Overview and Synthesis

Hazel Qureshi and Marie McNay
Acknowledgements
The authors would like to thank Carol Lupton and Anne Mercer at the Department of Health for their valuable support during the Initiative. The authors would also like to thank service user and academic reviewers for their contributions throughout the Initiative, and to acknowledge the hard work and commitment of the researchers who undertook the projects that comprised the Initiative.

Finding further information
Inevitably, an overview and synthesis such as this cannot do justice to the depth and detail of the findings of individual projects in the Research Initiative. Brief summaries of the findings of the seven most recent projects can be found here, and full final reports are available on the website overview page. A full list of publications arising from the projects can be found in Appendix 3.

Disclaimer
The production of this overview report was funded by the Department of Health as part of the Social Care Workforce Research Initiative. The views expressed in the report are of the authors only and not necessarily those of the Department of Health.
# CONTENTS

EXECUTIVE SUMMARY ................................................................................................. i - x

INTRODUCTION .............................................................................................................. 1

WORKFORCE COMPOSITION AND WORKING CONDITIONS .............................. 7

SUPPLY OF THE WORKFORCE: RECRUITMENT AND RETENTION .............. 22

DEVELOPING KNOWLEDGEABLE CARE WORKERS ..................................... 44

SOCIAL WORK AND THE SOCIAL CARE WORKFORCE ............................... 54

COMMISSIONING ........................................................................................................... 80

PERSONALISATION AND GROWTH IN THE USE OF PERSONAL BUDGETS ......... 92

INTEGRATED SERVICES, AND FINAL REFLECTIONS ...................................... 102
  Integrated Services .................................................................................................. 102
  Final Reflections and Recommendations ............................................................. 106

REFERENCES ............................................................................................................... 121

Appendix 1 .................................................................................................................. 130

Appendix 2 .................................................................................................................. 131

Appendix 3 .................................................................................................................. 138
EXECUTIVE SUMMARY

Introduction
The Department of Health Social Care Workforce Research Initiative comprised nine research projects conducted between 2007-2011. The projects covered: commissioning and contracting and their influence on recruitment and retention of a care workforce for older people; international care workers; agency workers; the sector's capacity for skill development; social work graduates readiness to practice; diversity and progression among social work students; the role and tasks of support workers; and the social care role in integrated settings. The Initiative website includes a description of all projects and individual summaries of the findings of the seven most recent projects, as well as giving access to full final reports. This Executive Summary is linked to a longer overview that aims to draw out the implications of the Initiative findings, and other related research, for current and future social care policy.

Workforce composition and conditions

Background
People who work in adult social care are overwhelmingly employed by the independent sector. Figures published in 2010 showed half of the total workforce in the private sector, and a further quarter in the voluntary sector. In addition, the penetration of larger companies into the sector is growing. One in ten of the workforce were personal assistants working for individual service users. The remainder (17% of the workforce) worked for local authorities (13%) or the NHS (4%). Social workers were just under 2% of the workforce, nearly 57% of whom currently work in local authority statutory social work. The number of social workers in Children’s services is greater than and far outweighs the number in Adult services, given the relative size of the two sectors. An appraisal of GSCC registration data (undertaken for this report) indicated that there could be approximately a quarter of all registrants employed in social work currently working in the independent sector, though the data are not precise.

Differences by sector
There is evidence of differences in terms and conditions by employment sector. Pay is lowest in the private sector, slightly higher in the voluntary sector, and highest in Council in-house services. Similarly, turnover among care workers is higher in the private than the voluntary sector, and lowest (but extremely variable) among Council workforces. There are no current comparable figures for pay or turnover among personal assistants, although some evidence suggests large variations in pay. The average weekly earnings of social workers are well down the list of occupations classified as ‘professional’ but they are relatively well paid for a job in which women predominate.

In adult social care, voluntary sector providers in general offered better human resource practices than for-profit providers and had lower levels of staff turnover. Limited evidence suggests that quality as perceived by service users, and by the regulator, is on average lower in the private sector than the voluntary sector, and highest for Council in-house services, although costs for the latter are greater.
Differences by type of service

Pay and conditions of service differ with the type of service, and, on average, domiciliary care providers have more difficulties in recruiting and retaining staff than care homes. Both vacancy and turnover rates are higher in domiciliary care than in care homes, and care homes and nursing homes have more success in retaining new recruits than domiciliary care providers. Care homes (particularly with nursing) pay on average slightly lower starting pay to care workers than independent domiciliary care agencies, although both are close to the national minimum wage; there are slightly more opportunities for pay progression in care homes than in domiciliary care, presumably because there is a higher proportion of senior posts in the workforce. Care homes can offer more guaranteed working time, although domiciliary care can offer more flexibility of hours to suit workers’ availability. Travel for domiciliary care workers is sometimes reimbursed and sometimes not, and there is some evidence that suggests that agencies that do reimburse travel time are perceived as offering a higher quality service by service users. Care homes rated 3* provided better pay and pay-related conditions than other homes.

Sector as a whole:

The social care sector displays many of the features of the classic definition of a secondary labour market: workers are generally low paid (excluding the small minority of managerial and professional groups), have insecure employment, are less unionised and have few opportunities for advancement compared with the national workforce; levels of turnover are relatively high and the workforce is dominated by women, and minorities are disproportionately represented.

Care workers are aware of, and dissatisfied with, their low levels of pay, but they report high job satisfaction linked to the intrinsically rewarding nature of the work, and their relationships with service users. However, there is some evidence that cost-driven changes in the organisation of care, for example shorter visit lengths in domiciliary care, are seen to restrict the opportunities for care workers to form relationships with service users.

A number of problems in the working conditions of social workers were identified, particularly: IT systems; high workloads; limited access to professional (case) supervision; the overall quality and consistency of frontline management and the pressures under which managers and supervisors were working. The implementation of the Personalisation agenda is reported to be causing difficulties in many areas, particularly because of bureaucracy, output targets and a managerialist culture. However, social workers, like many care workers, put job satisfaction above other factors, including pay and prospects, in relation to their intention to stay in a job but this is qualified by the particular circumstances of the team in which they work.

Supply of workers

Vacancies and recruitment difficulties

The proportion of employers reporting current vacancies, and the proportion of jobs vacant, is twice as high in adult social care as in other sectors. Vacancy rates for

---

There were no significant relationships between star ratings and pay or HR practices for domiciliary care providers
social workers in local authorities across the UK rose from 10.9% to 11.3% in 2009, ranging from 4.6% to 15.3% in England.

A study conducted for the Initiative found that 28% of care homes and 39% of independent domiciliary care providers said that recruitment was very or quite difficult. Local labour markets were influential, for example: strong labour demand affected recruitment and retention in domiciliary care, and, in areas where the median pay for women in part-time employment was relatively high, care homes were more likely to offer higher quality human resource practices (although not necessarily higher pay). A social work study in the Initiative found that recruitment in social work was uneven, with only about two thirds of new graduates finding social work jobs within their first year, despite high vacancy rates. Of these, over three-quarters were working in local authorities (higher than the national rate), over half of whom were in Children’s services and many of whom were in child protection work. This is where the vacancies are but recruitment problems from the employers’ perspective were reported to include a need to appoint experienced workers.

Retention
There is a high rate of departure from the social work field in the first five years and a reduced length of working life as a social worker. This may reflect a reduction of good work/life balance and also an increase in the stress of the job reported in the social work study. A project has been commissioned by the Social Work Reform Board to build a supply and demand model for social workers employed in the health and social care sectors. Our research suggests that there is a need to go beyond information on the number of social workers qualifying each year and their demographic characteristics. It suggests the need to look at the less quantifiable factors, such as the impact of motivations and values, on retention in the long term. Without this, it is argued, it will be impossible to identify whether those who go into the workforce remain there or whether their experiences ultimately mean that they will seek employment elsewhere.

In adult social care, there is evidence that care homes are more successful than independent domiciliary care agencies in retaining new recruits over a twelve month period.

Strategies to tackle recruitment and retention problems
Such strategies included the use of agency workers and the recruitment of workers from outside the UK:

Evidence from the Initiative indicated that local authorities have made progress in terms of reducing the costs associated with agency working (largely through the use of managed vendor schemesa), but less progress has been made in tackling the underlying recruitment and retention difficulties. There is a need to raise awareness as to what constitutes good practice in the procurement management of agency workers in the workplace, and for a more nuanced view as to what constitutes both over-reliance and under-reliance on agency workers.

---

a Schemes that use an intermediary or a third party to negotiate with employment agencies
Immigration policy changes mean that the recruitment of workers from outside the European economic area will no longer be an available strategy, despite the positive views of such workers expressed by many respondents in the study of international recruitment. Workers from Europe were more likely to have found their way to care work after trying other employment within the UK. The impact of recession on recruitment is thus uncertain: there may be more recruits from the UK (for whom care work might not be a first choice), but fewer from Europe and overseas. A reduction in the availability of recruits from overseas and migrant labour is likely to have more impact in the South East and the Midlands than in the North.

Evidence from the Initiative also indicated that having a supportive team was important for retention. The finding suggests that social work employers should consider how well teams work together and that investing in creating a supportive team could improve retention.

Other evidence suggests that organisations should regularly evaluate how far their equality and diversity policies are achieving their objectives, both for better working relations as well as potentially improved retention outcomes.

Under all feasible future scenarios the number of care workers required to provide front line social care is expected to rise significantly in future. Evidence from the evaluation of individual budgets indicated that people using these required more social work input than people using conventional services, so the demand for social workers in adult social care is also likely to rise as personalisation progresses.

**Consequences of staff shortages**

The number one feature that 90% of providers were seeking in their recruitment of care workers was a positive and friendly attitude towards care work, although availability for weekend work, early starts and late evenings were also important necessary factors for the majority of providers. Shortages of suitable staff were such that 40% of independent sector providers reported occasionally, or often, having to hire people as care workers whom they knew lacked the full set of desired attributes. Similarly, 30% of homes and 43% of independent domiciliary care providers had, at least sometimes, to put up with poor staff performance because of recruitment difficulties.

The finding from the social work study that over half of newly qualified workers were employed in local authority Children’s services adds to the evidence nationally and internationally that newly qualified workers are disproportionately employed in child protection. Reports have highlighted the risks to organisations experiencing recruitment and retention difficulties of an over reliance upon newly qualified workers.

---

*Including absenteeism, poor timekeeping, and skimping on the time spent with service users.*
Developing Knowledgeable Workers
Regulation that included targets has helped to improve the numbers of care workers receiving training and obtaining vocational qualifications.

Training and learning opportunities are valued by care workers, particularly if training is not too theoretical, offers them practical ways in which they can better assist the people they are working with, and is, preferably, delivered on-site. Some care workers are motivated to enter the sector by opportunities for training, and the chance to obtain qualifications, despite the low additional rewards that are on offer for those who succeed.

Both formal and informal learning are important sources of skill development, particularly in social care where relational aspects are so important to quality. Organisations differ in the learning environments they offer care workers and in the degree to which external compulsion is a necessary impetus for change and development. Some are innovatory and proactive and may not need external compulsion to deliver skill development. Others are less so, and the more external pressures, and the less available resources, the more difficult it is to take a pro-active approach and offer expansive learning environments to staff.

Studies in the Initiative have highlighted the importance of shared collective learning in creating knowledgeable workers and shaping new roles in integrated settings. In integrated teams (including health and social care staff), informal learning supports the development of skilled care professionals who have learned to work productively in the ‘grey area’ where professional responsibilities overlap.

Potentially, isolation of personal assistants reduces their opportunities for collective and participatory learning, and if these members of the workforce are to be offered opportunities for training and personal development, then there is a need for formal mechanisms to be introduced to overcome this isolation.

Social Work Education and Graduates’ Readiness to Practice
One of the social work studies investigated the particular circumstances of minority groups of students to understand what factors affected their experiences and progress on social work programmes. The study identified both barriers to progression and opportunities that could harness difference and diversity as a source of learning in order to contribute to better progression rates. The study found that monitoring of progression rates on social work programmes was limited and that many staff were often unaware of the extent of the problem. It was suggested that programmes should introduce more reliable systems for monitoring the factors in the learning environment that may be contributing to differential outcomes for student progression and that more effective use could be made of existing institutional and national data in order to do this. In examining the learning environments of several university providers of social work education, a key finding was that a whole organisational approach appeared to have a very positive impact on student progression.

The other social work study investigated how well prepared social work graduates were for practice. Overall, three quarters of the graduates felt well prepared for their
current job by their degree programme but this was strongly related to how they perceived the job and whether they were enjoying it. The ability to apply their values and to engage with the job, which included wanting to learn and emphasis on working in partnership with service users and carers, were the most significant factors. For graduates who did not have the opportunity to put their values into practice or transmit them to others, there was a correlation with not feeling well-prepared. Perceptions of preparedness were affected by how supportive a team graduates were in, the more supportive the team, the less ‘preparedness’ was an issue. Only half of new graduates were satisfied with the amount of contact time with service users or carers’ and a third were dissatisfied, dissatisfaction being higher among those working mainly with children. Dissatisfaction with contact time links to motivations for doing the work, the graduates being principally motivated by the sense of being able to improve the quality of service users’ lives and tackle injustice. Graduates also wanted more help in understanding the situations with which they had to deal - more help in supervision in applying theoretical approaches to their practice. They identified gaps in knowledge which were causing them some anxiety but with a friendly and supportive team, graduates were less likely to identify any ‘knowledge gaps’

The study reported findings about high workloads, a performance management culture for supervision and problems in working conditions (already stated). The overall picture for many was one of increasing pressure and dissatisfaction with the nature of the work available. The findings overall link to general issues currently in the social work workforce about the development of a managerialist, target oriented and performance management culture and about the lack of satisfaction with time spent with service users and the opportunity to build relationships. These raise issues about the current role of social workers, their historical role and what their future role should be. The study findings pointed to problems with facilitating the traditional and fundamental aspects of social workers’ development - values, knowledge and skills in social work.

The Social Work Reform Board and Munro proposals should provide a significant impetus to bringing much needed change in these areas. However, findings from the study also provide new insights into graduates’ perceptions of their role and what is required to meet their needs. Several findings coalesce around one major theme – wanting to work with service users and offer a professional service to them. These are: dissatisfaction with the amount of contact time with service users or carers; ability to put social work values into practice and transmit them to others; wanting more help in supervision to apply theoretical approaches to practice. The latter two are new findings and demonstrate the importance of qualifying training to new graduates in performing a professional role.

Employers and policy makers should consider these three key findings and provide the working conditions that make the fulfilment of these aspirations possible, which will contribute to both the quality of the service and the retention of workers.

Commissioning
Influences of commissioning
The commissioning environment influences pay and can be an enabler of better HR practices. The level of local authority fees is related to whether there are premium
payments for unsocial hours, and, weakly, to pay levels. Variations in fee levels to care homes are large and reflect differences in property markets more than labour markets. Higher fees are associated with relatively small increases in wages for care workers. Reliance on local authority funding does appear to dampen pay rates in care homes: the greater share of local authority funded residents (as opposed to self funders) the greater the likelihood of care workers receiving very low rates of pay. The voluntary sector care homes studied had a lower proportion of publicly funded residents than the private sector care homes.

**Commissioner views and practice**
Fee levels and contracting conditions give commissioners some tools to influence the pay and conditions of the workforce, and their use of these tools varies. There is a consciousness of the cost implications of improving workforce pay and conditions. Commissioners are having to address a number of potentially conflicting agendas, and, in their approach to independent social care providers, they currently take varying positions on a spectrum between cost minimisation and partnership. Cost minimising authorities had lower levels of user satisfaction with domiciliary care. (Figures on user satisfaction with care homes are not available).

Commissioners’ influence in the market place was affected by relative prevalence of self funders in local care homes, and the growth in national providers. Constant change in policies and organisational structures in some cases undermined longer term local strategic planning by commissioners, as well as leading to a need to unravel hard won arrangements with providers or health partners, that may have required considerable negotiation to achieve agreement.

**Provider views**
Collaborative working with providers through the provision of training and the use of consultation mechanisms, primarily provider forums, can in the view of providers (if done meaningfully) be of benefit to the workforce, both in terms of increasing skills and knowledge and in encouraging collaboration between providers to improve good practice, as well as giving opportunities for providers to influence commissioning practice.

Block contracts are in general being used less often. Providers prefer block contracts because they offer more stability to the workforce. In general, they would like to see higher fees, but also, in areas where this does not already exist, more variation in fees paid in recognition of different complexity of some cases, and/or of higher quality of care.

**Joint working with the NHS**
Joint working is evident in plans and planning processes but, with some exceptions, joint commissioning seems to have been largely restricted to intermediate care, which has often provided better paid (though arguably more skilled) work that has sustained in-house services.

The greater fragmentation introduced by personal budgets, that would apparently only be affecting social care, seemed likely to increase the complexities involved in joint financial arrangements with the NHS. If NHS commissioners had different
attitudes towards commissioning from the private sector this was seen to hinder the establishment of joint arrangements.

**Personalisation and the growth in the use of personal budgets**

*General concerns*

There is widespread commitment to the idea of personalisation, involving more choice and control for service users. However, many respondents were uncertain, and sometimes wary, about the process and mechanisms through which the current system of provision (of which personal budgets, and direct payments, form a relatively small part) would be transformed into a system where the majority, if not all, service users or their proxies (in the community) would have a personal budget. The benefits of personal budgets relative to conventional services have not been demonstrated for all service users. The total resources available may affect the degree to which the benefits of the potential greater flexibility of a personal budget can be realised.

Ways need to be found to support service users in developing networks of contact with each other, otherwise important opportunities for people to recognise common interests and jointly commission services might be lost.

Personalisation in care homes has received relatively little policy attention compared with personalisation in community care.

*Key issues in relation to the PA workforce were:*

The likely inadequacy of the future supply of people wishing to work as PAs, and the need for mechanisms to tackle their potential lack of access to training in general, as well as to support in dealing with difficult issues.

Issues that affect the recruitment of care workers are similar to those that affect the general recruitment of PAs.

It is of concern that few currently employed care workers would consider becoming a personal assistant to an individual service user. Their concerns centre on: the practical and financial risks - in terms of their own continuity of employment and the difficulties of work scheduling; and the emotional risks: usually described in terms of possible over-involvement, and lack of back-up in difficult situations.

There is a need for routine information about personal assistants to support workforce planning: their numbers, levels of pay and training for example.

**Changing the culture and Influencing behaviour**

*Teamwork and the supportive team*

Employers need to consider carefully how team building can take place to produce successful team working and how teams can be trained and supported in the workplace. Recommendations for training included: training should be provided in building and managing relationships within teams; changing skill sets should be recognised and documented to support mechanisms such as portfolio based career
progression; professional and vocational training should emphasise skills needed for ongoing learning and adaptation to a range of collaborative working models.

