Appendix 4:

Workforce issues in housing with care for adults with high support needs

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Background

Four key areas for exploration were outlined in the project brief for this review:

- skills and competencies;
- resources and support, including training;
- the role of specialism;
- key questions for funders and commissioners.

Identification of sources for this review

The review draws on existing evidence, knowledge and understanding gained from published material, including literature from reports, research, discussion papers and so on. It outlines what is known and perhaps what needs to be known. In essence this is a scoping review that both maps the range of literature in this field and sets out the gaps in the evidence base.

This scoping review started with an initial search of the references from major reports and studies already known to the project team, such as the reviews by Croucher et al. (2006) and Dutton (2009), together with the materials contained on the Housing Learning and Improvement Network (LIN) site. This helped inform the search strategies. The inclusion criteria were as follows:

- published in the UK after 2000;
- included the range of professionals with housing support, care and treatment roles (managers and direct staff), as well as less qualified workers;
- excluded family members or carers and other supporters in volunteer roles.

The importance of ancillary workers, such as cleaners or kitchen staff, has emerged but there is very little research focusing on this workforce in housing with care settings (or indeed in social care). The review was conducted in relation to adults, particularly older people (as outlined in the project brief) although there is a very small body of literature applying to other adults. The following electronic bibliographic databases were searched:

- Applied Social Sciences Index and Abstracts;
- Social Care Online and the SCIE research register;
- Google (with specific terms).

The third stage involved the searching of the following websites (and any others that emerged) for relevant studies or reports:

- Centre for Policy on Ageing;
- Thomas Pocklington Trust and other providers of housing with care in the third sector and the commercial sector, as well as the statutory sector;
- Beth Johnson Foundation;
- Department of Health;
- Department of Communities and Local Government;
- Age Concern/Help the Aged;
- Skills for Care;
- Housing LIN;
- Elderly Accommodation Counsel.

A set of telephone interviews and discussions were undertaken to confirm the saliency and continued relevance of the published material. In an iterative process, comments were received on drafts of this review to achieve greater confidence that material was up to date and that relevant matters had been covered.
The social care workforce: brief policy summary

Recent years have seen a steady increase in policy attention to the social care sector in England and its workforce. Government has sought to improve standards of care and support through initiatives such as the first ever national adult social care workforce strategy for England (Department of Health (DH), 2009a) with a view to meeting the aspirations for more personalised adult social care, set out in the ministerial concordat Putting People First (HM Government 2007). While the workforce strategy (DH 2009a) does not mention extra care or housing with care by name, it notes that what it terms ‘primary social care staff’ work with the wider frontline social care workforce in sectors such as housing and it remarks on the progress in integrating public services workforces (para. 87).

At the same time, the social care sector has undergone considerable structural and workforce change, most obviously with the continuing move from local council to private and voluntary sector provision, but also in the attempts to tailor services to new goals. Central to these changes has been the ambitious shift of the personalisation agenda (HM Government, 2007) with its purpose of facilitating greater choice and control among people receiving social care support. While this is generally applied in the context of home based care; it is also being thought about in the context of housing with care services, relating, for example, to the ethos of ‘More Choice, Greater Voice’ (CSIP, 2008) that sets out a typology of housing with care services.

In talking of raising standards and improving choice and control for users of social care, the need to develop a deeper understanding of the workforce often arises. But there is a tendency to see the workforce as part of the problem (responsible for poor quality care, inflexible services, building based provision) as well as part of the solution (able to provide more personalised and relationship based care, enhance independence and dignity). These themes thread through this review.

But first, we need to explore the workforce supporting older people with high support needs in housing with care provision. In this review we focus on the paid workforce, acknowledging that many families and volunteers provide significant amounts of care and support. We focus on staff in housing with care services; noting the importance of visiting NHS practitioners or other more specialist staff (these may be a key resource in helping staff manage difficult behaviour or distress, or supporting people who are dying). As well as care or support staff, the sector includes other components of the housing with care workforce, such as scheme managers, activities co-ordinators and ancillary workers (the latter not always explicitly mentioned in studies).

However, the very size of the sheltered housing and extra care sector is uncertain. At the moment there are about 4,000–5,000 non-regulated (by the Care Quality Commission) residential care-providing establishments in England according to Eborall et al. (2010, para 3.3.3). While these include staffed hostels and small group homes, this does include much extra care provision, the latter offering an estimated 20,000–35,000 units. These estimates will be revised following the start of CQC regulation of supported living and extra care housing under the Health and Social
Care Act 2008, being implemented in October 2010. From this, we are likely to know much more about tenants and owners, and importantly, about staff.

It is hard to distinguish workers providing care and support in housing settings from other members of the social care workforce (or indeed those working with people with high support needs from others). Only recently have systematic data emerged on the estimated 1.75 million paid jobs in adult social care (Eborall et al., 2010), in line with information on the health and education workforces. Through substantial investment, development of IT systems and in co-operation with the approximately 17,300 employers in the sector (including 40,600 establishments), Skills for Care (the social care sector skills council), has been generating a National Minimum Data Set for Social Care (NMDS-SC), including a classification of job roles (see Box 1).

