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The diversity of staff supporting family carers in England: findings from an analysis of a national data set

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What is known
1. Surprisingly little is known about social care staff whose roles, in full or part, are to support *family carers*.
2. Policy makers are *increasingly interested in supporting family carers.*
3. Some family carers express concern that services do not provide them with adequate support.

What this paper adds
1. Staff whose job entails support for *family carers* are mainly employed in home care services.
2. The analysis suggests lack of continuity of relationships with practitioners reported by some *family carers* may be due to high staff turnover in home care services as a whole.
3. Efforts to developing the potential of social care staff to support *family carers* require specific attention from social care employers and policy makers.

Abstract

Little is known about those employed to support *family carers* of disabled people or those with long term care needs. The term '*carer'* is used in England to refer to family members and others who provide unpaid regular and substantial support to adults with disabilities, including older people and others unable to live independently. Among the wider social care workforce some staff are employed to provide support for these carers but little is known about the composition and characteristics of this group of staff. The findings reported in this article are

derived from quantitative secondary analysis of the National Minimum Data Set for Social Care (NMDS-SC; n=499,034), which collects data from social care employers and reported to Skills for Care. This data set included information about the characteristics of the workforce employed to support carers and the organisations that employ them to do so.

Our analysis showed that this support workforce is mostly female, with a large number of part-time employees who are based in organisations with significantly higher turnover and vacancy rates than other organisations providing social care. Staff supporting *family carers* appear to be better qualified and to have longer experience within the care sector than other social care workers.

From these findings we conclude that this support workforce may be affected by staff shortages themselves and that high staff turnover rates may undermine the continuity of support given to *family carers* leading to problems for existing staff. We argue that developing the potential of social care staff to support *family carers* requires specific attention from social care employers and policy makers.

Background

In the United Kingdom (UK), the term *carer i*s used to refer to family members, neighbours or friends providing long-term or substantial and regular care to an individual who needs help with daily living activities such as washing, dressing and shopping (see Box 1). It is increasingly recognised that such carers make a considerable contribution to society as well as to the support of their family members. It is also recognised that being a carer may be demanding and exhausting and so, in England as in many other countries, there is sustained policy attention to how to meet carers' own needs and respond to their diverse wishes and circumstances (HM Government 2008; 2010).

There have been considerable developments across the globe in quantifying the numbers of carers, their economic contribution to society, their wishes and needs, and participation in different types of caring activities (Hollander et al 2009). One of the ways in which publicly funded services in the UK help to meet carers' own needs is through the employment of social care workers and other staff whose roles include support for carers.

However, many policy pronouncements appear to take for granted the presence of practitioners that are expert in providing support for *family carers* and appear to see that skills in supporting them are interchangeable with skills in supporting social care recipients directly. This lack of attention to what might be the skills needed to work with *family carers* may stem from several causes. These include, 1) the scant knowledge of social care work in general; 2) concentration on staff working in residential facilities, such as care homes and hospitals; and 3) a difficulty in establishing whether care work meets the, possibly separate, needs of carers as well as those of disabled older people (Parker and Clarke 2002).

Moreover, the focus on people whose needs are high level or at crisis point, sometimes as a result of having no one available or willing to act as a carer, or difficulties in sustaining the amount of family support needed (Audit Commission 2004) may cast *family carers* support in the shade. Nonetheless, there are numerous examples of social care roles and activities that are designed to support *family carers* and most require a workforce to deliver them. A recent systematic review of interventions supporting *family carers* in the UK included:

> *'those concerned with supporting carers to access services; those targeted at carers' physical health; interventions focused upon emotional and social support; education and training for carers; employment-related interventions; and carer breaks'* (Victor 2009, p1)

This limited knowledge of staff supporting carers may make it hard to build up a workforce that has the skills and experience to respond to *family carers'* own concerns. For example, there are consistent complaints that some do not regard their relationship with practitioners as supportive but less precision about to whom these criticisms specifically apply:

> '*carers can often feel excluded by clinicians – both health and social care professionals should respect, inform and involve carers more as expert partners in care'* (HM Government 2010, p6)

There is some evidence that some *family carers* think that some paid home care workers provide poor quality care or are unsupportive. This can be counter-productive, because *family carers* may then feel more stressed, or may insist on checking on home care workers' activities, rather than taking the break or respite that is on offer (Piercy and Dunkley 2004). Such studies do not generally report *family carers'* views on the ways in which workers are supposed to be supporting them (see, for example, Patmore and McNulty 2005).