Learning through participation
Findings from the Initiative emphasised the amount of learning that occurs informally (but within formal organisations), through experience of the work itself, relationships with service users and colleagues, taking part in communities of practice, and learning from practice within the organisation or team. New roles could be based on learning through participation, for example within new processes to take forward policies on Personalisation. Employers should consider how informal processes for learning can be fostered and maintained.

A learning culture
Utilising the concept of an expansive/restrictive continuum of learning environments can contribute to a shift away from the restrictive environments which have developed in some organisations in social care and social work. It is essential to move forward from the current culture to a learning culture if workforce development is to progress.

A whole systems approach
In understanding effective ways to create knowledgeable workers, training and learning should not be considered in isolation from wider organisational practice. Findings from the Initiative have emphasised the importance of whole organisational approaches in bringing about workforce change. These integrate training and personal development into organisational practice, and are committed to the idea that staff development, and respect for workers, is an important element in delivering quality care.

Compliance/targets
While targets have been very problematic, not all forms of compliance have been barriers to progress. In particular, for those employers who are not willing or able to institute improvements, forms of incentives need to be considered to ensure consistent quality across the workforce. In relation to targets, some can be helpful to ensure appropriate services are offered, but it may be worth noting that those targets that proved successful in this instance were a result of a formal review that involved all stakeholders, and their achievement was supported by central government funding.

Further evidence needed
Six areas have been identified
1. The research re-emphasises a gap in our knowledge of relationships between training and/or qualifications and service quality and outcomes in adult social care. Exploring this topic requires a scientific research programme that will break the question down into what content and style of training delivers what outcomes for whom in what circumstances (i.e. taking account of workplace influences on practice). Research needed using comparative methods, preferably controlled trials, and/or, where possible, large scale quantitative modelling. Such knowledge is

---

*From the Initiative’s study of integrated teams*
essential if we are to understand how best to invest in workforce training and development.

2. A further gap is in our understanding of the Impacts of pay and conditions of the adult social care workforce (and HR practices) on quality of care and outcomes. The meagre evidence available so far suggests that there are relationships between these factors. Controlled trials might present more difficulty here, so comparative analysis using primary or secondary survey data could be one way forward.

3. The effectiveness of social work supervision on outcomes is another gap in knowledge. Our research indicated the importance to social workers of having supervision that helped them apply theoretical approaches to their practice. Further research in this area could contribute to understanding the nature of theoretical understanding of service users’ situations through supervision and what impact this may have on the outcomes for the service users.

4. In relation to PAs there is a need for:
   Regular gathering by survey of routine information about pay, characteristics and deployment to complement NMD-SC and assist local area workforce planning. This should preferably include information on those working for self-funders.

   Research on: how PAs deal with issues such as the management of risk, abusive customers, becoming over-involved, how, when and whether they can access support, learning and/or training, and how they schedule their work if they have a number of customers.

5. As the use of personal budgets grows it will be important to understand how to encourage/enable service users using personal budgets to work together to develop ideas of services they would like to purchase collectively. (Research and development needed here, with user influence essential)

6. The findings indicate the importance of on-going monitoring/evaluation of the roll out of personal budgets to determine the best arrangements for different user groups, the impacts on collaboration with health, and how work scheduling operates at a system level as the number of people working as personal assistants increases.
Chapter one: Introduction

Purpose of this Report
This report presents evidence from the findings of the Social Care Workforce Research Initiative, funded by the Department of Health. The report does not aim to produce a complete synthesis of findings from all projects within the Initiative, but rather to draw on them to give an evidence-based view of some of the key issues affecting the social care workforce, and to draw out the implications of the findings for current and future social care policy. Whilst acknowledging the substantial contributions made by carers, particularly family members, as well as service users, to the labour involved in care and support, this report reflects the concerns of the Initiative in being focused on the paid workforce.

Policy Context
The Vision for Adult Social Care: Capable Communities and Active Citizens [1] published by the Coalition Government in 2010, emphasises support for individual freedom to choose services, along with the importance of strengthening communities. The promotion of personalisation is a central principle, manifested largely through a challenge to councils to provide everyone eligible with a personal budget, preferably as a direct payment. The Coalition’s Vision urges that ‘Local councils with substantial in-house provision should look to the market, including social enterprises, mutual and voluntary organisations, to replace them as a local service provider.’ The Vision recognises that social care is co-produced, with major contributions from service users themselves, family carers, neighbours and friends, as well as the voluntary and statutory sectors. The Big Society approach to social care, involving more community action and neighbourhood support, is seen as an important way of generating mutually supportive relationships that will assist people to maintain independence and prevent dependency.

With regard to Social Work, the Vision contains a commitment to give more decision making authority back to social workers and to allow staff to exercise judgement with skill and imagination. It is also anticipated that social workers will have a key role to play in community development, focused on supporting the generation of more care
and support locally. The Government is supporting the continuing work of the Social Work Reform Board, set up to implement recommendations for the reform of social work and social work education, and will be drawing on the recommendations of the Munro Review of Child Protection [2], which has already indicated that there has been an over focus on imposing and meeting managerial targets and regulation.

In relation to the wider adult social care workforce, the Vision argues that the contribution of this workforce should be celebrated, and that they will be crucial to delivering personalisation. It is envisaged that local councils will continue to play an important role, working with partners, to commission the workforce and lead local changes for existing staff. A strategy for achieving the vision is not presented in detail (a White Paper on social care is due in 2011) but it is indicated that recruitment and retention, training and skills development, new roles and career pathways, the specific needs of personal assistants, and occupational health issues will be addressed by the Department of Health, and various partners including other Government departments (BIS), employers and employer-led organisations including Skills for Care, and the National Skills Academy for Social Care.

As will be outlined, despite changes in adult social care policy since the Social Care Workforce Research Initiative was originally commissioned, the projects that comprise the Initiative have addressed issues that remain relevant in the new policy context, including workforce composition; ensuring a supply of suitable workers; training and skills development; commissioning; and the roles of support workers and care professionals.

**The Research Initiative in the changing policy and practice context**

The Department of Health Social Care Workforce Research Initiative was commissioned in 2007. Policy concerns at the time were reflected in the *Options for Excellence* review [3] (published by DH and DfES in 2006) that had outlined a vision for the future social care workforce and identified a number of challenges that had to be overcome to progress towards achieving that vision by 2020. The review had been undertaken in the context of the on-going implementation of the Care Standards Act, 2000, that had established, over several years, a framework of institutional structures designed to improve the quality of social work and care
services through standard setting, regulation, inspection, worker registration, training and skill development, and knowledge transfer. The Act introduced statutory requirements for induction and foundation training in April 2002, and targets were set for workers and registered managers to attain relevant National Vocational and other qualifications.

The Options for Excellence review highlighted concerns both about the future supply of workers and the level of skills in the workforce. The available statistics at the time showed high levels of turnover, particularly among home care staff, and high vacancy rates, with consequent high use of agency workers and international recruitment to fill vacancies. This led to a number of concerns about quality. It was recognised that the majority of the adult social care workforce (perhaps as many as 80% of frontline workers) had no qualifications, and that skill levels needed to be improved. At the same time, the growing development of direct payments, and their use for employing personal assistants, pointed to the need to consider the workforce development needs of this new kind of worker. Finally, the new three year social work degree had been introduced, intending to help raise the status of the profession as well as to improve practice, and there was concern that new social work graduates should be well prepared for their role.

In the context of the concerns highlighted by the review, the central objective of the Initiative was defined in the call for proposals as being “to address recognised workforce issues”, for example:

- Workforce composition, recruitment and retention: improving recruitment and retention, particularly of groups of staff where there are high vacancy rates; widening diversity of the workforce; and reducing the use of agency staff while maintaining quality;
- Training and qualifications: understanding the impact of training and qualifications on staff performance, quality and outcomes for users, and improving the take-up and completion of S/NVQs;
- Organisation of work and the work environment: evaluating and understanding the impact of organisational changes, new roles and
Nine projects were successful in the competitive tendering exercise. They covered: commissioning and contracting and their influence on recruitment and retention of the care workforce for older people; international care workers; agency workers; the sector’s capacity for skill development; the impact of regulation on training and development; social work graduates’ readiness to practice; diversity and progression among social work students; the roles and tasks of support workers; and the social care role in integrated settings. Details of the lead researchers and abstracts describing the aims of each project can be found here.

Since the research was commissioned there has been continuity and change, both in the policy context and in the situation on the ground. Changes in a number of the institutional structures implemented under the Care Standards Act 2000, have occurred at a sometimes unwelcome pace. The National Care Standards Commission (NCSC) merged with the Social Services Inspectorate in 2004 to become the Commission for Social Care Inspection (CSCI) which subsequently merged with the Healthcare Commission in 2009 to form the Care Quality Commission (CQC); the Training Organisation for the Personal Social Services (Topss), became Skills for Care in 2005; the General Social Care Council (GSCC), the regulator of the social work profession and social work education in England, is to be abolished (in 2012 at the earliest) and its functions in relation to the registration of social care professionals transferred to the Health Professions Council, that will be known as the Health Care Professions Council once the Health and Social Care Bill has been passed. The much discussed possibility of extending GSCC registration to other sections of the social care workforce seems likely to be resolved through the introduction of a voluntary register (or registers [4]). The framework of National Vocational Qualifications (NVQ) has been subsumed by the Qualifications and Credit Framework (QCF) with implications for past and future social care qualifications that are not yet fully clear. Research within the Initiative suggests that smaller providers, particularly, struggle to adapt quickly to such changes [5].
In terms of social work, despite investment in the new social work degree, problems have continued in the recruitment and retention of social workers and vacancy rates remain high, particularly in Children’s services [6]. As the Initiative began, a range of concerns had been identified, including the quality of qualifying training for social workers, resulting in the setting up of the Social Work Task Force (SWTF) jointly by the DCSF and DH in 2009 [7]. The SWTF produced 15 recommendations for the reform of social work and social work education over the next decade [8] and became the Social Work Reform Board (SWRB) with the remit to develop and oversee the implementation of the reforms. The Coalition Government has supported the work of the SWRB, albeit with some changes to the process. The additional review of child protection, the Munro Review [2], was tasked with building on the work of the SWTF, and Professor Munro is working closely with members of the SWRB. The SWRB process has considerable overlap with the process of the research study ‘Into the Workforce’, being concerned with the interface of qualifying training and the quality of newly qualified practitioners and of the subsequent development of the social work workforce.

In adult social care some trends have been continuing throughout the period of the Initiative. The growth in the numbers of people employed directly by service users as personal assistants has accelerated, with the idea of ‘personalisation’, manifested though the use of personal budgets\textsuperscript{a}, promoted originally by the Labour Government who argued that ‘We expect that every eligible person who wants a personal budget will get one’ [9], but now seen ideally in the Vision as “the norm for everyone who receives ongoing care and support”\textsuperscript{b}. In contrast to the growth in the numbers of personal assistants, the reduction in the Council workforce providing in-house services has continued, supported or accepted by Governments of all persuasions, since it began with the introduction of the purchaser/provider split in the NHS and Community Care Act in 1990.

Thus the research commissioned under the Initiative has been conducted across a time of considerable change and transition: a situation which, while not unfamiliar in

\textsuperscript{a} Personal budgets may include direct payments, but they may also encompass accounts held and managed by Councils or other third parties, or a mixture of approaches.

\textsuperscript{b} Paragraph 4.3
policy-related research, can require some difficult flexibility in changing research once in the field. The structural changes to institutions have meant that for some researchers their specific initial questions had to be modified, or, if already asked, the results had to be re-interpreted to extract information that was generalisable. Systems, such as commissioning, that researchers were attempting to investigate and classify, were in a considerable state of flux, so that they could, and did, change between two phases of the same project (and continue to do so). In this changing context, some policy-relevant recommendations can have a limited life span. For example, a finding from an early project [5] that NVQ targets were well embedded in the system, and that staff favoured their retention or even tightening up, seems now likely to fall on stony ground, given that NVQs have been subsumed into a new framework and targets are less favoured. In tough economic times though, it remains important to use the best evidence that we have to inform decisions that have to be made about meeting future needs for care. Despite the impact of the changing context, it is evident, from the similarity between the issues identified in the Vision and those addressed by the Initiative, that the studies commissioned under the Initiative continue to have relevance in relation to enduring issues that impact on the social care workforce.

This overview will begin by summarising some of the available statistics, to give a picture of the current social care workforce, its composition and the differences by type of service and by sector. It will then look at what has been learned from the Initiative about ways of ensuring a sufficient supply of suitable workers, their training and skill development, social work education, new graduates readiness to practice, and commissioning. The overview will conclude by looking towards the future and drawing out some of the implications for personalisation.
Chapter Two: **Workforce Composition and Working Conditions**

**General Composition**

All available statistics on the social care workforce have limitations, although the establishment and continuing improvement of the National Minimum Data Set – Social Care (NMDS-SC\textsuperscript{a}) represents a major step forward in terms of information. Even so, not all establishments make the required returns, and very few of the workforce who provide assistance to self funders are included. Skills for Care are researching the workforce who assist self-funders and so some data about this section of the workforce may become available later in 2011. The general picture of the workforce that follows is drawn primarily from two sources. First, the most recent Skills for Care report on the *State of the Adult Social Care Workforce in England*, which uses the NMDS-SC and other sources of data including national employment-related surveys\textsuperscript{[10]}. Second, results from the Initiative study by Rubery et al.\textsuperscript{[11]} which looked in depth at workforce related commissioning in 14 local authorities, selected on the basis of a prior national survey to reflect a range of commissioning practices\textsuperscript{[12]}, and also interviewed a sample of 115 providers\textsuperscript{b} working in those authorities and a sample of 98 care staff. The Rubery study complements the national data by providing a more in-depth picture of specific aspects such as working conditions and human resource practices.

The 2010 Skills for Care report details the composition of this workforce of more than 1.6 million people: over 80% are female; 19% were born outside the UK, and 15% are from black and minority ethnic groups. There is considerable variation in the composition of the workforce across different geographical regions and by type of service. Two examples illustrate this variation: London has by far the highest concentration of non-UK born workers (75% of ‘care assistants and home carers’ in London were born outside the UK); and, across the board, 25% of staff in independent sector care homes with nursing are from black and minority ethnic groups, compared with 9% of staff in day care services. The workforce is older overall in comparison with the working population in the country, but this is related to employees’ age on entry to this sector, there is less evidence that the workforce itself

\textsuperscript{a} A database of information provided annually to Skills for Care by CQC-registered establishments

\textsuperscript{b} 10 in-house and 105 independent providers
is ageing. There is a relatively small number of social workers in adult social care: 23,500 (less than 2% of the workforce). Our evidence [13] suggests that there is a difference of emphasis in their role according to whether they work in services for older people, or mental health and learning disability services. In the former their work is largely around assessment and care planning, occurring when a person is first referred to services. In the latter, they play a more on-going role in relation to the direct support of individuals. The changing roles of social workers will be discussed in more detail later.

Analysis by Type of Service

Figure 1

Estimated % of people working in adult social care by type of service, 2009
Total 1,603,000 people (Skills for Care Estimate 2010)

As figure 1 indicates, just over one third of the workforce is working in residential care, and a similar proportion provide assistance in people’s own homes. One in ten work in day services, and the remainder, including social workers and

---

a Residential care comprises two categories of homes: care only homes and care homes with nursing. Care only homes are 77% of CQC registered homes but contain only 57% of places because they tend to be smaller: average places: care only homes:18.4; care homes with nursing: 45.6

b This may be an underestimate because day services are not registered with CQC
commissioners, in community services. Almost one in three workers in the domiciliary care sector are personal assistants, and these workers are more likely than others to have more than one job in the social care sector.a.

Current policy aims, if achieved, will produce a shift in these proportions in the following ways: a growth in the proportion of personal assistants within the home care sector, as the use of personal budgets increases; and a possible decrease in the proportion of residential care workers relative to home care workers if admissions to residential care are prevented. The Big Society agenda may mean an increased focus on community work. A decrease in the proportion of workers in a given type of service does not necessarily imply a decrease in actual numbers because the overall workforce may be increasing. Where might the additional supply of personal assistants come from? Conceivably they might be recruited from residential or home care, as well as from outside the sector. The evidence is that, although both residential and home care services offer starting pay that is close to the minimum wage, the conditions of work differ in these different settings in ways that may influence the choices of people considering work in the social care sector.

Table 1 below indicates some of the contrasts between working conditions and employers’ perspectives in residential and care home services. Care homes can offer more guaranteed working time, and more full time work, although it is less likely that the employer will regard it as important to schedule work flexibly around the worker’s availability. Care homes (particularly with nursing) pay on average slightly lower starting pay to care workers than independent domiciliary care agencies (although both are close to the national minimum wage) but there are slightly more opportunities for pay progression in care homes, presumably because there is a higher proportion of senior posts in the workforce. Only domiciliary care involves travel, which is sometimes reimbursed, sometimes not [11]. As is evident in Table 1, NMDS-SC data shows that both vacancy and turnover rates are higher in domiciliary care than in care homes. Data from Rubery et al. further indicates that care homes and nursing homes are better at retaining new recruits than domiciliary care providers. These differences will be discussed in more detail later. Despite concerns

---
a Average number of social care jobs held by personal assistants: 1.6. For other care workers in domiciliary care: 1.04.
about high turnover, there is considerable variation in turnover rates. Although the average is relatively high, the NMDS-SC data indicated that half of all establishments have a turnover rate under 10%. Senior staff generally have lower vacancy and turnover rates than care workers (around 2% and 10%).

### Table 1. Variations in pay and conditions by type of service


<table>
<thead>
<tr>
<th>Domiciliary Care</th>
<th>Care Homes (some with Nursing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zero hours contracts the norm except for in-house LA services (69% of independent providers in Rubery et al survey),</td>
<td>More guaranteed working time, more likely to be full-time (though still around half work part-time).</td>
</tr>
<tr>
<td>Important (as perceived by employers) to schedule work to fit employees’ circumstances</td>
<td>Relatively less important to fit work schedule round employees’ circumstances, although efforts are made</td>
</tr>
<tr>
<td>54% paid mileage or re-imbursed travel costs. Generally no pay for time spent travelling. (Rubery)</td>
<td>N/A</td>
</tr>
<tr>
<td>Median hourly pay (NMDS-SC) Domiciliary care £6.82 Rubery data: Indep sector £6.65 LA in-house £9.16</td>
<td>Care only homes £6.48 With Nursing £5.95 (Eborall speculates that this lower pay is because these workers are support staff for skilled workers ie nurses) Rubery data: median normal pay in homes £ 6.08</td>
</tr>
<tr>
<td>Very limited opportunities for pay progression (Rubery data page 146, section III 3.2)</td>
<td>Limited opportunities for pay progression</td>
</tr>
<tr>
<td>Pay uprating most commonly influenced by level of LA fees Rubery data</td>
<td>Pay uprating most commonly influenced by changes to National Minimum Wage</td>
</tr>
<tr>
<td>All staff turnover: 22%</td>
<td>16% care only homes; 19% with nursing</td>
</tr>
<tr>
<td>Vacancy rate: 4.8% NMDS-SC figures (excludes Council sector)</td>
<td>2.9% care only homes; 2% with nursing</td>
</tr>
<tr>
<td>Rubery et al. % of new starters retained over 12 months 22%</td>
<td>Rubery et al. % of new starters retained over 12 months 60%</td>
</tr>
</tbody>
</table>

Note on in-house workforces: CQC data indicates that turnover among Councils’ social care workforces (on average 10.8%) is also extremely variable, not so much between regions but between authorities within regions. For example in London the turnover rate varied from 24% to 5.7%. Vacancy rates are higher at 8.2% but this may reflect posts remaining unfilled as a matter of policy. It is difficult to draw any conclusions given that the figures for Councils may be affected by the impact of re-organisations and changes in service delivery.
**Analysis by Sector**
Policy for the last two decades has dictated the growth of the independent sector, particularly the private sector, and the reduction of local authority in-house services. The role of local authorities as direct employers of workers in adult social care is declining steadily [10]. Figure 2 shows that around half of the workforce is employed by the private sector, and a further quarter by the voluntary sector.