The importance of this wider workforce to housing with care services is widely noted. Dutton argues:

The focus of research, policy, and providers needs to shift from silos and competing interests to common issues that cut across settings. E.g. recruitment and retention of care workers is a problem for all long-term care settings including extra care, nursing homes and home care.

(Dutton, 2009, p. 37)

Key features of the social care workforce overall are its low wages, its large numbers of part-time staff (facilitating some flexibility) and its horizontal and vertical gendered segregation – the former term used to describe the tendency for women to be in different jobs or occupations to those of men and its high morale and well-being (vertical segregation means that, within a particular occupation, women tend to hold the lower status and lower rewarded positions).

Box 1  Summary of the National Minimum Data Set for Social Care

The National Minimum Data Set for Social Care (NMDS-SC) is the first attempt to gather standardised workforce information for the social care sector. It is developed, run and supported by Skills for Care and aims to gather a ‘minimum’ set of information about services and staff across all service users’ groups and sectors within the social care sector in England. The NMDS-SC was launched in July 2007 and since then there has been a remarkable increase in employers completing the national data set. At the time of writing, there is under-representation of local authority employers as the NMDS has concentrated on the independent sector.

Two data sets are collected from employers. The first provides information on the establishment and service(s) provided as well as total numbers of staff working in different job roles. The second data set is also completed by employers; however, it collects information on individual staff members. Skills for Care request that employers advise their staff they will be providing data through the completion of the NMDS-SC questionnaires. No written consent from individual members of staff is required, however, ethnicity and disability are considered under the Data Protection Act to be ‘sensitive personal data’, thus consent for passing on these two items needs to be explicit.
The question arises whether it is possible to separate the workforce supporting people with high support needs in housing with care services from other staff groups in terms of data analysis and workforce strategies. At the moment, the NMDS-SC presents data by location and type of worker, so that some sheltered housing social care staff are distinguished from care home workers, for example. As Eborall et al. (2010) point out, some sheltered housing and supported living services are recorded in the UK Standard Industrial Classification of Economic Activity under SIC2007 68210 (renting and operating of Housing Association real estate). This is different from the division covering social care – 87 for residential social care activities.

In both sectors, direct care workers are distinguished from ancillary and other non-direct contact staff, although the contribution of workers such as cleaners, gardeners, cooks and so on is clearly important to tenants or residents. In light of the difficulty in distinguishing people with high support needs from others using care and support services, it may not be possible to identify which groups of staff work with people with high support needs, other than by registration status of the care provider. Overall this provides an important indication, but the moves to encourage continuity of care mean that boundaries are increasingly blurred. The brief points below outline two ‘hot spots’ of workforce issues in this sector overall.

1) **The vacancy rate in the social care sector** is double that for all types of industrial, commercial and public employment (Eborall et al., 2010). Many vacancies in social care are termed ‘hard to fill’ and this is generally attributed to the existence of skills gaps (that is, there is a shortage of suitably qualified candidates), rather than to there being an overall shortage of applicants. In terms of turnover, there is evidence that most social care workers leave to work for another social care employer or the NHS (‘churn’). Only a minority switch to the retail sector (Adams and Godwin, 2008; Hussein, 2010), although anecdotal reports suggest that this is a frequent occurrence. Predictions of the impact of the current recession are that there may be greater retention in the sector (King and Howarth, 2009). Within this context of staff recruitment and retention, Nelson (2006) describes a tailored approach to local recruitment in inner London Tower Hamlets to address workforce vacancies but also to increase the diversity of the staff group. We have little evidence of the effectiveness of various recruitment and retention strategies in the housing with care sector overall. It would be interesting to see if housing with care shares a general local pattern of shortages or skills deficits; or indeed that the experiences of some areas are commonly shared, in that jobs are easily filled by good quality candidates.

2) **Reliance on migrant or overseas workers**: Faced with shortages, some employers have looked to international recruitment as a way of managing staffing vacancies. While this is not a new phenomenon, the advent of the A8 EU accession states (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia) resulted in new ‘sending countries’ in addition to traditional sources, such as the Philippines. For people with high support needs, these staff may be valued; may possess health-related qualifications and be hardworking; however, there are concerns that supply may be unpredictable; that new immigration controls may continue to restrict entry from outside the EU; and that familiarity with local idioms, English language and care practices may be limited (Sale, 2005; Smith et al., 2008) (see Hussein et al., 2010). Research suggests that reliance upon migrant workers is
uneven, with providers in London and the South East in general and the private sector, in particular, being most reliant upon workers born outside the UK (Cangiano et al., 2009). The reliance on migrant workers in housing with care services, their contribution and needs, have not been measured.

In addition to initiatives developed by employers, the government is seeking to improve recruitment and retention, with national media advertising campaigns aimed at improving the status of social care and attracting more people to work in the area. The government has also sought to improve retention by providing additional funds for training, including offering money to employers to enable staff to undertake National Vocational Qualifications (NVQs) and to receive induction training. Evidence suggests that NVQ initiatives have permeated the sector with some notable successes – for example, in terms of the number of managers with qualifications at least at NVQ Level 4 – but that success has been differential with larger providers being better placed to offer NVQ qualifications to all staff (Gospel 2009). Apprenticeship schemes have recently been offered to the sector for young people without employment, under the title Care First Careers (HM Treasury, 2009b).

To illustrate work on offer in this sector, Box 2 summarises a recent (March 2010) staff advertisement.

