IMAGINING THE FUTURE: WORKFORCE

Report produced by Kerry Musselbrook for IRISS

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For more information about this research please contact

enquiries@iriss.org.uk

WORKFORCE

INTRODUCTION

Aims and ambitions

Over the next 10-15 years there are likely to be significant changes both in the numbers requiring access to support and the strategies for responding to this. As well as issues of supply and demand, other drivers such as public sector reform, personalisation and integration of health and social care are likely to have significant impacts on the workforce as will other developments such as new and assistive technologies and the broader socio-economic climate.

This paper was written to help stimulate thinking about the future social services workforce in Scotland in 2025. More specifically, its purpose is to:

- Increase awareness of the challenges and drivers likely to operate over the next decade (until 2025)
- Increase awareness of the ideas and resources that can assist individuals and organisations in their planning
- Encourage a willingness to respond creatively to these challenges and increase the level of practical innovation.

As such, this paper does not provide a definitive or comprehensive picture of the future, but a discussion of the scale, nature and shape of the social services as well as values, roles, relationships and working patterns. Some of these may be more or less predictable and more or less welcome.

Clearly, the future is not set but our ambition should be to consider what type of workforce we want and begin to articulate this to build support and resilience. This will be an ongoing process, beginning with an exploration of the issues and uncertainties on a path to a vision. Only by being clear about our future vision, and with strength and consistency of leadership at political, sectoral, organisational and practitioner level, can we rise to what will be considerable challenges in forging a different future.

Structure of the report

The report will begin by looking at the scale of future workforce, before considering future employers and the distribution of these.

Part 2 will take time to focus on future roles and some options within this as well as changing relationships and issues around the balance of power and responsibility.

In Part 3 future pay and conditions will be discussed, alongside registration and training and the relationship of these to the future supply of workers.

PART 1: FUTURE SIZE AND EMPLOYERS OF THE SOCIAL SERVICES WORKFORCE

SIZE OF THE FUTURE WORKFORCE

- The social services workforce employs 194,890, or 199,620 including Personal Assistants (SSSC, 2012b) - this is more people than those employed by the NHS (154,4250) (ISD Scotland, 2011)[1].
- The social services workforce increased by 53% between 1998-2008 at a time when the overall Scottish workforce has fallen (SSSC, 2011).
- In Scotland, the social services sector currently employs just under 8% of the total Scottish workforce (SSSC, 2012b).
- Based on Labour Force Survey (LFS) predictions – the Scottish social services could employ 216,000 workers as of 2020 - an increase of 18% on 2010 figs (SSSC, 2012b). If we continue this trend, it will increase to approx. 240,000 by 2025.

In predictions about the size of the future workforce, assumptions have been made that it will continue to expand at a similar rate based on past trends. We can no longer assume this, however, as LFS predictions do not take account of the current economic climate (nor policy drivers)[2]. This leaves the size of the 2025 workforce difficult to predict but there are a number of scenarios worth exploring.

1. If we have *enough for everyone* - this will be the result of having reduced demand, assuming budgets remain limited and predictions that funding will not return to 2010 levels for 16 years are correct (Beveridge et al, 2010). In this scenario the workforce will be smaller because we will have realised the ambition of the Christie Report (2011) to reduce failure demand (estimated as absorbing 40% of local public spending) through the adoption of preventative approaches that reduce health and socio-economic inequalities. We might also expect staffing reductions to have been achieved through the integration of health and social care, with opportunities for streamlining the workforce presented and efficiencies made. To what extent, however, is difficult to say, although tentative evidence suggests benefits (Weatherly et al, 2010) - while noting high set-up costs. As for cost savings through the roll out of SDS, this looks unlikely if the analysis of Rummery and colleagues (2012) is correct. This concludes that SDS will be cost neutral (excluding start up) - and assuming that this is based on an enlarged Personal Assistant workforce to replace other workers. We may also hope that UK's significant life science economy, with ongoing investment in pharmaceutical research

[1] Both NHS and SSSC figures are based on 2011 headcounts, not WTEs.
[2] LFS data is regarded as less robust that the more comprehensive SSSC data which has only been collected since 2008 as part of an annual dataset.

and development and medical technology and biotechnology will help people stay healthier for longer, although its impact remains unclear (CFWI, 2013).

2. If we have *insufficient resources for everyone* – the workforce will need to manage resources through rationing budgets, changing eligibility criteria and asking users to pay more. This assumes that demand and health inequalities have not been reduced, expected increases in the Scottish population are correct (General Register Office for Scotland, 2012a; b), and UK and Scottish political priorities do not change – nor is there the political will for increased taxation. An Ipsos MORI poll of 1,000 adults in Scotland revealed that 68% believed that care should be paid for as it is at present, based on a mixture of taxation and personal contribution. Interestingly, a 2006 UK-wide survey by the same pollsters showed half of those surveyed supported increases in taxation to better fund adult social care (the remainder were opposed or undecided in equal parts) (Ipsos MORI, 2006).

3. Another scenario is that health inequalities will prevail and demand is not reduced, with the result that *more funding is diverted to acute care* in an integrated health and social care system with shared budgets. At the moment the social services employ more people than the NHS, but this may be reversed in the future. In Northern Ireland, for example, Heenan and Birrell (2009) report that 'a hegemony of health persists' in their integrated system, with resources focused on and diverted to acute care. This has also been the experience of New Zealand (Ham et al, 2008), while the Norwegian Government has asked if all or parts of funding should be pooled and what are the associated risks?

4. As a future scenario, however, we may be more confident in predicting that health and social care will be engaged in more sophisticated strategic workforce planning. This will be achieved at a local or regional level (however that is defined) recognising different population densities, different population needs and degrees of inequality, different organisational structures, different delivery partners, and different overall budgets within a shared Scottish policy framework. In a best case scenario, competing needs and priorities will be balanced by health and social care partners with equal status and parity of esteem, informed by those using services and based on more transparent and equitable costings across the public, private and third sectors with greater focus on providing quality services and positive outcomes for people.

FUTURE EMPLOYERS AND LOCATION OF WORKERS

- 60% of the social services workforce was employed by public sector in 1994; in 2011 this had fallen to 33% (SSSC, 2012b).
- The private sector has continued to increase its share of the workforce. Recently it became the largest employer of the social services workforce, with a 42% share (SSSC, 2012b).
- The third sector employs 25% of the social services workforce (SSSC, 2012b) - LFS data shows this was the same proportion as in 2004, with the third sector having grown from a low base over the previous 10 years (Scottish Executive, 2006c).

Decline of the public sector

Prior to the current downsizing of the UK public sector, it employed almost exactly the same number of people (6 million) as it did in 1952 - although today these are largely front-line workers in schools, hospitals and local authorities rather than those employed by nationalised industries or public corporations of earlier years (Philpott, 2012).

Within the *social services* workforce in Scotland, there has been a rapid growth in the numbers of private sector and voluntary sector workers - rather than a decline in the number of public sector employees (SSSC, 2011; 2012a). However, the most likely scenario is that by 2025 the number of public sector employees will have shrunk considerably. This will be the result of public sector reform combined with an ongoing commitment to the outsourcing of services (begun in the 1990s) and the roll out of self directed support. This will require further disinvestment in large block contracts to provide more personalised, flexible, integrated, diverse and cost effective services. We might imagine that by 2025 the role of the public sector will primarily be that of commissioner rather than provider.

Nevertheless, there are some parts of the workforce that are likely to remain exclusive to the public sector, primarily because they are required by law to fulfill statutory duties.