The importance of gaining better knowledge of staff supporting *family carers* is further predicated on demographic trends, such as the ageing of the population, and the anticipated need for more carers, among whom will be people possibly in need of support themselves, such as older frail partners (Pickard *et al*. 2007). Some training materials have acknowledged the need for staff to have a dual focus on carers and on disabled people:

Principle 6: Respect carers' own needs, rights and aspirations, which may be different from those of the person being supported (Skills for Care 2010).

Despite the perceptions of some *family carers* that they are isolated or taken for granted (HM Government 2010), many have constructive and supportive relationships with those employed to care for their disabled relative or friend (for example, as home care workers or day services staff). Arksey *et al*.'s (2002) systematic review of the literature covering the support of carers of people with

mental health problems located four studies of home care support that encompassed *family carers* as well as the older person with dementia (the user group in all the studies). They found evidence that home care workers can postpone or reduce permanent placement in long-term care facilities (care homes), may help with overall coping and may reduce perceived levels of *family carer* burden.

In practice therefore, staff supporting *family carers* includes many practitioners who support older and disabled people and not just those with explicit roles to support carers. However, surprisingly little is known about these staff whose roles, in full or part, are to support *family carers*. The impetus for knowing more may be considered at three levels of questioning: the need to understand what works in practice for *family carers* and care workers; the need to improve systems of support for *family carers* by knowing more about workforce pressures and dynamics; and the need to know how resources (of which employment and managerial costs are significant) can be better utilised. Underpinning this lie questions about choices between models of carer support developed by Twigg and Atkin (1994) and articulated in the revised government Carers' Strategy in England (HM Government 2010) in which *family carers* are conceptualised as '*partners*' with staff (see also Association of Directors of Adult Social Services 2010). Lack of clarity about underpinning models, for example, whether carers are seen as partners or co-clients, complicates debate about their capacity and effectiveness, since different models are predicated on different ideal-type relationships. This gives rise to questions such as whether the interests of *family carers* and disabled people converge or diverge.

Aim of this article

This article draws on the analysis of a new large national data set on the social care workforce in England, the National Minimum Data Set for Social Care (NMDS-SC). Using this employer-provided anonymised data about individual workers, the aim of this article is to examine the profile of the sections of this workforce that are employed to work with *family carers* and, by drawing a picture of their characteristics, begin to answer some of the questions identified above. We set this profile in the context of the known characteristics of the overall social care workforce (see Box 2) using a range of descriptive and bivariate analyses with suitable statistical tests. In this analysis we use the term *disabled adults* to refer to adults of all ages, although the great majority are older people, and this includes people with mental health problems, learning disabilities (intellectual impairment), and those who may be ill or frail. Again, for reasons of space, we will refer to *carers* as family members, mindful of the fact that some carers are not family members but friends, same sex partners or neighbours (Manthorpe and Price 2006). While some evidence exists about the potential benefits of practitioners specifically termed '*carers support workers'* as an intervention (Victor 2009), these are a small section of the workforce; furthermore, because such job titles are used variously and inconsistently in the UK (Manthorpe *et al.*

2010a), this article investigates the wider social care workforce and is not restricted to specific job titles.

