualifications	31%	109
To take on more responsibility in my role	28%	98
It was a requirement for me to get this job	27%	93
To increase my pay	22%	77
Other (please specify)	9%	30

Respondents were asked why they completed qualifications. The most frequent response (66%) was '*to develop my skills & help me in my job'*. Just over half (53%) said it was '*to improve the quality of care I provide to service users'.* When comparing the higher response rates of these two factors with the other answer choices, it suggests that respondents were motivated more so by the needs of service users (being altruistic), than as a requirement (by the position or management) or reward (promotion, pay or career development). The least commonly reported choice was '*to improve my pay'* (22%). While this may suggest that SCW were less motivated by monetary gains, it may indicate the assumption that having qualifications won't necessarily lead to better pay, so would not be a motivator for doing so.

5.4 Why staff have not completed HSC qualifications

Answer choices	Responses	
I cannot afford to pay course fees	41%	104
It is not required for my job	29%	74
Other (please specify)	29%	73
There is no/little reward for doing qualifications	27%	70
I do not have time to study	15%	38
I don't have resources to help me study (Computer, IT skills, books childcare etc.)	8%	20
I couldn't get on the course of my choice	7%	18
I am not interested in studying	5%	12
I am not planning on staying in social care long-term	4%	9

The most frequent reason reported for not undertaking qualifications was *'I cannot afford to pay course fees'*. Three other answers were selected by approximately one-quarter of respondents: '*It is not required for my job'* (29%), '*other'* reasons (some said they had other qualifications) (29%), and *'there is no/little reward for doing qualifications'* (27%). This suggests that rewards and requirements, while not the most significant motivators to undertake qualifications, (as reflected in the preceding question) become more significant, alongside financial barriers, as deterrents to undertaking qualifications.

5.5 Level of 'other' qualifications achieved by social care workers

Level	Examples	Number
Level 1-2	O Levels, GSCEs, QCF, NVQ Level 2, RSA, City & Guilds	7% (n=15)
Level 3	A-Levels, BTEC National Diploma, NVQ Level 3, Access Diploma, LLM business & management	18% (n=38)
Level 4	NVQ	2% (n=4)
Level 5	HNC, HND, foundation degree, diplomas	13% (n=27)
Level 6	Undergraduate degree	28% (n=58)
Level 7	Post-graduate certificate, diploma, masters	11% (n=24)
Other	Unknown, unclassified, qualified nurse*	21% (n=43)

** Eight respondents were qualified nurses, but did not outline the type of qualification held, so the level could not be determined.*

Just over one-third (36%) reported that they had qualifications that were different to the HSC ones listed in the survey. Many provided a list of qualifications held, and these often straddled several levels. For the purposes of analysis, respondents were categorized according to the highest academic level they had achieved:

- 28% held undergraduate degrees (this was the most prevalent response category) and 11% had post-graduate degrees, meaning that nearly two-fifths (39%) had higher education qualifications.

- The second most prevalent category (excluding 'other' as these responses could not be sorted into academic levels) was level 3 qualifications held by 18% of those who answered the question.

- Qualifications in health & social care and related subjects were evident across all levels. Examples include childcare, psychology, nursing, social work, occupational therapy, counselling, sign language, assessors award, first aid, and deaf-blind communication

- Examples of other subject areas included health and beauty, business and management, hospitality, catering, cake decorating, personal training, train the trainer, project management, politics, carpentry, sports coaching, engineering, fine art and reflexology. This reflects a workforce with diverse skills and expertise.

- 82% of respondents have English GCSE (or equivalent) and 70% have maths GCSE (or equivalent).

5.6 Factors that help or hinder staff to complete qualifications

1. Paid time to study and attend classes- Time to undertake qualifications (to study and to attend classes) accounted for over one-third of responses (36%). The comments indicated that staff find it difficult to meet study commitments, when they need to work and/or spend time with their families. Conversely, being given paid time away from work duties, and reallocation of shifts to enable attendance, are enabling factors.

> *Low wages means workers have to work long hours to make ends meet, no extra time to learn.*

2. Support from employers- Assistance from employers and managers also accounted for over one-third of responses (35%) and was the second most frequently cited factor. Support was described in terms of being encouraged to do qualifications, alongside practical measures to assist staff to get onto courses and be able to commit to the requirements of study. Being encouraged pointed to a culture of learning within the organisation:

> *A good annual appraisal instead of handing forms out and filling them in to be sent off. Staff require support and direction to access the appropriate training routes.*

However, some commented on low morale and expectations in developing workers. Several said that staff were discouraged, as qualifications were not required, and others noted issues around equity amongst staff. Workload pressures were reported as a barrier. Poorly managed rotas and staffing issues creates difficulties, with staff having to cover sickness and annual leave. This often results in staff prioritising service user and organisational needs, meaning they have little time for qualifications.