Mixed economy of care

By 2025 it is also likely that we will continue to see a mixed economy of care (albeit with a smaller public sector). This reflects current differences across the social services sub-sectors. *(See Appendix A)*

For example, 'care home for adult services' are predominantly delivered by the private sector, while offender accommodation services by the voluntary sector. There are some services (including residential child care and 'housing support/care at home') where there is a more even split across the public, private and voluntary sectors. Childminding

and Personal Assistants are, by their nature, part of the private workforce (although Personal Assistants are not normally included in official figures).

Employer types also varying according to locality, and we can expect this to continue:

- Currently, the private sector is the largest employer in over two-thirds of local authority areas; the voluntary sector is the largest employer in two
- The parts of Scotland with the largest public sector presence are the three island local authority area: Shetland, Orkney and Eilean Siar, with over 75% of the workforce employed by the public sector (SSSC, 2011).

Arguably, a higher level of public sector employees in some areas is down to a lack of alternative providers. Private companies are interested in more profitable areas and tend to avoid more regulated client groups. Rural populations, for example, do not offer the same economies of scale as urban ones, with access to travel and the costs of this also an issue. In the future, this may be less applicable to new business areas such as telecare and online support (with significant public investment already made in this area).

In the future, we can imagine that the integration of health and social care may also lead to changes in employment status – either because local health boards and local authorities wish to make joint appointments, or because they wish to TUPE transfer existing staff from one sector to another. In the Highlands, for example, 1400 staff in adult community care services transferred from Highland Council to NHS Board while 230 staff in child health moved the other way. This was the result of the decision to delegate lead responsibility for adult services to the NHS and responsibility for children's services to the council. Of course, this is only one of several approaches to integration, recognising that there is no single agreed definition (Robertson, 2011).

This may lead to a real diversity of integrated models by 2025, the mix of which is uncertain. This can mean that services are delivered by interagency teams (in which members are employed by more than one organisation or organisation type) or by multidisciplinary teams (with the same employer). Staff may be co-located or work at a distance from each other – and some may have no office at all as peripatetic workers. Increased diversity in employment patterns and models is likely to be a key feature of 2025, with planning to be led locally in accord with integration planning principles (Public Bodies (Joint Working) (Scotland) Bill), but with no prescribed models for locality planning. This will have implications for staff support and development, as explored in Part 3 of this report.

Role of hybrid organisations

In the less developed countries of the Global South, third sector, non-government or voluntary organisations are the major deliverers of welfare. The first world has taken notice, envisioning a future scenario where third sector organisations and social

enterprises have a significantly larger part to play, swelling this workforce. These organisations potentially offer the following advantages:

- The ability to offer a different approach and ethos between a profit driven private sector and the one-size fits all public sector.
- They are non-government or non-statutory organisations and 'do not need to exist' – and as such they are more flexible and adaptable.
- They are more 'customer-focused'.
- They can be for profit or not for profit – with the former reinvesting surpluses to support their social objectives.
- They are competitive on price because they do not need to generate profits for stakeholders.
- They are *generally* regarded as more dynamic and innovative pioneers who are more responsive to change, can plug gaps and co-operate with public authorities.
- Perhaps, most importantly, they can engage local communities in service design and commissioning – to help find local solutions to local problems, empowering citizens, building on assets and strengthening and regenerating communities by employing local providers. Unlike normal contractual arrangements, they can also be owned by the community or by its employees (see Part 2, community connecting for further discussions).

In Scotland, politicians have grown closer to the third sector and have set up various initiatives to support the growth of social enterprises. By 2025 we can imagine that both will have grown in stature and scale - but this may depend on the success of new commissioning models at local level and finding successful ways of seeding social enterprises.

The system of competitive tendering, usually involving a funder specifying the service required with limited scope for contractors to input into service design, remains an obstacle to the greater involvement of third sector agencies (Osborne et al, 2012). The third sector has also been affected by cuts – with many absorbing this by making savings elsewhere, trying to securing new funding streams or using accumulated underspends from previous years (while understanding that this is unsustainable). As noted, its share of the social services market has remained steady at 25% between 2004-2011.

We might also note that attempts to grow social enterprises so far have been largely unsuccessful. Despite Futurebuilders Scotland (Scottish Executive, 2004), the launch of *A Strategy and Action Plan for Social Enterprise in Scotland* (Scottish Executive, 2007) and a £93 million investment in the development of social enterprises, a 2008 study revealed that there was 'little reliable evidence on the flow of new social enterprises into the sector, or churn of existing organisations within it' (EKOS Ltd, 2008). Success has also been assessed as hard to measure, and defined on a case by case basis (Coburn and Rijsdijk, 2010).

PART 2: FUTURE RELATIONSHIPS AND ROLES

RELATIONSHIPS

Changing expectations

It is important to note that the public has increasing expectations of social care. An Ipsos MORI survey (2006) of 2,053 adults across Britain revealed a gulf between expectation and provision: 81% wanted to be able to make decisions about their own life if they became disabled or developed long-term conditions, while 90% wanted support to be able to stay in their own homes. They expected social services or public agencies to provide basic needs such as food, shelter and medical care (88%) and provide them with the choice *not* to live in a residential care home (87%).

In addition, research by Leadbetter and Lownsbrough (2005) revealed that 'people do not want to feel their lives are being run by other people, no matter how well meaning; they feel entitled to a say in shaping services to suit their needs'. This is fuelled by increased public access to information about conditions, services available and how they are delivered (CFWI, 2013) with it anticipated that today's young people will be more demanding than their parents.

More personalised approaches

If Scotland is to deliver on expectations, the future workforce will need to provide more person-centred care that will require relationships with those receiving support to be re-defined. This will need to be true across health and social care, perhaps with a new and shared language to describe this.

With respect to assessment, this will require a shift away from the 'expert' culture and mindset of professionals and the commissioning of services geared to meeting outcomes for people *as identified by them* (Miller, 2012) - rather than focusing on what 'goes in' to services. In accord with the principles of personalisation and self directed support, the role of the professional will become less about being a 'fixer' of problems and more about being a co-facilitator of solutions (Boyle et al, 2010), promoting collaboration and co-production (Morgan and Ziglio, 2007) based on mutual respect. Perhaps, most significantly, this involves doing things 'with people' rather than 'to them.'

If this vision for 2025 is to be realised, current barriers to relationship-based care need to be overcome. These include: insufficient time for listening to people and building relationships; continuity of care; a lack of equality or respect; system blocks and silos; professional protectionism. Perhaps the most important skills the future workforce needs to develop, however, are those around listening and communication. If the workforce is to respond to the rising numbers experiencing dementia - projected to double in the next 40 years - then we can imagine that future workers will have been

trained in new communication approaches eg dementia diaries, talking mats or multi-media storytelling to overcome communication challenges.

In 2025, we might also imagine that workers may understand and apply more 'assets-based' approaches, with the sector building evidence on the success of this approach between now and 2025. In this scenario, workers will work with people to identify their strengths (including family, friends and community networks) to provide successful care packages that focus on possibilities and solutions (Saleebey, 2006). If achieved, this will mark a significant shift away from medical or deficit-based approaches to highlight factors that support human health rather than those that cause disease (Antonovsky, 1987).

Furthermore, self directed support and person-centred approaches (whether in a homely or hospital setting) will require a different way of managing and assessing risk. By 2025, workers may have become adept at *balancing* tensions between empowering citizens and protecting them and fostering independence and responsibility *balanced* against dependence. The Scottish Human Rights Commission has developed a major capacity building programme, Care About Rights, to support care workers and others in this, and consider developing a shared understanding of risk between individuals, families and workers as a key to future success. In 2025, we might imagine that staff will feel more confident and empowered in this area, with the training needs highlighted by Cunningham and Nickson (2013) delivered.