Methods

The NMDS-SC is comprised of returns from social care employers who are requested by the sector skills council, Skills for Care, to complete two main files; the first, called the provisional data file, relates to their organisation as a whole and provides aggregate information on the total number of staff employed in different job roles, the overall number of leavers during the previous 12 months and other information. Employers then provide more detailed information on all, or a sample, of their staff, the individual workers' file. The data explored in this article are from the detailed individual workers' files (June 2010) but we have linked these data to information provided in the provisional data file, with the aim of investigating factors such as size of employing organisation, overall turnover, and vacancy rates in the organisation, type of main service provided and sector (statutory, voluntary (not for profit) or private (commercial) sector). This is a huge data set with data relating to 24,301 employers who had provided details on 499,034 individual employees with over three-quarters of these records updated during the previous 12 months. It should be noted, however, that currently the NMDS-SC under-represents the statutory sector (local government) and over-represents the independent sector (private and voluntary – the main providers of adult social care in England). Similarly, it may under-represents 'micro' employers (mainly people employing their own care workers); For fuller discussion of these limitations and their implications see Hussein (2009, 2010). Nevertheless, the NMDS-SC is the most comprehensive dataset covering the social care workforce in England.

Analysis commenced by exploring the proportion of social care employers who describe support for *family carers* as their main activity or support for carers as part of their wider services. Employers provided information on their total (aggregate) number of permanent and temporary workers in the NMDS-SC provisional file, which enabled exploration of the percentage of staff supporting carers among aggregate workers reported in the NMDS-SC. The detailed information on some, or all in some organisations, workers in the NMDS-SC individual workers file was then focused upon because this provides personal and workplace characteristics. Social care support for *family carers* in England is usually provided by organisations such as home care agencies offering services to disabled adults, so we examined the profile of individual staff working in organisations providing support to *family carers* exclusively or as part of their services. Although the NMDS-SC includes information on organisations that provide services to *family carers* (generally parents) of children and young people, we did not include them as part of the current analysis. Thus, we focused on social care services for adults and their paid employees, not volunteers or kin. Statistical analyses exploring the profile of social care staff supporting family

carers and comparing them to other social care staff were conducted using R Statistical Environment (ver. 2.1; R Development Core Team, 2007).

Limitations of this study

While current returns of the NMDS-SC do not form a census of the entire social care workforce in England; they provide information on 54.5% of all Care Quality Commission (CQC) registered social care providers with an additional 10,661 non-CQC registered providers. The latter group includes organisations which do not provide personal care, such as community (voluntary and private sector) day care, some residential services such as hostels and sheltered housing, and some domiciliary care services offering various support services (such as shopping) but not offering personal care (generally defined as help with washing, eating or toileting). It is likely that the staff of these organisations also provide *family carers* with support, for example, advice services, day-time support and household maintenance. The current limits of the coverage of the NMDS-SC should be noted but the strength of the data lies in its unprecedented and unparalleled coverage of the disparate English social care sector.

Findings

Distinguishing staff supporting *family carers* from other social care staff

Employers identified the *main* service they provided out of a pre-coded list of possible services. They then listed *all* the services they provided. In this analysis, among the 24,301 employers who completed the NMDS-SC only 0.4% (n=97) indicated that their *main* service was to support *family carers* but when considering those who provided services for them as their main or additional service, this proportion increased to 8.5% (n=2,064) of employers. Using the aggregate data we calculated the proportion of those staff working for employers whose *main* services were support for *family carers* and then calculated the proportion of those working with providers of *any* services to *family carers*.

Out of the total number of workers (n=92,864) only 0.4% worked in organisations that said *family carers*' support was their main service, while 13.1% worked in organisations that provided support to *family carers* amongst their activities (any carer service). These findings were expected, given that few organisations, such as Carers' Centres, solely provide support *family carers* because such support is usually only a part of what many social care organisations offer (for example, staff in a home care agency may work for many clients but not all of their clients will have carers).

Employers provided detailed information about 46,274 out of the total 92,864 staff in organisations providing any services for carers. By comparing the detailed profile of this 46,274 with the rest of the workforce (such as those care home workers who were not recorded as providing services to carers), which we

identified through the NMDS-SC individual data file, possible differentials covering personal, job, and organisational characteristics were explored.