**Box 2  Job vacancy, Midlands, March 2010**

*Personal Support Assistants (Care Workers)*

Day time 16 or 24 hours per week  
£6.89 to £7.87 depending on qualifications  
Night time 18 and 27 hours per week  
£6.89 to £7.87 depending on qualifications  
+ £0.50 per hour night allowance

Friendly? Caring? Committed? Our residents need you to provide all round support, including personal care, issuing medication, cleaning and laundry. You’ll actively encourage residents to get more out of life emotionally, physically and intellectually and have a can do attitude whilst performing a very demanding role.

The following sections outline four areas of particular relevance to workforce provision and performance.
Skills and competence

The Care Quality Commission (2009) states that the health and welfare needs of people who use services ‘are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job’ (p127) However, there are arguments that some social care employers will find it difficult to build up a workforce with this level of skill given that ‘poor employment conditions are embedded in the contracting system’, with some commentators asserting:

The universal right to care is based on cheap labour. Attempts to improve service quality through regulation, training and choice are undermined by the fragmented supply system. The result is a low and deteriorating quality of employment in elderly care.
(Rubery and Urwin, 2009)

Training has been identified as an important way of improving recruitment and retention and of ensuring that workers have the skills to meet the future demands of their role, although it has been observed that the provision of training may not be enough on its own to improve skills and thus the quality of care (Wanless, 2006). The Learning and Skills Council is responsible for planning and funding vocational training in conjunction with the Sector Skills Councils. Results from the English National Employers Skills Survey (NESS) show investment in funding training for social care workers, albeit from a very low base, with Skills for Care spending an average of £2,000 per employee per annum compared with the average of £1,550 in the other sector skill councils (Learning and Skills Council, 2006, p17). This has resulted in a considerable increase in the number of care staff with NVQ Level 2 or 3 qualifications (Gospel, 2008; Rainbird et al., 2009).

However, it is estimated that many direct care workers may lack some of the skills needed to learn effectively. Others may not have the fluency to follow training delivered in English so it has been suggested that estimates of the funds needed to provide vocational qualifications might need to include funding for these additional needs (support is available for those needing help with literacy).

Training is seen as the answer to almost all the problems of social care, including difficulties of the social care workforce (Manthorpe, 2008). It is cast as a way of improving recruitment and retention and of ensuring that workers have the skills to meet the demands of their role. Of course, it is not a ‘magic bullet’ as the provision of training may not be enough on its own to improve the quality of care (Wanless, 2006) but, for a number of reasons, training is seen to be crucial. The quality of training is less a feature of research than its quantity; thus new moves to endorse training are being developed by the National Skills Academy for Social Care and the National Dementia Strategy (DH 2009b) which explicitly voices its interest in improving the quality of training (as much as its quantity). These debates may be more advanced in social care than in housing sectors where management functions over buildings, resource management and marketing may be distinct from care provision.

Within this debate, there is agreement that direct care workers need a wide range of skills (Fleming and Taylor, 2007), although it is not clear whether housing with care work with people with high support needs necessarily differs from skill sets for care
home or home care workers. Nationally, 66 per cent are working towards a relevant qualification (Skills for Care, 2007) (as illustrated by Box 3). Regulations have substantially accelerated the pace of training (Gospel 2009) meaning that while incentives have their place, it is compulsion that has worked for many (‘stick more than carrot’). The positive relationship between levels of training and outcomes is supported by evidence from some studies (for example, Godfrey, 2000; Bourgeois et al., 2004; Kuske et al., 2009)

Some researchers argue that there is a mismatch of staff attitudes and the capacities (meaning disabilities) of older residents in housing and care settings (here classified as sheltered/very sheltered housing and care homes) (Abbott et al., 2000). However, other researchers focus more on the necessity of skills in ‘building communities’ that may be needed in housing with care facilities. Callaghan et al. (2009), for example, describe how staff in newly opened extra care schemes began to develop social activities and community engagement during the first six months, identifying and addressing facilitators and barriers to social participation.

These forms of skills and competencies may not be covered by more clinical or personal care curricula, such as NVQs. One key area for research could be to assist in the development of a consensus about the skills and competencies of housing with care staff. If NVQs are to change, then this may be an ideal opportunity to debate what training might look like and the evidence base for the choices that will need to be made. Much will depend on what people are being employed to do.

Interestingly, the Standard Occupational Classification of job roles (SOC2000) from the Office for National Statistics (ONS) makes some key distinctions between the role of Housing and welfare officers (3232) and of the role of Care assistants and home carers (6115). Skills for Care (2009) notes that there are as many as 27 different roles in social care. These roles are well worth exploring to see if hybrid roles or new ways of working are being developed in extra care.

Will there be further compulsion and greater incentives for training: providing at least minimum levels? Gospel (2009) argues that so far this has been a policy success, with perceptions that this was a burden for the sector largely dispelled (citing a Cabinet Office report that it had been a ‘wake-up’ call to the sector). However, we should not assume that there will be resources to fund training as much as it is needed or desired. It may be necessary to develop some priorities.