In rebalancing power and moving towards more person-centred care and support we might summarise this shift as shown in the Table below:

Past/present		*Future*
Expert/ provider-centred		Person-centred
Inflexible 'one-size fits all'		Flexible services
Inputs/outputs focused		Outcome-focused
Needs/deficit model		Strengths/assets-based
Protection/risk averse	Co-produced/ managed risks	Autonomy/individual decision-making
Dependency	Inter-dependency	Individual responsibility

FUTURE ROLES

Statutory duties

We can probably assume that in 2025 statutory responsibilities and safeguarding roles will stay the same. While the governance framework produced following Changing Lives (Scottish Executive, 2006b) does not claim to set out *all* of the functions of the social worker, it does reserve certain areas to them, ie cases involving the care and protection of children or adults, cases relating to mental health, adults with incapacity, or criminal justice (Scottish Government, 2010d). This clearly states that where there are competing needs, risks and rights that need to be balanced, final decision-making and accountability lies with a registered social worker trained for this job – not other partners or anyone else they line manage.

In the future, we can expect demand to have grown if population predictions are correct and inequalities are exacerbated by austerity measures. In the area of criminal justice for example, Scottish Government projections suggest a 20% increase in prisoner numbers by the end of this decade (Christie Commission, 2011). This is despite recent successes in reducing probation and social enquiry reports by 8% between 2009/10-2010/11 and reductions in one year reconviction rates over the last eight years (SSSC, 2012b).

Care management

Care management is a term associated with community care reforms and the re-naming of many social workers as 'care managers'. It is a job title that has been shared with a growing number of staff without social work degrees and can be associated with a tick box approach to assessment and resource allocation, partly driven by the pressure of large case-loads.

In the future, we might consider that personalisation or self-directed support will provide the opportunity for social work to focus on 'good' rather than 'bad' care management, based on holistic and person-centred (rather than tick box) approaches. This is the 'therapeutic role' referred to in Changing Lives (2006), freed from bureaucracy, risk aversion, and mechanistic and technical approaches. In another scenario, self-directed support may be responsible for *increased* levels of bureaucracy and poor use of human resources based on emerging evidence from England (Slasberg et al, 2012).

We might also imagine other future scenarios where care management is broken down into different parts – with a range of implications for the workforce.

Resource allocation
In one scenario, resource allocation could remain a function of the local authorities, with social workers devoting time to statutory (and/or more complex cases) requiring holistic assessment. For other cases, assistant social workers or care managers without a social work degree would continue to apply more tick box approaches, with the focus

of any interaction on determining eligibility for funding – and perhaps providing information on local providers. This would supplement direct marketing from providers to future customers or information from on-line comparison sites like those currently used to buy holidays or insurance. It would be assumed that most people, like self-funders, would be able to balance their own risks and reach decisions about what support to purchase in discussion with their family.

As an alternative model, Bernard and Statham (2010) have hypothesised that in the future, resource allocation may be removed from council control and passed to the Department for Work and Pensions. This could provide a cheaper and more standardised assessment of needs linked to payments as part of the benefits system. This would ultimately separate resource allocation from support brokerage and planning and lead to a further shake up of central and local government relations and create legislative and political tensions between the UK and Scotland on devolved areas (assuming that Scotland has not voted for independence in the 2014 referendum).

Support planning and brokerage
Some have argued that support planning and brokerage should be independent from resource allocation (Dowson and Greig, 2009; Dowson, 2011). Dowson (2011) makes the point that 'people who require social care won't trust the system until they know whether the professional at the door has come to help them, sell them a service, or ration their funding'. A recent English survey also highlighted how staff are struggling to deal with people who are angry and upset about cuts to their budgets (Community Care survey on personalisation, 2012). Dowson concludes that social workers need to escape this role as there is an inherent conflict of interest between a) assessing needs to allocate budgets and ration public funds and b) putting together a creative and holistic care package that will yield imaginative results and not confine people to specialised services. If others agree, we need to consider who might fulfill the role of independent broker in the future. This could be a trusted family member or friend, but might also be a community or user-led organisation specialising in this area such as Inclusion Glasgow who pioneered the use of Individual Service Funds. In England and Wales, local authorities have been encouraged to use user-led organisations (Cabinet Office, 2005).

In Dowson's model, independent brokerage is not just about agreeing contracts, recruiting staff or co-ordinating the different elements of the plan. Rather, it includes person-centred planning, evaluating the risks and benefits and gathering information to arrive at a coherent plan. This plan is *then* submitted to the local authority for (final) approval having been given an indicative budget, perhaps using a points based 'resource allocation system'. We might consider that in this scenario, some social workers may wish to re-locate to third sector agencies and that this might not mean the end of care management for social workers?

The separation of resource allocation and brokerage is also likely to be driven and affected by the numbers taking up self-directed support in Scotland. Moreover, whether or not separation of care management roles proves to be cost neutral (or more or less expensive) is likely to be a significant factor in what happens in the future.

Personal Assistants (flexible, unregulated workers)

Personal Assistants provide a new breed of flexible social services worker, marking a shift away from agency-based employment of paid carers to direct employment by the person receiving care. The employer has a free choice about who to employ with no regulatory requirements on these workers. Accessed through self directed support, the emphasis has tended to be on the quality of the relationship and not just on agreeing tasks around personal or domestic care to support participation in social activities, employment, education or training (as and when this is required).

It is difficult to estimate the future size or popularity of the Personal Assistant workforce. While calculations (SSSC, 2012b, p 34) estimate 4,730 Personal Assistants in Scotland as of at March 2012, the proportion of Personal Assistants in care packages has fallen: out of 2,291 people in receipt of SDS in 2007, 63% of direct payment packages included a Personal Assistant; by 2012 this was 39% (out of a total of 5,409) (SSSC, 2012a). At the moment we lack sufficient data to understand real trends - although we do know that many people employ more than one Personal Assistant (the average is 2.4)(SSSC, 2012a) and that Personal Assistants often have more than one job (Reid Howie Associates, 2010).

Nevertheless, we might consider a future where satisfaction levels between employers and Personal Assistants remain high (Reid Howie Associates, 2010; IFF Research, 2008), with three-quarters of Personal Assistants considering it 'quite likely' that they would be a Personal Assistant in five years time (Reid Howie Associate, 2010). Alternatively, these relationships may have soured. The lack of regulation, including requirements to carry out PVG checks at recruitment, may lead to more incidences of abuse or dissatisfaction. As such, the future popularity of Personal Assistants may be driven by the success of attempts to address concerns about a lack of information and support around employment rights and duties on both sides of the employment contract (Reid Howie, 2010). Bernard and Statham (2010) have also considered that there may be a public backlash to self directed support, particularly in the use of payments to fund leisure pursuits (with Personal Assistants to support this) - rather than viewing this as a legitimate way to maintain health and wellbeing.

Related-opportunities?
In 2025, the anticipated rise of a Personal Assistant workforce may also present new business opportunities and roles for others:

- Direct payment holders could be offered services such as payroll, insurance, reference or PVG checking as well as training for themselves and Personal Assistants (assuming this was resourced through self directed support). This is something that some third sector agencies already do, for examples Centres for Independent Living. It has also been proposed that in the future, this could be a role for re-invented local authorities (Yapp and Howells, 2013).
- Independent brokers offering advice and support to clients may employ Personal Assistants directly.
- More Personal Assistant agencies may be set up (possibly registered for

inspection by the Care Inspectorate). A recent study reported that just under 10% of Personal Assistants were recruited via an agency and that, overall, just over 20% of employers had contracted with an agency for part of their hours (Reid Howie Associates, 2010). In the future, agencies could address needs for ad hoc or emergency/ holiday/ sickness cover. These may be similar to agencies set up to provide 'just in time' childcare – although childminders need to be registered whereas Personal Assistants do not.