Eight% (n=40,450) of workers were employed in organisations that provided services to carers of older people, 7% (34,782) in organisations providing services to carers of other disabled adults (excluding children). However, this is not a strict demarcation; the same individuals were working with the *family carers* of adults and/or older people. Overall, 9.3% (46,274) were working in organisations providing services to *any* carers (of adults or older people), while 5.8% (28,944) worked in organisations providing services to *both* carers of adults and those of older people. We will focus on the 9.3% and investigate their characteristics further and refer to this group as staff supporting carers.

The characteristics of staff supporting family carers

Like the rest of the social care workforce, the majority of people employed to support *family carers* were direct care workers (63.6% among carers' workforce and 57.6% among the rest of the workforce). However, there were fewer senior care workers (4.9%) compared to the rest of the workforce (7.1%). Similarly, there were fewer registered nurses, standing at 2.8% compared with 4.4%, possibly arising from the nature of community nursing services. In England primary care or community based nursing is part of the National Health Service (NHS) and not social care services. Another clear difference in job roles related to those of ancillary staff and other non-care providing staff; only 3.6% of the carers' workforce were ancillary staff compared to 8% among the rest of the workforce.

Differences concerning specific main job roles were reflected in the grouped job roles (Box 3). Three-quarters of staff supporting *family carers* had direct care roles as their main jobs, being care workers, senior care workers or support workers, compared to 71% of the rest of the care workforce. Similar proportions (9%) performed managerial or supervisory roles as their main jobs and similar proportions of 6% each undertook professional roles, like social work or occupational therapy. However, the workforce contained proportionally fewer staff whose main jobs were non-care related (or 'other') jobs such as administrative and ancillary jobs. These differences are statistically significant with χ^2=664.1 and p<0.001. The reason for this may lie in their main occupational sector; many are home care workers for whom overall supervisory, administrative and managerial roles are thinly spread (Sims-Gould 2010). For example, home care workers are not generally responsible for medication, nursing procedures, or the administration of facilities and equipment.

Work patterns

Most (82.5%) staff supporting carers held permanent contracts of employment but this was significantly lower than the rest of the care workforce (88.6%);

(χ^2=3350.2 and p<0.001). The percentage of agency workers, those not employed directly but working for employment agencies, was also relatively higher among staff supporting carers in comparison to the rest of the social care workforce (4.8% vs. 1.2%). Full-time and part-time employment patterns were much the same among staff supporting carers and the rest of the care workforce. Around 40% of each groups worked part-time and 46-49% worked full-time (the rest generally had flexible work arrangements).

Personal profiles

Table 1 shows that the average age of staff supporting carers was almost identical to that of 'other' workers, i.e. care workers identified through the NMDS-SC individual workers' files to be working in organisations that do not provide services to carers of adults or older people. However, a higher proportion of women were found among the staff supporting carers (χ^2=200.8, p<0.001). Similarly, the ethnic profile of staff supporting carers differed slightly but significantly from the rest of the care workforce (χ^2=239.7, p<0.001) with slightly more being 'White'. Proportionally significantly fewer staff supporting carers were disabled compared to the rest of the care workforce (1.8% vs. 2.3%; χ^2=33.0, p<0.001).

Table 1 Distribution of staff supporting carers by personal characteristics compared to those of other members of the social care workforce, NMDS-SC individual workers' file, June 2010

Personal Characteristics	Staff supporting informal carers %	Other adult care workforce %
Age		
Valid N	32,176	326,091
Mean	42.5	42.6
standard deviation	12.9	13.1
Gender		
Men	14.2	16.9
Women	85.8	83.1
Valid N†	39,595	398,235
Ethnicity		
White	83.2	82.0
Mixed	1.1	1.6
Asian or Asian British	4.5	5.6
Black or Black British	9.2	8.3
Other groups	2.1	2.5
Valid N	32,056	326,740
Disability		
None	98.3	97.8
Any	1.8	2.3
	32,176	326,091

† Missing values varied for different data item; valid N indicates base number of calculations after excluding missing values

At the beginning of 2010 the NMDS-SC started collecting data on nationality and country of birth of workers; by 2010, employers had provided such information for 89,437 individual workers, of which we identified 8,492 as supporting carers. Using these initial returns, staff supporting carers appeared to comprise proportionally fewer overseas or non-British workers, with 14.4% identified as non-British in comparison to 17.5% among the rest of the workforce (χ^2= 53.3; p<0.001). This is likely to be because many care workers from the Philippines, and other countries from which people are recruited to work in the UK care sector, are employed in care homes as senior care workers or nurses, having been granted immigration permission to work in these shortage occupations (Hussein *et al.* 2010).