3. Funding for qualifications- The third highest factor was the cost of studying, and the need for financial support to pay for courses. It is helpful when employers fund places and provide paid study time:

> *Being on minimum wage and not being able to afford the fees!*

4. Access to courses and study resources- access was often described in terms of having the opportunity to do qualifications. The responses also explored accessibility in terms of the timing of classes alongside work rotas, the method of delivery (online versus in person), the geographical location of in-person courses relative to where one lives, full or part-time provision. Some also referenced the need for help with IT literacy, access to IT equipment, transport and childcare:

> *Easy access to training venues if possible, more local courses available for the individual's area of choice. Funding /sponsorships for workers to access courses. Realistic timeframe to complete qualifications around other work/family commitments.*

> *Timely information. Flexible working. Management support. Bursaries. 1st rate childcare. Colleague encouragement and support. Access to car/ good public transport.*

5. Incentives & rewards- The incentive to do qualifications is linked to whether there are perceived benefits. This can be weighed against the investment required of the individual. Perhaps unsurprising amongst the sector was a desire for appropriate remuneration. Respondents want rewarded financially, and opportunities for career progression, such as more senior positions or increased pay as recognition for completing qualifications.

> *Financial rewards such as wages or bonus for completing a qualification.*

6. Intrinsic factors- While most of the findings were about factors external to individual workers, some SCW noted intrinsic factors such as age, prior educational experience, or a willingness to learn. It was acknowledged that study requires confidence and motivation. Having had some prior positive experience of learning was also an enabling factor. Several respondents commented that being too old to study was a barrier:

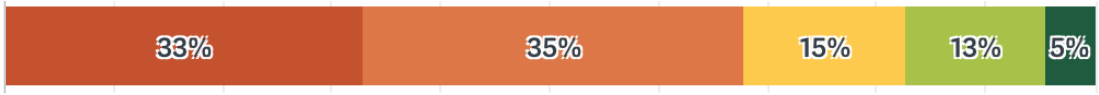
> *I was not allowed to put in for qualification courses from work because I was too old. Only younger people were given the opportunity by gov funding. AGEISM in care!!!!!*

5.7 Social care workers' views qualifications & career opportunities

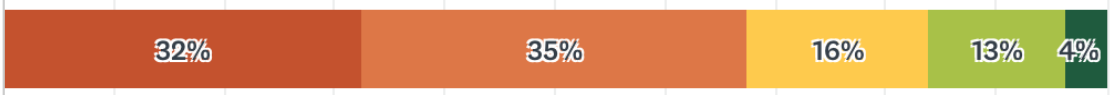
Respondents were asked to indicate the degree to which they agreed or disagreed with statements about social care qualifications and career progression. The results are as follows:

1. Social care staff should have relevant qualifications

2. Having qualifications helps staff to do their jobs better

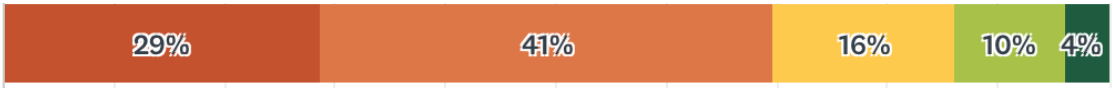


3. Qualifications improves outcomes for service users

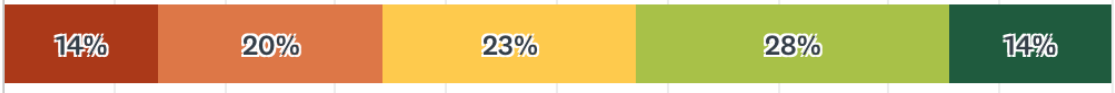


4. Qualifications give staff more confidence to do their jobs

5. Qualifications provide recognition for staff developing in their roles



6. Only staff that have qualifications should be able to get promotions

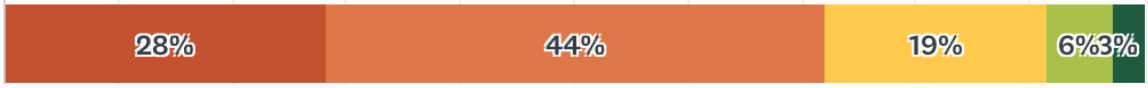


7. Social care staff with qualifications should be paid more than those without qualifications

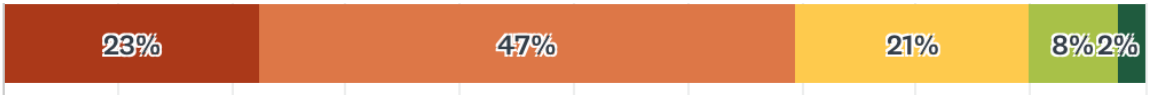
8. Staff who have done training courses (not formal qualifications) should be paid the same as those with qualifications