Figure 2

![Pie chart showing the distribution of workers in adult social care by sector in England, 2009](image)

- **Private**: 48%
- **Voluntary**: 25%
- **NHS**: 4%
- **PAs**: 10%
- **Council**: 13%

Although adult social care is still predominantly delivered by small businesses, major companies’ (including large voluntary organisations’) share of the market is increasing: 66% of places in care homes with nursing were operated by major companies in 2009 [10], and around half of the domiciliary care providers in the study by Rubery et al. were part of national chains. Some commissioners expressed concern about the prospect of becoming reliant on national providers, because of possible impacts on the local supply chain, and thus on commissioners' ability to foster a diversified supply of care provision. Skills for Care’s ‘rough estimate’ in 2010...
was that there were 17,320 organisations providing or organising social care for adults and older people (and employing social care workers) in England in 2009. These organisations ran over 40,000 local establishments, three-quarters of these having less than 20 employees.

There is some evidence of differences in terms and conditions by sector. Pay is lowest in the private sector, slightly higher in the voluntary sector, and highest in Council in-house services (Median hourly pay of care workers: Private sector £6.00; Voluntary sector £7.03; Council £7.73). Turnover among care workers is higher in the private than the voluntary sector (24% in the private sector; 18% in the voluntary sector). There are no current comparable figures for pay, vacancy levels or turnover among personal assistants. Figures from a survey of direct payments users [14] in 2007 suggested median pay of £7.41 (in 2006 - estimated from table 7.4) but a small scale study cited by Manthorpe et al. [15] showed personal assistants recruited through a domiciliary care provider being paid at lower levels than other domiciliary care workers in the same organisation. This might mean that people recruited directly by service users receive higher pay than those recruited through independent domiciliary care providers, but this is speculative, and, even if it is so, such a pattern may or may not continue as personal assistants become a larger proportion of the workforce. Research in 2006 on the workforce employed by service users in receipt of direct payments, indicated large variations in the rates of pay received by personal assistants [16].

**Residential and domiciliary care by sector**

Figures 3 and 4 show the split by sector for residential and domiciliary care services separately. In both services the majority of people work for the private sector a. Residential care is overwhelmingly provided by people working in the private sectorb. Most of the remaining residential care is provided by those in the voluntary (not for profit) sector. The voluntary sector employs 22% of the residential care workforce but 8% of the domiciliary care workforce. The majority of employees in domiciliary care work in the private sector, and most of the remainder are personal assistants.

---

a In day and community services people working in the private sector are in the minority (9% of the total).

b 73% of care homes and 89% of care homes with nursing are privately run
Figure 3

Residential care - people in all workforce jobs by sector
596,000 people: Skills for Care estimate for 2009

Figure 4

Domiciliary care - people in all workforce jobs by sector
559,000 people: Skills for Care estimate for 2009
Care Workers perspectives on the nature of the job, pay and working conditions

Much previous research ([17] [18] [19]) has indicated that care workers experience high levels of job satisfaction derived from the intrinsic nature of the work. Providing assistance to others and developing relationships with service users are experienced as rewarding by many. The opportunities for training and the flexibility of working hours can also be seen as an advantage. Studies in the Initiative show that this continues to be the case [20] [11]. At the same time as they experienced satisfaction from the nature of the work, care workers reported low satisfaction with pay, and with some working conditions such as a lack of pay for travel time and low, or non-existent, enhancements to pay for unsocial hours. Workers who were paid travel time and extra pay for unsocial hours were less likely to perceive their pay as unreasonable. The proportions who said that pay was not reasonable varied by setting: care homes 86%; independent domiciliary care 59%; LA domiciliary care 28% [11]. Older workers were more dissatisfied with pay than younger ones - perhaps reflecting the limited chances for pay progression with experience. However it is informative that while 64% overall said the pay was not reasonable when asked directly about pay, only 19% mentioned it as an aspect of the work they were unhappy with in an open question. Even so, this was still the most commonly cited aspect of the job with which care workers were unhappy. Certainly, for most it was not a motivation to leave the sector: 85% intended to stay in some form of care work, although 27% intended to leave their present employer, most often saying that they would like to work in the NHS or undertake nurse training. There were limited opportunities for career progression, but many care workers expressed no desire to progress to senior posts, although it was difficult to disentangle whether this reflected their attachment to hands-on care work, or their perception that senior posts involved far more responsibility for limited extra reward. Interestingly, the small number of male care workers interviewed were much more likely to be interested in career progression [11].

SOCIAL WORK

The information in this section is drawn primarily from the General Social Care Council (GSCC) and Skills for Care NMDS-SC data.
General composition

Appendix 1 shows the current employment of social workers by the organisations for which they work at 7th March 2011 (provided by the Knowledge Manager, GSCC\(^a\)). Nearly 57% of social workers work in local authority statutory social work but the GSCC does not collect separate information relating to the adult and children’s sectors. Approximately 3.5% work in the Health sector and 2% are categorised as ‘Other – Public’, making an approximate figure of 62.5% in the public sector. Nearly 5% are categorised as working in the private sector (‘Other – Private’) and just under 3% in the voluntary sector. However, the ‘Other’ category, nearly 18%, includes social workers in a variety of organisations that could be included in either the private sector or the voluntary sector\(^b\). So if this category is combined with the figures for the private and voluntary sectors, the figure is likely to be nearer 26% for the private and voluntary sector as a whole. 3.74% work for private agencies and only 1% appear to be unemployed, but for 7.64% of registrants there is no information.

Though the data are not precise, they give some indication of the relative proportions in the sectors. On the same calculations, the figures for a year earlier show that there was a higher proportion in the public sector, 67% and a lower proportion in the private and voluntary sector, approximately 21%. Though the overall numbers of social workers increased that year, there was a decrease in the public sector, from 55,826 to 54,520 and an increase in the private and voluntary sectors, from 17,693 to 22,515. This seems to indicate that there was a trend away from the public sector to the private and voluntary sectors over the year from March 2010 to March 2011. Similar figures for previous years are not available for comparison.

At 7th March 2011 there were approx 3,675 newly qualified social workers i.e. those registered with the GSCC as a qualified social worker in their first year after qualifying.

Skills for Care NMDS-SC data contain separate data for Adult and Children’s services and the last published data shows that there were 50,500 social workers (both full-time and part-time) in social services departments in councils in England at

---

\(^a\) The figures provided rely on the information that is provided to the GSCC by the registrants and this is not always clear cut.

\(^b\) Our examination of a sample of the organisations categorised as “other” suggests that few of them were in the statutory sector.
30 September 2009. Of these, 23,545 were in Adult services and 26,955 in Children’s services [10]. The number of social workers in Children’s services far outweighs the number in Adult services, given the relative size of the two sectors, with about 1.8 million people using adult social care services (some of whom will not encounter social workers) [21], compared with 375,000 children in need and 64,400 children looked after [22]. The NMDS-SC data include turnover rates but there is a low return so they are not presented here.

The Into the Workforce study found from its samples of graduates in 2008 and 2009 that over three-quarters of first-year graduates were working in local authorities, many more in Children’s departments (49% in 2008 and 57% in 2009) than in Adults (29% and 31% respectively), especially in 2009. The results from this study show that local authorities continue to be the main source of employment for social workers, especially those who are newly qualified, with comparatively few participants working for the private and voluntary sectors.

**Pay**

The average weekly earnings of social workers are well down the list of occupations classified as ‘professional’, the median gross weekly pay being £555 for full time and part time earnings combined. Social workers were earning less on average than all types of teaching staff but more, on average, than nurses and occupational therapists [10] (p. 116). However, social workers are relatively well paid for a job in which women predominate. Newly qualified social workers fare well compared to teachers and health professionals, typically higher than both. UNISON commissioned Income Data Services to undertake research on market levels of pay for social workers to inform pay negotiations and a job evaluation is currently being conducted [23].

**Working Conditions**

The Social Work Task Force identified a number of problems in the working conditions of social workers, particularly: IT systems; high workloads; limited access to professional (case) supervision which includes professional development; the overall quality and consistency of frontline management and the pressures under which managers and supervisors were working [24]. The Into the Workforce study
found a similar picture and tended to confirm many of the problems in need of reform. The Task Force introduced a framework for employers and practitioners to assess the ‘health’ of their organisation, the ‘health check’, looking at five key areas which can affect working conditions and this was taken forward in the reform process.

However, it is considered that some conditions are worsening with the cuts in funding currently in the public sector. Community Care has conducted surveys of social workers in recent months and reported problems in several areas including social workers caseloads and the turnover of line managers:

*Four in 10 social workers feel their caseload is unmanageable and two-thirds say it has increased in the past 12 months, a survey has found.*

(McGregor, Community Care online, 12 August 2010)

*High turnover of line managers is plaguing social work, leading to increased stress levels and problems with supervision….. Our exclusive survey of frontline social workers found two-thirds have had two or more line managers since April 2010. The high turnover rate was more apparent in children’s services (69%) than in adults’ services (59%).*

(McGregor, Community Care online, 07 June 2011)

In terms of the ‘health check’, a survey of around 550 agency and permanent social workers reported in Community Care suggests that:

*Half of social workers say their employer has failed to complete a workload "health check" amid reports that caseloads have increased over the past year…. when asked whether their employer had followed the Social Work Task Force’s recommendation to carry out a health check of a range of issues including caseloads and vacancy rates, half said no and another third (36%) said they were unsure.*

(McGregor, Community Care online, 15 June 2011)

A survey has been conducted by BASW over a nine month period in response to members concerns about changes to adult social work. Seminars have taken place in a range of locations in England with the aim of sharing experiences of the participants and to capture key messages. Two hundred and fifty social workers have attended to date, only 25% of whom are BASW members. Similar issues have
been identified across all the locations about conditions in the workplace, increased workloads, an evident managerialist culture with a shift in power from social workers to managers, the implementation of the Personalisation agenda and Integration with Health. Many issues concur with those reported earlier. The impact of cuts has been more variable with some local authorities trying to protect social care services whilst others have to make cuts - but not all the cuts have been worked through yet (Godden). Poorer areas have been worst hit because of the change in the formula for allocating funding to local authorities [25].

Social workers are said to be very frustrated by the bureaucracy associated with their work: respondents to a BASW survey [26] reported that the majority of their time was spent inputting into computers. In their view, much of the IT systems are not fit for purpose and the inputting in part relates to output targets, which they understand should have been reduced. In relation to personalisation specifically, artificial targets for performance are being imposed, leading to inflexibility of service. Many social workers report that older people particularly do not want to have the stress of managing a personal budget, but social workers were being heavily leant on by managers to impose them. Similarly, prescriptive assessment forms, supposedly designed to encourage personalisation are reported to be mechanicistic and inflexible. An example was given of one authority where social workers have to ask people in their nineties “how they see themselves in 10 years time” The social workers report that that they are not allowed to ignore this question, which is seen as essential by managers as it demonstrates a person centred approach.

The achievement of target numbers within timescales is also a problem since managers are reported to be under pressure to find ways to meet the targets; ways not necessarily in the interests of service users. Outcome targets are thought to be very useful but should come from the ‘bottom up’, in line with service users’ needs. Some of the concerns are also about the transfer of responsibilities to non-qualified social workers, who do not always have the skills and knowledge to assess and support service users and carers with the complexities and challenges of managing personal budgets. In terms of Integration with Health, the Health system of ‘Payment By Results’ for mental health has been imposed and this conflicts both with social workers’ values and the Resource Allocation System of Adult services, both of
which have to be used. Concerns also include issues around privatisation and commissioning. Some commissioners are thought not to understand social work or enough about what they are commissioning. Overall the key message coming out of the BASW survey is that “professional” judgement and skills have been / are being eroded by a managerialist and risk averse culture. Parallel to this is the failure of employers to recognise the value of relationship based intervention in social work, which leads to poor decisions being made and a poor service. The social workers consistently say they want a Munro for adults [26].

In the Into the Workforce study, ‘manageable workload’ was a significant factor for some (although this appeared to have a much smaller effect on job enjoyment or on retention than values etc - see Chapter Three). Between a quarter and a third of graduates responding to the survey were dissatisfied with their caseloads. Graduates wanted supervision that focused less on performance management and passing on agency policies and wanted more time spent on putting theory into practice. Forty three per cent of respondents were also dissatisfied with the IT systems in their organisation and their concerns were echoed by the line managers interviewed as part of the study.

Conclusion
It is evident that the low wages and poor conditions faced by many of the care workers in our samples reflect the recognised position nationally. In its report to the Government on the National Minimum Wage in 2011 [27] the Low Pay Commission stated:

Evidence this year again highlighted the difficulties faced by some care workers as they tried to ensure they were paid at least the minimum wage. In some instances, home care workers on zero hours contracts were being paid per visit rather than by the hour, unpaid for travel time, and unpaid or underpaid for travel and other work costs. The complexity of the pay systems used left them, and sometimes it seemed even their employer, unsure whether they had been paid at least the National Minimum Wage. (Para 4.14)

All research on labour markets has shown them to be divided or fragmented. Dual labour market theory indicated that there was a division into a primary and a
secondary labour market, and, although further segmentation is now recognised, the social care sector displays many of the classic features of a secondary labour market (as argued in the Initiative study of international workers [20]): ‘These occupations tend to pay lower wages, have insecure employment, are less unionized, and provide less opportunity for advancement. Levels of turnover are high and the workforce is dominated by women and minorities.’a Gender bias in the social construction of value leads to the undervaluingb of work primarily performed by women [28], to an extent that cannot be explained solely by gender-specific preferences regarding labour market investments, and in the allocation of resources between the household and the workplace [29]. As we have seen, the social care workforce is predominantly female, one in five workers are migrants and the workforce as a whole is disproportionately drawn from BME groups. Excluding the small minority of managerial and professional groups, pay is close to the minimum wage and pay progression is limited. Conditions of work, particularly in the domiciliary care sector, are relatively poor although flexibility and some control over working hours may suit some workers. Members of the workforce recognise the poor pay and working conditions. In short, the vast majority of the social care workforce operates in a secondary labour market doing undervalued work.

Despite this, care workers often report high job satisfaction, and some compare the work favourably to alternative low paid and low skilled jobs that they have experienced [11]. Care workers enjoy the intrinsic nature of the work, and value the training opportunities [30] even though being trained, and having low level vocational qualifications, brings little increase in material rewards. The perception that care work is relatively more rewarding than other available alternatives, makes it important for retention that changes in the organisation of care, particularly domiciliary care, should not undermine those factors that are the principal cause of job satisfaction. Knowing that large sections of the existing workforce enjoy their work and are committed to the sector cannot provide reassurance that there will be a sufficient additional supply of suitable workers to meet current and future workforce shortages. The next section will consider current and future adequacy of the supply of workers.

---

a Online dictionary of the social sciences
b Defined as a higher quality of labour for a given wage
The sectors in which social workers are employed appear to be experiencing a change with a possible trend from the public to the private and voluntary sectors, though the comparison was just for one year and should be treated with caution. Working conditions appear to be worsening in the public sector but any possible shift to the private and voluntary sectors will be due to a variety of factors. Social Work Graduates in the Into the Workforce study were more likely to be looking for another job if they were already working in the private or voluntary sector (see next chapter) but this may reflect short term contracts or that they feel they need experience in the statutory sector. The Into the Workforce study also shows that social workers, like many care workers, put job satisfaction above other factors, including pay and prospects, in relation to their intention to stay in a job but this is qualified by the particular circumstances of the team in which they work (see next chapter).
Chapter Three: Supply of the Workforce: Recruitment and Retention

Skills for Care’s workforce simulation model has produced projections of the numbers of social care workers that may be needed to meet the future social care needs of adults and older people in England, to 2025 [10]. Making such forecasts is as much art as science, given uncertainty about the prevalence of ill-health and disability in later life in the future, as well as the variety of possibilities for the ways in which assistance may be delivered to those who need it. Certainly, we do know that the number of people over 85 is set to almost double between 2010 and 2026 (Health Committee quoting ONS 2008-based population projections [31]), and the Wanless report in 2006 concluded that ‘In the context of expected increases in demand for care in the future, there is a very real issue of whether it is possible realistically to expect supply to increase in response’ [32]. The projections of future workforce demand made by Skills for Care and Development currently cover four hypothetical scenarios. These scenarios combine projections of future demand for long-term care of older people and of adults (made in 2008 by the Personal Social Services Research Unit (PSSRU) for the Department of Health) with a range of assumptions about future patterns of service delivery and available resources [10]. Under all scenarios the number of people required for providing social care rises (to between 1.8 million and 2.6 million depending on the scenario).

The Health Committee sounded a note of caution about “demographic despair and alarmism”, arguing that the demographic challenge is partly a cohort effect, caused by the ageing of people born in the post-war “baby boom” thus leaving a “window of opportunity” in which to prepare before this group of older people reach the age at which their need for services increases. However, the report emphasised that “on all reasonable assumptions, the social care system will face considerable increased pressures” [31].

Given this future scenario it must be of concern that staff shortages are already evident in the sector. Drawing on the National Employers Skills Surveys, Skills for Care reported that the 2009 survey showed that the proportion of employers reporting current vacancies was just over twice as high in social care as in other

---

\[a\] Page 13/14 of the State of the Workforce Report
sectors: 25% compared with the all-sectors level of 12%. For hard-to-fill vacancies there was a similar discrepancy. The overall proportion of jobs vacant in the social care sector was 3.1% which compared with an all sector rate of 1.4%. Falling vacancy rates in this, and all, sectors since 2007 have been attributed to the effects of recession. One third of care organisations in the study by Rubery et al. said that recession had eased their recruitment difficulties, but this effect, because we must hope that its cause is short term, does not represent a solution to the question of how the evident need for a longer term increase in supply of care workers can be achieved.

Supply of the social work workforce
There is no national system for analysing or forecasting social worker supply and demand. There is a lack of detailed information about the characteristics of the workforce, on key trends such as vacancy rates, and on the number of social workers needed in local areas. As a consequence, workforce planning at local and national levels is severely constrained [33].

