ISSN 2047-9638
Issue 9- September 2010

KING'S College LONDON

SOCIAL CARE WORKFORCE RESEARCH UNIT

Social Care Workforce Periodical

THE DEMENTIA SOCIAL CARE WORKFORCE IN ENGLAND

Shereen Hussein, BSc MSc PhD

September 2010

ISSUE **9**
SOCIAL CARE WORKFORCE RESEARCH UNIT
KING'S COLLEGE LONDON
Correspondence: Dr Shereen Hussein
shereen.hussein@kcl.ac.uk

About *Social Care Workforce Periodical*

The *Social Care Workforce Periodical* (SCWP) is a regular web-based publication, published by the Social Care Workforce Research Unit, King's College London. SCWP aims to provide timely and up-to-date information on the social care workforce in England. In each issue, one aspect of the workforce is investigated through the analysis of emerging quantitative workforce data to provide evidence-based information that relates specifically to the social care workforce in England. The purpose is to share emerging findings with the social care sector to help improve workforce intelligence. Such updates are useful in highlighting specific issues for further analysis and to inform workforce policy. The first few issues of *Social Care Workforce Periodical* provide in-depth analyses of the latest versions of the National Minimum Data Set in Social Care (NMDS-SC). We welcome suggestions for topics to be included in future issues.

About the author

Shereen Hussein is a senior research fellow at the Social Care Workforce Research Unit (SCWRU), King's College London. Shereen holds a Ph.D in statistical demography from the London School of Economics and an MSc in Medical Demography from the London School of Hygiene and Tropical Medicine. Prior to working at the SCWRU she worked with a number of international organisations, including the Population Council and the United Nations. Her current research interests include modelling workforce dynamics and profile, safeguarding older people, and migration and long-term care. Shereen is a member of the National Dementia Strategy's Workforce Advisory Group.

For further information on SCWP please contact Dr Shereen Hussein; email: shereen.hussein@kcl.ac.uk; phone: + (44) (0) 207 848 1669.

Acknowledgments

The author is most grateful to Skills for Care for providing the latest NMDS-SC data files. Special thanks to colleagues at Skills for Care and the Social Care Workforce Research Unit. This work is funded under the Department of Health Policy Research Programme support for the Social Care Workforce Research Unit at King's College London. The views expressed in this report are those of the author alone and should not necessarily be interpreted as those of the Department of Health or Skills for Care.

Executive Summary

Dementia is a progressive and largely irreversible clinical syndrome that is characterised by a widespread impairment of mental function. It is estimated that there are 700,000 people with dementia in the UK and approximately one million people are caring for family members with dementia. There is growing concern about the quality of formal or paid care provided to people with dementia in the UK. Globally, dementia care is increasingly provided not in hospital settings but through social care services. Caring for people with dementia within social care settings requires much more than just having '*a kind heart and common sense*' but needs to be built upon evidence-based psycho-social interventions (Moniz-Cook and Manthorpe 2009). At the same time, current working conditions and career pathways do not always help to improve skills and cultures of care. In England, the *National Dementia Strategy* (Department of Health 2009) seeks to transform the quality of dementia care through encouraging at least a minimum standard of dementia training for all social care staff. Objective 13 of the *National Dementia Strategy* identifies the crucial role of training and workforce development in realising the overall objectives of the *Strategy*.

The aim of this Issue is to use the latest data from the NMDS-SC (June 2010) to investigate the characteristics of the social care dementia workforce as presented by employers who completed the NMDS-SC. Such data contain detailed information on around 500,000 social care workers. One aim is to examine the specific profile of workers who are identified as working in social care activities that explicitly provide services for older people with dementia relative to workers in other settings. The analysis also has a specific focus on qualifications obtained and being worked towards among those working with people with dementia compared to other workers.

The NMDS-SC data indicate that 42 percent of all workers are employed in establishments that explicitly provide services to older people with dementia. Findings based on analysis of recent information related to workers' nationality indicate that larger proportions of the dementia care workforce are non-UK nationals compared to other parts of the social care workforce, with possible consequences in relation to communication, cultural understandings of dementia and language proficiency. Recent additional data also indicate that workers within the dementia care workforce are more likely to hold no relevant qualifications and are not working towards any qualifications when compared to other workers. However, it should be noted that these findings are based on relatively smaller number of returns relative to the overall NMDS data (89,437 and 11,904 workers respectively).

Examining the profile of the dementia care workforce using data based on 499,034 individual workers' records, a number of distinctive characteristics of the dementia care workforce emerge. On the personal level, dementia care

workers were significantly more likely to be women and of Asian ethnicity than other workers. They were significantly less likely to hold qualifications higher than NVQ level 2/2+ or to be working towards same higher levels of qualifications. The job profile of dementia care workers was also distinctive, with significantly higher levels of agency (temporary) workers and part-time workers. Dementia care workers were significantly more likely to be working in the private sector and in settings providing domiciliary care work than other care workers.

A number of implications arise based on these findings and these may directly relate to quality of care provided to older people with dementia. The fact that the dementia care workforce is less likely to hold qualifications higher than level 2 and the suggestion that they are more likely to hold no relevant qualifications are of particular concern. This may be exacerbated by the suggestion that there is a higher prevalence of non-UK nationals within this workforce, which may highlight issues related to communication and language proficiency. Another important factor is the high prevalence of agency workers and temporary workers within this workforce and implications of this on their levels of training, skills and continuity of care.

A large proportion of social care in England is provided by the independent sector (both the private and voluntary sectors); the analyses indicate that dementia care workers are significantly more likely to work in the private sector but significantly less likely to be working in the voluntary sector when compared to other workers (while accounting for other factors). Again these findings may affect the quality of care provided, given the lower pay rates and less generous working conditions observed within the private care sector. Similarly, issues of safeguarding older people with dementia are highlighted in relation to the high likelihood of dementia care workers to be providing care in older people's homes.

Background

The number of people with dementia in the UK, as well as other countries, is growing (Downs and Bowers, 2008). At the same time, there is a growing concern about the quality of care provided to people with dementia in the UK. Globally, dementia care is provided away from hospital settings and social care settings increasingly provide care for people with substantial cognitive impairment (Howe & Kung, 2003; Reilly *et al.* 2006). Caring for people with dementia within social care settings requires much more than just having '*a kind heart and common sense*' model which has been reported as attracting most care workers (Doyle and Ward, 1998). At the same time, current working conditions and limited career pathways do not always help to dramatically change this perception.

There are an estimated 600,000 to 750,000 people with dementia in the UK. One-third of people with dementia are estimated to live in care homes, this figure is expected to double in 30 years. Two-thirds of care home residents have a form of dementia, according to the Alzheimer's Society (2010). Different types of dementia and symptoms pose unique challenges to social care workers, with requirements for skills wider than simply 'recognising' dementia and social care support now includes working within new models of choice and control (personalisation), advocacy, safeguarding, mental capacity, carers' support, and managing challenging behaviour. The encouragement of specialist skills amongst staff to meet the particular needs of people with dementia is an international ambition. Within new models of social care in England, often known as the 'personalisation agenda', person-centred assessment and problem-solving approaches are recommended to support people with dementia (Aberdeen, Leggat and Barraclough, 2010).

The *National Dementia Strategy* states that by 2014 services are expected to be able to support early diagnosis and intervention, and enable everyone to *'live well with dementia'*. Yet evidence from the Department of Health's consultation on the Strategy suggests that the quality of care is being undermined by a major skills shortage (Community Care 2009). Everyone who comes into contact with older people will be required to have some knowledge of dementia and best practice in dementia care (Department of Health 2009). While national recognition of the need to improve the quality of care to people with dementia is gaining momentum, a recent survey by Community Care (March 2010) showed that two thirds of respondents (mostly frontline practitioners) felt that the *National Dementia Strategy* has had little or no impact in their area of practice and nearly half, 42 percent, felt that the quality of dementia care in their areas is poor (Community Care 2010).