Impact on other parts of the sector
A recent study (Rummery et al, 2012) revealed that existing providers regarded Personal Assistants as competition – although the general perception was that the loss of business would not be extensive and that demand would take time to filter through.

We can plausibly relate a fall in adult day care services to disinvestment in the bricks and mortar infrastructure to allow for people to take up self-directed support. Between 2008-11, there was a 10.2% fall in adult day care workers (SSSC, 2012b) and by 2025 we can expect this to have shrunk further. If there is a backlash to self directed support, Scotland may be in a position where people ask to go back to day care and regulated services which no longer exist.

In the case of those working in care homes for adults, SSSC data (2012b) identified a modest increase in staff (0.3%) between 2008-11 (with only four years of SSSC data available to discern trends). However, what may be more significant is that this has been accompanied by a *reduction* in the number of care homes between 2001-11 (1,669 to 1,329) and a fall in the number of older people in residential care (40,524 to 37,511). This may be explained by the fact that more older people are looked after at home, with supported self-management and reablement programmes playing a part in preventing admission to hospital or residential care. As for 2025, we might imagine that this trend continues, with residential care a proportionately smaller part of the workforce as those entering care homes do so only in the last months or year of their life.

With respect to 'care at home', we may be surprised that the number of people receiving this has continued to fall in recent years, with a drop from 70,710 in 2007 to 62,832 in 2012 (Scottish Government, 2013a). At the same time, the 'care at home and housing support' workforce grew by 1.8% between 2008-11 (SSSC, 2012a). We might speculate that this is because Personal Assistants are providing care to more people (reducing the number of 'clients') whilst the slight increase in care at home workers is due to them working with people with more intense support needs and a shift towards more personal than domestic services (Scottish Government, 2012b). Certainly, the average number of care at home hours has risen from around five in 1999 to just over 11 in 2012 (Scottish Government, 2013a). The growth in the care at home workforce may also reflect efforts to grow reablement programmes where short intensive periods of support are needed. However, we cannot be sure that these patterns are not driven by changes to eligibility criteria, nor are we certain on the relationship between the Personal Assistant and care at home workforce. Nevertheless, one future scenario is that home care workers will work with those with the most intense support needs while Personal Assistants will work with the others. By home care workers, we may also want

to contemplate whether in 2025 these are the generic/hybrid roles explored in the following section.

The generic worker/hybrid roles

By 2025 we might imagine that there may be many generic health and social care workers to promote rehabilitation and provide seamless, more immediate and holistic care in a homely setting. Most often, this would be with older people with complex needs where the line between medical and social care is blurred (Taylor, 2001). Evidence to date shows that the responsibilities of these workers varies, but includes: simple nursing tasks such as catheter care, stoma care, wound dressing and routine administration of medication; personal care and assistance with daily living eg shopping, nutrition, engagement in social activities and safe usage of equipment (RiPfA, 2008). Some generic workers may also be responsible for record keeping and monitoring and providing feedback on a person's progress and working with a range of health and care professionals as part of a multidisciplinary team. Others foresee generic workers taking on more responsibilities including helping people: develop life skills to plan for their future; get involved in developing their support plan; connect to their communities and get involved in the design of local services through forums and groups. If Scotland were to adopt the Swedish 'Esther' model of integrated care, generic workers would provide a 'Welcome Home' package for anyone discharged from hospital. This can help ensure that everything is in place (and re-admission is avoided) by ensuring the home is tidy, food is in the fridge and the right medication, alarms and networks are provided.

In terms of providing a case for the creation of these roles, evidence suggests that they can prevent unnecessary admission to long-term residential care (Curtice, no date), help people to stay in their own homes (Challis and colleagues 1989; 1995; Hek et al, 2004) and increase peoples' confidence and ability (Stanmore, 2006). Generic workers have also played an important role in promoting mental health and wellbeing (Curtice, no date), providing emotional support (Hek, 2004), and providing continuous relationships that prevent people from having to deal with multiple professionals. For this reason, Taylor (2001) regards generic or hybrid workers as in an excellent position to identify changing needs and prevent deterioration - while others fear this may reduce time spent with other professionals with negative consequences (Stanmore, 2006).

There are key challenges in delivering a future workforce that includes generic workers, however. There may be limited capacity within the existing workforce to take up these roles - so ways to recruit people from elsewhere may need to be identified. Furthermore, we may consider that these roles require up-skilling from SVQ Level 2 (Health and Social Care) to SVQ3 to support a shift from task-focused to recovery- and relationship- focused roles. The costs of training and remunerating these workers may also be prohibitive, particularly at this time. We might furthermore contemplate that the emergence of these workers may depend on the success of integration, joint planning and commissioning processes as well as an increased understanding of where these roles sit in relation to others. Current evidence indicates that fears around job losses, the blurring of roles (Howarth, Holland and Grant, 2006), and possible loss of professional identity and status (Heenan and Birrell, 2006) all stand in the way of new

roles spanning both sectors. In one scenario, this could lead to retrenchment; in another these would be overcome and present new career opportunities for workers from both sectors.

The unpaid workforce

In 2025 we can expect the current unpaid workforce to be ever more important. Family carers provide a much bigger source of care than the state ever can – approximately 77% of the total social services workforce (SSSC, 2012b) or around one in eight of the population. It is estimated that they contribute somewhere between £7.68 billion to £10.37 billion every year, with this comparable to the total cost of the NHS (Buckner and Yeandle, 2011). Without their help, the health and social care system in Scotland would be unsustainable.

Currently the unpaid workforce includes:

- An estimated 657,300 carers including a substantial number of young carers (Scottish Government, 2010b) – and numbers may be significantly higher as not all choose to identify themselves

- An estimated 3,300 foster families (Fostering network, 20 March 2012, Fostering in Scotland)[3]

- Approximately 1.2 million adult volunteers in Scotland in 2008/9 based on Scottish Council for Voluntary Organisations estimates - with a third of childcare centres having unpaid volunteers (Scottish Government, 2010c).

With respect to carers, the largest group, the Carers Strategy 2010-15 has gone some way to redress the previous lack of recognition of carers' significant contributions (Scottish Government, 2010a), building on previous work (Scottish Executive, 2006a). This reinforces that they are equal partners in the delivery of care and recognises their need for respite and support 'to have a life of their own outside caring'. The Getting it Right for Young Carers Strategy also asserts that young carers have a right to a childhood (Scottish Government, 2010b). A workforce education and training plan has been specifically developed for adult carers (SSSC, 2012b) and telecare has been identified as having key benefits, bringing carers greater peace of mind, more opportunities to take a break from caring or gain or retain paid employment (Jarrod and Yeandle, 2010; IRISS, 2010). Furthermore, the Social Care (Self Directed Support) (Scotland) Act 2013 clarifies that local authorities can release resources to support carers in their role to reduce negative impacts on their health and wellbeing. However,

[3] Currently only around half of foster carers in Scotland are paid anything at all, with Scotland the only country in the UK not to have a national minimum fostering allowance. Where fees are received, these vary from one local authority area to another. The Fostering Network has called on this to change as part of the Children and Young People Bill to be introduced to Parliament some time in 2013. Fostering Network Survey, 2012) Aligned to this have been questions as to whether foster carers should be registered and required to obtain certain qualifications.

if carers are to meet growing needs in the future, it seems paramount that Scotland is able to deliver on this more effectively than at present. If not, we are likely to place further strain on services and may see a resurgence in the need for residential care homes if carers are not able to support their loved ones at home.