Qualifications

Employers provided specific information on the highest qualification level each worker held and if members of staff were working towards any qualifications. However, this information contained a large number of missing values. For this reason, among others, Skills for Care introduced further questions specifically asking whether an individual worker had '*no qualification*' or was not working towards any qualification. These data items were only introduced during 2010 and were completed by a relatively small number of employers, so they are used as indicative here. Employers reported that around 11% of staff supporting carers held no qualifications and another 10% were not working towards any qualifications. These proportions were very similar to those among the rest of the care workforce and are not significantly different (χ^2= 3.82 and 0.25; p=0.06 and 0.61 respectively).

In relation to highest qualification level, proportionally and significantly more staff supporting carers held National Vocational Qualification (NVQ) level 2/2+ qualifications and at the higher level NVQ 4/4+ (46% vs. 38.8% and 16.8% vs. 12.9% respectively) than the rest of the workforce. On the other hand, relatively fewer of staff supporting carers held higher level 3/3+ qualifications (22.7% vs. 29.4%). A similar concentration around level 2/2+ qualifications was reported in terms of qualifications being worked towards, where 56.5% of staff supporting carers were working towards level 2/2+ compared to 42.7% of the rest of the workforce. Employers indicated that nearly three-quarters of staff supporting carers (74%) had completed an induction period; this figure was significantly higher than the 68.6% reported among the rest of the workforce (χ^2= 302.9; p<0.001).

Source of recruitment

Information on sources of recruitment was provided in respect of 37% of all detailed individual records (n=186,788). Staff supporting carers appeared to attract or recruit fewer people who had not been previously employed (2.5% vs. 4%) or were from outside the UK (1.1% vs. 3.1%) when compared to rest of

the care workforce. This may be directly linked to the type of job roles performed by staff supporting carers. For example, in relation to recruiting from outside the UK, staff supporting carers were less likely to be nurses. One reason for this may be that most nurses in social care work are employed in care home settings which are less likely to describe themselves as supporting carers, as indicated in the next section.

The employers of staff supporting carers

The majority of staff supporting carers (54%) worked for organisations whose main business was domiciliary care (home care), in contrast to the rest of the workforce where the majority worked for organisations providing residential care (59%). In terms of the main service provided, over half of staff supporting carers was employed in organisations providing home care services, in comparison to only 20.5% of the rest of the workforce. After that, one-fifth of staff supporting carers was employed in care homes in the main, with or without nursing services on site. A significant minority of staff supporting carers (4.7%) worked for organisations providing social work and care management services, consistent with the requirements for local government social services departments to provide assessments for carers and to support them (Seddon *et al.* 2007). The distribution indicated that less than 3% of staff supporting carers were employed in day care services and only around 2% in organisations offering mainly carers' support such as not-for-profit Carers' Centres.

Table 2 Workforce stability indicators for organisations where staff supporting carers are employed compared with the rest of the social care workforce, NMDS-SC individual workers' files linked to provisional files, June 2010

Stability indicators	Staff supporting informal carers	Other adult care workforce
Turnover rate		
Mean	40.16	18.58
Standard deviation	245.70	64.28
Valid N	42,418	396,623
Vacancy rate		
Mean	3.94	2.39
Standard deviation	10.25	6.35
Valid N	42,418	396,623

As with the rest of the social care workforce, the majority of staff supporting carers was employed in the private (commercial) sector (63.5% vs. 63.3%), followed by the not-for-profit voluntary or third sector, at around 16%. A further 17.5% of staff supporting carers and 16.8% of the rest of the workforce were employed in the statutory, local government, sector; but these differences were not significant. However, staff supporting carers appeared to be more concentrated within organisations with higher mean vacancy rates, 3.94% vs. 2.39% for the rest of the workforce. Also the standard deviation was higher for

the group of staff supporting carers but the difference was not as wide as that observed for the mean turnover rate. Table 2 shows that staff supporting carers were, on average, working for organisations which have higher staff turnover than the rest of the care sector.