The role of in-service and continuous training, including induction, additional training and opportunities to develop and achieve further qualifications, are important in ensuring the quality of service provided by the dementia care workforce. However, the impact of in-service training on dementia may be short-

lived.. In-service training can be patchy and may range from watching videos to receiving several days training. The House of Commons' Committee on Public Accounts (2010) raised serious concerns over the slow pace of improvement needed to ensure the quality of dementia care, which had been previously identified as a matter of 'urgency' (House of Commons 2007). The *Strategy* also points to a lack of quality assurance for training programmes. In social work, the main professional qualification in social care, all degree courses include awareness of dementia, under the core subject areas of human growth and development, and mental health and disability. To boost learning, a long-term pledge of the *Strategy* is to upgrade the degree and post-qualifying awards to include specific modules on dementia.

In a systematic review of factors affecting the recruitment and retention of nurses to work in dementia care in Australia, Chenoweth and colleagues (2010) identified pay parity to be key in retaining staff. From England, Hughes and colleagues (2008) found that the knowledge of care staff in care home of dementia was reasonable, however, confidence in dealing with related situations was lower. Based on the results of 254 completed staff questionnaires, an earlier study suggested that staff in care homes have received relatively little training, particularly related to the mental health needs of older people including depression and dementia (Mozley *et al.* 2004). While they noted a low level of training, they suggest that even limited training opportunities may improve the perceived confidence of care staff in caring for people with dementia.

In England, the *National Dementia Strategy* seeks to transform the quality of dementia care through minimum dementia training for all social care staff. This is in the context of growing concern about the limits of specialist training for professional and non-professional practitioners working with people with dementia (for example, see Downs *et al.* 2009). Objective 13 of the *Strategy* identifies the crucial role of training and workforce development. The Strategy's pledge to develop '*an informed and effective workforce for people with dementia*', acknowledged the basic training needs of all care staff and the added need for continuing professional learning for social care staff providing care mainly to people with dementia. A mapping exercise undertaken for the Department of Health, Skills for Care and Skills for Health (DH, SfC and SfH, 2010) identified principal gaps in the dementia accreditation framework at Qualifications and Credit Framework (QCF) levels 1, 3, 4 and 5. This scoping exercise maintains that all staff will encounter people with dementia at one point of time. Additionally, those working in specific dementia settings require a comprehensive accredited dementia framework developing specific relevant skills.

The aim of this Issue is to use the latest data of the NMDS-SC (June 2010) to investigate the characteristics of the social care dementia workforce as presented by employers who completed the NMDS-SC. Such data contains detailed information on around 500,000 social care workers. One aim is to examine the specific profile of workers who are identified to be working in provision that explicitly provide services for older people with dementia compared to workers in other settings. The analysis also presents a specific focus on qualifications obtained and being worked towards among those staff working

with people with dementia compared to other workers. The results are then critically discussed within the current policy climate of increasing attention to the importance of workforce development to ensure better quality care for people with dementia.

Methods

The current Issue uses the NMDS-SC, end of June 2010 release, which covers returns from social care employers in England up to the end of June 2010. The data were completed by 24,203 employers providing detailed information on 501,734 employees. We restricted the analysis on employees aged over 16 and under 76 years of age; we also removed some duplicate records, this resulted in 457,031 unique workers' records. Over three quarters of NMDS-SC returns, June 2010, were updated during the previous 12 months. These returns contain data from 13,542 providers, which are registered with the Care Quality Commission (CQC), accounting for 54.4 percent of all CQC registrations. The dataset also contains information on a considerable number (10,661) of care providers that are not CQC registered (for example, because they are day care centres and do not have to register), mainly from the private and voluntary sectors[1].

The June 2010 NMDS-SC data release contains new data items that were introduced from the beginning of 2010 but will formally constitute part of the NMDS-SC from October 2010. The new items include improvements to the qualification questions and additional information on nationality and country of birth. These data items have only been completed by a small minority of employers who have updated their records very recently. Here these new data items are analysed as complimentary elements to the main analyses based on the main data returns, but the limitations of the data need to be borne in mind.

The current Issue employs descriptive and multivariate statistical analysis with the following aims:

- To identify the proportion of the workforce which work in organisations which support older people with dementia as a client/user group;
- To explore whether the characteristics of this dementia care workforce differ from those working in employment supporting other client groups; and
- To explore in depth the variations in levels of qualifications held, and those being worked towards, among the dementia care workforce in comparison to the rest of the workforce.

In this Issue we will refer to workers who are reported to be working in settings that support older people with dementia (either as the main service users' group or not) as the 'dementia care workforce'. This group will be compared to 'other workers'; those working in settings that do not support older people with dementia.

[1] Figures provided by Skills for Care for the NMDS-SC Data User Group meeting on the 2nd of September 2010

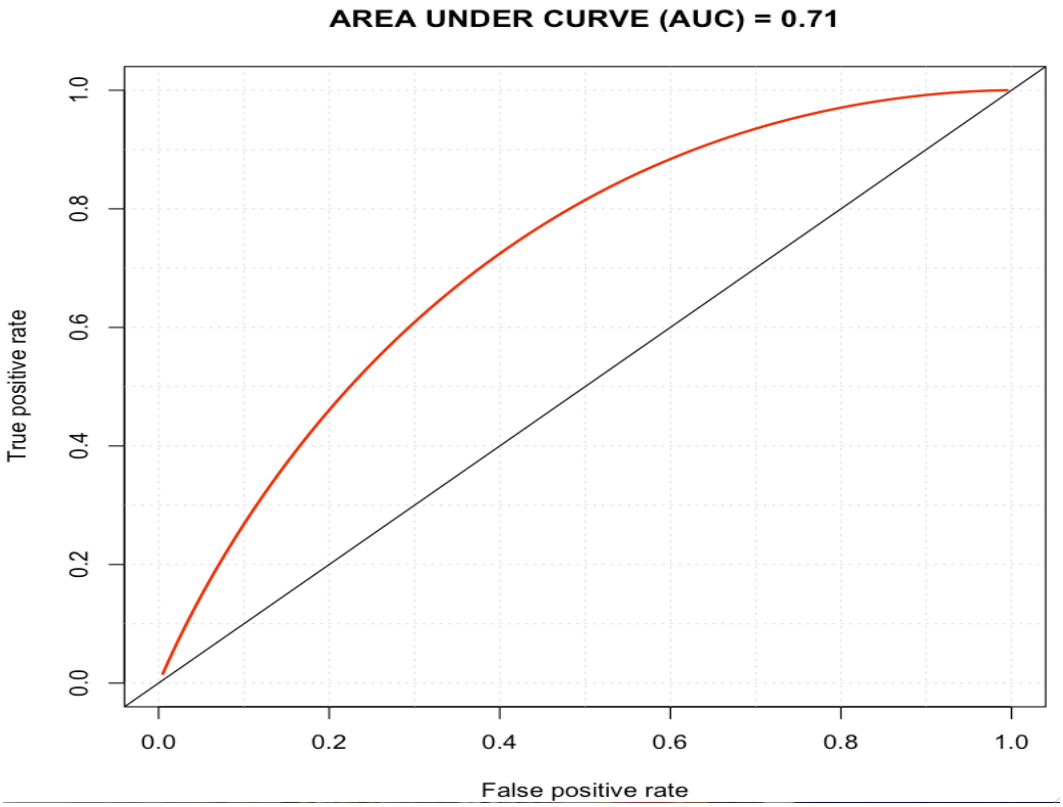
The descriptive analysis is used to inform a logistic regression model which is designed to identify any significant differences between the dementia care workforce and the rest of the care workforce. The model used can be simplified in the following equation:

$$\log it(DementiaWorkForce) = \alpha + b_1 Age + b_2 Gender + b_3 Disabled + b_4 Ethnicgroup + b_5 Qualification + b_4 Employmentstatus + b_5 Workpattern + b_6 Jobgroup + b_7 Establishmenttype + b_8 MainService + b_{11} Establishmentsize$$

Equation 1

The results of the logistic regression model identify how and in which ways the dementia care workforce is different from other sections of the care workforce while taking into account the effect of all factors together. The final model fitting is predicted to have 'very good' discriminatory power with Area Under the ROC Curve (AUC) criteria value of 0.71 (Hosmer and Lemeshow 2000), which is presented in Figure 1.