9. ‘On the job’ training means that qualifications aren’t really necessary

10. Undertaking qualifications in social care can lead to better jobs



11. Undertaking other training courses can lead to better jobs



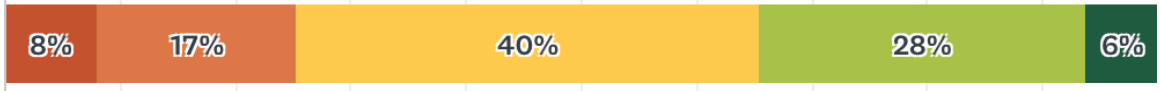
12. It is important for me to hold social care qualifications

13. It is important for me to get regular training to help me do my job well

14. Social care staff should have an HSC qualification to be able to register and work as social care workers

15. There are too many social care workers with qualifications & not enough jobs for promotion.

16. There is too much expectation placed on social care workers to do qualifications



17. Social care workers are not given enough support to do qualifications

Summary points:

- Overall, there was general support for having qualifications and recognition of benefits associated with undertaking qualifications.

- The statement with the largest proportion of 'strongly agree' responses (56%) was "*It is important for me to get regular training to help me do my job well*", which increased to 93% when combining 'agree' responses.

- The statement with the largest proportion of 'disagree or strongly disagree' responses (44%) was "*On the job' training means that qualifications aren't really necessary*".

- The statement with the largest proportion of 'neither agree nor disagree' responses (40%) was "*there is too much expectation placed on social care workers to do qualifications*".

- Respondents were asked about expectations of the SC workforce (Q14-17). A cursory glance shows higher rates of neutrality (which could be also interpreted as an implicit 'don't know' or ambivalence, as beyond their own experiences, SCW may have limited knowledge about the views of the workforce.

- There was acknowledgement that training opportunities are also important. The rewards of promotion and pay should not be the preserve of qualifications, and there needs to be rewards for those who have not attained formal qualifications.

5.8 Social care managers' perspectives of learning and development

The survey of social care managers provided data about learning and development provided to SCW at a range of time points:

	Mandatory/ induction	Supervision/ Appraisal/ PDP/review	Optional/ role/ Specialist	Qualifications
Pre-employment	60%	-	-	-
0-4 weeks	97%	14%	-	-
5-8 weeks	97%	15%	-	2%
9-12 weeks	37%	19%	32%	3%
4-6 months	44%	27%	19%	3%
7-18 months	36% (refresher)	32%	15%	22%
19+ months	49% (refresher)	29%	27%	15%

- Induction and/or mandatory training was prevalent at the earlier time points of employment (97% reported induction activity in the first 8 weeks), and this activity was continued by some at 9-12 weeks (37%), and 4-6 months (44%), and from 7 months onwards (37-49%), reflecting the on-going nature of learning for new staff.

- Supervision, appraisal and/or personal development plans were reported by less than one-third of respondents (14-32%) and featured across all timelines.

- Role specific training (available from 9 weeks onwards) was reported by less than one-third of respondents (15-32%)

- At 7 months onwards there is a significant increase in the provision of vocational qualifications (22%), and up from 2-3% at earlier time points, albeit the rates remain low.

- In summary as the induction phase declines, and staff become settled into their roles, other learning and development activity increases. While

the response rate may appear low, respondents were not asked about any particular type of activity. Furthermore, these findings are from a small sample (n=59) and cannot be generalised to the wider population. The findings reflect that there is no significant presence of qualification-based training in the early career stages. Further research could examine learning and development activity for more experienced staff.

5.9 Access to relevant qualifications through work

Qualification	Responses	
Level 2 Diploma in Health & Social Care (Adults)	73%	(n=40)
Level 3 Diploma in Health & Social Care (Adults)	84%	(n=46)
Level 4 Certificate in Principles in Leadership & Management	25%	(n=14)
Level 4 Diploma Adult Care	15%	(n=8)
Level 5 Diploma in Leadership & Management for HSC (Adult Care)	64%	(n=35)
Level 5 Diploma in Leadership & Management for HSC (Adult Residential Care)	33%	(n=18)
Other health & social care qualifications (please specify)	22%	(n=12)

The survey of employers indicated that staff could access qualifications through work. The majority of respondents reported that staff could complete the level 3 Diploma, the Level 2 Diploma. Approximately two-thirds reported that staff could undertake the Level 5 Diploma in Leadership & Management for HSC (Adult Care), and one-third said staff could do the same qualification for Adult Residential Care.