The Social Work Reform Board has commissioned The Centre for Workforce Intelligence (CfWI) to lead on work on social work supply and demand. The CfWI is looking at social workers employed in the health and social care sector and the project is building a supply and demand model for social workers, split between adult and children’s social care. The model looks at qualified and registered social workers using data from GSCC and NMDS-SC, with an overall national/regional model, and with the ability to add additional information at local level to improve the accuracy of modelling. Social workers employed in the private, voluntary and independent sectors will be included in the model by extrapolating the available data where this is possible. Social workers employed outside of health and social care, such as Probation Officers, are not included. A number of scenarios are being used to investigate the impact of various drivers of supply and demand, for example the changing higher education funding and government cost reduction targets. (Information from the Analytics & Modelling Head, Centre for Workforce Intelligence, March 2011).

---

Some caution should be exercised here because some children’s services could not be separated out from these data. However the vast majority of services included were for adults.
The model will improve understanding of the factors that influence social worker supply and demand, and provide a forecast of the number of social workers needed in future years. This will support the development of a more effective system for planning, particularly at a local level where the model can be used and refined to provide better knowledge of workforce requirements, and reduce the potential for over or under supply. The intended completion date is the end of July 2011 (Information from the Joint Social Work Unit, June 2011).

In relation to this work, the Into the Workforce study suggests that there is a need to go beyond information on the number of social workers qualifying each year and their demographic characteristics. It suggests the need to look at the less quantifiable factors, such as the impact of motivations and values, on retention in the long term. Without this, it is argued, it will be impossible to identify whether those who go into the Workforce remain there or whether their experiences ultimately mean that they will seek employment elsewhere [34].

**Recruitment**

**Social Work Education**

There has been no shortage of recruits to social work programmes, applications and places on programmes having increased substantially since the onset of the new degree in 2003. In 2009-10, 6,113 students enrolled on the social work degree in England, a five per cent increase on the previous year and the second highest since the degree was introduced [35]. The number of applications to the 2010-11 full-time undergraduate degree nearly doubled, to 60,000 from 37,000 in 2009-10, according to the Universities and Colleges Admissions Service (UCAS). This made social work the ninth most popular subject out of more than 180. However, a cut in the number of undergraduate places is planned for 2011-2012, expected to fall slightly in England by 8%. Reasons cited are a lack of practice placements and uncertainty over future funding arrangements for higher education [36]. A reduction in student places may be welcomed by some in the sector, partly because of a shortage of good quality practice placements but also because of the number of newly qualified workers who are having difficulty in finding jobs (see later). McGregor also reports that, despite an overall slight decline, the number of postgraduate places available as a proportion of the total in England has steadily increased.
There is also concern in the sector that by increasing the fee level for social work programmes from 2012 that:

“potential social workers will not be able to afford to qualify, or sustain repaying their student debt and this will result in shortages of applicants and social workers at a time of increasing need for family and community strengthening.”

(Joint letter to Ministers: Subject Centre for Social Policy and Social Work (SWAP); Joint University Council; Social Work Education Committee (JUC/SWEC); Association of Professors of Social Work (APSW), 1.11.10).

Many applicants to social work programmes are in older age groups, have dependents and under the proposed arrangements are likely to earn a salary already eligible for loan repayment when they begin work after qualifying. This may deter a range of people who are currently on programmes from applying in future. This could result in a narrowing of the diversity of the intakes to applicants who can afford the fees or are able to sustain long term loans. This may affect postgraduate programmes particularly as postgraduate students are not generally funded to the same extent as undergraduate students.

Concern has also been expressed about the calibre of some entrants to qualifying education and training and thereby to the profession. The reported variability of graduates in social work has led the Social Work Reform Board to recommend strengthening the criteria (including UCAS tariff points) for entry requirements to programmes [37]. Some of the concerns have centred on intellectual requirements and writing skills but also on the qualities of the individual, which has resonance with those described in other studies in the Initiative. Concepts such as being ‘resilient’ have become a much discussed characteristic, reflecting concerns about the ability of some social workers to withstand the pressures of social work and confront the dynamics of difficult and complex situations. Such concerns were shared by line managers taking part in the Into the Workforce study. In terms of intellectual ability, there was a consensus within Higher Education Institutions (HEIs) in the study that good intellectual ability was required for social work but that this was not necessarily best measured by UCAS tariff scores at entry. HEI staff noted that ‘high flyers’ do
not necessarily make good social workers. It was also noted that most social work programmes score very well on the value-added dimension – taking people from a relatively low base to achieve quite well at the end of the course [34]. Concerns were expressed that the widening participation agenda of HEIs might be adversely affected by any mandatory minimum tariff score, and therefore the diversity of the workforce, acknowledging the widely held view across social work programmes that a diverse workforce needs to be recruited to meet the needs of service users [34]. The Diversity and Progression project was set up to examine factors in the experiences of some minority groups on social work programmes with the ultimate objective of contributing to policy developments aimed at increasing the diversity of the social care workforce so this study also has important findings to consider about factors contributing to building such a workforce.

*Social work jobs*

In terms of recruitment to jobs, the Into the Workforce study showed that this was uneven, with some graduates unable to find jobs. The surveys of first-year graduates in 2008 and 2009 showed that 69% and 68% respectively of the total number of respondents to the surveys were currently working as social workers. This approximates to national data for 2008-09, collected by the GSCC - 67.3% took 0 – 6 months and a further 1.8% took 6 – 12 months to find jobs [38]. 12% of the graduates in the Into the Workforce study in 2008 and 7% in 2009 were in employment outside social work, but the great majority of these were in jobs elsewhere in social care. 12% in 2008, increasing to 16% in 2009, were not in paid work at all and still looking for a social work job at the time they replied to the survey [34]. Although there are differences in sampling strategies and response rates between the two studies which cannot be discounted as contributing to some of this difference, this appears to compare unfavourably with the Wallis-Jones and Lyons study which found that in 2002, 93% of newly-qualified social workers were employed in social work within a year of qualifying, and just one per cent were unemployed [39].

Though five years ago, the Options for Excellence report [3] quoted 39% of newly qualified social workers (NQSWs) taking up posts in the organisation where they undertook their practice learning, arguing that there were clear benefits for
employers in terms of recruitment and retention. However, in the Into the Workforce study, only one fifth of newly qualified workers had found a job this way which may be an indication of the fluctuating market for jobs and the restructuring and decrease of posts in Adult services. Newly qualified workers also report that higher requirements for experience are expected from some employers. Of the first year graduates in social work jobs, three-quarters were working in local authorities, many more in Children’s departments (49% in 2008; 57% in 2009) than in Adults (29% in 2008; 31% in 2009). In terms of service user group, child protection accounted for by far the highest proportion of first-year respondents (41% in 2008 and 53% in 2009) [34].

The study of international care workers included new data about the profiles of international social workers, noting that they were seen often as good quality and more experienced. Comparisons with newly qualified UK social workers were therefore hard to make [20].

Vacancy rates in local authorities across the UK rose from 10.9% to 11.3% in 2009, ranging from 4.6% to 15.3% in England. McGregor states that:

“Experts have blamed the persistently high turnover of staff in both adults’ and children’s services on a combination of negative public perception, low morale, high caseloads and spending cuts, which have led some authorities to freeze recruitment.” [40]

Thus, a mixed picture has emerged of high vacancies rates while at the same time there are unemployed newly qualified workers with the proportion increasing over the time of the Into the workforce study.

**Agency workers**

In the study of agency working [41], local authority managers who recruited agency workers to temporary posts were asked why they did so. The reason most frequently given for recruiting professional staff was difficulty in recruiting, or needing to fill a post quickly, particularly when safeguarding issues were involved. The use of agency social workers is often criticised as costly and a hindrance to team development [42], [43], but positive uses of this resource are not always acknowledged. Spending by local authorities on agency workers is variable: in a
survey of local authorities conducted as part of the Initiative, expenditure varied between 17% and 4% of the adult social care staffing budget. The highest proportion of expenditure on agency workers was in London [41]. Options for Excellence [3] outlined a number of strategies for reducing overreliance on temporary staff, most of which were designed to improve recruitment and retention more generally, although promoting ethical international recruitment was also considered to be an option. However, the Initiative study of agency working concluded that:

"while local authorities have made progress at the level of reducing the costs associated with agency working, less progress has been made to tackle the underlying recruitment and retention crises which means that agency workers continue to play an important role in the social care workforce." [41]

Costs had been reduced by using a range of managed vendor schemes that use an intermediary or a third party to negotiate with employment agencies on behalf of local councils. Some employment businesses felt that new arrangements meant that their expertise in matching people to suitable posts was now disregarded, but the evidence of reduction in costs to authorities was clear. What agency social workers themselves often valued was the ability to escape from uncongenial working conditions (in terms of team relationships, and management regime) and reposition themselves elsewhere in the sector. For the newly qualified, agency work could be a way to find a team and a permanent job that they would really like, although employers sometimes do not accept such workers from an agency because they are looking for someone who can get on with the job without too much induction or support.

The researchers concluded that although staff shortages continued to be the main reason for using agency workers, these workers are increasingly being brought in to manage specific projects or pieces of work (for example, to tackle a waiting list) rather than just to fill a vacancy or provide cover in an unspecified way. This was regarded as an example of good practice, in comparison with a range of "less legitimate" management practices that included:

Accepting an imbalance whereby the majority of a team are agency workers
Using agency workers during a recruitment freeze instead of working out which posts are really needed - in the end this may cost more

Expecting newly qualified workers to act as if they were fully experienced

Constant reorganisation of senior management meaning that decisions are not made about long-term permanent posts but in effect posts are filled in a long-term way by agency workers

In situations of high staff turnover, recruiting agency workers instead of addressing the reasons for turnover

Giving agency social workers complex caseloads but denying them access to induction training and supervision that their permanent colleagues would get

The researchers conclude that there is a need to raise awareness as to what constitutes good practice in the procurement management of agency workers in the workplace, and also a need for a more nuanced view as to what constitutes both ‘over-reliance’ and ‘under-reliance’ on agency workers [41].

Care Workers
Rubery et al. found that in 2010 significant problems in the recruitment of care workers still remained despite the effects of recession, particularly in domiciliary care: 28% of care homes and 39% of independent domiciliary care providers in the study said that recruitment was very or quite difficult. Staff shortages meant that 34% of domiciliary care providers had some staff working more than 45 hours per week. Domiciliary care providers had particular difficulties in finding people to do weekend or evening work, perhaps unsurprisingly as there were often no pay enhancements for unsocial hours (69% reported this problem). Recruiting for night work was not reported as a problem quite as often, with 37% of domiciliary care providers and 15% of care homes reporting this. When asked about common problems of poor staff performance such as absenteeism, timekeeping and skimping on time or services provided, 30% of homes and 43% of independent domiciliary care providers
admitted that they put up with poor performance, at least sometimes, because of recruitment difficulties [11].

How do care providers recruit care workers? The majority of independent establishments recruited senior staff from within their existing care staff, with 56% relying on this method exclusively\(^a\). For care workers, word of mouth was by far the most popular method, generally involving asking staff to recommend suitable others. 85% of providers used this method, and homes were more likely than domiciliary care providers to believe that word of mouth was their most effective recruitment method. Interviews with care workers confirmed that substantial proportions were influenced by family and social networks (66% said family or friends worked in social care). Local advertising was also used by 80% of providers, mostly in the local press but some independent domiciliary care providers also used their own shop fronts. 72% used Job Centre Plus, and around one third kept a list of those who had previously expressed an interest.

How were shortages of care workers addressed? 16% of independent domiciliary care providers and 6% of homes reported using fee-charging employment agencies, although local authorities rarely used such agencies [11]. Local authority managers interviewed in the study of agency workers [41] reported that recruitment of agency workers who were not professionally qualified was generally not in response to staff shortages but rather for specific tasks or projects, or when services were being reconfigured (for example to maintain continuity when in-house services were being closed). A small group of black African agency care workers, interviewed in the same study, reported that they worked for an agency because of flexibility in terms of hours per week, the possibility of taking longer periods off, and their degree of control over the work.

Some 17% of care homes and nearly 10% of domiciliary care providers reported recruiting care workers directly from outside the UK, and 13% of care homes and 19% of independent domiciliary care providers had used agencies that specialised in

\(^a\) 6% of organisations had no senior care workers.
finding migrant workers [11]. In the study of international workers that was part of the Initiative [20], interviews with human resource managers and employers revealed that the main driver for recruiting international workers was to address workforce shortages. Most international care workers interviewed had either been recruited directly from their home country or had come accompanying a family member. Workers from the EU, who have a right to enter the UK, differed slightly from other international workers in that they were more likely to have found their way to care work after trying other employment in the UK. Although the need to recruit international workers has given rise to concern about the quality and suitability of workers recruited, most employers and human resource managers interviewed had found international care workers in general to be hard-working, productive and reliable employees, with a caring approach. Some were over-qualified for care work but were seeking to improve their English or familiarise themselves with local culture, before moving on to work for which they were qualified, for example nursing. In some instances language skills had also been useful in assisting communication with service users whose first language was not English. Given the important contribution of international care workers, particularly including those from outside the EC recruited in the main to do this kind of work, it is understandable that the English Community Care Association (an employers’ association) was sufficiently concerned about the immigration cap to oppose it in the courts [44]. Of course, as we have seen, the degree to which the social care workforce includes international workers varies across different regions of England, and so a reduction in international recruitment is likely to have more impact in the South East and the Midlands than in the North.

Selection
Care Workers

Despite the popularity of word of mouth to find interested candidates, nearly all organisations used standard ways to vet applicants for care work: application forms with work history; formal interviews, perhaps after telephone screening; references and person specifications. The number one feature that 90% of providers were

---

a Local Authority domiciliary care providers in the study, in contrast, generally favoured press advertising for their recruitment, rarely used agencies (to find care workers) and did not use international recruitment or word of mouth at all.
seeking in their recruits was a positive and friendly attitude towards care work [11]. Universal, among a selection of organisations that had been identified as examples of good employment practice, was the desire to recruit people with the sensitivity and communication skills to relate and respond to service users’ needs and wishes; that is, people who could respond to care needs in more than a purely technical manner [30]. Being the right ‘sort of person’ was more important to prospective employers than training or qualifications (the latter tended to be rated desirable, but not necessary), but availability for weekend work, early starts and late evenings were also important necessary factors for the majority of providers [11]. Research with service users who employ personal assistants found that they too tended to value personality traits over proven skills and experience [14], although the users and carers interviewed in the study of international social care workers did value care workers with whom they could communicate in English [20].

It is a reflection of the impact of staff shortages in the sector that 40% of independent sector providers reported occasionally, or often, having to hire people as care workers whom they knew lacked the full set of desired attributes [11]. However, it seems that all employers, from service users through small and large organisations, believed that, given the right material, they could shape their recruits to meet their requirements.

Retention

Intention to leave social work posts

When divided into five year periods after qualifying (based on GSCC registrants at 31.12.2008), the rate of departure from the social work profession is reasonably constant, on average 10% in the three five-year periods from 5-20 years but it is higher in the first five years - about 16.2% leave in that period [45]. Other work has also pointed to high rates of exit from the profession and a reduced length of working life as a social worker [46]. A lower departure rate during the first few years, accelerating as time goes on, could be expected, especially for a profession where motivation starts high. To lose almost one in six qualified people in their first five years may indicate something about the nature of jobs for the newly-qualified. In terms of workload, graduates in the Into the Workforce study reported a reduction of good work/life balance in their second year. There was also an increase in the
number of participants reporting that they found it difficult to cope with the stress of their job. Both these findings were significant at the 10 per cent level – suggesting that although the results could have arisen by chance, with a larger sample, they might be statistically significant. However, further supporting evidence would be needed in order to place confidence in this finding. These trends are consistent with the study of newly qualified social workers in Children’s services [47] which found about a third of their sample scoring above the threshold for stress on the GHQ-12 and many newly qualified social workers reporting they did not have (or at least they thought they did not have) the 10 per cent reduction in caseload that they were meant to have as newly qualified social workers [34].

The findings from graduates in the Into the Workforce study regarding their intentions to stay with their current employer indicated that “over half the first-year graduates expected to remain with their current employer for at least the next two years; slightly more for the shorter period of between two and four years than for the longer period of the next five years. One in eight of these graduates was already looking for another social work job – more in Britain than abroad. A quarter expected to start looking for a new social work job within the next two years. However, only 1% expected to leave social work altogether within the next two years.” Analysis from another related question showed that discontent about being able in their present job to apply properly ‘the theory I learned during my degree programme’ was associated to some extent with intention to stay or leave; 45% of those unhappy about not being able to apply theory in their practice expected to change jobs or leave social work altogether, compared with only 27% of those happy about this aspect.

Another possible factor affecting job-changing decisions was frequency of supervision. A sizeable proportion – varying between 13-22 per cent across the three waves of data collection received supervision less often than once a month. The longitudinal survey data indicated that in their initial job, a quarter of those who subsequently moved to another social work job received supervision less than once a month, compared to only one in ten of those who stayed in the same job with the same supervision frequency in the same early stages of their career. This suggests that too little supervision may have been a factor in the decision to move.
After controlling for all other factors, what influenced graduates most to stay in their present job was having a supportive team, whereas they were most likely to be already looking for another job if they were working in the private or voluntary sector. The finding that having a supportive team decreased likelihood to look for another job is important in policy terms, because it suggests that social work employers concerned about retention should consider how well teams work together, and that investing in creating a supportive team improves retention - see Chapter Five. The reasons for the finding that graduates working in the private and voluntary sectors were more likely to be looking for another job probably lie in the ambition of newly-qualified workers to work in the statutory sector and because of pay differences. This too has important policy implications, with the extension of Social Work Practices in both Children’s and, now, Adult services. However, Social Work Practices may come to be seen as equivalent to working in the statutory sector, as these organisations may be undertaking statutory work, which is a complicating factor.

Job satisfaction is generally associated with better retention. The Into the Workforce study found high levels of job satisfaction (as measured by the extent to which participants were enjoying their job) - almost 90% of graduates were ‘very much’ or ‘quite’ enjoying their jobs in social work. The study also found that only 13% of graduates enjoying their job were already looking for another job, whereas this rose to 43% among those not enjoying their job. The question of job satisfaction is discussed further in Chapter Five.

Intention to leave - Care workers
As we saw in Chapter 2, care workers reported low satisfaction with pay and some working conditions, but most intended to stay in some form of care work, although for a minority this might be through undertaking nurse training or moving to work in the NHS. These findings resonate with smaller scale research commissioned by Skills for Care [17] which notes that, problems with retention appear to be linked more often to management relationships, styles and techniques and competence rather than to workplace, the job role or the service user group. A key recommendation of that study was that managers should focus on human resource
practices critical to recruitment and retention. These include supervision, appraisal, flexibility, career progression, training and qualifications.