Figure 1 Overall model fitting, AUC[2], for the logistic regression model presented in Equation 1



[2] This area is interpreted as the likelihood that a case will have a higher π than a control across the range of criterion values investigated. The nearer the value of AUC to 0.5 the more likely that the results are not more than random, the closer to 1 the more likely the results of the model reflects true associations and thus have high discriminatory power.

Size and characteristics of the dementia care workforce

Personal Characteristics:

After identifying providers who reported providing services to older people with dementia (either as the main service user group or part of other groups) we were able to examine the profile of all workers in such settings in comparison to workers in other settings. The NMDS-SC collects information on a number of personal characteristics including age, gender, disability and ethnicity. Employers also provide detailed information of all (and highest) qualifications held and being worked towards for each worker. Qualifications data in particular have high levels of missing values; mainly to do with the inability to distinguish between workers whose employers do not know their qualifications (true missing) and those with 'no qualifications'. Skills for Care has introduced some additional questions to enable better response to this area and to report qualifications more accurately. These additional questions have been in operation for a relatively short period of time (from three to six months) and are discussed further later in this report. Additionally, the NMDS-SC started collecting detailed data in relation to nationality and country of birth; again these recent additions were completed by relatively small number of employers. Analysis of these new items is therefore limited because information is not widely covered in all NMDS-SC returns but it may provide some indications about areas where knowledge gaps exist, particularly in relation to migration. Levels of missing values for each of these items vary and are reported in the corresponding tables.

Age, gender, disability and ethnicity

The NMDS-SC individual data records (June 2010) indicate that 42 percent[3] (n= 191,716) of workers are reported to be working in organisations that provide care for people with dementia. The mean age is very similar between the two groups of workers (those working in settings providing care for people with dementia and those who are not). However, the dementia care workforce is more female dominated than the rest of the workforce, with 87 percent of the former being female. Reported disability was much lower among the dementia care workforce than the rest of the workforce. In terms of ethnicity the distribution of the dementia care workforce was quite similar to the rest of the workforce, except that it contained relatively more Asian or Asian British workers (this is mainly due to proportionally more 'other Asian'). These findings are summarised in Table 1 below.

[3] This percentage is 48 percent if calculated from the aggregate data on total workers provided in the provisional data files

Table 1 Personal characteristics of workers employed in organizations supporting people with dementia compared to social care workers employed in other settings, NMDS-SC June 2010

Personal Characteristics	Other care workforce	Dementia care workforce
Age		
Mean	42.5	42.0
SD	12.9	13.2
Valid number of records	265,315	191,716
Gender		
Male	19.5	12.8
Female	80.6	87.2
Valid number of records	256,864	180,967
Reported disability		
None	97.1	98.7
Any	2.9	1.4
Valid number of records	199,503	158,764
Ethnicity		
White	82.9	81.1
Mixed	1.8	1.2
Asian or Asian British	4.8	6.5
Black or Black British	8.1	8.7
Other groups	2.4	2.6
Valid number of records	202,193	156,603

Qualifications held and worked towards

The NMDS-SC collects information on highest qualification level held by each worker as well as highest qualifications being worked towards among workers who are undertaking qualifications. By end of June 2010, information on the highest qualification level was available for 148,726 workers and 44,498 workers were identified as working towards some qualifications (9% of the dementia workforce was identified to be working towards a qualification compared to 10% among the social care workforce in other settings). Table 2 presents the distribution of workers in dementia settings and other settings by highest qualification held and highest qualification being worked towards among those with valid information on qualifications.

Table 2 shows that among workers for whom information on qualifications is available a considerable higher proportion of the dementia workforce possesses NVQs at level 2 or 2+ than those working in other settings (47% vs. 33%). On the other hand, proportionally fewer workers in dementia settings hold the higher qualifications, NVQ levels 3 and 4 (37% vs. 46%). In terms of qualifications being worked towards, over half (56%) of the dementia workforce which is working towards any qualifications, is working towards NVQ level 2 or 2+ compared to

only 36 percent of those in other settings. Proportionally fewer of the dementia workforce are working towards NVQ level 3 or above.

Table 2 Distribution of care workforce in dementia settings and those in other settings by highest qualifications held and highest qualifications worked towards, NMDS-SC June 2010

Qualifications	Other care workforce	Dementia care workfoce
Highest qualifications held		
Other relevant qualifications	20.1	14.4
Entry or level 1	1.0	1.0
Level 2 or 2+	33.3	47.4
Level 3 or 3+	30.5	26.5
Level 4 or 4+	15.1	10.7
Valid number	84,660	64,066
Highest qualification worked towards		
Other relevant qualifications	17.2	8.8
Entry or level 1	2.1	0.3
Level 2 or 2+	35.8	55.8
Level 3 or 3+	35.2	26.9
Level 4 or 4+	9.7	8.2
Valid number	26,757	17,741

As discussed earlier, information on qualifications is missing for large numbers of workers. This is partly due to the way the questions on qualifications were asked in the NMDS-SC; with previously no option to identify workers with no relevant qualifications. To improve responses to the questions about qualifications Skills for Care introduced new questions on qualifications during 2010, to become a formal part of the NMDS from October 2010. The purpose of these additional questions is to separate missing values from reporting that workers hold no qualifications or are not working towards any qualifications. By the end of June 2010, the new questions specifically asking employers whether workers hold no qualifications or are not working towards any qualifications were completed for 11,904 workers (6,266 workers in dementia settings and 5,638 in other settings).

Among this sub-sample, as Figure 2 shows, employers identified that 9.6% of dementia workers hold no qualifications compared to 8.7% for other workers (these differences are not statistically significant χ^2=3.208, p=0.073). For this subgroup of workers, dementia care workers were identified to be significantly more likely not to be working towards any qualifications (11.1% vs.7%; χ^2=57.12, p<0.001). According to this sub-sample, the dementia care workforce appears to have larger proportions of workers with no qualifications as well as larger proportions of workers who are not working towards any qualifications. It is important to note, however, that these new questions have been completed by a small number of employers and provide information on a relatively small sample of the workforce. Such indications will need to be re-examined at a

further date once the new questions on 'no qualifications' are completed by larger proportions of employers.

Figure 2 Percentage of dementia care workers and other workers who are identified to have 'no qualifications' and 'are not working towards any qualifications'[4]

In addition to highest qualification level held, data are collected on whether each worker holds (or is working towards) individual qualifications. Employers are asked whether each employer hold or is working towards any qualification and they provided such information on 150,335 and 44,498 respectively for the dementia and other care workforces. Tables 3 and 4 provide detailed information on the percentage of workers who have achieved different qualifications and those working toward qualifications among the dementia workforce and other workers.

Table 3 confirms that among workers with reported qualifications, dementia care workers are more likely to hold 'health and social care' or 'care' NVQ level 2 when compared to other workers. But the proportions of dementia care workers who hold higher NVQ levels are considerably lower than those among other workers. However, slightly more dementia care workers hold registered nursing qualifications (8.9% vs. 7.9%) than other workers.