We may also want to signal some caution about the role of families in providing care. Many older people live alone and are not geographically close to family members, with a recent report finding that over three-quarters of over 75s are lonely (WRVS, 2012). We have also moved away from single-earner households in the main (Philpott, 2012) and have more intensive jobs (Overell et al, 2010), making it increasingly difficult for families to balance work and look after children and older parents (or meet fostering shortfalls). This has implications for how childminding and family nurse partnerships can help as much as reablement programmes for older people. It also begs the question as to whether wider society can provide unmet needs –with community connecting and strengths-based approaches offering one potential solution.

Community connecting

Mapping and co-ordinating peoples' personal and community networks, whether small or large, could be the new starting point for care planning and not an optional extra in the future (2020PSH, 2013). The Barclay Report (1982) in England identified community-based approaches to social work as the solution to rising demands and unmet needs. At the time, however, many saw its proposals for the social work profession as romantically aspirational, 'wild and woolly', undeliverable (Rhodes and Broad, 2011) or nothing new (see for example Kilbrandon, 1964; Seebohm, 1968; Griffiths, 1988). Since 1982, however, many of Barclay's ideas have been re-visited and built upon. These emphasise the importance of engaging with communities and not just individuals to help design and commission more responsive and joined up local services that might also help regenerate communities and reduce inequality (Griffiths 1988; Ferraro 2003).

Fostering empowered citizens

We know that many communities lack skills, knowledge and confidence in becoming involved in decision-making (LTS, 2011). We might consider that in 2025 it could be the job of social workers or local area co-ordinators[4] to build community capacity and broker user-engagement at various steps in the commissioning, design and re-design process. This would support the ambitions of the proposed Community Empowerment and Renewal Bill in Scotland (2012a) that considers mechanisms for achieving peoples' input eg through Community Planning Partnerships or community councils. It also asks whether or not local people should be able to manage certain areas of public spending, have the right to buy land in urban (as well as rural areas), be able to manage local housing or take on unused or under-used assets or have greater access to allotments (with potential legislative changes to support some of this).

[4] Local Area Co-ordination is currently funded by local authorities or NHS Boards, but not necessarily in all areas: http://www.scld.org.uk/local-area-co-ordination/what-local-area-co-ordination

We might also consider that the future workforce could help people take (managed) risks, develop resilience and (through co-production) create and sustain local social networks that cannot be created through the allocation of personal budgets alone eg to set up time-banking schemes, be-friending and peer support programmes, projects to distribute food that would otherwise go to waste, or local housing campaigns. We can imagine that these could optimise the use of social media or mobile phone networks to connect and organise people – giving them a stronger voice and helping them maximise their assets.

Duffy (2012) warns, however, that this type of power shift will not happen without real leadership. Others have also cast doubt on the willingness of people to get involved in their local communities. An Ipsos MORI poll (May 2010) revealed that while most people supported the principle of greater local control and involvement in the delivery of services, far fewer were personally interested in getting involved (Defty, 2011). Volunteering research has also highlighted that 'engaged individuals tend to be more highly educated which in turn is correlated with political efficacy and interest' (Musick and Wilson, 2008; Rochester et al, 2010) while the Big Society Audit (2012) identified a gap between the most disadvantaged and affluent communities in the levels of trust between people, community engagement and social action. This has left people questioning exactly *how* to increase levels of voluntary activity across the piste (Wilson and Leach, 2011).

Supporting community regeneration

Yapp and Howells (2013) have also cast doubt on the ability of macro-economics to stimulate the economy, citing Demos funded research that shows that community development practices in two Birmingham neighbourhoods have increased citizen engagement and regenerated the area (Wind-Cowie, 2010). Yapp and Howells postulate that while markets have been regarded over the last 30 years as the most effective way of driving productivity, they are better at exploiting (not driving) innovation and have had a negative impact on local communities. Outsourcing, for example, has tended to favour larger 'out of town' companies, taking jobs and money out of local economies. It has also privileged longer contracts and greater standardisation and in terms of providing better quality of services or value to the taxpayer, the evidence is mixed. In addition, markets stand accused of emphasising profit at the expense of care eg through the incentivising of private companies (such as ATOS) to reduce the welfare bill by designing systems that re-evaluate people so that they are no longer eligible for support.

At its core, what Yapp and Howells call 'Community Sourcing' is the co-production between individuals, public agencies, local associations and business to build social and economic capital. If members of the social work profession are to support this, Rhodes and Broad (2011) argue that the language of contracts, tenders, competition, specifications and monitoring will need to change – although the detail around *what* will replace it is sketchy. In this scenario, however, Personal Assistants, micro-providers, social enterprises and third sector organisations may form part of the answer in providing the 'granularity in local service design' by giving power back to communities.

That this will be challenging and likely to involve some accountability of the workforce to central government to ensure resources are not being wasted is acknowledged.

By 2025 we might also hope to be better informed about co-production in the commissioning of services and how to make this a success. Investment in this area has recently been announced (May 2013) by the Scottish Government which has funded the People-Powered Health and Wellbeing Programme to take forward and learn about co-production in action. Nevertheless, we can imagine that these approaches may break down professional and 'client' barriers and those between service provider and user, worker and volunteer.

Advocacy

The functions of advocacy are unlikely to change by 2025. These include helping individuals to: get the information they need, understand their rights, make their own choices and, perhaps most importantly, have their voices heard (MacIntyre and Stewart, 2013).

Advocacy however is not always well understood (Fazil et al, 2004). It involves a range of activities such as providing moral support during formal proceedings (Featherstone and Fraser, 2012), interpreting and translating information and helping people apply for housing benefit and social support (Newbigging et al, 2011). We can anticipate that demands for these services will grow in the future. To highlight one area, a recent report concluded that Scotland is unlikely to escape rising homelessness, despite policy commitments to strengthen the statutory safety net and despite reductions in recent years in the number of homeless people and those sleeping rough (Fitzpatrick et al, 2012). The authors identify UK welfare reforms as jeopardising attempts to minimise the levels of homelessness in Scotland, with housing benefit caps and under-occupancy penalties most likely to affect families and children who lack financial and social capital to deal with this.

By 2025 we might like to consider that current shortfalls in advocacy will be reduced. At present we have a 'postcode lottery' with shortages most acute for specialist groups such as those with mental health problems or BME groups (Newbigging et al, 2007); other reports have identified the need for additional and separate advocacy for carers (DSDC, 2003). We also have a shortage of trained advocates, particularly in relation to mental health (Scottish Government, 2009), despite the duty on local authorities to provide advocacy to those covered by the Mental Health (Care and Treatment) (Scotland) Act, 2003.

Increased funding for advocacy in the future may be unlikely, however, due not only to financial pressures but a lack of robust data about its effectiveness in providing improved outcomes for people (McNutt, 2011). This creates an onus on the sector to generate this evidence if future funding for comprehensive and continuous services is to be secured. Otherwise, there may be too few advocates, with future workers affected by short-term project funding, lurching from one contract to another. This will frustrate

advocates in attempts to build trusting relationships with people that we know are important for successful advocacy (Palmer et al, 2012).

By 2025, there may have been changes to *who* is delivering advocacy. While advocacy fits well with the core values of social work to help people achieve self-fulfillment, relationships between social workers and the people they are supporting can be compromised with social workers torn between managing scarce resources and representing the views of the person they are supporting (Beresford and Croft, 2004). Independent advocacy has also been shown to be important where relationships between people and social workers have been damaged (Featherstone and Fraser, 2012), with this traditionally provided by third sector or voluntary organisations. However, some have accused the third sector of losing its independence and being distracted from advocacy as it competes for public contracts in scarce financial times (Rhodes and Broad, 2011; Alcock, 2012a) at the expense of tackling structural inequality or discrimination in society (McCabe, 2012).