Discussion

This analysis rests on a broad definition of staff supporting *carers*. We adopted an inclusive definition because the main services identified as providing carers' support were proportionally very few. Furthermore, it is likely that carers receiving services from self-declared carers' services, such as a Carers' Centre, may also be in contact with staff working in services directly related to the people they care for, particularly home care services. Developments in care homes also indicate the benefits to their staff if they form relationships with families, or former carers. This may meet carers' needs for support and may also improve the quality of life for care home residents (Nolan *et al.* 2003; Woods *et al.* 2007). Our analysis shows, however, that few care home managers at the moment appear to report that the staff they employ are providing support to residents' family carers.

This preliminary analysis of the profile of people working in social care services and providing support to carers in England suggests, at first glance, that they tend to be better qualified than other workers; but this relates to their being significantly more likely to have completed their induction period of initial orientation than others. This is not a huge matter for congratulation; it exposes the very low levels of training among social care workers overall and the failure to meet even the lowest of the NVQ target levels set by the government as minimum standards for the sector, despite expressions of general support (Gospel and Lewis 2011). Overall there is still a lack of qualifications, possibly low expectations that social care workers are able to benefit from training and skills development. This may set support for *family carers* and the wider social care sector at a disadvantage in responding to demographic change and higher levels of disability among older people in community settings, especially at end of life (Wild, *et al.* 2010; Exley and Allen 2007). This disadvantage may also be related to the low status of home care work in England, where extra training prompts little or no extra remuneration and may even be seen as inappropriate or unnecessary by staff themselves (Moriarty *et al.* 2010), many of whom, as the data show, have worked previously in this sector. An analysis of the profile of home care aides in the United States (US) also revealed that these workers tend to be older and have poorer education than other types of aides working in nursing homes or hospitals (Crown *et al.* 1995). In the US, too, the long-term care sector, at home and in care homes, is characterised by low pay and few employment benefits for its workers (Yamada 2002; Harris-Kojetin *et al.* 2004).

Three unexpected findings in this analysis deserve further exploration. First, the workforce supporting carers seems less diverse in terms of ethnicity. This reflects the fact that so few people from Asian ethnicities work in home care settings in

the UK. White and Black African/Black British populations receiving care services for themselves or for others in later life may be able to choose care workers from similar cultural backgrounds but this may not extend to all minority groups. This finding suggests the continued importance of communication and other training for social care staff of all ethnicities in addressing cultural and equalities issues (Manthorpe *et al.* 2010b) especially in less diverse communities. However, in other developed countries there is substantial ethnic diversity among home care workers (Montgomery *et al.* 2005) and so this profile may not be fixed. Far more difficult to change may be the female dominance of caregiving and the whole social care workforce (see Vector Research 2009).

Second, staff supporting carers were more likely to be agency or temporary workers, again reflecting the employment profile of home care workers to meet the peaks and troughs of demand. High turnover in some agencies may cause some distress to people using home care services and their relatives (Woodward 2004; Devlin and McIlfatrick 2009). If staff supporting carers are working in organisations which have higher staff turnover than the rest of the sector, then it is hardly surprising that lack of continuity of care features in carers' complaints. The solution to this, therefore, lies not merely in training the workforce but in other developments in the sector to reduce turnover and increase retention (as reviewed in the US by Wiener *et al.* 2009). This point seems confirmed by the small amount of evidence from staff supporting carers themselves in the UK. In one of the few qualitative studies of staff supporting carers, seven support workers for disabled people and their families reported that they viewed their work as personally rewarding (Ryan *et al*. 2004), to the extent that some staff perceived themselves as 'part of the family' being so close to disabled people and their caring relatives.