Although care workers experience high levels of job satisfaction derived from the intrinsic nature of the work, and their relationships with service users, Rubery et al. [11] observed that some growing trends, such as the reduction in visit lengths in domiciliary care, could pose a threat to important components of job satisfaction. Provider managers in domiciliary care said that visit lengths were tightly defined, and it was clear that short visits to users were the norm (modal responses to questions about minimum and average visit lengths were 15 minutes and 30 minutes.) Electronic monitoring was providing opportunities to pay for shorter segments: in one Local Authority this was per minute of contact time. On the face of it, these limited time periods might seem to militate against the development of relationships, and indeed, one third of independent domiciliary care providers replied ‘no’ or ‘to some extent’ when asked whether staff had the opportunity to develop good relationships with service users. In contrast, 94% of care homes replied ‘yes’ to this question [11].

Staff turnover - care workers

High staff turnover has a number of potential consequences that might have deleterious impacts on quality, for example: effects on continuity (of care and of people providing care); effects on employers’ investment in training; and effects on attempts to establish and maintain an organisational ethos of care. We have seen that average turnover rates are high, but there is considerable variation and apparently high rates may not always be seen as a problem [11] [19]. One in three domiciliary care providers experienced turnover rates (excluding new recruits) above 30%. We have seen in Chapter 2 that turnover is higher in domiciliary care than in care homes. Data from the Initiative suggests that care homes were more successful at retaining new recruits than domiciliary care agenciesa. Of course, as we have seen, there are differences in working conditions in these different types of service. What is known about those staff who leave? Without exit interviews it is difficult to know directly the views of leavers, but care staff did have some views about new recruits who did not stay. Two main issues they identified were: the nature of the job

---

a As indicated in Table 1, based on a subsample of 87 providers who supplied the necessary information
and the unpredictability of working hours. It was felt that new recruits, especially younger ones with no prior caring experience, expected jobs in domiciliary care to involve ‘cooking, cleaning and a bit of company’, and so were unprepared for the sometimes distressing or difficult situations they would encounter, and the degree and intensity of personal care that was required. With regard to working hours, some staff were said to have left because they were unhappy with unpredictable and unsocial hours and the pressures to work additional hours at short notice.

Responding to a question about all leavers, provider managers reported that reasons for staff choosing to leave were: family reasons, the desire for more convenient working time, and improved pay or job prospects [11].

Experiences of racism and discrimination

The study of International workers reported evidence of racism, bullying and discrimination in the workplace [20] with varied responses by managers from positive to expecting workers to just ‘put up with it’. Although with the passage of time (spent in the UK) such incidences were reduced, this nevertheless raises issues about whether such processes might impact on retention for some workers.

The Diversity and Progression study [48] showed that a number of overt and hidden processes interact to shape the overall learning experience of, social work students from minority groups, which may have an impact on progression outcomes. The study suggests regularly evaluating how far institution-wide, as well as at programme level, equality and diversity policies are achieving their objectives. This would seem an important measure for all organisations to rigorously adopt, particularly in social care, both for better working relations as well as potentially improved retention outcomes.

Predicting HR outcomes

Given the observed variability in recruitment and retention outcomes, one of the aims of the Initiative was to investigate factors that influence these variations. Using multivariate analysis it was found that local authority fee levels, and local labour market conditions do appear to affect pay, human resource practices, and outcomes such as turnover and perceived recruitment difficulties for care workers, but the relationships are complex. Not all providers respond in the same way to these
factors and disentangling cause and effect can be difficult. Three examples illustrate these complications: being part of a national chain with its own policies seemed to dilute the impact of differences in local authority fee levels on pay; voluntary sector providers in general offered better HR practices than for-profit providers and had lower levels of staff turnover; in areas of strong labour demand it was possible that some providers introduced improved HR practices\(^a\) as a strategy because they were experiencing high turnover or recruitment difficulties, thus leading to an initially unexpected negative relationship between these factors\(^b\) [11].

Local labour markets do appear to have an influence. Independent domiciliary care providers in areas of strong labour demand were more likely to have negative views about recruitment difficulties and staff retention. Care homes in areas where the median pay for women in part-time employment was relatively high were more likely to offer higher quality HR practices (but not necessarily higher pay). Better HR practice can be associated with some good HR outcomes: the more that domiciliary care providers were able to offer attractive and less demanding working time schedules\(^c\) the better the outcomes for recruitment and retention.

Size of establishment and ownership also have effects: the smaller the provider, the better the summary index of recruitment and retention outcomes; locally based independent domiciliary care providers had better recruitment and retention outcomes than national chain providers in the same area; national chain homes were more likely than other ownership types to have staff working long hours and long weeks, and least likely to pay premiums for unsocial hours, but more likely to provide regular pay uprating. Interestingly, these differences in HR practices by ownership were not evident among domiciliary care providers, where it seemed from interviews that pay and HR practices were more likely to be set locally, even among national chains.

\(^a\) Such as regular pay uprating, paying for CRB checks, use of formal recruitment methods and offering guaranteed hours contracts.

\(^b\) A cross-sectional study can only point to quantitative associations and offer plausible explanations about the direction of causality, although these explanations can be reinforced by qualitative data that includes participants’ own reasons for action.

\(^c\) This index included: work schedules that fit staff preferences; less requirements for weekend working; fewer long hours or long weeks; time off for training
Finally, there is some evidence that the commissioning environment influences pay and can be an enabler of better HR practice. The level of local authority fees is related to whether there are premium payments for unsocial hours, and, weakly, to pay levels. The weakness of the latter association suggests that that employers are not passing on a ‘fair’ share of their increased income to staff in the form of pay increases, but, at the same time, national minimum wage levels were clearly maintaining a ‘floor’ to wage levels in low fee local authorities. In the case of care homes, pay would be a lower proportion of overall costs: variations in fee levels to care homes were large and reflected differences in property markets more than labour markets. However, reliance on local authority funding does appear to dampen pay rates in care homes: the greater the share of local authority funded residents (as opposed to self funders) the greater the likelihood of care workers receiving very low rates of pay. Fee levels are related to geographical position\textsuperscript{a} and local labour market conditions\textsuperscript{b} but the relationship was described as ‘not fully consistent’. The nature of the authorities’ relationships with providers also had some influence, but this factor will be discussed in the next chapter which is focussed on commissioning.

**Pay and HR practice and quality of care**

Chapter 2 showed that there is a gradient of pay and working conditions: they are highest in the Council workforce, followed by the voluntary sector and then the private sector. Does this larger investment in the workforce produce a higher quality of service? The very limited evidence available does point to some on-average differences in quality.

The Chair of the Care Quality Commission reported to the House of Commons Health committee in 2010: “Council services have got the largest proportion of good and excellent ratings at 87%, voluntary sector services at 86% and 74% for privately run services.” (Para 146). Also, Netten et al. [49] reported, on the basis of a national survey of home care users in 2003, that “higher levels of satisfaction and reported service quality are associated with in-house provision.” However we are not comparing like with like. The independent sector is delivering services at much lower

---

\textsuperscript{a} Lower in the North and higher in the South

\textsuperscript{b} The correlation was significant and high at .66. All high fee payers were in areas of high female labour demand, but there was one authority that paid low fees in an area of high female labour demand.
cost, for example: 2008/9 figures indicate that the average cost of local authorities own provision residential care is £824 a week compared with the cost for residential care provided by others £445 per week; cost of own (LA) provision homecare is £23.20 per hour as opposed to the cost of homecare provided by others which is £12.60 per hour [50]. Clearly, some of the cost savings are achieved through lower pay and worse conditions of service for care workers. But would improving pay and conditions improve quality? The comment from the Chair of CQC suggests that better pay and conditions in the voluntary sector do seem to be producing on average better quality than in the private sector (however Rubery found that voluntary sector homes had on average a lower proportion of LA funded residents than private homes). The survey by Netten at al. [49] also found higher levels of user satisfaction with providers who employed older and more experienced workers, who allowed 10 or more minutes travel time between visits, and those who had levels of staff turnover that they did not perceive to be problematic. There is some further evidence from the Initiative, based on CQC quality ratings of the providers in the telephone survey. This analysis showed that 3* care homes provided better pay and pay-related conditions than 1* and 2* homes (but 2* homes seemed to have the best practices when it came to employee voice\textsuperscript{a}.) However there were no significant relationships between star ratings and pay or HR related variables for domiciliary care providers [11]. In truth, this uncertainty reflects a gap in our knowledge: although there may be many plausible reasons to suppose a connection, we have very little evidence of the impacts of pay and working conditions of the workforce on the quality of care.

**Conclusion**

**Care Workers**

Even at a time of recession there remain recruitment and retention difficulties in social care, particularly in domiciliary care where the majority of new recruits in our study left their jobs in less than a year. Qualitative accounts suggest that the working time conditions (and sometimes the nature of work) cause staff to leave, and quantitative data suggests that if working time conditions are not so demanding then recruitment and retention difficulties are less. Care homes seem unlikely to compete

\textsuperscript{a} Staff meetings (frequency); staff surveys; union recognition
for staff through offering higher pay, but tight labour markets do seem to improve the quality of human resource practices in homes. One solution to the shortage of care workers has been the employment of migrant workers, recruited internationally or following arrival in the UK. This has been a way of recruiting some able, committed and hard-working staff, but the immigration cap seems likely to restrict this avenue of recruitment. The recruitment of workers from the EU remains a possibility, although if the numbers coming to England for any kind of work are reduced because of the recession, then there will be a corresponding reduction in those who find their way to social care after experiencing other kinds of work.

It must be a matter of concern that a significant proportion of providers find that on occasions they are compelled to employ care workers whom they feel lack some of the desired attributes. Recruitment difficulties can also mean that employers, carers and users have to accept poor performance such as absenteeism or skimping on the time spent with service users. Under all possible future demand scenarios the need for care workers is set to increase. Somehow, ways must be found to attract and retain more people in the sector. Attempts to improve the sector’s image have already been made, but evidence from this Initiative, and other studies, has shown that groups who are currently underrepresented are deterred by poor working conditions, remuneration, and the perceived lack of career prospects, as well as, in the case of men, the perception of care work as women’s work. Some may doubt whether there is an untapped pool of the ‘right sort’ of people who are willing to accept the pay and conditions on offer. There is some indication from our evidence that smaller providers and voluntary sector providers offer better conditions of service, slightly higher pay, and have fewer recruitment and retention difficulties. However this may not have any implications for the overall supply of workers, although very limited evidence suggests that it may have implications for care quality. It is a gap in our knowledge that we are not able to convincingly demonstrate the links between workforce characteristics, pay and conditions and the quality of care provided.

Will the growth of personal assistants, and other directly employed workers, bring new people into the workforce? Some initial evidence suggested that around two thirds of personal assistants had previous work experience in the sector, so this
suggests there may be some new entrants, although their commitments may, at least initially, be restricted to assist only someone that they already know [14]. Research on the conditions that affected the recruitment of personal assistants showed them to be remarkably similar to the general conditions that affect the recruitment of care workers, (for example perceived low levels of pay, and difficulties in recruiting in rural areas [16] p 72), so we may not be tapping a new pool.

Securing an adequate supply of social care workers remains an enduring problem that is likely to be partially eased only in the short term by recession, and unlikely to be solved in the longer term without improvements in pay or conditions that will attract and retain new workers. However, care workers enjoy the intrinsic nature of the work, and many value the training opportunities [30], even though being trained, and having low level vocational qualifications, bring little increase in material rewards. The perception that care work is relatively more rewarding than other available alternatives makes it important for retention that changes in the organisation of care, particularly domiciliary care, should not undermine those factors that are the principal cause of job satisfaction. Knowing that large sections of the workforce enjoy their work and are committed to the sector cannot provide reassurance that there will be a sufficient supply of suitable workers to meet current and future workforce shortages.

Social Workers

Chapters two and three indicate some worrying trends for the supply of the social work workforce. There are high vacancies rates in many areas, some very high, but at the same time some newly qualified workers appear to have difficulty in getting jobs. There is also a high rate of departure of workers from the profession in the first five years after qualifying, leading to greater turnover. These pose considerable challenges for employers and policy makers.

One solution to the shortage of social workers has been the use of agency staff. The high cost of this solution has led many local authorities to introduce arrangements such as managed vendor schemes to keep costs down. However research within the initiative has shown that, while costs have been reduced, the underlying recruitment and retention problems that led to high vacancy levels have often not been
addressed. The use of agency workers has given rise to concerns about their levels of knowledge and skills in relation to the types of work they are given. While the employment of agency workers for specific short-term pieces of work, or to fill vacancies while recruitment takes place, can be good practice, examples remain where agency workers constitute over half of social work teams and where newly qualified social workers are expected to "hit the ground running" with complex and intractable cases.

The finding from the Into the Workforce study in Chapter Two that over half of participants worked in local authority Children's services adds to the evidence nationally [39] [51] and internationally [52, 53] that newly qualified workers are disproportionately employed in child protection, partly because this is where vacancies are and partly because it is seen as a 'starting off point' for their future careers. At the same time, reports [54] Social Work Task Force, 2009a have highlighted the risks to organisations experiencing recruitment and retention difficulties of an over reliance upon newly qualified workers. It is important to recognise that recruitment difficulties in child protection are not restricted to the UK; there is international evidence [52] [55] suggesting they happen elsewhere. Thus, the results presented in the Into the Workforce study may have a greater salience beyond the experiences of newly qualified workers in England and imply there is a need for further research aimed at understanding differential patterns of recruitment and retention across different organisations and types of service [34].

The finding that over three-quarters of first-year graduates were working in local authorities also raises important issues. The changes to Adult and Children's services over the past 30 years have been characterised by a shift from publicly funded and provided services to services that continue to be publicly funded but are mainly provided by private and third sector organisations [56] [57]. As a result, there are varying views on how this has affected employment terms and conditions within the social care workforce. There is some evidence that there is now a more flexible labour market, enabling workers to achieve more control over the hours and times of day that they work set against other indications that employment terms and conditions, such as access to employment-based pensions, are less favourable [58] [59] [11]. Social workers have been comparatively unaffected by this trend until
relatively recently, because they have generally worked in the public sector — with the exception of those working for temporary employment agencies [41]. However, there is some indication (Chapter Two) that the pattern may be changing with possibly a quarter of the social work workforce now in the private and voluntary sectors. The Into the Workforce study highlights the need to monitor the impact of any changes away from publicly provided social work services towards more pluralistic models. For example, will the greater autonomy that Social Work Practices [60] are intended to provide mean that they can attract the most experienced workers, leaving those services that are still retained by local authorities increasingly dependent upon newly qualified workers? Alternatively, will new forms of social work service prefer to recruit from newly qualified workers on the assumption that they may be more creative and possibly cheaper than those whose social work experience has been largely obtained undertaking what some consider to be overly bureaucratic types of social work [61] [62] [34].
Chapter Four: Developing Knowledgeable Care Workers

Introduction
The shaping and development of knowledgeable workers entails both formal and informal learning. It is understood that, to deliver a quality service, skilled workers must also operate in a workplace, or within an organisation, that is organised to enable good practice to be delivered. What is it that care workers are learning to do? Care work involves emotional, physical, and mental labour. Emotional labour involves working on and through the feelings of others, with the aim of producing an effect on their emotional state. Although, to work successfully, it may demand that staff give something of themselves, it may also require that workers to control their true feelings and display emotions that are at odds with their inner state. The relational aspect of the work, while it is evidently the source of considerable rewards in terms of job satisfaction for workers, can also be hard, emotionally exhausting work. Often though, it is seen as in some way ‘natural’, particularly for women. However, overcoming the relational difficulties in working with people who have dementia, or learning disability and challenging behaviour, for example, can require considerable knowledge, and skill in face to face interactions. For many service users there are communication difficulties to be overcome. The physical work of the role is not just about lifting and handling people, although the technical skills involved in this are recognised in induction training. The physical work is also body work, involving touching, manipulating and assessing the bodies of others, not only in dressing and bathing, but also in what Twigg [63] describes as ‘dirty work’: dealing not just with human waste (although that certainly figures), but also with truths that the wider society prefers to remain hidden, in the shape of decline, physical and mental failure and death. These are the aspects of care that sometimes prove a shock for new recruits. In two different studies, one in ten care workers reported the death of clients to be a negative aspect of the work [18], [11]. It is understandable, if not always recognised, that the job requires careful preparation, skill development and on-going support, whether informal or formal.

Informal learning
Findings, from studies of integrated teams [13] and of the capacity for skill development in the sector [30], emphasise the amount of learning that occurs
informally (but within formal organisations), through experience of the work itself, relationships with service users and colleagues, taking part in communities of practice, and learning from practice within the organisation or team. For both care workers and professionally qualified staff, learning takes place through all these avenues, giving rise to concept of learning through participation, that can be contrasted with concept of learning as acquisition, which characterises learning in educational institutions. Accessing learning from other workers might be thought to be more difficult for those in domiciliary care than in care homes, but as well as mechanisms such as induction, supervision and appraisal, 70% of independent domiciliary care providers said work in pairs might be used around half the time to reflect the specific needs of service users [11].

New roles could be based on learning through participation: for example, the “skilled care professional” was an emerging new role in integrated teams, that was based on expertise and experiences that were personal to the worker rather than defined by formal professional training. Formal training provided a foundation for learning ways of “integrated” working, but much of this learning had to be undertaken informally on the job, learning and “picking up skills” from others, particularly those in other professions, as the nature of the work in an integrated team compelled workers to move beyond their professional role into a plurality of tasks that they had not formally been trained to do [13]. It is important to emphasise that it is not being argued that informal learning is an inferior substitute for formal learning, but rather it is an essential part of learning for which there may be no formal substitute.

**Training**

When it comes to the delivery of formal training in the private sector, it is well recognised that the market delivers imperfectly [30]. It can be cheaper to employ a member of staff who has been trained by another employer, than to invest in the training of one’s own staff. The fact that sufficiently well-informed customers may wish to choose to use organisations that employ trained staff, even if it costs them more, does not get round this fundamental problem. Trained staff can be “poached” from those who trained them. Because they can never be certain they will receive the full benefits of their investment, rational self-interest on the part of employers can result in a level of investment in training which is less than optimal [64]. Therefore, if
it is desirable from the point of view of society that employees should receive training, and if it is not to be directly provided to individuals through a formal education system, then a range of incentives for employers is needed to ensure that training happens. Such incentives can be coercive for example regulation, which may embody targets, inspections or accreditation. Coercive systems may not be unwelcome because they create a level playing field in which all are required to do the same thing. Additionally, social institutions may offer positive incentives such as the provision of funding streams\textsuperscript{a}, or grants to employer organisations for training, or recognition in the form of awards, or preference in the awarding of contracts.