Currently, citizen or peer advocates do not fill the need gap and smaller community-based organisations are less likely to secure government contracts and support – with talk of 'bifurcation' within the sector and growing gap between insider an outsider organisations (Alcock, 2012b). Recruitment problems have also been documented, with issues a round confidence and fear of stigma or discrimination cited as a cause (National Children's Bureau, 2004). We might conclude that independent advocacy is at real risk and that there may be a real shortfall in the future. Without it, the Equality and Human Rights Commission (EHRC, 2009) conclude that inequality will grow.

PART 3 PAY AND CONDITIONS, REGISTRATION AND TRAINING

PAY AND CONDITIONS

- We have no data on the average lifespan of providers of social care, nor data on job tenure as an indicator of job stability or security.

- The Low Pay Commission identifies social care as a low paying sector - although the number of social care jobs paid at the minimum wage has fallen in recent years (SSSC, 2011).

- More generally across all UK jobs/professions, pay is higher for public sector workers than private sector ones (ONS, 2012a; b) – whilst recognising the difficulties of making comparisons for comparable jobs.

- In 1998 the number of part-time workers in the sector's workforce accounted for 41% of the total, by 2007 this had fallen to approx. 36% (SSSC, 2011), explained by a rise in full-time posts. This data does not include Personal Assistants.

- Excluding Personal Assistants, just under one in four of the workforce are on non-permanent contracts (21%) (SSSC, 2012b).

- Trade union density in health and social care is 42% (including heavily unionised occupations such as nurses, midwives, and therapy professionals in the NHS). Membership is significantly lower in the private and third sectors than the public sector (Brownlie, 2012).

Stability of employment

It seems logical to argue that the decline of the public sector may lead to less secure employment conditions in the future. However, we do not possess data on the average lifespan of companies in the social services sector. Nevertheless, we are aware of the high profile collapse of certain private companies such as Southern Cross. To some, this has highlighted how little financial scrutiny there is. Buyouts, bond issues, refinancing and inter-company loans (and even offshore tax havens) can contribute to the complex and sometimes risky financial arrangements of some private investors and companies - making it difficult for local authority commissioners to keep track. These companies are also at the mercy of markets and changing economics. In the case of Southern Cross for example, they were vulnerable to huge rent increases (having sold off their housing stock to rent back for short-term profits). The Corporate Watch study (2012) of Britain's 10 largest care home providers also found dangerously high levels of debt in some.

While Southern Cross was taken over by another operator, some have identified the regulatory hole as an issue. We might imagine that in the future, the Care

Inspectorate's call for greater monitoring of the financial viability of employers has been heeded, as has Audit Scotland's advice that councils have contingency plans in case providers close as a way to manage the increased risks of greater private and third sector involvement (Audit Scotland, 2012) as well as work more locally. Retendering processes may also have changed, taking notice of concerns that they did not identify risk (or were impact assessed) before being taken forward (CCPS, 2008) to avoid service and staff transfer or disruption to services. If unheeded, we might imagine a future where legal action is more than just a threat.

We might also envisage that in 2025 current European Union Proposals for a revised Public Procurement directive (with legislation planned for 2014) has happened. These proposals have been welcomed by CCPS as a positive step towards better procurement of social services, with potentially less frequent competitive retendering and greater focus on quality. However, others regard these moves as anti-competitive and likely to favour long, inflexible and large (sometimes global) companies over SMEs and social enterprises. If true, this could run counter to community connecting and sourcing ambitions to regenerate local communities.

The point has also been made that those using self directed support have the *potential* to move contracts faster than local authorities. Theoretically, if unpredictable numbers of users were to renegotiate contracts or opt out at short notice, providers could be destabilised and put workers out of jobs. There is little evidence of this to date, however. Rather, fears and anxieties have been expressed about the *potential* for this to happen, along with worries that direct payment holders will be less reliable at making payments on time (leading to cash flow problems) or will poach staff to become Personal Assistants (Rummery et al, 2012). Some have hypothesised that in this scenario, providers may develop new business approaches - such as introducing longer notice periods, risk premiums or framework agreements that fix a price but provide no commitment on the volume of service (Rummery et al, 2012). In this scenario, unit costs would increase to support stability. As Rummery and colleagues (2012) note, however, this assumes a future where we have *not* shifted in large scale to using Personal Assistants.

Pay and conditions

The Low Pay Commission identifies social care as a low paying sector along with others such as hospitality and retail. This should be understood within a wider context whereby Britain has witnessed the decline of manufacturing and skilled and unskilled manual labour over the last 50 years. At the same time, there has been a rise in managerial, professional and technical jobs as well as growth in relatively 'low skilled' 'personal, sales and customer services, creating a widening pay gap as part of a diverging western wage economy (Philpott, 2012). Social services workers in the main are near the bottom of this scale.

Women have also entered the labour market, with pay differentials between men and women widely acknowledged, in significant part due to occupational segregation and

different patterns of full and part-time working (ONS, 2012a)[5]. Women, as we know, make up 84% of the social services workforce (SSSC, 2012b). UK-wide and across all sectors, we also know that public sector workers earn on average 14.9% more than private sector workers (ONS, 2012b). Some private employers in social care have reported feeling embarrassed at the low wages they are able to pay, blaming local authority payment rates which have not kept pace with costs (Rainbird, Holly and Leisten, 2002). While the average pay for a Personal Assistant is above the Living Wage, there are also clear variations across different areas (Reid Howie Associates, 2010).

We can speculate that in one future, inequalities of pay across the public/private/ third sector spheres of the social services workforce may have been reduced - if not eradicated. If so, this may be because commissioners have changed their processes, setting budgets in advance of inviting tenders and applying the same best value and quality criteria in all cases. This may be supported by future successes of the Living Wage Movement, which currently commits public sector employers covered by the Scottish Government's pay policy to apply the Scottish Living Wage. However, while the Scottish Government has urged others to follow suit, hopes to extend this to procured services financed by the public purse have not been realised, with some citing legal challenges as a block to this.

It is also possible that by 2025 trade unions (strong in the NHS) might have attracted more members from social service workers - particularly if job losses and issues around equitable and comparable pay are brought to the fore as a result of the integration of health and social care. The creation of more generic or hybrid roles highlight these challenges and raises questions around *who* the employing organisation should be (NHS, local authority, or Health and Social Care Partnership) and appropriate pay and grading. As to whether we can imagine a future where trade unions are able to secure a framework agreement linking pay to qualifications on the SCQF across health and social care, this is by no means certain. The National Review of the Early Years and Childcare Workforce (Scottish Executive, 2006d) concluded that it was not possible to determine pay and conditions nationally given the range of employers across the public, private and third sectors. Nevertheless, the same review *believed* that a common description of the roles of leaders, practitioners and support workers which could be applied nationally and in different settings, may lead to clearer career pathways and better recognition and reward (linked closely to the registration agenda).

In another future, we might conclude, more pessimistically, that there are unlikely to be any significant pay increases to social service workers - *unless* there are recruitment shortfalls or *unless* any savings made as a result of integrating health and social care are passed onto an up-skilled, qualified and redistributed workforce. If Scotland's economy does not recover we may see more pay freezes or cuts in hourly rates such as those reported by third sector employers in the social services sector (Cunningham, 2011).