[4] Based on recent returns to NMDS-SC covering information on 11,904 workers

Table 3 Detailed qualifications achieved among workers in dementia settings and other care settings, NMDS-SC June 2010[5]

Qualifications held	Other care workforce	Dementia care workforce
Health and Social Care NVQ level 2	22.4	34.3
Health and Social Care NVQ level 3	13.8	11.4
Health and Social Care NVQ level 4	2.5	1.8
Care NVQ level 2	20.2	24.8
Care NVQ level 3	10.2	8.5
Care NVQ level 4	2.0	1.4
Caring for Children & Young People NVQ level 3	1.2	0.2
Any Learning Disabled Awards Framework	7.2	1.4
Other health and care-related NVQs	2.0	1.5
Registered Manager's (Adults) NVQ level 4	4.6	3.6
Registered Manager's (Children's) NVQ level 4	0.1	0.0
Other management award(s)	3.0	1.8
A1, A2 or other Assessor NVQ	4.5	3.1
V1 or other Internal Verifier NVQ	0.4	0.4
L20 or other Mentoring NVQ	0.1	0.1
Social Work degree (UK)	0.8	0.4
Social Work diploma or other approved UK or non-UK social work qualification	2.5	1.1
Combined Nursing & Social Work degree	0.1	0.1
Post-Qualifying Award in Social Work (PQSW-1)	0.6	0.3
Advanced Award in Social Work (AASW)	0.1	0.0
Child Care Award (CCA)	0.1	0.1
Mental Health Social Work Award (MHSWA)	0.1	0.1
Practice Teacher Award (PTA)	0.4	0.2
Introduction to Practice Teaching (5 day)	0.1	0.1
Mentor Award	1.1	0.9
Other Post-Qualifying Social Work Award	0.6	0.1
Any professional Occupational Therapy	0.4	0.5
Any Registered Nursing qualification	7.9	8.9
Any nursery nursing qualification	0.5	0.4
Any childcare qualification	0.5	0.4
Any teaching qualification	1.6	0.9
Any qualification in assessment of work-based learning other than social work	0.6	0.5
Any other relevant professional qualification	2.7	2.2
A Basic Skills qualification at Entry Level	1.4	2.2
A Basic Skills qualification at level 1	0.8	0.8
A Basic Skills qualification at level 2	1.3	1.2
Any other qualification relevant to social care	9.2	9.4
Any other qualification relevant to the job role	22.9	18.3
Number of workers with any information on qualifications achieved	84,660	64,066

[5] Columns will add up to more than 100% as each worker may hold more than one qualification. Figures are based on workers with any reported qualifications and exclude workers where employers did not provide any information on their qualifications. Same note apply to Table 4.

Table 4 presents data about the detailed qualifications being worked towards among workers whose employers indicated that they are working towards some qualifications. As indicated in Figure 2, the percentage of dementia care workforce who is working towards any qualifications is lower than that among other care workforce. Considerably larger proportions of the dementia care workforce are working towards level 2 qualifications, which may indicate that the dementia workforce is starting from overall lower levels of qualifications. This is also reflected in the higher proportions of non-dementia care workers who are working towards levels 3 and 4. However, a lower proportion of the dementia care workforce is working towards basic skills qualifications at entry level in comparison to the other workforce (0.2% vs. 2.1%) indicating a concentration of activities around NVQs level 2.

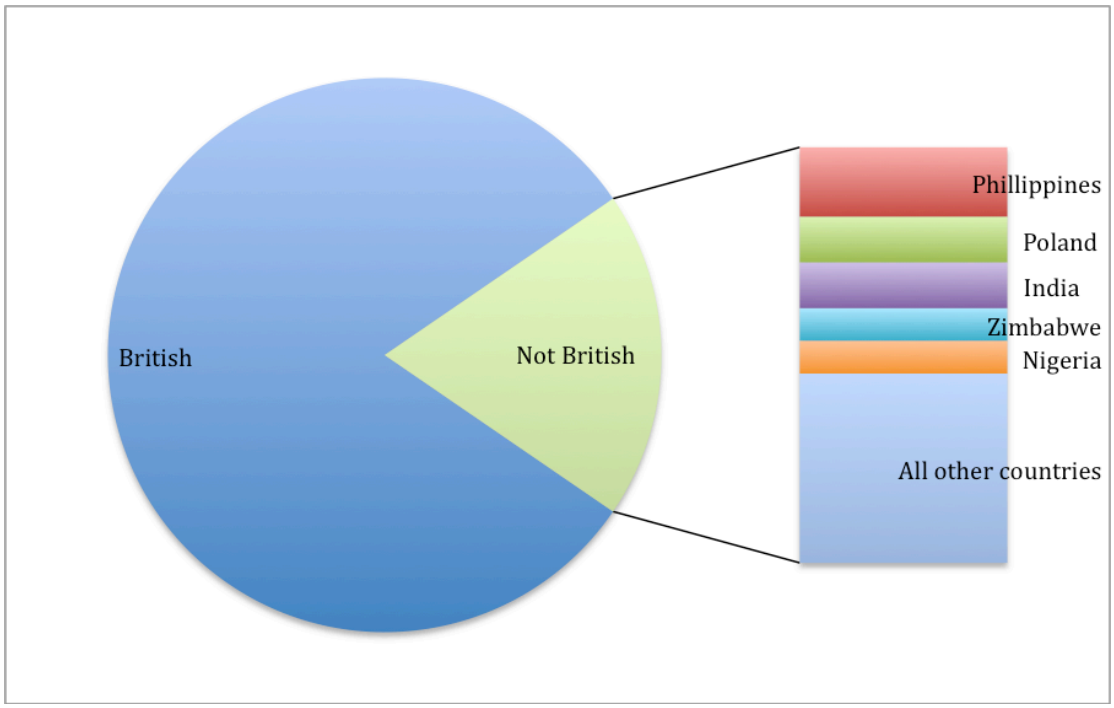
Table 4 Detailed qualifications worked towards among workers in dementia settings and other care settings, NMDS-SC June 2010

Qualifications worked towards	Other care workforce	Dementia care workforce
Health and Social Care NVQ level 2	19.5	38.2
Health and Social Care NVQ level 3	17.7	16.3
Health and Social Care NVQ level 4	3.4	3.0
Care NVQ level 2	16.0	18.3
Care NVQ level 3	10.4	7.8
Care NVQ level 4	1.2	1.4
Caring for Children & Young People NVQ level 3	0.8	0.1
Any Learning Disabled Awards Framework	5.9	0.9
Other health and care-related NVQs	0.9	0.7
Registered Manager's (Adults) NVQ level 4	2.8	2.6
Registered Manager's (Children's) NVQ level 4	0.2	0.0
Other management award(s)	1.3	0.8
A1, A2 or other Assessor NVQ	3.9	1.1
V1 or other Internal Verifier NVQ	0.2	0.1
L20 or other Mentoring NVQ	0.3	0.4
Social Work degree (UK)	2.4	1.4
Social Work diploma or other approved UK or non-UK social work qualification	0.1	0.1
Combined Nursing & Social Work degree	0.1	0.1
Post-Qualifying Award in Social Work (PQSW-1)	0.1	0.0
Advanced Award in Social Work (AASW)	0.0	0.0
Child Care Award (CCA)	0.0	0.0
Mental Health Social Work Award (MHSWA)	0.1	0.0
Practice Teacher Award (PTA)	0.0	0.0
Introduction to Practice Teaching (5 day) Award	0.0	0.0
Mentor Award	0.0	0.1
Other Post-Qualifying Social Work Award	0.1	0.0
Any professional Occupational Therapy	0.1	0.1
Any Registered Nursing qualification	1.2	1.3
Any nursery nursing qualification	0.1	0.0
Any childcare qualification	0.1	0.0
Any teaching qualification	0.3	0.1
Any qualification in assessment of work-based learning other than social work	0.4	0.2
Any other relevant professional qualification	1.1	0.6
A Basic Skills qualification at Entry Level	2.1	0.2
A Basic Skills qualification at level 1	0.3	0.2
A Basic Skills qualification at level 2	0.6	0.4
Any other qualification relevant to social care	2.1	2.2
Any other qualification relevant to the job role	10.6	6.0
Number of workers with any information on qualifications worked towards	26,757	17,741