Alternatively, will there be an influx of skilled workers in the sector, if nurses, therapists and activities co-ordinators are attracted to social care and housing with care employment, bringing their specialist skills in rehabilitation, dementia and palliative care at managerial and supervisory levels, if not to frontline care. Will new investments in social care (e.g. the National Skills Academy for Social Care) promote an expansion of leadership skills among managers and senior practitioners? If yes, this might stem the flow of care workers upon the gaining of qualifications (indicated in Hussein, 2010) into the NHS and create two way traffic and exchange of skills, good practice and learning opportunities.
Box 3  Job vacancy in housing with care complex or village, Midlands, March 2010

Team Leaders

(22.5 and 30 hrs per week) £9.33 - £9.89 per hr entry level rates, depending on qualifications

We’re looking for a number of experienced Team Leaders capable of taking responsibility for managing teams of Personal Support Assistants, providing the full range of support and personal care services to Village residents.

You will have a hands-on role in planning services for residents, making sure that support packages are flexible and tailored to individual needs. You’ll be committed to achieving high standards and have good leadership skills. You will be responsible for recruiting, training and the ongoing development of your team members and will have previous supervisory or management experience. You should be qualified to NVQ Level 3 in Social Care or be prepared to work towards this standard.
Resources and support, including training

In a research based document, the Institute of Public Care (IPC) (2005) identifies some ways in which housing with care staff may be supported (see Box 4). This is an unusual approach because the well-being of staff is not often addressed. Widespread calls for training are commonplace in housing with care services, but are not generally set within the context or culture of their employment. The IPC report also outlines a research based set of competencies which local authorities, registered social landlords, voluntary and independent sector providers may use in defining the tasks and duties of scheme managers. Such material highlights how extra care managers have much in common with care home managers, but the demands on housing with care managers may be changing and complex.

Much depends on the ways in which managerial duties are allocated, for example, if ‘care’ and ‘housing’ are under different managerial hierarchies. The former may rely heavily on the culture and practice of social care; the latter on traditions related to hospitality and leisure. Joy (2008), drawing on the experience of the housing with care provider Brunelcare, describes managerial work in extra care as including responding to the possible distressing symptoms relating to dementia though seeking support from other professionals, to permitting extra staffing when necessary, and increasing the dignity, independence and quality of life for residents, through hugely varied interventions around person-centred care, building design, educating relatives, keeping active and making the most of technology. The extent to which these are similar in other settings and among providers might be worth investigating.

Longitudinal and in-depth studies involving managers may be important to secure recruitment and leadership skills (similar to studies of social care managers and nurse managers). These would help in determining if the skill sets identified by Croucher et al. (2006) as part of the roles of scheme managers are unique or if they are converging with those of other managers in health or social care (NMDS-SC job role: Front line manager (M)). While managing housing with support may be different from managing other community or residential facilities, we do not have evidence about different managerial layers and the ways in which they gain support, build up their own networks or operate in business environments and corporate settings. Current work by the Personal Social Services Research Unit (PSSRU) at the University of Kent may assist in developing answers to these questions.

Box 4 Staff characteristics and outcomes

A safe and facilitative working environment

Characteristics:
1. Staff day room.
2. Staff training room.
3. Rooms and facilities for staff providing waking and sleep-in night cover.
4. The provision of a safe and attractive working environment.

Outcome:
A working environment which attracts and keeps high quality staff, and contributes to morale and team building.
**Trained and supported staff**

Characteristics:
1. Well paid, well trained staff with a definite career pathway.
2. Clear lines of management and financial accountability.
3. An understanding of one’s own role and that of others.

Outcome:
Support for the expansion of a skilled ECH workforce committed to empowerment of older people and the provision of a high quality of life.

*Source: Institute of Public Care (2005)*

Regulation has been one of the major ways by which the government has sought to raise standards of social care as well as directing what it wants from the workforce. The passage of the Care Standards Act 2000 and the complementary legislation in Scotland, the Regulation of Care (Scotland) Act 2001, established a set of National Minimum Standards covering issues such as the level of training received by staff and the establishment of a social care register (see below), recently superseded by the Health and Social Care Act 2008 (Regulated Activities) and the 2009 Regulations.

There are strict standards for entry into social care work and similar work with ‘vulnerable people’, including criminal record checks. Following the passage of the Safeguarding Vulnerable Groups Act 2006, a new Independent Safeguarding Authority (ISA) has been set up to check people’s suitability to work with children and vulnerable adults and prevents people deemed to be unsuitable from working in this area. The definition of a ‘vulnerable adult’ is broad and it is likely that many housing with care services will need to register with the ISA and will need to be aware of their responsibilities under the Act and what constitutes regulated activity. At the time of writing, the ISA is under review (August 2010).

In addition, all four UK countries have established Social Care Registers. These registers of people who work in social care, who have been assessed as trained and fit to be in the workforce, following checks on their qualifications, health and ‘good character’. Currently only social workers and social work students in England are covered (and it has been announced that care workers’ registration will be voluntary), but progress adding other workers to the register in other UK countries has been faster. The housing with care sector will need to be alert to the implications for staff teams if registration categories are enlarged. At the time of writing (2010), this looks unlikely.

However, in all four UK countries, Codes of Practice for Employees are used to hold social care workers to account for their conduct. There have been calls for the parallel Employers’ Code of Practice to be placed on a statutory basis. Research in this area has not covered the housing with care sector or the interface of the Codes with the voluntary Code of Practice for Housing-Related Support produced by the Centre for Housing Studies.