The need for intervention by social institutions will equally be necessary to ensure that those personal assistants, who wish it, are able to acquire skills and qualifications that will support their personal development and provide career pathways. Employers who are service users are unlikely to feel any commitment towards the need for training other than to enable personal assistants to meet their particular needs: in a survey, direct payments users did say that if they were offered grants or subsidies they might be more likely to offer training, but, in general, they felt that the wider organisation of training and development was not their responsibility - only 7\% had arranged any training other than on the job training [14].

\textit{Impacts of regulation}

Through the period of the Initiative there were multiple, changing, sources of funding that could be used for social care training, combined with targets embodied in regulations, for example that 50\% of workers should obtain NVQ level II qualifications. Although small organisations were more likely to struggle to keep pace with changes, and to understand complex funding streams [65], our results suggest that regulation worked in improving the numbers of staff with vocational qualifications [30] [5]. Research conducted as part of the Initiative concluded that the regulatory framework had driven considerable progress between 2003 and 2008 in terms of the quantity and quality of training in social care [5]. The study of the sector’s capacity for skill development [30] found that regulation had been a significant lever for quality improvement, and had resulted in increased demand for training, and the allocation

\textsuperscript{a} For example the current Workforce Development Fund, formerly known as Training Strategy Implementation funding.
of internal and external resources to training and assessment of staff. After an initial ‘regulatory shock’ both management and staff in case studies were mainly supportive of the regulatory framework and, if anything, favoured a tightening up of some of the arrangements in the area of targets, inspections, and registration [5]. Of course, organisations can vary in their response to regulation, so that not all will be waiting for action from regulators before making improvements. Rainbird et al. [30] distinguished pro-active from reactive approaches, the latter involving waiting for inspectors to let people know what to do, and developing human resource management (HRM) on a piecemeal basis, the former planning ahead for future regulatory changes and using a range of HRM techniques (recruitment and selection, training) to improve the quality of the workforce and services provided. Again small establishments that were part of larger organisations had access to more resources to assist them in these respects, than did single homes or small groups.

Aside from the impacts on the amount of training, regulation had also contributed to forms of partnership at regional level by taking training out of competition. In some places regional consortia had emerged as a mechanism for sharing resources amongst employers, building capacity and exchanging good practice. The availability of funding, and the need to apply for it, had been what had normally initially brought people together, but the consortia that were studied had subsequently expanded beyond their original purpose. Despite their value to those involved, particularly smaller organisations, these consortia were identified by the researchers as institutionally fragile because they usually depended on the presence of enthusiastic local actors who were enthusiasts for learning, and for the sector, and whose cosmopolitan links into the wider sector provided a significant source of learning [66].

At the front line (establishment level), providers were not necessarily aware of the sources of financial support for training. Homes in one study knew of the availability of ‘free’ courses, of varying quality, and were aware of the costs to them in terms of staff time for involvement in training and assessment [5]. The majority of providers paid staff for time spent training, but additions to wages for obtaining NVQ2 were limited: where the amount was stated, these additions were in main limited to less
than 50p per hour [11](p 147). Although those interviewed said, or implied, that were the National Minimum Standards to be removed, they would still continue to train at higher levels than had been the case in the early 2000s, a number referred to ‘undercutting’ and the fear that others would not so train if the incentive provided by the target were removed [5]. Multivariate analysis indicated some evidence of a relationship between local labour demand and the achievement of NVQ targets, concluding that “achievement of NVQ targets is negatively related to labour demand, with an especially strong penalty effect on independent domiciliary care providers in strong labour demand areas. This may be an indication of poaching of qualified workers in tight labour markets, a problem that is not confined to the social care sector.” [11]a The 50% target had not yet been universally metb. Further, this study suggested that independent domiciliary care agencies had more difficulty in meeting this target than care homes. Managers in domiciliary care attributed their difficulties primarily to higher staff turnover and problems related to finding trainers or assessors or securing funding, rather than lack of staff motivation.

Despite the general acceptance of the benefits of regulation, there were a number of reservations [5] [30] [11] about the NVQ system itself and the degree to which all targets were appropriate:

- The processes involved were bureaucratic and cumbersome
- It was an assessment procedure rather than training process
- Considerable variability in implementation of NVQ’s: from distance learning and self completed paper assessments, to regular ongoing support and underpinning knowledge sessions.
- Assessment practice was very variable within and between institutions
- There was not always the capacity to provide NVQ assessment (particularly acute for homecare workers, personal assistants and agency workers because of the difficulties of assessing competence on the job)
- Focus on NVQ targets might restrict access to other more appropriate training

---

a Page 283 Final Report
b 65% of independent domiciliary care providers in the study had met or exceeded the target, compared with 89% of homes.
Some in care homes with nursing felt that the registered manager qualification was less relevant to them than to managers in care homes, particularly if they already had nursing qualifications. The amount of Progression to level 3 was disappointing (the conventional wisdom was that people needed to be working in jobs which had more with supervisory elements, although this is not necessarily the case).

It is too early to say whether the new QCF framework, within which existing NVQ’s will be recognised, will be found to address these issues, and whether the abandonment of targets for training will have the kinds of impacts that concerned some providers.

The requirement for induction training has also met with some success. A range of evidence from this Initiative indicates that statutory induction is well embedded delivered (with only a few exceptions) to all new workers including those born outside the UK and is in most cases valued by staff. An exception is agency care workers and social workers who tend to be expected to ‘hit the ground running’. The way in which induction is delivered varies, involving not just specific induction training but also, variously: shadowing, working under supervision, probation and mandatory training courses. There are differences between providers in how long they expect it to take for a new worker to become competent. Local authority providers thought the longest period (50% more than a month); followed by homes; followed by independent domiciliary care providers (27% thought they could do it in less than a week).

**Care staff views**

In 2008 staff had come to take the new regulatory regime and its effects on training as a given, and a ‘good thing’. Offering extensive training was seen as a defining characteristic of good employer by staff, and is a reason why some people entered the sector. Care workers particularly valued training that they could put into practice: that they could immediately see was related to the specific needs of users that they worked with. They were more negative about training that they saw as too theoretical and classroom-based. Staff and managers expressed a
preference for on-site training, even if delivered by external trainers [5]. The opportunity to undertake training made staff feel valued by their employer, and offered a positive contrast to some other low paid jobs for unqualified workers [11]. Some care workers wanted more training in specialist areas, in particular dementia: an area where the need to improve the skills of the workforce is well recognised [67][68]. There is some evidence that the workforce who work with people with dementia is less well qualified than the social care workforce in general [69]. Courses in dementia care were said to be compulsory in 52% of homes, and 44% of independent domiciliary care providers [11] although we have no indication of the quality of courses. Interviews with managers suggested variability in the quality of training providers in general [5]. Inconsistency in quality of dementia care training has led to calls for accreditation for trainers in this field [67].

International workers did not describe any particular barriers in relation to accessing and gaining training, and variations in quality of training were similar to the variations experienced by UK workers. A few international workers did receive extra language and cultural support [20]. Agency care workers might be offered on the job training and sometimes help by the agency to obtain wider qualifications\(^a\) but in contrast most agency social workers\(^b\) felt they were not able to access the same level of training and support as their permanent colleagues. This was often accepted as part and parcel of being an agency worker [41].

**Organisational environments**

In understanding effective ways to create knowledgeable workers, training and learning should not be considered in isolation from wider organisational practice. From interviews with policy stakeholders and case studies of successful organisations, Rainbird and colleagues [30] identified a range of approaches to skill development. In analysing these approaches they used the concept of expansive/restrictive continuum of learning environments to contrast reactive, and compliance-driven, approaches with whole organisational approaches, where the latter integrate training and personal development into organisational practice, and are committed to the idea that staff development, and respect for workers, is an

---

\(^{a}\) Based on a small sample of 15 agency care workers

\(^{b}\) Based on 45 interviews with qualified agency social workers
important element in delivering quality care. The study identified the following influences that contribute to the development of knowledgeable workers (page 69):

- Culture of the organisation and the quality of management

- Quality of the working conditions and the work environment (although care work is not well paid it can be satisfying work. Working conditions can, for example, recognise work/life balance issues, and respect and value staff and their views on care)

- The quality of the learning environment and how this can be enhanced through education and training (the workplace itself is a source of learning, generating shared collective knowledge).

- The significance of interconnections between training, learning and other HRM practices for workers and the significance of other sources of learning outside the immediate workplace

- For managers and owners, wider networks and engagement in regional coordinating structures are a mechanism for connecting with leading practice

Of course, organisational culture and practice are also important in encouraging or discouraging good practice that has been learned. Workers can be frustrated or discouraged if they find themselves unable to put their knowledge into practice [20][67].

**Training, quality of care and outcomes**

We currently lack a systematic understanding of the relationships between staff training and/or qualifications and outcomes for service users [32]. There are many difficulties in establishing these relationships: for example the range of what is meant by training, the workplace characteristics that influence whether training can be put into practice, the complexities of outcome measurement in social care, and the cost
of conducting high quality evaluative studies. Certainly there is evidence that after undergoing training, staff report increased competence, greater self-confidence, enhanced job satisfaction and morale and better teamwork [70] and that staff acquire new knowledge [71], but findings such as these alone cannot demonstrate that service users or carers benefit. Still, there some positive indications about outcomes for service users: first, a SCIE review of research on communication training found that such training could improve the way that staff communicated with older people in care homes, and, that if such training led to improvements in the quality of social interactions between staff and older people, this could in turn lead to improvements in older people’s quality of life and well-being [71]; second, analysis of a survey on workforce productivity by PSSRU concluded that ‘Although the impact of training and qualifications such as NVQ are not strong, there are indications that these are positively associated with outcomes.’ [72] The SCIE review concluded ‘There is an urgent need for economic evaluations of training which could help care homes reach decisions about which types of training they should invest in’. No simple relationship between training and quality of care or user outcomes can be expected. Rather research might valuably ask what training works for whom in what circumstances and with what outcomes?

**Conclusion**

Both formal and informal learning are important sources of skill development, particularly in social care where relational aspects are so important to quality. In integrated teams, informal learning supports the development of skilled care professionals who have learned to work productively in the ‘grey area’ where professional responsibilities overlap. Organisations differ in the learning environments they offer care workers and in the degree to which external compulsion is a necessary impetus for change and development. Some are innovatory and proactive and may not need external compulsion to deliver skill development. Others are less so, and the more external pressures, and the less available resources, the more difficult it is to take a pro-active approach and offer expansive learning environments to staff. Regulation that included targets has helped to improve the numbers of care workers receiving training and obtaining vocational qualifications.
Training and learning opportunities are valued by care workers, particularly if training is not too theoretical, offers them practical ways in which they can better assist the people they are working with, and is, preferably, delivered on-site. Some care workers are motivated to enter the sector by opportunities for training, and the chance to obtain qualifications, despite the low additional rewards that are on offer for those who succeed. A gap in research evidence is that we do not have any systematic understanding of the relationships between staff training and/or qualifications, quality of care and outcomes for service users. Studies in the Initiative have highlighted the importance of shared collective learning in creating knowledgeable workers and shaping new roles in integrated settings. Potentially, isolation of personal assistants reduces their opportunities for collective and participatory learning, and if these members of the workforce are to be offered opportunities for training and personal development, then there is a need for formal mechanisms to be introduced to overcome this isolation.
Chapter Five: Social Work and the Social Care Workforce

Introduction
Two studies in the Initiative were wholly concerned with social work - the Into the Workforce study and the Diversity and Progression study. During the period of the Initiative, as indicated earlier, a major review of social work took place and the government-initiated Social Work Reform Board (SWRB) has formulated proposals for the reform of social work and social work education. The process of review and reform has been the biggest undertaking since the review of social work, in the late 1960s, culminating in the Seebohm Report [73] and the reorganisation of social services in 1971. A key aspect of both reforms is a whole system approach which links with discussions in several of the studies in the Research Initiative. Since social work and social work education and training are undergoing substantial reform, the main issues for social work are set out separately in this chapter though connections will be made with themes across the Research Initiative as a whole.

Over the past decade, there have also been major changes to the regulatory, policy, and labour market context in which social workers practise and in the higher education sector in which social work is taught. In order to understand the current context, a brief review of changes over the last decade is presented, picking out the key developments that have affected the social work workforce and that link to the social work studies in the Research Initiative. Recent developments are then presented. It should be noted that the longitudinal study of social work students [74] and then graduates (Into the Workforce) was commissioned in 2003, when the Department of Health had responsibility for all social work and social work education provision.

Policy context
Regulation
Unlike professions such as nursing or medicine, regulatory and registration schemes for social work in the United Kingdom (UK) have been established comparatively recently, the General Social Care Council (GSCC) with responsibility for England having been set up by the Care Standards Act 2000 [75]. As stated in Chapter One, the GSCC is expected to be abolished with a transfer of functions to the Health and
Care Professions Council (as it is planned to be), in 2012. The emphasis of the current government is on achieving effective and proportionate regulation [76] and so the transfer of functions to the HPC may denote less regulation – at least for post qualifying (PQ) education. The current regulatory PQ framework within the GSCC, which includes the approval of courses, will be replaced with the Continuing Professional Development framework of the HPC, which does not include approval of courses. The advantages and disadvantages of regulation in social care is one of the issues identified within this Research Initiative and will be discussed later.

Children’s Services
The report into the death of Victoria Climbié [77] and subsequent consultations formed the basis for Every Child Matters, the Next Steps [78] and the Children Act 2004 [79]. The Act set out a number of changes to services for children, including the appointment of Directors of Children’s Services. This resulted in one of the most dramatic changes to local authority social services departments since their establishment in 1970 – their separation into Adult and Children’s departments (although a minority of authorities chose to maintain a unified structure and some have reunified since). Central government responsibility for the workforce in Children’s Services moved to the former Department for Children, Schools and Families (DCSF), now Department for Education. This was followed by further central government initiatives, including the establishment of the Children’s Workforce Development Council (CWDC) in 2005 with responsibility for workforce reform in the non-schools sector [Department for Children, Schools and Families, 80]. The CWDC subsequently established a Newly Qualified Social Worker (NQSW) scheme [81]), which started in 2008. This is a year-long development programme aimed at enabling newly qualified social workers to broaden and develop the knowledge gained in their initial qualifying training.

In terms of recent policy developments, as mentioned earlier, the Munro Review of Child Protection was established in June 2010 and produced three reports, concluding with the Final Report in May 2011. The recommendations broadly include:
• A radical reduction in the amount of central prescription to help professionals move from a compliance culture to a learning culture, where they have more freedom to use their expertise in assessing need and providing the right help.

• Revisions of statutory, multi-agency guidance to remove unnecessary or unhelpful prescription and focus only on essential rules for effective multi-agency working and on the principles that underpin good practice.

• The establishment of a Chief Social Worker, whose duties should include advising government on social work practice and the effectiveness of help offered to children and young people.

[2] (pp6-7, p9)

Adult Services
Chapter One outlined recent policy developments affecting Adult Services. However, in terms of social workers, there was a major shift in their roles with the community care reforms of the early 1990s. Since then, the majority of social workers working with adults have undertaken care management roles in which their main tasks are to undertake assessments and arrange services generally from the private sector [61, 82]. Postle argues, from a survey of care managers, that

“there has been a reduction in what staff took to be the ‘real’ task of social work, forming and developing relationships with people to facilitate change, and an increase in bureaucratic procedures, driven by the needs of a managerialist ethos.” p13 [61]

This view typifies what are seen to be problems currently. With the move to personal budgets, a more personalised system of care and increased emphasis on self assessment, the role of social workers has become a subject of debate. It was recognised that the majority of the work undertaken by local authorities in assessing and providing services would not be done by social workers but that skilled social work would continue to play a role when assessing the needs of people with complex problems [83]. Later, reports emerged that some authorities considered that social
workers were ‘too expensive’ to employ and that personalisation policies would be a way of reducing the need for social workers in Adult Services [84] except in a small number of complex or safeguarding cases. Such policy ran counter to the findings of the evaluation of individual budgets pilots that showed that people using individual budgets took up more social work time on average than people using conventional services [85] [86]. A joint document issued by the Department of Health, the Association of Directors of Adult Social Services (ADASS), the British Association of Social Workers (BASW), and the Social Care Association (SCA) [87] declared aspirations for a continued role for social workers in assessing and planning care and envisaged the potential for new roles in advocacy, brokerage and more therapeutic work.

The recent policy document, A Vision for Adult Social Care, envisages a continuing role for social workers, including new roles in community development. It also announced plans to extend Social Work Practices whereby social workers and other staff work in organisations providing services on behalf, but independent, of local councils’ Adult Services, following experiences of Social Work Practices in Children’s Services authorities [60]. These policies have the potential to create significant changes for social work (and other staff) in adult services and elsewhere.

Currently, with local authorities at different stages in implementing personalisation, further work is taking place to clarify roles in Adult Services. A recent project usefully sets out some of the current issues. This was in the West Midlands Region of Skills for Care where concerns about changes of role for social workers and social care workers in Adult services led to the project, aimed at providing a regional picture of the impact on the workforce of ‘access’ and ‘care management’ redesign processes and of workforce development needs arising from the changes [88]. Changes in role were found at all levels – managers, professionally qualified and other social care staff – and an expectation on all staff to take greater levels of responsibility, including managing greater complexity. Skills and knowledge deficits for the changes were found across all social care roles. Although social work roles varied, there was considerable agreement across the region about the workforce development needs for social workers. These were primarily focussed on a need for social workers to develop greater professional confidence as services became more multi-disciplinary.
and were delivered in partnership with other agencies and also an understanding of outcomes-based assessment. There was a shared vision of potential new roles for social workers but this was mainly aspirational, for example, the development of a social work role to support community development, market shaping and developing social capital. A list of twelve development needs were identified, interestingly some of them similar to gaps identified by graduates in the Into the Workforce study. The primary workforce deficit was a shift in culture from a care management system to the emphasis in personalisation on outcomes-based assessment.

A final policy development to note was the setting up of the NQSW programme [89] in 2009 for social workers working in Adult services. The Options for Excellence review [3] had proposed the establishment of a Newly Qualified Social Worker (NQSW) status for the first year in practice after qualifying, to build on initial training and to set the tone for future career development. Similar to the CWDC scheme, this recognised the need for NQSWs to receive good quality induction and supervision. Both the Skills for Care and CWDC NQSW programmes were being established around the time that the Task Force began its work which was taken forward by the Social Work Reform Board (SWRB) in 2010.

Social Work Education and Training
Cuts in funding in real terms have been occurring in higher education for some years creating pressures in most Higher Education Institutions (HEIs), reported in the HEI interviews in the Into the Workforce study. The changes to higher education funding as a result of the Browne review [90] are anticipated by some to bring further pressures. The consequences of removing the cap on the level of fees that universities can charge are uncertain but, in terms of the widening participation agenda, may restrict potential applicants from a range of groups, with negative consequences for the diversity of applicants currently recruited to social work programmes, as mentioned in Chapter 3.