Nationality and country of birth

Skills for Care introduced the collection of information on nationality and country of birth of workers at the beginning of 2010. However, these items are not yet a formal part of the NMDS until October 2010. By end of June 2010 employers provided such information on a total of 89,437 workers (44,568 of them work in settings providing care for older people with dementia). This initial sample indicates that the dementia workforce contains significantly more non-British workers (19.1% vs. 15.3%; χ^2=231.3, p<0.001). The main nationalities of non-UK workers among the dementia workforce are the Philippines (17%, n=1437) followed equally by Poland and India (10.8%). Nearly 8% are from Zimbabwe and Nigeria each (presented in Figure 3). The relatively large percentage of dementia workers from the Philippines is reflected in the workers' overall ethnicity where larger proportions are from 'other Asian' groups when compared to workers in settings which do not provide dementia care. The current sample with nationality data is relatively small; however, the data provide some indication of the level and composition of migrant workers within the dementia care workforce. The main 'top' nationalities of migrants are not particularly different from those among other migrants in the care workforce (Hussein, Stevens and Manthorpe 2010), but the data suggest that the prevalence of migrant workers is higher among dementia care workers.

Figure 3 Distribution of dementia care workforce by whether British or not and main nationalities if not British[6], NMDS-SC June 2010



[6] Based on recent returns to NMDS-SC during 2010 (information available for 44,568 workers in settings providing care for older people with dementia)

Job Characteristics

In addition to the personal profile of the dementia care workforce it is important to understand their job characteristics. What are the main jobs they undertake? Do their working patterns and arrangements differ from that observed among other workers? Using the NMDS we are able to identify different elements of job characteristics, including specific and broader job roles, work patterns and status as well as contracted and additional hours worked during the previous week.

Job roles

Table 5 shows the distribution of dementia care workers by broad main job role[7] compared to that of other workers in the care workforce. The data indicate that nearly three quarters (74%) of the dementia care workforce are involved in direct care jobs (such as care workers, senior care workers and support workers) this is compared to 69% among other workers.

Table 5 Distribution of dementia care workers and other care workers by main job role, NMDS-SC June 2010

Main Job role	Other care workforce	Dementia care workforce
Direct Care	69.2	73.7
Manager/Supervisor	9.9	7.2
Professional	7.2	5.2
Other	13.7	13.9
Valid number	290,769	208,265

Table 6 shows that the main difference is attributed to larger proportions of 'care workers' among the dementia care workforce (63% vs. 54.7). Only 5 percent of the dementia care workforce has professional roles, mainly because there are fewer social workers among the dementia care workforce (0.8% vs. 2.2%).

[7] Grouped as: 1. 'Managers/supervisors': senior management, middle management, first line manager, register manager, supervisor, managers and staff in care-related jobs; 2. 'Direct care': senior care worker, care worker, community support, employment support, advice and advocacy, educational support, technician, other jobs directly involving care; 3. 'Professional': social workers, occupational therapists, registered nurse, allied health professional, qualified teacher; 4. 'Other': administrative staff, ancillary staff, and other job roles not directly involving care.

Table 6 Distribution of dementia and other care workforce by main job role, NMDS-SC June 2010

Main job role	Other care workforce	Dementia care workforce
Senior Management	1.4	1.4
Middle Management	1.0	0.8
First Line Manager	2.4	1.3
Registered Manager	2.1	1.5
Supervisor	1.6	1.5
Social Worker	2.2	0.8
Senior Care Worker	6.7	7.2
Care Worker	54.7	63.0
Community Support and Outreach Work	4.6	2.2
Employment Support	0.2	0.0
Advice Guidance and Advocacy	0.2	0.1
Educational Support	0.1	0.0
Youth Offending Support	0.0	0.0
Counsellor	0.0	0.0
Occupational Therapist	0.2	0.2
Registered Nurse	4.4	4.1
Allied Health Professional	0.2	0.1
Nursery Nurse	0.0	0.0
Childcare Worker or Childcare Assistant	0.1	0.0
Teacher	0.2	0.0
Educational Assistant	0.2	0.0
Technician	0.2	0.1
Other care-providing job role	2.1	1.0
Managers and staff in care-related but not care-providing roles	1.3	0.6
Administrative or office staff not care-providing	3.9	2.6
Ancillary staff not care-providing	7.1	8.3
Other non-care-providing job roles	2.7	3.0
Number of valid cases	290,769	208,265

Work patterns and employment status

The NDMS-SC collects information on work patterns for each worker, such as whether they work full or part time or have flexible arrangements, the data also include information on the employment status of each worker (permanent, temporary etc.). The distributions of dementia and other workers according to both work pattern and employment status are presented in Tables 6 and 7.

Table 7 shows that full-time working patterns are slightly lower among dementia care workers (47% vs. 49%) while part time working is more evident (42% v. 37%). Flexible working was also lower among dementia care workers. Table 8 shows that the majority of the workforce is employed on a permanent basis,

however, agency workers appear to be more common among the dementia care workforce (2.9% vs. 0.6%). Statistics presented in Table 7 indicate that the percentage of temporary workers is higher within the dementia care workforce (3.9% vs. 2.8%).

Table 7 Distribution of dementia care workers and other care workers by patterns of work and employment status, NMDS-SC June 2010

Job characteristics	Other care workforce	Dementia care workforce
Work patterns		
Full-time	49.4	47.2
Part-time	37.2	42.2
Flexible	13.5	10.6
Valid cases	221,359	155,117
Employment status		
Permanent	89.2	86.5
Temporary	2.8	3.9
Bank or pool	6.0	5.0
Agency	0.6	2.9
Student	0.1	0.2
Volunteer	0.1	0.1
Other	1.1	1.4
Valid cases	239,077	162,620

Table 8 shows that dementia care workers are significantly more likely to be on 'zero hours' contracts (18.2% vs. 7.8%; χ^2=10866; p<0.001). Zero hours contracts usually refer to workers who do not have a set number of working hours per week and may reflect the flexibility of this workforce (despite that the majority are on permanent contracts; see Table 7). This may explain the difference in the percentages of dementia care workers who undertook any additional hours in the previous week (23.6%), which is significantly higher than the 17.6 percent observed among other workers (χ^2=731.4; p<0.001).

Table 8 Distribution of dementia and other workers by number of contracted hours per week, NMDS-SC June 2010

Number of contracted hours per week	Other care workforce	Dementia care workforce
Zero hours	7.8	18.2
Up to 15	6.5	6.8
16-25	20.9	22.8
26-35	21.4	22.3
36+	43.4	29.9
Number of valid cases	322,446	176,588

Source of recruitment

Employers provided information on source of recruitment for each worker who was included in the detailed workers' file (employers provide detailed information on all or some of the workers). They provided information on source of recruitment for 47.9% of the dementia care workforce (91,769) and 35.8% of other workforce (95,019). Table 9 shows that the distribution of recruitment sources is almost identical between the two groups. It should be noted that although the proportion of workers reported to be recruited from abroad is identical among dementia and other care workforces at 2.9 percent but the percentage of workers identified as 'not British' is higher among the dementia care workforce. Such observations may have a number of explanations. First, recruiting from abroad may refers only to workers who were recruited directly from abroad or those who had moved to the UK and their current job is their 'first' job in the country. Thus these figures do not include any workers whose nationality is not British but have not been recruited directly from abroad and those whose current jobs are their seconds or subsequent jobs. The other explanation may relate to the coverage of the current nationality data as they only reflect information on relatively small parts of the workforce (89,437 workers). Analysing nationality and country of birth data at a later data, when more employers have completed questions related to them, will help ascertain which assumption is correct.