While such matters relate mainly to ‘care’ provision, it should not be forgotten that housing with care may be subject to complex sets of regulations; the Care Quality
Commission (covering care and treatment), the Supporting People Quality Assurance Framework covering housing-related support and the Tenant Services Authority (TSA) covering housing management and provision (TSA, 2010). The impact of possible gaps and overlaps related to staffing might need to be investigated. At the least, the ability to manage multiple regulatory demands may be an aspect of managerial skill that could be explored to see if scheme managers find this work particularly burdensome or welcome the checks and balances entailed. One area for particular exploration might be the practical implementation and the effectiveness of the new principle of co-regulation espoused by the TSA (2010). Might this lead to better outcomes than other more formal scrutiny? Can it flourish in the context of other regulation applicable to care services?
The role of specialism

Is there a housing with care workforce? There was no great agreement on this term in the consultation undertaken for this review. There is some suggestion that there is a ‘housing support workforce’ (Cameron, 2010) but this workforce is largely employed in community settings, such as ‘floating support’ for individuals living in their own homes or social housing, as opposed to extra care or very sheltered housing or similar. Foord and Simic (2005) argue that the changes which have taken place in supported housing over the last few years have probably been greater than in any other aspect of housing. They detect almost a new profession of ‘housing carers’, but this term is often used to mean that the worker is promoting ‘independence’ (almost the avoidance of social care support) rather than providing personal or quasi-nursing care (though the two are not mutually exclusive.

In a review of the use of the term ‘support workers’, Manthorpe et al. (2010) observe that the term is being applied to a very wide range of roles and that the addition of, say, the word ‘housing’ to the term ‘support worker’ does not necessarily mean that there is any greater clarity of role. For people with high support needs, a variety of terms such as ‘care worker’ or ‘senior care worker’ may be in use and the use of the term ‘support worker’ may be highly misleading.

Manthorpe et al. (2010) recommend for great clarity of roles in the sector, highlighting the risks that may emerge if there is misunderstanding about a worker’s level of skill and competence, or ambiguity about their role. As noted above, the Independent Safeguarding Authority (ISA), after review, may help clarify terms such as ‘vulnerable people’ but also the extent to which staff working in care settings contribute to their support (see, for example, the case illustrated in Box 3 where it is arguable that the person does have regular contact with vulnerable adults and would need to register and to be checked by the employer with the ISA if this is not substantially revised).

Wright and colleagues (2010, advance access) also comment on the confusion about roles that currently exists in extra care housing. They highlight the tensions that occur between some residents/tenants and staff over the specific roles of housing and care workers. In their study they observe residents and care staff disagreeing at times about the extent to which staff should promote independence among residents and residents’ preference for greater amounts of reassurance and support than either the scheme or individual workers deem are necessary.

The case for specialist or generic workers in care settings, or undertaking the care of specific populations, is under discussion. In light of current policy efforts to improve the care and support of people with dementia (a group where many people may have high support needs), there are moves to make some aspects of dementia care a ‘specialism’ with greater consistency of approach to training and competence (in line with the National Dementia Strategy, DH 2009b) but to acknowledge that general skills in dementia care will be needed by many public service workers.

Work by the Personal Social Services Research Unit (PSSRU) at the University of Manchester (Prof David Challis) is exploring the evidence behind dementia specialisms in home care, while Darton and Callaghan (2009) observe that new
extra care housing is anticipating dementia support as integral to its provision of care – as an aspect of what might be called ‘core business’ (and therefore not a specialism). Garwood’s (2010) commissioning checklist for extra care housing and dementia covers workforce issues in section 7. She warns of the danger of mismatches between the needs of people with dementia and the numbers of staff able to support them, but also the risk of poor outcomes if workforce practice is too ‘skeletal, prescriptive and time and task based’. However, it is also important for staffing to provide continuity and consistency, and for housing and care staff, if they are separate, to have good training, leadership and support.

Likewise, better awareness of the importance of nutrition and hydration among older people with high support needs is being encouraged as part of the skill set for all staff and supporters, not just clinical or care professionals. This relates to growing attention to problems that may lead to inpatient admissions if left undetected. The ability of staff engaged in general health promotion activities to identify when precisely to call in professional or expert assistance is not known.

However, there is evidence of specialists emerging and being encouraged. Burns et al. (2009) provide a case example of Rowan Court’s specialist service for people with dementia in combining a social housing model with on-site specialist domiciliary care and the remodeling of sheltered housing often includes such developments (Croucher et al. 2008). Further clarification of what is ‘specialist’ might be warranted and whether models of provision where there is a specialist adviser ‘on site’ or ‘on tap’ may need investigating to see which is most cost-effective. There is by no means agreement over which types of specialist advisers might be needed and why. Still less, do we know about the creation and sustaining of such specialists and what might work well here?

It is possible, therefore, that while the term ‘dementia’ can cover various symptoms with degrees of severity, work in housing with care settings may involve support of people with high levels of disability, fluctuating health status and exhibiting possible challenging behaviour (some of this may relate to the levels of health need and disability when taking up tenancies/leases or may emerge later on). Commitments to providing continuity of care may entail larger numbers of registered nurses (Wild and Szczepura, 2008); access to staff willing to work flexibly, and care workers who are confident in providing palliative care, manage risk and restraint if appropriate, and reducing the distress of challenging behaviour (recent resources from the Social Care Institute for Excellence (2009) explore requirement for the safe use of restraint and the Mental Health Commission for Scotland (2007) covers ‘Safe to Wander’).