[5] According to the Office of National Statistics, the gender pay gap for full-time workers fell to 9.6% in April 2012. If we look at all employees (full and part time), the gender pay gap is larger: 19.7% in 2012, down from 20.2% in 2011. For part-timers, the pay gap remains negative, meaning women are better paid than men. (Annual Survey of Hours and Earnings, 2012 Provisional Results. Office for National Statistics)

As for conditions, 79% of the current workforce are on permanent contracts - although this is significantly lower in some sub-sectors, particularly childcare and nursing agencies. While a substantial proportion of staff are in part-time roles (39% compared with a national average of 28% based on LFS data), there is no evidence to say whether or not social service workers are 'underemployed' or choosing to work fewer hours for their own reasons. Nevertheless, a recent study across a range of sectors indicates that the number of people working part-time who want a full-time job has risen from 70,000 in 2008 to 120,000 in 2012 (Joseph Rowntree Foundation, 2013). It may be that Personal Assistants (excluded from this data) may change the face of the future workforce forever, with fears that this casualised and unprotected group of workers may undermine others' terms and conditions. Presently, evidence suggests that a significant minority of Personal Assistants (15%) do not have employment contracts, leaving them vulnerable to mistreatment and legal and personal reprisals (Reid Howie Associates, 2010). We also know that, on average, they work 18 hours a week, but we do not know if they feel underemployed; we do know, however, that many have more than one job, often outwith the sector (Reid Howie Associates, 2010).

The 'good work contract'

Research by economists and psychologists shows that while a reliable income and job security remain important to employees, people are more likely to engage (and stay) with their organisation if it provides:

- a clear sense of organisational purpose
- autonomy and scope for discretion and control over their pace of work
- a supportive climate
- a dynamic workplace with the ability to participate in decision making (Overell et al, 2010).

We might consider that, in 2025, social services workers have been given the professional autonomy they are currently lacking - with workers having less control and influence than they did 20 years ago, notably in social work, education, financial services and hotels and restaurants (Overell et al, 2010). According to one report, considering workforce issues in the context of self directed support, (Scottish Government, 2013b) this would see a shift to: …

> 'nurturing a skills set which will focus on individual and personal creativity and the collaborative skills of co-production… A human rights model of collaborative leadership where the rights and involvement of **all** stakeholders are held in balance…'

If we are to address failure demand, we should also consider the growing literature that shows that too much stress without control translates into serious health conditions, affecting more employees lower down the pecking order as well as Chief Executives. In the future, approaches that foster autonomy may help build emotional commitment and wellbeing and support retention by moving the workforce away from traditional risk

averse and hierarchical management structures. Of course, one drawback to this approach is that the flatter hierarchical structures associated with it present fewer opportunities for career advancement and promotion, with obvious tensions between providing intermediate roles as part of a career pathway eg assistant social worker roles, and creating 'leaders' in the workplace.

Another scenario is that none of this will have been achieved by 2025. Plans to empower workers have failed as there is a mismatch between the skills required and the people who can be recruited for the level of pay offered.

Registration and training

We can imagine that by 2025, registration of the vast majority of the social services workforce may have been completed - with or without the contentious inclusion of Personal Assistants. In this scenario, Scotland will have achieved its goal of registering most of the social services workforce by 2020, with registration linked to holding approved qualifications, with the ambition of improving standards, providing career pathways and increasing the status of workers. If this succeeds, it will create a degree-led workforce to bring the social services workforce into line with other professions such as nursing, teaching and medicine.

As an alternative scenario, Scotland's commitment to registration could be derailed. Ongoing cuts to college and university funding may have resulted in fewer student places being available, leaving many unable to secure a place. Furthermore, if college mergers lead to the creation of 12 regional colleges (from 41 local colleges), many prospective students may be unable or unwilling to study further away from home or meet the additional costs of travel or childcare. Scotland's future commitment to free tertiary education is also uncertain given constraints on budgets and differing policies across political parties. Arguably, this threatens the future supply of qualified social service workers as large numbers may simply abstain for fear of indebtedness.

In another scenario, registration may be delivered, but the expected improvements in care (or hoped for increases in pay and status) are not. The approach in Scotland is significantly different to that in England where providers are required to register with the Care Quality Commission (the equivalent of the Care Inspectorate in Scotland) but there are no such requirements on staff. (The only exceptions are for social workers and managers of care homes.) It is the view in England that there is insubstantial evidence linking qualifications to improved care. Duffy (2013), for example, argues that we need to learn much more about what makes for success in the employment and training of staff before putting in place regulatory controls that limit peoples' choice of employee and create costly bureaucratic controls. Only time will tell if Scotland or England's approach delivers real benefits - both to workers and to those receiving support.

We might also consider that support for ongoing training (as well as more autonomous workplaces) may be more significant in delivering desired-for improvements in care and worker confidence. Ironically, limited funds for training and ongoing staff development

have meant that many employers are prioritising training that leads to a qualification (Alliance of Sector Skills Councils, 2011). That the number of SVQ registrations in 2011 was the lowest since 2006 is perhaps explained by registration deadlines that are some way off (SSSC, 2012b). As to whether training per se is being reduced is unclear, but a popular theory is that training budgets are the first to go when money is tight. Where training for Personal Assistants comes from and who should deliver it has also been identified as a critical issue for the sector, with some suggesting that this could be a role for local authorities or third sector agencies, funded from SDS packages.

Last, but not least, we might consider that by 2025 the integration of health and social care will have led to the establishment of multi-agency training and joint staff development. We might expect cross-agency secondments, job shadowing, rotational programmes and peer or mentoring support to have become standard practice for newly-qualified practitioners and social care students. Those receiving care or their carers may also be expected to be integral in the delivery of training, modeling existing good practice such as that of the Good Life Group who provide training for service providers across the board - from consultants to cleaners – and speak at conferences, provide advocacy and serve on various quality assurance committees to improve person centred care. Similarly, we may see more users of services trained to provide feedback on undergraduate social workers on placement (and shape future job descriptions and person specifications too) - extending existing requirements to involve them in informing the curriculum. In this scenario, practitioners will be improvement agents too, engaged in action research or applying improvement methodology, working closely with those using services, to improve the care they deliver and create an evidence-base for new approaches.

On-line tutorials, courses and materials may be more prevalent in the future also. Existing barriers around access to vimeo case studies or restrictions preventing 17% from accessing the Social Services Knowledge Scotland (SSKS) portal (IRISS, 2012) might have been overcome with the lifting of firewall restrictions. It is unlikely, however, that these will replace the need for face-to-face contact in the future. The isolation of more mobile and flexible workers may be a real danger *unless* line managers are prepared to work outside traditional office hours or unless other forms of support eg practice forum initiatives are provided. Furthermore, the future may allow for greater celebration of successes (extending Care Accolades) and be more prepared to enter into honest dialogue around failed ideas!

SECURING THE FUTURE WORKFORCE

- The average social services worker is 43 years old, 10% are over 60 (SSSC, 2012b).
- Personal Assistants are on average 40 years old (Reid Howie Associates, 2010).
- 84% of the social services workforce is female - rising to 94% for childcare agency staff, 97% of daycare for children workers and 100% of childminders (SSSC, 2012b).
- The Early Years and Childcare Workforce along with Early Education and Childcare provision are two areas highlighted by the Scottish Government as needing to recruit more men (Scottish Government, 2011).
- We have no data on: the length of time that social service workers in Scotland stay in a job or the sector; when they enter or leave.
- A 2009 SSSC survey indicated that 3% of social services workforce are migrant workers. This may be as high as 5% in care homes for adults (SSSC/Skills for Care and Development 2009).

The average age of Scotland's social services workers, coupled with issues around low pay, raise questions around the future recruitment and sustainability of the workforce.