Table 9 Distribution of dementia and other workers by reported source of recruitment to their current jobs, NMDS-SC June 2010

Source of recruitment	Other care workforce	Dementia care workforce
Social care sector[8]	55.7	54.0
Health sector	6.2	6.5
Retail sector	4.0	4.3
Abroad	2.9	2.9
Not previously employed	3.9	3.8
Other sectors/sources	27.4	28.5
Number of valid cases	95,019	91,769

[8] Includes internal promotions, returners, students on placements and those moving within and between the adult and children care sector

Workplace characteristics

In this section we explore workplace characteristics to investigate where the dementia workforce is employed. Table 10 shows that three quarters of the dementia care workforce are concentrated in the private sector compared to just over half of other workers. Only 11 percent of the dementia care workforce is working in the voluntary sector or in adult local authority provision. Dementia care workforce is a large part of the total adult domiciliary care service (39.5% vs. 15.5%) and around the same proportion (but slightly lower) of those working in residential care.

These findings reflect the concentration of the private domiciliary care as a support for people with dementia and they highlight that many older people with dementia use such services, which appear to be more concentrated in small to medium businesses. There are clear implications of these findings both in relation to possible occupational burn out and stress as well as adult safeguarding, because people with dementia have been identified as particularly vulnerable to abuse (Selwood and Cooper, 2009). Previous analyses of the NMDS-SC show that a number of workplace characteristics are prevalent in the private sector (Hussein 2010a and 2010b). These include low pay and high turnover levels, but relatively low vacancy rates, suggesting the presence of stressful work schedules with relatively fewer staff members. High turnover rate may indicate a degree of burnout, but it is not possible to ascertain this without further research.

Previous research conducted by the Social Care Workforce Research Unit in relation to the protection of vulnerable adults indicated that certain types of abuse (harm or risk of harm) are more likely to be reported within domiciliary care settings. Financial abuse was particularly more likely to be reported in domiciliary settings than other settings; while physical and emotional abuse appear to be more prevalent in residential settings (Hussein *et al.* 2009). When supporting older people with dementia who can be very vulnerable, it is important to take into account the stress and pressure on the workforce arising from certain working conditions, including low pay, and also to be alert to possible implications in terms of protecting vulnerable adults. Figures related to types of abuse are based on cases which were referred to the Protection of Vulnerable Adults List, and of course greater numbers of cases are estimated not to be reported due to a number of factors including when, where and who else is present when such incidents occur.

Table 10 Distribution of dementia and other care workers by sector and main service provision, NMDS-SC June 2010

Workplace characteristics	Other care workforce	Dementia care workforce
Sector		
Statutory local authority (adult services)	17.0	11.0
Statutory local authority (children's services)	2.1	0.1
Statutory a local authority (generic)	0.5	0.2
Statutory local authority owned	0.8	0.5
Statutory health	0.3	0.3
Private sector	55.3	74.6
Voluntary or third sector	20.4	11.0
Other	3.6	2.3
Valid cases	289,763	207,431
Staff size group[9]		
Micro	9.6	3.8
Small	55.5	44.4
Medium	29.3	48.9
Large	5.6	3.0
Valid cases	245,605	202,548
Main service provided		
Adult residential	58.6	52.1
Adult day services	3.3	1.4
Adult domiciliary	15.5	39.6
Adult community care	6.1	4.5
Children's residential	2.5	0.0
Children's day services	0.0	0.0
Children's domiciliary	0.2	0.0
Children's community	1.3	0.1
Healthcare - NHS	0.2	0.1
Healthcare - Independent	4.3	0.1
Other	8.0	2.2
Valid cases	290,769	208,265

[9] Establishment size is grouped as follows: micro employers = less than 10 staff members, small = 10-49 staff members, medium = 50-199 and large = 200 or more staff members.

How different is the profile of the dementia care workforce from other workers?

The analysis presented in the previous sections indicates that there are some specific characteristics of the dementia care workforce as reflected by the NMDS-SC data. On a personal level, the dementia care workforce (those working in settings where services to older people with dementia are provided) appear to be of the same average age but are more female dominated, with some over-representation of Asian workers. Initial data provided by some employers hints at the higher prevalence of migrant workers within this workforce, however, further data will be needed to confirm this. Dementia workers are more concentrated in the private sector with larger proportions on 'zero hours' contracts, agency and temporary contracts. They also appear to be more often working in adult domiciliary services and to work in small to medium size organizations. In terms of highest qualifications held, a concentration around NVQ level 2/2+ qualifications is evident, with relatively fewer dementia care workers possessing higher level qualifications. To account for possible interactions between these factors and to identify the main profile of the dementia care workforce we constructed a logistic regression model as explained in the methods' section. The model identifies three groups of characteristics on personal, job and organizational levels and examines their associations with being part of the dementia care workforce or not.

Table 10 presents the results of the logistic regression model. The results indicate that indeed age is not significantly different among dementia and other workforces, however, most of the other personal, job and organisational characteristics are. On the personal level, the logistic regression model confirms that the dementia workforce has significantly more representation of women and workers from BME communities (particularly Asian). The odds ratio of women among the dementia care workforce in comparison to other workers is 1.77 ($p<0.001$); and that of Asian ethnicity is 1.72 ($p<0.001$). The results also confirm the concentration of dementia workers with NVQ level 2 qualifications. The odds ratio of holding lower or higher qualifications than level 2 (or 2+) range from 0.63 to 0.73 (all with $p<0.001$) when compared to that among other workers.

On the job characteristics level, the largest magnitude is found in relation to being agency workers. The odds ratio of dementia care workforce to be working for an agency is 5.74 ($p<0.001$) when compared to the other parts of the social care workforce. They are also significantly more likely to work part time (or through other arrangements) than full time.

Table 10 Results of logistic regression model (presented in equation 1); showing significantly different characteristics of the dementia care workforce

Independent variables included in the predicting model	Odds Ratio	95% Confidence intervals		p-value
		Lower	Upper	
PERSONAL CHARACTERISTICS				
Age	1.00	1.00	1.01	0.089
Women	1.77	1.69	1.84	<0.001
Any disability	0.60	0.54	0.66	<0.001
Ethnicity (ref: White)				
Mixed	0.82	0.72	0.93	0.003
Asian	1.72	1.62	1.82	<0.001
Black	1.11	1.05	1.17	0.000
Other	1.49	1.36	1.64	<0.001
Highest qualifications (ref: lev2/2+)				
Entry/1	0.73	0.64	0.83	<0.001
Lev3/3+	0.72	0.69	0.74	<0.001
Lev4/4+	0.63	0.60	0.66	<0.001
Other relevant qualification	0.69	0.66	0.72	<0.001
JOB CHARACTERISTICS				
Employment status (ref: permanent)				
Temporary	1.08	0.98	1.20	0.130
Bank	0.79	0.72	0.86	<0.001
Agency	5.74	4.87	6.80	<0.001
Other	1.31	1.14	1.52	<0.001
Work pattern (ref: full time)				
Part-time	1.23	1.20	1.27	<0.001
Neither of these	1.16	1.07	1.25	<0.001
Main job role (ref: managers/sup)				
Direct Care	0.84	0.81	0.88	<0.001
Professional	0.85	0.79	0.90	<0.001
Other	1.25	1.17	1.34	<0.001
ORGANISATIONAL CHARACTERISTICS				
Sector (ref: local authorities)				
Private	1.83	1.74	1.92	<0.001
Voluntary	0.71	0.67	0.75	<0.001
Other	0.99	0.91	1.07	0.744
Service setting (ref: adults residential)				
Adult day	0.67	0.61	0.73	<0.001
Adult domiciliary	3.60	3.47	3.73	<0.001
Adult community care	1.93	1.81	2.07	<0.001
Staff size group (ref: small)				
Micro	0.34	0.32	0.36	<0.001
Medium	1.64	1.59	1.69	<0.001
Large	0.67	0.60	0.74	<0.001

The findings presented in Table 10 also confirm the higher likelihood of dementia workers to be working in the private sector, in adult domiciliary settings and in medium sized organizations (OR= 1.83, 3.60 and 1.64 respectively; p<0.001). On the other hand, they are significantly less likely to be

employed in the voluntary sector, in adult day care settings and in micro and large organizations.