This is in addition to the skill sets necessary for the evidence-based application of psychosocial interventions in dementia care (see, for example, the description of reminiscence activity in an extra care housing facility in Liverpool by Joyce (2005), which is generally underreported in contrast to the interest in end-of-life care.

There is not yet any consensus over the combination of specialisms that lead to the best outcomes, whether there should be end-of-life dementia care nurses or dementia nurses skilled in palliative care who might be called upon by housing with care services or might be employed in the care facility. However, there may be interesting comparisons that could build on recent work on medication management within care homes emerging from the PSSRU at the University of Manchester.
Medication management may be needed by a wide range of owners or tenants. It is particularly difficult to manage well in care homes; we know even less about how frontline staff and managers undertake this task in housing with care provision, if needs arise.

Several of those consulted for this review made reference to the potential for housing with care provision that takes on the support of people with high levels of disability to develop relatively insular communities within the larger facility. They described the different lifestyles and professional cultures that could emerge; with little contact or interaction between ‘care’ recipients and their staff teams and the wider facility. Some spoke graphically of ‘walls’ between different types of support. The consequences of this for staff are that they too are separated by the same ‘walls’, with different managerial systems, requirements, terms and conditions of employment, salary levels, and roles. Others spoke to us of the ways in which housing with care support could in some circumstances have far less to offer an older person than a good care home. Interestingly, one perceived advantage currently was the greater likelihood that housing with care schemes seemed to have better staff ratios and workforce stability, alongside the possibly higher wage levels associated with the voluntary sector in social care. These features may not be guaranteed.

In the current context, proposals to revise NVQ curricula may be informed by the blurring of tasks and skill sets that are characterising the social care and health workforces (see New Types of Worker programme, sponsored by Skills for Health and Skills for Care). However, there may be needs to work with staff whose first language is not English; to promote safeguarding as well as empowerment. Garwood (2002) and Parry (2005) are some of the few to comment on housing with care staff’s needs to be alert to the risks of abuse and neglect.

If there are to be even higher levels of disability and ill-health among new residents/tenants and if there is to be a reduction of care home places and consequent delay in entry to care facilities, then there may be higher expectations that housing with care workplaces will be ready to cope. Jones (2008) notes the importance of training wider housing staff, for example, about legislation, cultural awareness, equal opportunities and anti-discriminatory practices; to this might be added disability awareness and mediation or conflict resolution if there are to be tenants/owners with very different expectations about their investment and rights.

While a focus on dementia alone may be overly limited; it has proved useful in throwing up some of the challenges affecting the workforce in housing with care services. Further work may be needed to help address some of the deficits in the evidence base, identified by Dutton (2009) as being:

- What are the benefits of integrated versus specialist-dementia models?
- How can good provision of end-of-life care be assured?
- What do we know about outcomes for different types of individuals in relation to the key variables of extra care settings, such as the design of the building and the environment, the organisation of care, medication management, delivering health care, recruiting and training staff, and the management of transitions to and from schemes?
What are the costs and benefits of housing and service models?
What can we learn from studies that address fundamental issues such as eating, drinking, sleeping, pain management, continence management, socialisation, and staff communication with tenants with dementia?
What emerges from comparisons of extra care housing with available alternatives?

Debates over the variations in whether employers or providers develop highly specialised staffing teams are mirrored in the study of retirement communities and their health impacts undertaken by Kingston et al. (2001). This suggests that peer support, a balance between safety and security, and ‘autonomy with inclusion’ are key factors in maintaining tenants’/owners’ health status. Staff are likely to be key influences here (but not, of course, the only ones). There is little on the patterns of support available to staff, in terms of their day-to-day practice, but also in helping them reflect on issues such as loss and bereavement. Training needs analyses may need to be undertaken more consistently and shared more widely.

To this may be added the need for staff to support tenants with sensory impairments (Croucher et al., 2006), not just as specialists but as general staff. While a combination of independence and security is valued by tenants/residents, people who are very frail or who have sensory and cognitive impairments are consistently reported to be on the margins of social groups and networks. Being able to offer them opportunities for social interaction and companionship may require specialist skills and experiences; and perhaps greater confidence.

Brooker et al. (2009a) point to the need for mental health promotion to be part of the ethos of care housing, which broadens the debate and skills sets required beyond the need to provide support for dementia or physical care. The Enriched Opportunities initiative by Brooker and colleagues (2009b) is an extensive programme of research and development around the stimulation of activities and quality of life through investment in staff. Here individual staff were employed to act as ‘locksmiths’ to promote or ‘unlock’ the social inclusion and quality of life of residents with high support needs. While outcomes were highly positive, we know little of the long term impact of this role and the scope for such initiatives as part of workforce development. Like many initiatives, the impact of a pilot may not be the same when such a development becomes part of routine practice (if it does).