Evidence suggests that Scotland has been more effective at handling recruitment and retention than England (Cosh, 2011). This is explained as the result of better workforce planning from 2003 following concerns about shortages in some areas, with SSSC support for workforce development highlighted as a positive factor. Furthermore, the then Scottish Executive introduced one-off payments for staff to remain for an agreed number of years, as well as a fast track scheme to bring in extra social workers by enabling people to qualify in two years without having to leave their jobs. Cosh's (2011) comparative study of the two nations has also put Scotland's successes down to a reduction in the use of agency workers (influenced by the introduction of Agency Workers Regulations which gave them the same rights as permanent staff after 12 weeks) to create a more stable workforce. She also notes newly-qualified social workers in Scotland have had less problems finding a job than their English counterparts (Cosh, 2011). Last, but not least, we might consider that although 15% of respondents to a 2010 Sector Skills Assessment questionnaire had been recruited from out with the EU in the previous 12 months, the latest labour market information suggests that this need has largely dissipated, resulting in increased restrictions by the Migration Advisory Committee on recruitment from countries outside the EU (SSSC, 2012b). On this basis, we might conclude that Scotland has been effective at matching supply and demand and has the workforce planning skills to avoid serious recruitment and retention issues in 2025.

In another future, the picture may be quite different. If we envision a future workforce composed of large numbers of Personal Assistants, the sector may be alarmed by reports that recruitment is a real problem (IFF, 2008; Reid Howie Associates, 2010). Mental Health Officers also seem to be in short supply (SSSC, 2012b), while Care Inspectorate reports indicate that retention of nursery staff can be an issue while other reports indicate that care workers are hard to recruit and retain on the basis of low pay and conditions (and often zero hour contracts) combined with few opportunities for career advancement except retraining as a nurse (Scottish Care, 2013). A future Scotland may be insufficiently informed about recruitment, retention and the reasons that people choose (or do not choose) a career in the social services - let alone prepared to find ways to recruit younger workers or men, for example by targeting school-age pupils or challenging stereotypes. The current 'snapshot' data on vacancies is confusing and arguably not fine grained enough or gathered in a regular or consistent manner. For example, 78% of respondents to a 2011 SSSC questionnaire indicated that they had not experienced difficulties in filling vacancies and a Scottish Care employer engagement exercise (with eight events over 2012) concluded recruitment was not a prominent issue. Other studies, however, have suggested that social services have more hard to fill vacancies compared with averages across 'other industries' (3% and 2% respectively) (SSSC, 2012b p45-46) - although an IFF study (2011) disagrees, concluding that the sector has the same proportion of hard to fill vacancies (1%) as everyone else (IFF, 2011).

We might consider that in the future, the sector has better data on vacancies which can be analysed alongside information on entry or exit to the profession, job tenure or 'churn' to better-understand employment patterns. Arguably, we need to ascertain the extent of any problem as a first step.

CONCLUSION AND DISCUSSION

In terms of future roles for the 2025 workforce, previous attempts to shift the focus onto wellbeing and community have failed. If this happens again, we may retreat to practice defaults based on minimum and statutory requirements and crisis management at a time of shrinking budgets. This remains a real possibility without effective leadership, although perhaps less so as a result of legislative changes (actual and potential), coupled with acceptance that things cannot stay the same.

Within some of the future roles identified and options within them, it should also be acknowledged that they are inter-related and will have different sets of consequences for future *jobs*. This is perhaps most starkly illustrated in relation to social workers as different roles or functions could be included in their job description - or could equally be distributed to others in different combinations.

More generally, we might conclude the following about the social services workforce in 2025:

1 We cannot predict the size of the future workforce without more sophisticated workforce planning, jointly achieved by health and social care working together to bring together local data that recognises regional difference and diversity.
2 We cannot be certain that health and social care will be equal partners or that funds will not be diverted to acute care if more preventative and people-centred approaches fail. This will require real determination and strong leadership at all levels with issues around parity of esteem between the two sectors to be addressed.
3 It is a real prospect that need will continue to outstrip supply and workers will need to manage and assess budgets using eligibility criteria. It is improbable that this will become the function of the DWP unless the UK government is prepared to further upset relationships between central and local government and Scotland. This may also be determined by Scotland's vote in the 2014 independence referendum.
4 The public sector will continue to decline; however any significant increase in third sector organisations or social enterprises is uncertain.
5 Peoples' increasing expectations will drive more personalised approaches, reablement and self-management to provide more care at home or in a homely setting - with changes to the composition and skillset of the workforce.
6 A more flexible and mobile workforce will emerge. Logically, this should see a decrease in the hospital world, residential homes and day care centres and a slimmed down infrastructure built around bricks and mortar. History might guard us against making such assumptions, however.
7 There will be greater power-sharing with those receiving care, with professionals moving from the position of expert to one of facilitator and co-producer. Relationship-focused (rather than task-focused) jobs will increase in prominence and require up-skilling of the workforce.
8 There will be a greater focus on assets and ways to support health rather than

approaches that concentrate on deficits and disease; however, this may or may not be extended to communities to realise ambitions around empowering citizens and helping regenerate communities.

9 The future functions of the social worker are uncertain, with others able to take on many of its roles including care management. The one exception relates to its statutory duties.

10 Brokerage and support planning may be separated from resource allocation and delivered by independent brokers or user-led organisations in the third sector.

11 While increases in the size of the Personal Assistant workforce are anticipated (along with opportunities to support recruitment, payroll and training needs or provide agency PAs) its successful rise is not guaranteed. There may be a backlash to self directed support.

12 Independent advocacy is at risk, particularly if there are more cuts to third sector funding with widening inequalities likely to be the result.

13 We can predict that telehealth, telecare and telemedicine will continue to grow to support more people to stay at home longer, and this will require carers as well as workers to develop skills in this area. New roles related to their design, installation and maintenance may also emerge and may attract more men to the sector.

14 In 2025, we can imagine that there will be closer working with healthcare professionals, with some co-location of staff, shared staff development and the emergence of new generic or hybrid roles. Clarity on what functions are reserved to social services and healthcare staff will be required, and again will call for leadership to ensure a streamlined workforce fit for purpose. New courses and qualifications will need to be developed for these roles, and recruitment strategies considered if there is not capacity in the existing workforce.

15 The role of unpaid carers will remain essential and critical to delivering care, with the ambition that they be treated and included as equal partners in this. Supporting carers will also be paramount if Scotland is not to generate increased demand on its services.

16 The marketplace for providers (and their employees) *may* become less stable, although changes to procurement and commissioning may alleviate this.

17 Inequalities of pay across the public/private/third sectors may be reduced if budgets are set in advance and the same best value and quality criteria are applied to all tenders. The location of roles on a shared qualifications framework may also reduce inequalities.

18 There are unlikely to be any significant increases in pay unless there are recruitment shortfalls or unless the upskilling of staff through the registration and professionalisation agenda converges with savings in a redistributed health and social care workforce.

19 Scotland is committed to the registration and regulation of the workforce to recognise and drive higher standards. England is not. This invites comparison and may influence future decision-making. The capacity of the college sector to deliver this workforce and ongoing commitment to free tertiary education may derail this agenda or lead to a shortfall in qualified workers.

20 Workers with a clear purpose and autonomy in decision-making are likely to be more creative and productive with higher levels of retention and wellbeing.

However, this will require cultural change and real commitment from leaders and low pay may present a barrier.

21 The integration of health and social care and more flexible, mobile workers will require new approaches to staff development and training to support shared understanding, multidisciplinary working and prevent isolation. Online support will have a significant part to play but will not remove the need for face to face contact.

22 In 2025, innovation might be fostered by greater celebration of successes and more honest debate around failure.

23 The future supply of workers does not seem to be a significant problem based on current evidence- however, we need better data on vacancies, job tenure, entry and exit from the profession or ‘churn’. It would be unwise to be complacent.

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APPENDIX A