The organisational characteristics of the dementia care workforce thus are significantly different from those observed among other care workers. Dementia care workers are significantly more likely to be working within adult domiciliary and adult community care settings and are more commonly found in private and medium size establishments (50-199 staff members).

The logistic regression model confirms the specific profile of the dementia care workforce and identifies that this workforce is particularly less likely to hold qualifications of levels 3 or above, identifying an important skills gap. The significant high likelihood of agency workers (OR=5.74) working in dementia care is also a concern because it may be more difficult to establish the quality of training and induction (Cornes *et al.* 2010).

Discussion

Levels of training and qualifications of the dementia care workforce are receiving increasing policy attention. According to the Alzheimer's Society, two-thirds of all care home residents have a form of dementia meaning that there are large numbers of social care staff working in dementia care. The *National Dementia Strategy* seeks to transform the quality of dementia care through minimum dementia training for all social care staff. Objective 13 of the *Strategy* identifies the crucial role of training and workforce development in meeting the needs of people with dementia. Within this context, it is important to understand the profile of the dementia care workforce with a particular focus on their qualifications and those being worked towards. The purpose of the current Issue of *Social Care Workforce Periodical* is exactly that.

The analyses presented here aim to provide a unique insight into the dementia care workforce in England as identified through the National Minimum Data Set in Social Care. Using the NMDS-SC data, release end of June 2010, we identified all workers in the sector who work in organisations that provide services to older people with dementia. The NMDS-SC, of course, does not provide a complete coverage of the workforce, but currently over half of CQC registered providers in England have completed the NMDS-SC returns. An additional sizable number of non-CQC registrants also completed the returns. The NMDS-SC identifies workers working with older people with dementia and of course there are workers supporting younger people with dementia that the current data may not capture. Additionally, a growing number of people with dementia (or their families) may be employers themselves, employing their own care workers through personal budgets (funded by local government adult services) or privately. Nevertheless, the current data provide information on the largest group providing care for older people with dementia. In total we were able to examine the profile and characteristics of 191,716 workers who work, directly or indirectly, with older people with dementia (calling this group the 'dementia care workforce'). We also compared their characteristics to 265,315 workers who do not provide any services to older people with dementia (we call this group 'other care workforce'). The NMDS-SC data indicate that 42 percent of all workers provide social care services to older people with dementia.

We employed descriptive and regression analyses to examine the characteristics of the dementia care workforce in comparison to other parts of the care workforce. The NMDSC-SC includes information on a number of personal, job and organisational characteristics. Personal characteristics include age, gender, disability, highest qualifications and qualifications being worked towards for each worker. More recently a number of additional information has been introduced. These included further information on qualifications and nationality. The latter items have been completed by relatively small proportion of employers. We present some findings related to these new data but further analysis will be needed to ascertain the reliability of such findings.

Employers indicated that, among a total of 11,904 workers, 9.6% of the dementia care workers hold no qualifications compared to only 8.7% among other workers. Among the same group of workers, dementia care workers were also identified to be less likely to be working towards any qualifications (11% vs. 7% are not working towards any qualifications respectively). In terms of qualifications held and being worked towards, dementia care workers are concentrated around NVQ level 2/2+. A logistic regression model shows that they are significantly less likely to hold higher qualifications than other workers, particularly in relation to level 4/4+. Data on qualifications being worked towards also reflect the concentration on level 2 (whether health and social care NVQ2 or care NVQ2). Over half (57%) of dementia care workers are working towards NVQ2 in comparison to only 35 percent of the other care workforce. On the other hand, 13.4 percent of the dementia care workforce are working towards NVQ level 4 (health and social care, care or registered managers) compared to 17 percent among other care workforce.

Among the more recent data items collected by the NMDS-SC are information on nationality and country of birth. These data were provided by employers on a total of 89,437 workers. This is around 18 percent of the total number of workers for whom detailed data about them are provided in the NMDS-SC returns. This initial sample indicates that the proportion of non-British workers is significantly higher among the dementia care workforce than other care workforce (19% vs. 15%). Main countries of birth identified by employers are consistent with those observed in the wider care workforce (Hussein *et al.* 2010). Nearly two fifths of non-UK dementia care workers are from the Philippines (17%); and 11% are from each of Poland and India. This was followed by 8% from each of Zimbabwe and Nigeria.

Findings from the logistic regression model based on the majority of care workforce data, indicate that the likelihood of workers with Asian and other ethnicities is significantly higher among the dementia than other care workforce (OR= 1.72 and 1.49 respectively; $p<0.001$). In terms of job characteristics, the analysis indicates that professional and managers/supervisory staff are less represented in the dementia care workforce in comparison to other workforce. One of the most important findings is the over-representation of agency workers among the dementia care workforce (2.9% vs. 0.6%). The regression model shows that workers are significantly more likely to be working part-time and to be agency workers within the dementia than other care workforces (OR= 1.23 and 5.74 respectively; $p<0.001$). The prevalence of a 'zero hours contract' arrangement was significantly higher within the dementia than other care workforces (18.2% vs. 7.8%).

Another important finding is that dementia care workers are over represented in the private sector while under-represented in the voluntary sector when compared to the rest of the workforce. They are also more likely to be working within adult domiciliary care settings. This may relate to the nature of services provided to older people with dementia, where domiciliary services tend to be provided through the private sector (House of Commons 2010). However, given

the differential unfavourable pay rates within the private sector (Issues 6 & 7 of *SCWP,* Hussein 2010a and 2010b) and the greater identification of unfavourable working conditions as a reason for leaving jobs within the private sector (Issue 8 of *SCWP;* Hussein 2010c), such concentration requires some attention. It is well documented that issues of pay and working conditions affect workers' stress levels and satisfaction with the job (Bishop *et al.* 2009). Issues of safeguarding people with dementia, who can be in vulnerable situations, need to be addressed.

Conclusion

A number of implications arise from the findings presented in this Issue of *Social Care Workforce Periodical*. These may directly relate to the quality of care provided to older people with dementia. The fact that the dementia care workforce is less likely to hold qualifications higher than level 2 and the indicative results that they are more likely to hold no relevant qualifications are of particular concern. This may be exacerbated by the indicative result of higher prevalence of non-UK nationals within this workforce and may highlight issues related to communications and language proficiency. Specific skills may be required for better quality services and better capacity been shown to improve job satisfaction among dementia care workers (Coogle, Head and Parham, 2006). Another important factor is the high prevalence of agency workers and temporary workers within this workforce and the implications of this on their levels of training, skills and continuity of care.

A large proportion of social care in England is provided by the independent sector (both the private and voluntary sectors); the analyses indicate that dementia care workers are significantly more likely to work in the private sector but significantly less likely in the voluntary sector when compared to other workers (while accounting for other factors). Again these findings may affect quality of care provided given the unfavourable differential pay rates and working conditions observed within the private care sector. Similarly issues of safeguarding older people with dementia are highlighted in relation to the high likelihood of dementia workers to be providing care within domiciliary care settings in older people's homes.