In other observations, Easterbrook and Valelly (2008) note that staff in extra care housing may be supporting people with extensive care needs. If housing care is provided in purpose built housing with 24-hour support, meals, domestic help, leisure and recreation facilities, it can offer intermediate care (hospital avoidance and early discharge care) and end-of-life care. Such services will now (from October 2010) fall under regulatory scrutiny with staffing profiles that need to be acceptable to the Care Quality Commission and to Skills for Care if employers wish to access training and other financial support. Croucher et al.’s (2006) review of practice around end-of-life care suggests that this area is one where staff will need not only training but also support.
Key questions for funders and commissioners

Local analyses of the social care workforce are emerging through work on the National Minimum Data Set (NMDS) and local scrutiny of its findings (see Skills for Care’s development of the InLAWS project, which takes the NMDS data and applies it to localities). These local messages may be related to the commissioning questions developed by Garwood (2006) about the planned purposes of housing with care services and specifically around dementia (Garwood 2010). From this scoping study, a set of four further questions emerge in the context of the transformation of social care – both the growth of personal budgets (personalisation) and the reprovision or closure of care homes.

First, what will be the impacts of personalisation? The roll-out of Personal Budgets means that every adult using publicly funded social care in England – or their proxy – will have control over their care budget (through various deployment routes). This will affect housing with care providers (since tenants and owners are eligible whereas care home residents as yet are not) and the workforce. There are five possible hypotheses, not all of them mutually exclusive:

1) If service users purchase support themselves, their support workers may leave care establishments (including housing with care), preferring to work for individuals, perhaps nearer home.

2) Support workers may be interested in having multiple forms of income, some from individuals and some from larger employers but may be less able to respond to housing with care managers’ needs for immediate assistance or staffing (the flexibility called upon by Garwood, 2010).

3) People whose behaviour is extremely challenging may find it harder to recruit staff, or may find that staff are not willing to provide the support needed for the money on offer.

4) Highly tailored work with people with high support needs in community settings may provide care workers with beneficial experiences, the fostering of values respectful of independence and dignity, and skills in communication and personal care that can be useful in larger care settings; this may mean that the philosophy of personalisation permeates care and support practices.

5) If care teams become fragmented will training and skills development wither away?

Overall, increases in Direct Payment deployment options of personalisation could exacerbate recruitment and retention problems among care providers; it is estimated already that of the 76,000 individuals working as Personal Assistants for people with Direct Payments, 11,000 have left home care or nursing agencies in order to do so (Adams and Godwin, 2008).

Care providers or others may face difficulties in maintaining standards and professional boundaries whilst competing with independent Personal Assistants to provide the types of services desired by Personal Budget users or their families.
(regulations permit this since November 2009). Further synthesis of the implications of personalisation is contained in the consultation, older people’s discussions, staff interviews, and desk research from the Building Choices project co-ordinated by Housing 21 (Vallelley and Manthorpe 2009; Garwood 2009). Current research funded by the new National Institute for Health Research (NIHR) School for Social Care Research being undertaken by the PSSRU at the University of Kent (Prof Ann Netten and colleagues) is exploring the impact of personalisation on people with high support needs.

Second, commissioners may need evidence that housing with care can meet desired outcomes. McCarthy (2009) observes that data from providers about staffing and training may be useful indicators of a high quality service both for public sector commissioners and self-funders. This suggests the value of good recording of these characteristics, and the NMDS-SC enables employers to benchmark themselves against others locally or against others in their sector. Housing with care providers may wish to make greater use of this data, calling on Skills for Care to refine data collection to make it more relevant if necessary. There is no other source of data that is so comprehensive about the care workforce nationally or internationally (see the Social Care Periodical series, Hussein, 2010).

Third, models of organising housing care and support services are various and a range of workforce deployment alternatives is supported by research (Shipley and King, 2005). Alternatives consist of:

   a) The separation of scheme management and care/support provision, since the ways schemes are commissioned affect their workforce profiles.
   b) The integration of scheme management and care/support provision.

Commissioners may need to be alerted to the extensive scope for reaching good outcomes by different routes (Box 5 illustrates the views of tenants/residents with high support needs in one evaluation (Garwood, 2008) of the contribution to their well-being made by staff). In the context of reprovisioning and service changes that are occurring through personalisation and in the current economic climate, there may be greater opportunities to outline how the skills of staff, as well as the physical environment, need to be more clearly delineated beyond simple or unspecified claims of having had training or mentioning values. Evans and Vallelley (2007), for example, suggest that each tenant/owner should have a key worker, as this is likely to reduce the risk of social isolation (noted by Shipley and King, 2005).

Expectations about the role of staff to provide support for tenants/owners may vary between housing with care providers and so their role needs to be made explicit in the contract between the provider and the prospective occupant (and, of course, to staff). What is paid for and what is provided can vary between schemes and there may need to be research on the implications of current (2010) changes to Supporting People budgets for the housing with care workforce. Tinker et al. (2008) note that while remodelling may be expensive for commissioners to consider, it appears to have considerable advantages for many older people and support staff who are living and working in remodelled buildings.
Box 5 The importance of staff for end users

Residents could not speak highly enough of the calibre of staff. One resident who had long-standing lesions on her legs when she came to Reeve Court attributed her recovery to the skill of the Reeve Court nurses. In the same way as care and general support is delivered in an integrated, seamless way, so too the nursing input. Similarly, the nursing input is flexible and responsive at Reeve Court. Residents can ring the handset and someone will go back and see them. A resident who has a minor fall and needs a dressing doesn’t have to wait until the district nurse arrives for the scheduled visit or call a doctor. It can be attended to promptly by an on-site nurse. There is continuity of care with the same three nurses who know what is going on with all residents in the band. (Garwood, 2008)

Finally, there is great interest in commissioning technology and telecare within extra care and similar provision. This may be the choice of people who have access to a personal budget rather than direct care staff. Workforce needs and capacities are underdeveloped here. Tinker et al. (2007) caution that all such technology needs to have able but also willing staff to operate such systems.