The Social Work Reform Process
In 2008, Lord Laming was asked by the Secretary of State for Children, Schools and Families to chair an inquiry in the aftermath of the media coverage of child protection services in Haringey following the death of Peter Connelly (‘Baby P’) [DCSF, 91].
Alongside commissioning a report from Lord Laming, because of concerns generally about the state of the social work workforce, the government decided to set up a Social Work Task Force (SWTF):

…to undertake a nuts and bolts review of frontline social work practice and make recommendations for immediate improvements to practice and training as well as long-term change in social work. [7]

The Task Force was required to report to both the Secretary of State for Children, Schools and Families and to the Secretary of State for Health.

The Task Force concluded its deliberations by reporting that:

The Task Force has also heard from many sources that initial education and training is not yet reliable enough in meeting its primary objective, which must be to prepare students for the demands of frontline practice. Some employers are telling us that they are unable to appoint newly qualified social workers (NQSW) because of a lack of suitable applicants. Some NQSW cannot find jobs. Others who do enter the workforce are often expected to take on unrealistically complex tasks because of the acute recruitment and retention problem in many authorities. Equally, employers need to be realistic about the time people need to progress from achieving a professional qualification to operating as a full professional, and what therefore a newly qualified social worker should be asked to do. (para 1.6) [8]

This quote summarises some of the main areas investigated by the Into the Workforce study. The final report of the Task Force included a list of 15 recommendations that were accepted by the then government. Following its election in May 2010, the Coalition government confirmed its commitment to implementing these recommendations. The overall policy recommendation of the Task Force was the creation of a single national reform programme for social work.
This brief review has sought to show the changing policy context in which the studies were designed and executed and to explain some of the difficulties facing the social work profession currently. A changing context for research can present a number of challenges, as discussed in Chapter One. However, the Into the Workforce study has considerable overlap with the work of the SWRB work, although predating it, and thus has central relevance to many of its debates. The themes developed in the Diversity and Progression study are enduring and continue to preoccupy the social work profession. Several themes from both studies resonate with themes in the Initiative as a whole and will be considered later.

**Background to the Studies**

The Into the Workforce study, commissioned in 2007, was a modified continuation of the degree evaluation [74], as noted. The new degree for qualifying education in social work had been introduced in 2003 as part of wider government policy objectives to modernise social care services and develop a skilled and motivated workforce. The evaluation of the social work degree (SWDE) was commissioned as a multi-method longitudinal study. The current Into the Workforce study followed the students, now graduates, ‘into the workforce’ to see whether fuller answers could be provided to answer the central question about

‘the perceived relevance of the new qualification to the posts graduates assumed and the extent to which the graduates and their employers felt they were ‘ready to practice’’ [92].

The degree evaluation took place as the degree was being implemented and the first large group of graduates emerged in 2006. The SWDE findings were broadly favourable about the implementation of the degree with views that the degree generally was leading to higher standards and that recruitment to social work programmes was rising. However, the changes in Higher Education Institutions (HEIs), and in statutory social work (including the separation of Adult and Children’s services) together with concerns about the quality and quantity of practice placements provided by agencies, posed considerable challenges for the ‘new’ degree in social work education.

The Diversity and Progression study [48] was also commissioned in 2007. The differential progression rates of students from black and ethnic minority backgrounds
and also of students with disabilities on social work courses had been identified as a source of concern for some time [93], especially by the GSCC. There was also anecdotal evidence that some students from lesbian, gay and bisexual backgrounds faced direct or indirect discrimination on social work programmes because of their sexual orientation. Thus the study aimed to provide an in-depth examination of the particular circumstances of these groups of students to begin to understand what individual and structural factors interact to affect their experiences and progress on social work programmes.

**The Into the Workforce study**

Several of the findings have been discussed in a previous chapter in relation to recruitment and retention, and this section concentrates on the wider questions to do with the overall job and the relevance of education and training to new graduates [34]. While graduates, line managers, employers and HEI staff in the study all had ideas about ways in which qualifying training could be improved, the study suggested that questions about the extent to which professional qualifying programmes prepare social workers to be effective practitioners are much more complex than were presented in reports leading up to the establishment of the SWTF. The study found that the workplace context encountered by newly qualified workers has a considerable bearing on whether they feel appropriately prepared, or not. It suggests that a range of inter-relating factors affect the concepts of ‘preparedness’ and ‘readiness to practice’.

The graduates were asked about their motivations for choosing social work, from a list of 13 items. They were principally motivated by the sense of being able to improve the quality of service users’ lives and tackle injustice, although aspects of the work which lead to a sense of fulfilment (stimulation, variety) were also important. These two principal motivations were found to be closely related to job satisfaction and are important to how many graduates perceive their work.

---

*a This was a multi-method study using results from three surveys of graduates from two cohorts of the social work degree, from face-to-face interviews with line managers of new social work graduates, sampled independently, from two surveys of Directors in Children’s and Adult services, from focus groups with service users and carers and an advisory group and from five regional meetings with 30 Higher Education Institutes (HEIs).*
As reported earlier, the Into the Workforce study found high levels of job satisfaction (enjoyment) among new graduates. However, a range of factors affected the extent to which graduates were enjoying their job, and taking all these into account, the study built a set of regression models which showed that three main factors were significant in predicting graduates’ job enjoyment:

- Ability to put values into practice
- Job Engagement (a mix of wanting to learn, and emphasis on working in partnership with service users and carers)
- Feeling well-prepared by degree programme.

Whether or not graduates were enjoying their current job was highly correlated with their sense of preparedness: six times as many of those who felt unprepared were not enjoying their job (33%) in comparison with the small minority among those who felt they had been well prepared and were not enjoying their job (only 5%). Overall, three-quarters of first-year graduates in social work jobs felt well prepared for their current job by their degree programme. The results were strongly related to perceptions of their current job, with Ability to apply values and Job engagement having the most significant effect. The findings highlight the multiplicity of factors which contribute to job satisfaction. These factors suggest that the type of work available to, or expected of, new graduates may not always meet their expectations in helping service users. On the one hand, job satisfaction was related to whether respondents felt well prepared by social work qualifying education. At the same time, the factor of being able to put social work values into practice suggested that respondents had internalised a fundamental part of the curriculum which was very important for their work. On the other hand, job satisfaction was also directly influenced by their working environment - job engagement. Thus it was felt that the finding, that social work graduates’ beliefs about how well their degree had prepared them for working life, was to some extent a function of their actual job experiences. This was a key conclusion of the research.
Graduates who felt unprepared (‘not very’ or ‘not at all well prepared’) (20%) were more likely to be: postgraduates (29%); working in local authority Children’s departments, especially in Child Protection (26%) and agency workers (25%).

A further factor concerned supervision. Managers taking part in the study described a process by which the frequency of supervision tapered as workers became more experienced, as discussed in Chapter Three. This description was endorsed by the graduate survey data. However, graduates wanted more help in supervision in applying theoretical approaches to their practice – three-quarters of second-year graduates picked this as top of the list (followed by reflection and self-awareness) of what they most wanted more of, from supervision. Only one in five respondents reported that supervision helped them in this area. Taken alongside answers to attitudinal questions about theory, the study suggested that insufficient attention is given to helping graduates to apply theory to their practice. The frequency of supervision is relevant to this, monthly supervision, the most common frequency, offering little time to undertake this activity.

A further set of factors (possible gaps in knowledge) were identified as causing graduates anxiety about their practice:

- Knowledge of mental health conditions (among very many more graduates than work specifically in mental health)
- Knowledge of child protection
- How to deal with hostility, aggression or conflict
- Assessing risk
- Preparing reports for legal proceedings

Interestingly, with a friendly and supportive team, graduates were less likely to identify any ‘knowledge gaps’, presumably because they felt confident that someone would be able to help them with any queries, further confirming the relevance of the work context to the perception of what constitutes ‘job preparedness’.
In the study, line managers generally spoke positively about the NQSWs in their teams, praising their energy, enthusiasm and commitment. A strong theme from managers was that the degree was not training social workers to apply their learning in the contexts they would be faced with in practice. Comments were made about some gaps in practice skills and knowledge, some similar to those described by graduates. However, line managers did recognise that it was not possible to prepare students fully for the realities of professional practice, and that much development could only come through experience. This links with other studies in the Initiative which will be discussed later.

In the group interviews with Higher Education Institutions (HEIs) teaching staff, they commented on the time it takes for social workers to develop professionally, especially for the complex nature of social work. Respondents were unanimous that the aim of qualifying education was to produce professional social workers, with a range of skills, knowledge and values which they could apply in a variety of working situations, and develop with practice experience over time. They were clear that graduation marked a ‘threshold’ of professional competence, or the first rung of a ladder. However, they were also clear that social work was a profession that, like others, carried various connotations, including independent professional autonomy – taking responsibility for and being accountable for your own decisions and behaviour. In terms of social work practice, they felt that there were unreasonably high employer expectations of NQSWs which had risen as the demands of front-line practice intensified over recent years - both the volume of work and its complexity were perceived to have increased. This seemed to mark a difference in expectations between employers and HEI respondents since the latter saw professional development as long term and that there was a need to match the caseloads of newly-qualified social workers with their level of experience. Many of the line managers also identified and accepted the need to manage NQSWs’ caseloads carefully. HEI respondents believed graduates should be ‘professionally ready’ to begin work in a range of settings rather than ‘functionally ready’ to work in specific jobs, especially with complex cases. They also felt that much work in statutory agencies was no longer about the ‘traditional’ role of social work - working with relationships - which they felt was what they were training students to do [34]
The evaluation of the social work degree study (SWDE) drew on the conceptualisation of stages of professional development [94] [95] whereby social workers start their careers as ‘advanced beginners’ and develop with time and experience into competent, proficient workers and perhaps eventually experts. This model was incorporated into the early thinking of the Social Work Task Force and has influenced the Reform Board’s proposed Professional Capabilities Framework (PCF) and Career Structure. The PCF aims to distinguish the levels of knowledge and skill of the nine ‘capabilities’ of the framework, linked to the different stages of the career structure. It will help place the point of graduation on a continuum of learning and development, thereby facilitating better understanding of ‘preparedness’ and of what it is reasonable to expect from new graduates.

The issues around ‘preparedness’ and ‘readiness to practice’ are not particular to social work and so it was agreed by the Into the Workforce research team that additional work reviewing current knowledge about the process of transition into the workplace among newly qualified social workers, teachers, nurses, and allied health professionals would be undertaken to help inform data collection and data analysis for the Into the Workforce study. The process of transition into the workplace was reported to be challenging among all the professions included in the review, even if newly qualified professionals were satisfied with the quality of their qualifying education (which the Huby study reports) and the amount of support they had received once they had entered the workplace. Tensions between employers’, educators’, and newly qualified professionals’ perspectives about the extent to which newly qualified professionals are prepared for practice were reported to be across professions and internationally. For this reason, the review concluded that given the impossibility of preventing any gaps in newly qualified professionals’ preparedness, ultimately it might prove more valuable to identify changes in their preparedness over time i.e. from students through post-qualification [96].

Surveys of Directors in Adult services and in Children’s services were conducted in 2006 (as part of the Social Work degree evaluation study) and 2009, for Into the Workforce, about their overall satisfaction with ‘the quality of the newly-qualified social workers (NQSWs) they had recruited over the past three years. Directors of Adult services were generally more satisfied than those in Children’s services. The
perceived improvement over time was similar but in Children’s services there was also a slight rise in the proportion dissatisfied, as well as satisfied – in other words, it is possible that their views appeared more polarised in 2009 than in 2006. (When the survey was conducted in 2006, NQSWs would have predominantly had the former two-year qualification, the Diploma in Social Work [DipSW].) This finding might indicate that there are higher expectations among some Directors in Children’s services of the work which NQSWs undertake.

The Diversity and Progression study

The study was an exploratory study and the findings were indicative rather than conclusive [48]. It explored the particular circumstances of black and ethnic minority students, disabled students, and lesbian, gay and bisexual students to identify the specific factors that contribute to their experiences on social work programmes.

The results of the study indicated that a number of factors may be having an impact on the three groups of students in both similar and distinctively different ways. In particular, the main messages from the research were that a number of overt and hidden processes interact to shape the overall learning experience in the HEI and practice learning environment, which may have an impact on outcomes for black and ethnic minority students, disabled students, and lesbian gay and bisexual students. An overall conclusion of the study was that areas of inequality in social work education could still be identified, despite the introduction of a range of initiatives and policies designed to counteract them.

The study highlighted a number of interacting situational and institutional factors that had a bearing on student engagement, which in turn could affect timely progression or likelihood of completing the programme on time. The cumulative effect of combined and intersecting disadvantage, (for example, for dyslexic black and ethnic minority students with financial, as well as caring responsibilities), meant certain

---

a The study methods involved semi-structured interviews and focus groups with black and ethnic minority students, disabled students and lesbian and gay students and semi-structured interviews with key informants in a variety of HEIs.
students were particularly vulnerable to delayed progression. However, many participants were able to overcome cumulative disadvantage and barriers to progression, suggesting levels of persistence and resilience, which rendered them well suited to the demands of contemporary social work practice.

Participants from all three target groups experienced feelings of marginalisation and reported divisions in the learning environment. However, black and ethnic minority and disabled students were more likely to report that these had affected their academic confidence. Factors mitigating feelings of marginalisation included: support from personal tutors and practice assessors; more opportunities to work in small groups; anonymous marking; effective use of the Virtual Learning Environment (VLE) and internal resources of self-belief and determination. Students from the three target groups varied in their approaches to help-seeking. This was often dependent on how available, both physically and emotionally, tutors were perceived to be. In particular, where programme tutors reflected the diversity of the student group, student participants said they usually felt more confident in seeking support.

Although examples of good practice in practice-based learning were found, concerns about equity in the provision of practice learning for the three target groups were also raised. These particularly related to experiences of black and ethnic minority students in social work agencies where staff were predominantly white, the transfer of some disability services for disabled students from the university into the practice setting, and the absence of awareness about the needs of lesbian, gay and bisexual students. Black and ethnic minority students particularly valued the following features in their practice learning settings: teams where practice issues relating to racism and cultural diversity were openly debated; teams with diverse multicultural staff groups; practice assessors, some of whom were from black and ethnic minority backgrounds themselves, that acknowledged black and ethnic minority students’ experiences and offered support to them in challenging racism. The key factors necessary to support disabled students in their practice learning were identified as: early identification; thorough assessment; forward planning; skilled and supportive practice assessors. Lesbian, gay and bisexual students welcomed practice learning environments where they felt it was safe to ‘come out’ to their practice assessors,
where homophobia and heterosexism were challenged and good social work practice with lesbian, gay and bisexual service users was embedded.

In those HEIs where the programme seemed able to harness difference and diversity as a source of learning, rather than as a source of division, progression rates tended to be better. Evidence from this study suggests an ‘institutional effect’ on rates of progression for students from the target groups which is confirmed by the results from multi-level modelling using population level data on full time undergraduate students [97]. Whilst some of this ‘institutional effect’ could be seen as relating to the quality of centralised and programme level support, much seemed to centre on the overall institutional culture and priority afforded to equality and progression.

**Links with other studies in the Initiative**

Several common themes emerged in the social work and other studies and it is useful to consider some of them for the Initiative as a whole.

*Expansive / restrictive (learning environments)*

Rainbird and colleagues’ use of the concept of an expansive/restrictive continuum of learning environments [30] (drawing on the work of Fuller and Unwin) to contrast reactive and compliance-driven, approaches with whole organisational approaches has potentially wide application.

The Diversity and Progression study identified both barriers to progression and opportunities that could harness difference and diversity as a source of learning in order to contribute to better progression rates. However, in examining the learning environments of several university providers of social work education, a key finding was that a whole organisational approach appeared to have a big impact on student progression. One particular university had a strong commitment to equality and diversity and had appointed a senior academic manager with an exclusive brief to deliver the university’s equalities agenda. Structures, specialist posts and staff development were put in place to ensure that good practice was disseminated and equality and diversity values were embedded throughout the university. Thus, the study found that where social work programmes were embedded in a wider institutional context which prioritised equality in terms of: leadership; a systemic
change approach; staff training and development; and inclusive teaching and learning strategies, black and ethnic minority progression rates were comparatively high [48].

The concept of learning environments is also relevant to the Into the Workforce study and the approach taken by the SWRB. The learning environments for many newly qualified graduates appear to be restrictive, reactive, and compliance-driven and much will need to change if social workers are to more easily become capable professionals at different levels and provide an effective service.

*Learning through participation / learning through acquisition*

The concepts of learning through participation and learning through acquisition, the latter characterising learning in educational institutions involving a formal curriculum and a transfer of codified knowledge [30], also present a useful framework. The Initiative study of integrated teams is complementary to this and suggests that formal training provided a foundation for learning ways of “integrated” working, but much of this learning had to be undertaken informally on the job, through experience of the work itself. The study focused on integrated care at the front line, as delivered by multi-disciplinary teams that included health and social care workers [13]. The study was designed to look at the way social care roles and responsibilities are distributed in ‘integrated’ community service settings, but it became evident that the concept of ‘social care role’ was not one that was in common use at the front line, while the meaning of “integrated team” proved inconsistent and variable, both between and within organisations. With regard to roles, the researchers found that “tasks and responsibilities were distributed among team members in a way that defied fixed definitions of ‘health care’ ‘social care’ ‘professional care’ and ‘care support’.”

Distinctions between professional domains (particularly nursing and social work) became blurred in practice as people took on work within a ‘grey area’ where the tasks required were defined by the needs of the service user and could not be

---

a The study design included scoping of integrated teams; a postal survey of staff in samples of teams; in depth qualitative case studies in eight team settings (including interviews with 120 staff) and feedback and consultation on findings. In analysis, project data were combined with secondary data from other studies outside the Initiative.

b Page 22 of final report
c Those who were more likely to emphasise their professional identity tended to be the minority professions such as occupational therapists and psychologists.
unequivocally labelled health or social care. Professionals’ experience and expertise in dealing with the needs of a specific user group were important elements of their developing human capital.

In the report of this study it was argued that non-formal learning was crucial to the development of people’s “know how” and that it was often unstructured, unscheduled and opportunistic. When workers were asked how they closed the gap in their skills created by the reconfiguration of roles and relationships, “people invariably spoke of non-formal processes whereby they sort of collected the knowledge ("just picking things up”, mentioned earlier) as they went about working with others”. This is not particular to integrated teams and describes what happens when people are learning a new job, whether newly qualified or more experienced, though clearly the nature of what is learned will vary. For professionals interviewed in this study, respectful and mutual recognition and understanding of capabilities, rather than the validation of individual professional roles, were what seemed to underpin good working in a team. Quantitative analysis based on Workforce Dynamics Questionnaires\(^a\) suggested that relationships in teams are important for job satisfaction and for quality of care (as defined by team members). Case studies of teams indicated that roles within teams varied across localities, being formed through relationships and depending on individual expertise and experience. Based on this evidence of the importance of relationships in teams, and of the human capital acquired by care professionals by working in the “grey area” with specific service user groups, the Huby study’s recommendations for training included: training should be provided in building and managing relationships within teams; changing skill sets should be recognised and documented to support mechanisms such as portfolio based career progression; professional and vocational training should emphasise skills needed for ongoing learning and adaptation to a range of collaborative working models.