Finally, Parker *et al.* (2009, p60) have argued that it is important to look more closely at different types of carers and note the dominance of studies of certain conditions in the wider health research literature. This may cloud differences in levels and types of professional roles in supporting, informing and liaising with carers and the frequent professional encounters with home care and other staff working in domestic settings. Parker *et al.* (2009) concluded that there seem to be a myriad of influences on carers' experiences and views of staff, such as:

> *'the nature and trajectory of the patient's condition; their understanding of the patient's illness and ways of managing it; the patient's family structure and dynamics; the structure of services; carers' access to and use of social and external support; their relationships with professionals, and their relationship with the patient'.*

Sims-Gould and Martin-Matthews (2008) have similarly pointed to the complexities of caregiving and the need to think further about who helps whom in their study of home care workers in Canada.

Conclusion

Rather than restrict the definition of staff supporting carers to people working in organisations explicitly providing mainly carers' support, such as Carers' Centres, we included those working in organisations providing any services to carers in our analysis of the NMDS-SC. This, we argue, has the potential to expand our conceptualisation of staff supporting carers and to see home care and care home work as being part of a complex set of relationships if carers are present. We suggest that understanding of social care work and labour should move beyond its current main focus on care homes to the wider home care sector, where professional practice engages with diverse day to day activities, domestic patterns, and relationships. In future, in England, there are also likely to be changes arising from the adoption of *personalisation* i.e. social care funds provided directly to disabled people or their carers, which means that those carers may have a greater influence on the direct employment of care workers and indeed may wish to be paid themselves or pay other members of their family to care for a disabled family member (Manthorpe *et al.* 2011). In addition, while many social care employers do not describe themselves as providing services to carers, possibly because some clients may not have carers or family members, this is not the case for them all. We would anticipate that more social care providers will see that working with family members could become part of their commitment to person-centred or relationship-based care.

This analysis has raised the possibility that the lack of continuity of relationships with professionals reported by some carers may be due to high staff turnover in home care services as a whole. One solution to this may lie in carers employing their own staff to care for their relatives through personalisation or in carers reaching agreement with care providers that continuity of care will be a way of knowing if good outcomes are being met (a quality indicator). Investigation of this large data set of social care workers has provided new opportunities to think about the diverse characteristics of staff supporting carers. It may be potentially useful to those seeking to improve support for carers by enhancing the skills of staff supporting carers, to consider issues of their diversity, to help social care services overall to meet the needs of carers and people needing care and support.

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Box 1: Defining Carers

In the United Kingdom (UK), the term *carer* is used in legislation and policy, generally replacing the term *informal carer*. In some countries the alternative term 'caregiver' is commonly used (e.g. United States). Elsewhere, similar terms may include *primary carers*, i.e. those individuals who provide the most care to disabled or frail aged people or care-giving/caregiving (Australia, Canada). Most of these definitions centre on the term *care*r being applied to a person, often a family member, who provides unpaid support to a person unable to manage activities of daily living independently owing to disability or illness. Such support may be substantial and regular, being beyond the socially normative activities of family life, friendly relationships, and neighbourly behaviour. In this article, we use the term '*carers*' to refer to informal carers and '*care workers*' to refer to paid or formal carers.

Box 2: Defining social care

A recent UK Parliamentary Committee (Hansard 2012) declared '*we decided, quite early on in the report, that it would not be possible to define adult social care. We could only define its purpose... A lot of what adult social care currently provides is what other organisations do not provide—health services that are not provided by the NHS or housing services that are not provided by housing*.' Nonetheless, social care may be defined as care and support provided to assist people with activities of daily living, including personal care, supervision, practical and emotional support. Social care may be provided at home, in day centres, care homes and in other community settings. The paid social care workforce includes care assistants, home care workers and a minority of professional workers such as social workers and occupational therapists.

Box 3: 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.