5.10 Organisational support for social care workers undertaking qualifications

Support activity	Responses	
Provide funding	70%	(n=40)
Provide day-release	70%	(n=40)
Provide study time	65%	(n=37)
Provide backfill	25%	(n=14)
Mentoring	67%	(n=38)
Coaching	40%	(n=23)
Other (please specify)	14%	(n=8)

Respondents were asked what their organisations did to support social care workers who were undertaking qualifications. Nearly three-quarters said they provided funding and day release to support staff undertaking qualifications. Approximately two-thirds provided mentoring or study time. Two-fifths provided coaching while one-quarter said they provided backfill for staff released from duties for study leave. Several respondents commented on other ways in which they support staff. Examples included signposting, helping staff to access external funding, the provision of vocational qualifications and assessment within the organisations (e.g., being an assessment centre), and encouraging a group of staff to do the qualification at the same time, so they can have peer support.

5.11 Other learning and development or qualifications supported by employers

39% said that they provided support for other types of training or qualifications. The same number reported other qualifications they would like to assist staff in obtaining. Five respondents commented on barriers around qualifications:

> *Yes, but there is so much pressure to increase capacity it can be difficult to find the time to release staff. With a value based workforce as staff progress their skills, we often find significant gaps in their essential skills, e.g. maths and English, though we really need to add ICT as an essential skill. Therefore whilst they are capable of progressing, the gaps identified can be a barrier to them progressing into a more manager office based role.*

> *We would like to be able to offer all staff the opportunity to attain qualifications. However, as a small provider we find this difficult to fund ourselves.*

> *As you can appreciate when funding is cut the training budget is the first to go. However, we have initiated E learning to compensate for this inhouse. We have also fundraised to get training for our staff and all Managers have a NVQ Level 5 Qualification. All staff have NVQ Level 2 and 3. One good thing during covid is that there was lots of free training, which our staff availed of.*

These quotes reflect the challenges around widening access, funding and delivery that impede opportunities for staff.

Section 6: The voice of social care

In any proposed reform in HSC, it is important to involve the workforce. Responses to the DHSSPS Consultation on the Future of Adult Social Care said that staff need to be listened to (DOH, 2013). The Delivering Together report outlined a commitment to working in collaboration with staff and highlighted the negative experiences of staff in previous change initiatives. Yet:

> *Social care workers are the silent majority in our health and social care system* (NISCC, 2017:6)

As social care operates across the HSC system, it is important that social care has enhanced representation at strategic and leadership levels. There are professional bodies and professional leadership posts for other occupations within HSC. Social care workers' needs are often subsumed within discussions about social care service delivery and alongside social work. This can make SCW needs invisible.

The findings from the survey of SCW and the policy review both assert the need for relevant advocacy and representation, a recommendation proposed by Kelly and Kennedy (2017: 59):

> *"That the NISCC further considers the representation of the social care workforce in the development of a professional body to ensure that the voice of frontline staff is effectively heard in the transformation of care strategy."*

As a regulator, the Council would not have a remit for this recommendation. However, the Council can use its workforce data and intelligence and engagement with the sector, to inform developments and influence others about social care reform that is needed. The Council and DoH are undertaking reform work for social care, and trade unions represent the (mainly statutory) social care workforce alongside other staff groups. There remains an opportunity for the provision of leadership such as Social Care Champions, to advocate specifically for the social care workforce.

Section 7: The future of social care

7.1 Future career plans

The survey asked respondents about their future career plans and provided the list of responses below:

Answer choices	Responses	
I am happy with the job I do & have no plans to move	36%	167
I am not interested in advancing my career	8%	35
I would like to do more training but not qualifications	11%	52
I would like to do more qualifications	36%	168
I would like to get a better job in social care	40%	186
I am working towards progressing into other professional roles (e.g., nursing, social work, OT, dietician)	16%	75
I would like to leave social care	12%	57
Total respondents		464

One-third of responses indicated a ‘no change’ scenario, with (36%) being happy with the job they do and have no plans to move and 8% were not interested in advancing their career. 12% wanted to leave social care, and 16% wanted to move to other professions, higher numbers wanted to progress but remain in social care, with 11% interested in doing more training, 36% wanting to do complete qualifications, and two-fifths (40%) said they wanted to get a better job in social care.