The Thomas Pocklington Trust (McCullagh, 2004) argues that people with sight problems are not getting access to advice or provision of technologies but sets this in a wider skills deficit:

> The disciplines who would provide such advice ie Occupational Therapists and Rehabilitation Workers, are not technical experts, and in the case of the latter, have low training and status. These are national workforce issues. (McCullagh, 2004)

While not specific to housing with care services, this point raises the need for people with high support needs to have access to primary and secondary NHS and integrated services (that encompass dementia support, palliative care, care and treatment for depression, and so on), as well as access to support from the service’s staff team. The evaluation of the Bradford Rowanberries extra care housing scheme (Bäumker et al., 2008) suggests that one important role for staff is the arranging of health care consultations for residents by staff and staff encouragement of such access to health care.
Conclusion

Behind the questions raised above are fundamental questions relevant to the workforce; in terms of its profile; composition; activities; labour costs and effectiveness. Evidence from this review suggests that while there is limited knowledge about the housing with care service workforce, then it may be helpful at this moment in time to see if the housing with care workforce closely approximates that of the care home sector and intensive home care support.

There is little evidence that housing with care providers have their own specialist workforce (but this may be emerging); and no consensus about what specialism might be prioritised. However, if current policy to reduce the reliance on care homes (DH 2009c; HM Treasury, 2009a) by English local authorities continues, then there may be opportunities that housing with care employers may wish to consider. These include; raising the quality of staff recruited (seeking specific evidence of skills, achievements and experiences); considering specific skills gaps in work units or teams; deciding upon a refresher or transfer model of training or induction to transmit values to and share learning with staff who are being recruited from other sectors. Engagement with any new NVQ curricula seems imperative.

Finally, Dutton (2009) asks these questions in relation to dementia care that could be applied more widely to people with high support needs:

- Which organisational and management characteristics and approaches foster effective staff-resident interactions and the implementation of successful practices?

- Which models of staffing and staff training, supervision and mentoring should be tested to determine how to best configure staffing for effective care for those with varying severity of dementia?

These questions might be broadened to include family members who often play a key part in care and support, even if their relative has moved home (Gaugler, 2005).

Future research

While there are many areas where further research might be useful, this review also points to some wider research considerations.

What is the capacity of the housing with care sector to keep abreast of current workforce research being undertaken by a variety of researchers? Is there a role for a workforce grouping such as that established through the new Housing and Dementia Research Consortium? Does the Social Care Research Register reflect this area of study and is its existence known to the field? Should workforce research developments encompass training, competencies and skills or be more focused on demand and supply?

How far can studies relating to the workforce and its performance in care homes be inclusive of housing with care? And if they are, can they compare the two
approaches rather than assume them to be the same? Is there a role for the *My Home Life* initiative to play a greater part here? For example, could housing with care researchers have greater engagement with the National Care Home Research and Development Forum? What is the capacity to expand the network being established with the Housing with Care Research and Development Forum (PSSRU, University of Kent)? How can workforce studies cover the very wide range of roles and tasks in housing with support and what should be the priorities? What has been the contribution of the Housing LIN to workforce development efforts and to act as a research clearing house and how might this network look in the future?

How can research on the social care workforce (which is extensive) be of greater use to housing with care stakeholders? (without presuming that the workforces are identical or unique). Is there scope for greater attention by research or evaluation commissioners to ensuring that data collection is not repeated, or overlapping, and that anonymised data sets can be shared? Are commissioners willing to fund more than case studies or descriptions? Can case descriptions pay more attention to workforce details? Can the authors of reports and guidance be asked to provide supplementary documentation of methods, evidence and measurement tools?

**Emerging gaps identified by this review**

There were few areas of this review where we can be confident that research provides a full or adequate picture of the housing with care workforce and its concerns and strengths. The workforce appears not to be shaping questions that are important to itself, such as its support, pay and conditions, and training needs.

Current concerns among key stakeholders are the implications of commissioning decisions (at local government, private and voluntary provider and individual level) for the quality and competence of the workforce in housing for care services, for example, in the context of personal budgets, reprovision of care homes, and the housing, care and support interfaces. At national level, questions are emerging about the possible impact of new regulatory regimes in registered care settings on workforces in frontline activity and at managerial and supervisory levels. As noted, how do these relate to co-regulation?

Lastly, what do we need to know about the ancillary workforce (cooks, gardeners, cleaning staff and so on) and how its members may bring wide benefits to housing with care schemes, their tenants/owners and their colleagues? Such questions are not unique to housing with support services but there has been surprisingly little interest in this group of staff who may have considerable influence on the success of a scheme.
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