The high likelihood of dementia care to be provided through domiciliary care (at people's homes) is in accordance with the proposed efficiency savings from increasing care in the community as set out in the Department of Health's *National Dementia Strategy* (House of Commons 2010). The implementation of the *Strategy* is dependent on achieving £1.9 billion of efficiency savings by reducing the reliance on care homes and increased care in the community. The same report highlights the danger of over reliance on domiciliary care staff in providing dementia care where workers do not have adequate understanding of dementia. However, concerns have been voiced around the extent to which the National Dementia Strategy should also be able to improve access to services and support (Boyle 2010) and thus demand may actually increase for care workers.

References

Aberdeen, S., Leggat, S. and Barraclough, S. (2010) Concept mapping: A process to promote staff learning and problem-solving in residential dementia care. *Dementia* 9(1) **129-151**

Alzheimer's Society (2010) Alzheimer's Society statistics, accessed online 14/9/10: http://alzheimers.org.uk/site/scripts/documents_info.php?categoryID=200120&documentID=341&pageNumber=1

Bishop, C., Squillace, M., Meagher, J., Anderson, W. and Wiener, J. (2009) Nursing Home Work Practices and Nursing Assistants' Job Satisfaction. *The Gerontologist*, 49(5), pp: 611-622.

Boyle, G. (2010) Social policy for people with dementia in England: promoting human rights? *Health and Social Care in the Community*, 18(5), pp:511-519.

Chenoweth, L., Jeon, Y., Merlyn, T. and Brodaty, H. (2010) A systematic review of what factors attract and retain nurses in aged and dementia care. *Journal of Clinical Nursing*, 19, pp:156-167.

Community Care (2009) Massive investment in training required to meet dementia strategy ambitions, Wednesday 11 February 2009. Accessed online on 14/9/10: http://www.communitycare.co.uk/Articles/2009/02/11/110688/workforce-skills-key-to-dementia-strategy-success.htm

Community Care (2010) Community Care's exclusive survey of views on the dementia strategy, Tuesday 23 March 2010. Accessed online on 18 August 2010: http://www.communitycare.co.uk/Articles/2010/03/25/114121/community-cares-exclusive-survey-of-views-on-the-dementia-strategy.htm

Coogle, C., Head, C. and Parham, I. (2006) The long-term care workforce crisis: dementia-care training influences on job satisfaction and career commitment. *Educational Gerontology*, 32, pp:611-631.

Cornes, M., Moriarty, J., Blendi-Mahota, S., Chittleburgh, T., Hussein, S. & Manthorpe, J., (2010) *Working for the Agency: The role and significance of temporary employment agencies in the adult social care workforce*. Final Report to the Department of Health, London: Social Care Workforce Research Unit, King's College London. http://www.kcl.ac.uk/content/1/c6/06/75/94/Cornesetal2010Agency-FinalReport.pdf

Department of Health (2009) *Living well with Dementia: the National Dementia Strategy,* London, Department of Health.

Department of Health, Skills for Care and Skills for Health (2010) *Working to support the implementation of the National Dementia Strategy Project. Mapping Existing Accredited Education/Training and Gap Analysis Report* . February 2010. Department of Health.

Downs, M. and Bowers, B. (2008) *Excellence in Dementia Care: Research into Practice*. Maidenhead, Open University Press.

Downs, M., Capstick, P., Baldwin, C. Surr, C. and Bruce, E. (2009) The role of higher education in transforming the quality of dementia care: dementia studies at the University of Bradford. *International Psychogeriatrics* (2009), Vol. 21, Supplement 1, S3–S15.

Doyle, C. and Ward, S. (1998) Education and training in residential dementia care in Australia: needs, provision and directions. *Australian and New Zealand Journal of Public Health*, 22, pp: 589–597.

Hosmer, DW. and Lemeshow, S. (2000) *Applied logistic regression*. New York, NY: Wiley.

House of Commons (2007) *Improving Services and Support for People with Dementia*. Committee of Public Accounts, Sixth Report of Session 2007–08, HC 228.

House of Commons (2010) Improving Dementia Services in England— an Interim Report. Committee of Public Accounts, Nineteenth Report of Session 2009–10, HC 321.

Howe, A. and Kung, F. (2003) Does assessment make a difference for people with dementia? The effectiveness of Aged Care Assessment Teams in Australia. *International Journal of Geriatric Psychiatry*, 18(3), pp:205–210.

Hughes, J., Bagley, H., Reilly, S., Burns, A., and Challis, D. (2008) Care staff working with people with dementia: Training, knowledge and confidence. *Dementia*, 7(23), pp:227-238.

Hussein, S. (2010a) Modelling pay in adult care using linear mixed-effects models. *Social Care Workforce Periodical*, Issue 7- June 2010; web published. http://www.kcl.ac.uk/schools/sspp/interdisciplinary/scwru/pubs/periodical/issue7.html

Hussein, S. (2010b) Pay in the adult social care in England. *Social Care Workforce Periodical*, Issue 6- May 2010; web published. http://www.kcl.ac.uk/schools/sspp/interdisciplinary/scwru/pubs/periodical/issue6.html

Hussein, S. (2010c) Reported reasons for job shifting in the English care sector. *Social Care Workforce Periodical*, Issue 8- August 2010; web published.

http://www.kcl.ac.uk/schools/sspp/interdisciplinary/scwru/pubs/periodical/issue8.html

Hussein, S., Manthorpe, J., Stevens, M., Rapaport, J., Martineau, S. and Harris, J. (2009) Banned from working in social care: secondary analysis of staff characteristics and reasons for their referrals to the POVA List in England and Wales, *Health and Social Care in the Community*, 17(5): 423-433.

Hussein S., Stevens M. and Manthorpe J. (2010) *International Social Care Workers in England: Profile, Motivations, experiences and Future Expectations*, February 2010. Final Report to the Department of Health, Social Care Workforce Research Unit, King's College London.
http://www.kcl.ac.uk/schools/sspp/interdisciplinary/scwru/research/projects/intl.html

Moniz-Cook, E. and Manthorpe, J. (eds) (2009) *Early psychosocial interventions in dementia: evidence based practice*, London, Jessica Kingsley.

Mozley, C., Challis, D., Sutcliffe, C., Bagley, H., Burns, A., Huxley, P. and Cordingley, L. (2004) *Towards quality care outcomes for older people in care homes*. Aldershot: Ashgate.

Reilly, S., Abendstern, M., Hughes, J., Challis, D., Venables, D. and Pedersen, I. (2006) Quality in long-term care homes for people with dementia: An assessment of specialist provision. *Ageing and Society*, 26, pp:649–668.

Selwood, A. and Cooper, C. (2009) Abuse of people with dementia. *Reviews in Clinical Gerontology*, 19, pp: 35–43

About NMDS-SC

The NMDS-SC is the first attempt to gather standardized 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 user groups and sectors within the social care sector in England. The NMDS-SC was launched in October 2005, and the online version in July 2007; since then there has been a remarkable increase in the number of employers completing the national dataset.

Two data sets are collected from employers. The first gives 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 about individual staff members. Skills for Care recommends 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 it is recommended that consent for passing on these two items needs to be explicit. For further details on NMDS-SC please visit http://www.nmds-sc-online.org.uk/

The NMDS-SC has provided the sector with a unique data set, providing information on a number of the workforce characteristics. However, it is important to highlight the emerging nature of the NMDS-SC, mainly due to the fact that data have not been completed by *'all'* adult social care employers in England, at this stage. Therefore, some of the findings may be under- or over-represented as a result of this. It is also equally important to bear in mind that data are completed by employers and not workers. This may also prompt some technical considerations when interpreting the findings. *Social Care Workforce Periodical* addresses such considerations in its discussions of findings.