7.2 Aspirations for the future of social care

347 social care workers told us about their aspirations for the future of social care. Perhaps unsurprising the topics raised correspond with the challenges regarding the worst things about working in social care. Respondents want to see improvements in rates of pay (and related terms and conditions), with better equity and fairness; recognition and appreciation for the work they do; better opportunities for qualifications (and/or training) and job promotion; and better support from employers, work practices and good staffing levels.

> *I would like salary scales to reflect qualifications and experience. I would like to see minimum mandatory qualifications to ensure staff are trained properly beyond tick box in-house training…I would like to see staff have a defined career pathway. I would like to see social care staff celebrated. These will help retain amazing care staff who we cannot afford to lose to sectors such as retail and hospitality, that pay more money and provide better conditions with a fraction of the responsibility.*

> *I would like us to be recognised not as a homogenous workforce, but a workforce that is progressive and has different skills and levels that are*

recognised. Years ago, it was more like a home help service, but now we are doing the job of District Nurses. We do basic wound care, catheter care, reposition, we are IDDSI trained to deal with swallowing difficulties. I get paid the same to make a cup of tea as I do when I am looking after a very complex service user, for example someone with Motor Neurone Disease, or end stage cancer. We are also more equipped to support and recognise mental health issues

Management posts going to individuals who have worked in social care.

A better system in order to give the time and respect to the clients, more funding to the social care sector but not siphoned into middle management to cover the many examples of the peter principal which abound.

When asked, social care workers articulated their visions for the workforce. If we wish to have a transformed and stabilized workforce, we need to ask them more questions about what they need and make a commitment to deliver better prospects.

Section 8: Key messages and conclusion

Messages from each review, policy document or strategy reinforces and builds upon the position asserted from previous reports; there needs to be investment in the social care workforce. The evidence base is unequivocal on this point. Delivering good social care requires a stable and valued workforce (NISCC, 2017).

The issues surrounding social care are well documented, as are the solutions explored in this report and elsewhere. Challenges and issues highlighted above, provide a compelling argument for the need for a whole-systems approach to workforce development.

- The survey findings illustrate a motivated and dedicated workforce that is committed to their roles, service users and colleagues.

- While some respondents have positive experiences of their role, remuneration and opportunities, adverse circumstances are clearly prevalent and need to be addressed.

- Social care workers report a lack of recognition and respect for the work they do, the skills and expertise they bring to caring. Social care workers want to be valued and respected. They need champions who will advocate for them, providing recognition of their contribution across the HSC system, and improved parity of esteem with HSC colleagues.

- Social care workers want better terms and conditions that promote equity and 'levelling up' between the sectors, and payment of a 'living wage' that better reflects the responsibilities of social care work.

- Social care workers want supported educational and career opportunities that enables social care to be a career choice, with different trajectories of career advancement (practice and management). Similarly, any career progression framework should cater for those who wish to remain in their present role and level of work with learning and development opportunities to enable them to deliver for service users. This will enable people working across the continuum of social care to be valued for the work they do.

There is a real need for concerted and timely change. We are reminded about the impact of inertia and lack of progress by Kelly & Kennedy's review:

> *"Plenty of reviews and lots of evidence but no action. This statement echoes the comments made in Professor Bengoa's report... which rather compellingly refers to 'review fatigue'. We sincerely hope that this paper will not be read as 'just another report', but that it will help in encouraging the radical rethink or 'reboot' we believe is necessary to challenge the current approaches, attitudes and established ways"*
>
> (2017: 11)

Leadership, investment and decision-making is needed. Recommendations, strategies and action plans need implemented. In the absence of a functioning government this remains a challenge. However, there are opportunities to make meaningful change that with creativity and vision, can be implemented in the current political landscape. It is acknowledged that there are on-going initiatives, such as the Skills Academy, the Apprenticeships Framework (albeit with age and sector barriers), and on-going work regarding traineeships, and wider reform of social care. We need to address the skills gaps identified, improve career opportunities in social care and expand the workforce to address the increasing and more complex needs. There needs to be radical reform to address the challenges that affect recruitment and retention of the workforce.

There is a responsibility on cross-departmental local and central government and social care providers, to collectively invest in a sustainable social care workforce that is responsive to societal needs and is valued and rewarded for the work they do. It is a compelling argument to invest in social care, and there is an imperative to get it right. Any reform has the potential to impact our lives personally as well as professionally, as we may be future recipients of social care services.

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