The finding from the Into the Workforce study that having a supportive team was the most significant factor in what influenced graduates most to stay in their present job links closely with the study of integrated teams. The latter shows that having a supportive team continues to be important even as social workers move away from being newly qualified and is an important area for employers to consider. The Into

\(^a\) Based on 1187 responses to surveys that were conducted as part of the project, combined with secondary data from other studies outside the Initiative
the Workforce finding that having a supportive team decreased intention to leave also feeds into the literature on high performance work organisations [98]. High performance work organisations aim to achieve benefits for the employer and employee in terms of the organisation’s performance and delivering greater autonomy and job security for the employee. The finding that more supportive social work teams are associated with an intention to stay suggests that if social work employers invest in creating more supportive teams by, for instance, encouraging communication, creating flexible working conditions, and celebrating achievements then they may find that this also helps to improve retention [34].

Huby et al. [13] also suggest that work in integrated teams may not be suitable for the newly qualified worker because of its complexity and the need to work in the “grey” area where professional role boundaries are blurred. Therefore, it is important for professionals to establish clarity and confidence about their own professional role before embarking on a role which requires some adaptation of this. The Into the Workforce study points to the importance of recognising the time needed to develop in professions, particularly on the job, before a level of ‘competence’ and confidence can be expected.

**Regulation**

The issues in Chapter Four around regulation, which may embody targets, inspections or accreditation, are central to some of the processes that concern the social work studies. The arguments in the Rainbird study [30] that the regulatory framework had driven considerable progress and had resulted in increased demand for training are important, though the availability of funding to assist in achieving targets was also clearly a factor. The use of regulation or some form of compliance has been debated in several of the Reform Board processes, a key issue being about the need for consistency, especially for national processes, against flexibility of local provision. Another issue concerns the principle of ‘entitlement’, embodied in the final report of the SWTF in the recommendation for Continuing Professional Development (CPD) – that a better national framework for CPD would include mechanisms to encourage a shift in culture which would raise expectations of an entitlement to ongoing learning and development [8]. One argument is that without compliance built in, provisions may not be made available. Some have argued that regulation can deter or limit creativity so it is interesting to hear also from the Gospel
study [5] that after an initial shock, both management and staff were mainly supportive of the regulatory framework. The comment that organisations can vary in their response to regulation - pro-active and reactive approaches - so that not all will be waiting for action from regulators to improve the quality of the workforce is also an important issue. The problem for the quality of the workforce and service delivery generally is that ‘good’ employers are likely to be proactive but the question is about what should be done about those employers who are not willing or able to institute improvements. Is some form of compliance necessary for (at least) threshold standards? In relation to the Into the Workforce study, many of the findings suggest the need for a national mandatory framework to ensure consistency and quality of provision.

The Diversity and Progression study found that internal monitoring of differential progression rates on social work programmes was limited and many staff were often unaware of the extent of the problem of differential rates. It was considered that systems should be required that would better demonstrate and tackle differential achievement. It was argued that programmes should introduce more reliable systems for monitoring the factors in the learning environment that may be contributing to differential outcomes for student progression. This would require regularly evaluating how far institution-wide, as well as at programme level, equality and diversity policies were achieving their objectives, and include a more reflective process whereby outcomes can be measured against targets set. The study indicated that the future Health and Care Professions Council could take responsibility for ensuring that systems are in place to monitor student rates of progression on programmes and how programmes might address any differential rates. It also suggests that effective use could be made of existing institutional and national data in order to do this [48].

The use of targets was discussed in Chapter three and is seen to have resulted in overly bureaucratic systems in Adult services. Munro reports likewise about Children’s services and says in her final report that she:

“..makes 15 recommendations which, taken together, I believe will help shift the child protection system from being over-bureaucratised and concerned
with compliance to one that keeps a focus on whether children are being effectively helped and protected. This move from compliance to a learning culture will require those working in child protection to be given more scope to exercise professional judgment in deciding how best to help children and their families” [2]

This move away from targets has been widely welcomed for the reasons Munro states but not all targets have been considered unhelpful by children’s social workers: for example, targets used positively to address accountability and drift, children’s needs, and for children who could get lost in the system. The point is to get the targets and the balance right. Munro says of the move from compliance that:

“This aligns well with current Government policy, which seeks to improve the balance between central prescription and local freedoms....However, rules and freedom are not inherently good or bad but depend on context.”, P.130

This raises the question of how to get the balance right. If central forms of compliance are thought to be necessary to achieve some goals, how is this to be achieved? This will be considered in the final chapter.

**Partnerships**

It is also reported in Chapter Four that regulation had contributed to forms of partnership at regional level - in some places regional consortia had emerged as a mechanism for sharing resources amongst employers, building capacity and exchanging good practice[30]. In the Into the Workforce study, the idea of more shared working with employers and shared responsibility for future social workers was welcomed by HEIs. It was thought important to work at partnerships in order to develop a workforce with the requisite knowledge and skill to function at the appropriate level that was expected. This is also a key plank of the social work reform process but the availability of funding may be a problem, noting that the availability of funding was the main initial impetus for the formation of consortia.

The risk identified by the research team that consortia could be ‘institutionally fragile’ if they depended on the presence of enthusiastic local actors and particularly if
funding is not available, has been a frequent observation in the reform process. This point has very important implications for how any partnerships are set up [66].

**Social Work Reform Board**
The findings from the Into the Workforce study tended to confirm many of the issues in need of reform as discussed in the Social Work Reform Board report in 2010 [37] and endorsed the SWRB proposals in general. However, there were some differences of emphasis in the Into the Workforce findings. The Into the Workforce research team made a submission to the SWRB which included key messages from the research as they related to the reform process - see Appendix 2.

**The Munro Review**
The recommendations from the Munro Review have been generally welcomed in the social work sector and, if implemented, should produce some better work processes for Children’s social workers and possibly for social workers in Adult services too. The Department of Health and the NIHR School for Social Care Research (SSCR) are considering the implications of the Munro review for Adult services, the former announced at a Working Group of the SWRB by the Head of the Joint Unit for Social Work, July 2011. This section will focus on the issues that relate to the Into the Workforce study.

**The first report**
The first report of the Munro review argued that the current problems in the child protection system were due to an imbalance which has developed between the demands of the management and inspection processes and professionals’ need for a work environment - and the right capabilities - to help them exercise professional judgment, provide effective help, and keep a clear focus on the best interests of the child [99].

The arguments are similar to the Rainbird study which argues that the ‘best practice organisations aim to tailor services to users’ needs through good management practices, for example, through their ethos of care, team-working, managing employees’ work life balance and allowing employees to become expert workers,
capable of making decisions autonomously’ [30]. The findings from the Into the Workforce study pointed to problems similar to the Munro review and would concur strongly with the Rainbird arguments, including the value of good team support in organisations.

Munro also discusses learning cultures and learning organisations in her first report. Many HEI participants in the Into the Workforce study compared the lack of a “learning culture” in social work employer organisations with the routine ongoing learning built in to other workplace settings, especially health. This may be partly a problem of organisational function, but it was felt important to build into the workplace a learning culture that can help social workers continue to develop if they are to achieve the professional skills necessary for the complex range of work required.

The Munro final report
Supervision
Munro states in relation to degree programmes that "Theory and research are not always well integrated with practice and there is a failure to align what is taught with the realities of contemporary social work practice’ (final report page 97). However, in her final report, despite a strong theme generally on professional development (which includes important ideas about how expertise is developed), there is no consideration of how theoretical understanding of situations can and should develop through supervision. (Nor is there such reference in her Interim report where she considers supervision in greater detail). Similarly, the SWRB Employers’ Standards propose a supervision framework, but without any reference to theoretical understanding or how this develops. The finding in the Into the Workforce study that graduates wanted more help in supervision with applying theoretical approaches to their practice is important. The study suggests that newly qualified graduates should get the type of supervision that will help them integrate what they have learned on their qualifying programmes if their development is to meet service users’ needs.

The degree in social work
The degree comes under some criticism, with Munro stating that:
“Not all newly qualified social workers are emerging from degree courses with the necessary knowledge, skills and expertise; and they are especially unprepared to deal with the challenges posed by child protection work.

“Degree courses are not consistent in content, quality and outcomes - for child protection work, there are crucial things missing in some courses such as detailed learning on child development, how to communicate with children and young people and using evidence-based methods of working with children and families.

The Into the Workforce study suggested that it may not be appropriate for newly qualified workers to deal with child protection cases. A social work blog recently commented on the Munro report that:

I have never understood, not really, why it is the jobs in child protection social work that are taken by the newly qualified social workers. Surely it makes sense to have some kind of post-qualifying training similar to the AMHP role before taking on what is one of the more complex and risky areas of social work. ([100]

The study argues that one of the issues with ‘preparedness’ is about what level of knowledge and skill can be expected at the point of qualifying. Munro recommends quite a lot of input into qualifying programmes, but what needs to be determined is how much and at what level it is appropriate (and what should be left out). This applies to many aspects of qualifying training, for example risk assessment, which is an understandable concern of newly-qualified workers. The HEI respondents in the study commented that qualifying programmes already struggle with how much content it is possible to include in the relatively short time available, but it is also inappropriate to include teaching that is better absorbed at a later stage of professional skill. The proposed Professional Capabilities Framework should go some way to helping clarify this, but for the newly-qualified worker this may well be a problem. The study states that clear messages need to be given about what can be expected at this early stage of professional development and about whether it is appropriate for NQSWs to take on complex work at this stage [34].

a Approved Mental Health Professional
Conclusion
The Into the Workforce study centred on the notion of ‘preparedness’ (or ‘readiness to practise’) and demonstrated that what constituted ‘preparedness’ was complex and related to the context in which new graduates were employed. This in one sense is unsurprising: respondents’ views about whether they were well prepared are likely to be affected by what it is they thought they were being prepared for. This will vary according to the type of job, in particular employer and service user group. Therefore, one implication of the interaction between work setting and how well prepared graduates felt might be that the degree programmes prepare people better for some jobs than others. However it is also the case that people in similar jobs felt more or less well prepared, which varied according to levels of support from managers and teams. This indicates that the perception of ‘preparedness’ was influenced by the working environment.

There appear to be higher or unmet expectations of newly qualified workers in Children’s services, seemingly supported by the Munro review in terms of child protection work and her recommendations for the social work degree. However, the teaching for Adult services on the degree may well be an issue with the implementation of personalisation which is having a radical effect on social workers’ roles.

Key themes in the Into the Workforce study concerned the working life of new graduates and the conditions which would help them develop, or not. Their concerns were to be able to put their values into practice and to undertake the work which had motivated them to go into social work in the first place. They also wanted to have more opportunities to develop their theoretical understanding. This has implications for their first year after qualifying when knowledge from their programmes is still relatively fresh. The intention of the NQSW schemes, as stated earlier, was to enable NQSWs to broaden and develop the knowledge gained in their initial qualifying training and set the tone for future career development. The HEI discussions suggested that analysis and critical perspectives were not being mapped in the Outcome Statements in the NQSW schemes. It seems important to ensure that the Assessed and Supported Year in Employment (AYSE) gives newly qualified
workers opportunities to develop theoretical understanding of their work, if the time spent in qualifying training is to be utilised effectively and for the development of a knowledgeable and skilled workforce. However, graduates in their second year after qualifying were keen to have the opportunity to develop their theoretical understanding so having processes available to facilitate the integration of theory and practice is important for all staff and for continuing professional development (CPD) generally. This suggests that line managers and/or supervisors must be able to meet this need and are appropriately trained. Frequency of supervision was also an issue for graduates with frequency tapering the longer they were in post, even if they had had regular supervision in the first place. Within a context of having processes to reflect and consider theoretical understanding, the current frequency proposed in the Employers Standards seem very minimal and unlikely to facilitate this aspect of supervision. Learning on the job is most effective when time for reflection and considering explanations of users’ situations is available. In house training was rated highly by the NQSWs in the Into the Workforce study and should be complemented by access to further HEI provision when appropriate. However, whilst formal training provides a basis for many aspects of learning, learning from colleagues is also important and an aspect of learning for which there is no substitute. The Into the Workforce study supports this and the Huby et al. recommendations for training should be an important area for policy development.

The recommendations coming from the Munro review include proposals to promote professional autonomy and to help social workers in child protection work on creating relationships with children and families. These are also views coming from the HEI respondents in the Into the Workforce study, one reason it is suggested why there is a mismatch in expectations between what they feel social work programmes attempt to develop in education and training and what new graduates experience in employment.

Recommendations for change usually have cost implications but as Munro shows, drawing on the work of cost effective projects, effective work can save money in the long run. The Rainbird study shows how whole organisational approaches can be successful and effective. The success of this type of approach is borne out by one of the case studies in the Diversity and Progression study where good practice was disseminated and equality and diversity values were embedded in the organisation.
The study has important messages for the social work and social care workforce in seeking to promote good practice around equality and diversity issues.

The use of regulation or compliance has its advantages and disadvantages but an important aspect to note from the Diversity and Progression study is the case for requiring all social work programmes to monitor targets and rates of progression to better assess the achievement of diverse groups of students.
Chapter Six: **Commissioning**

Policy on social care commissioning by Councils emphasises: separation of commissioning from provision; the importance of joint commissioning and strategic needs based planning with the NHS; the involvement of other stakeholders including service users [101]; and, more recently, the importance of preventative and early intervention services (such as re-ablement and telecare) [102]. These themes remain, as yet, consistent across the change in Government, perhaps with slight differences of emphasis. On workforce, the current policy view is that, although in-house workforces may - indeed should - be dwindling, Councils should take a leadership role in workforce commissioning in their area (Vision para 8.13). One study in the Initiative was designed to examine the ways in which commissioning might impact upon recruitment and retention of a care workforce most of which is not in-house. This study began with a survey of local authorities in England that examined variations in commissioning practice\(^a\). A typology of commissioning, contracting and care management arrangements, was derived from the results of this survey using cluster analysis [12]. Seven clusters of local authorities emerged from the analysis, each cluster including authorities that were similar in respect of their levels of activity in relation to: commissioning and contracting arrangements; employment practices; and flexibility in service provision at the level of the service user\(^b\). Two authorities from each cluster\(^c\) were then followed up in depth using interviews with commissioners, a telephone survey of 115 providers (including 10

\(^a\) Response rate 92/149 (62%)
\(^b\) Indicators were:
Commissioning and contracting arrangements: Number of stakeholder groups routinely involved in commissioning (10 or more); Pooling of ring-fenced monies or total agency budgets for the joint commissioning of services; Proportion of hours provided by independent providers that are block contracted (61% and over); Specify flexibility and around-the-clock services in tendering/contracting for domiciliary care; Standard price for domiciliary care within current contracts; Requirement for providers to separate the wages element from other costs in tendering/contracting processes; Time frame typically specified in contracts with independent providers (four years and over).
Employment practices: Form a training partnership with NHS; Same training courses provided to both independent sector and in-house staff; Describe commissioning arrangements as ‘A means of ensuring compliance with employment legislation’; Specify payment for travel time and/or mileage in tendering/contracting for domiciliary care; Specify payment for staff attending training in tendering/contracting for domiciliary care.
Flexibility in service provision at the level of the service user: Presence of intensive care management service; Arrangement for outcome-based commissioning of domiciliary care: ‘Assessor purchases required services from provider’.
\(^c\) With one exception: that three authorities were drawn from the largest cluster and one from the smallest
national providers), and complemented by in depth case studies of 20 providers that included interviews with 98 care staff [11].

The national survey in 2008 [12] found that managers with strategic responsibilities for commissioning and contracting were relatively senior (third tier or above in 71% of authorities), although, of course, care managers often undertake micro-commissioning in relation to individual service users. In 85% of authorities contracting was undertaken by a unit that was based solely in the adult social services department. Although the majority of local authorities had developed joint plans and planning processes with health partners, the majority only commissioned a small proportion of their services for older people with their PCTa. Almost all authorities (91%) jointly commissioned with the NHS for intermediate care, and these services were more likely to be provided by in-house staff than staff working within the independent sector. Stakeholders most likely to be involved in commissioning were care managers, PCTs, service users and carers, and providers (all above 80%). Employee representatives were involved in only 40% of authorities.

The proportion of domiciliary care services contracted out to independent providers had been increasing across the previous decade. Although only six authorities had no in-house domiciliary care provision, the majority (72%) allocated over 60% of their expenditure on domiciliary care to independent providersb. The number of independent providers varied from 2 to 150. Just under three quarters of authorities still had some in-house residential care but they typically focussed only on short term respite or intermediate care, and dementia-specific care (the latter both long and short term).

Block contracts with independent sector providers were more common for domiciliary than residential carec, but the prevalence of this method of contracting varied: 39% had no block contracts for domiciliary care, while about the same number had more than 60% of their hours allocated via block contracts. Other types of contract, apart

---

a A small minority (8%) jointly commissioned all their services for older people with the PCT.
b The corresponding % of allocated hours would be higher than 60%, given the higher cost of hours purchased in-house.
c Block contracts in residential care were mainly used for purchasing specialist services such as dementia and respite care, usually less than 10% of residential care purchased (in follow up study).
from spot purchasing, included cost and volume contracts and roll-on contracts (with options to extend). Contracts were usually fixed term and longer than a year. By the second stage of the research \[11\], a general move away from block contracts for domiciliary care was becoming increasingly clear, although there were exceptions\(^a\). Block contracts clearly offered more security and stability to providers, but commissioners often felt that the coming of personalisation introduced a degree of uncertainty about future arrangements that militated against these commitments. The major area of change was a switch from block contracts to preferred providers with either a framework agreement or a cost and volume contract with no guaranteed hours. Moves towards electronic monitoring of domiciliary care staff were also being introduced in some authorities, and others were planning to do so. Within care management, authorities had a variety of arrangements for commissioning of domiciliary care as part of a care package \[12\], most frequently ‘the assessor purchases required services from provider.’ However, care managers were usually unable to commit finance (and/or allocate in-house services) to implement a care package, without consultation with a first line manager. Arrangements that gave a provider a role in assessment were rare.

Commissioners could influence pay and conditions of the majority of the workforce, that they did not directly employ, through a variety of mechanisms including: conditions attached to tenders and/or embodied in contracts; quality monitoring in relation to workforce related issues; offering direct support to providers (for example in the form of access to training); the quality and nature of their relationships with providers; and price or fee levels \[11\].

**Conditions in tenders and contracts**

With regard to tendering and contacting in domiciliary care, over 85% of authorities specified items relating to induction and training for new staff, staff development, appraisal and supervision. In contrast, a minority (between a quarter and a third) specified provision of sick pay, payment for staff attending training, or payment for mileage. 42% required domiciliary care providers to separate the wage element from other costs. Almost two thirds of authorities had no standard price for domiciliary

\(^a\) 2/14 authorities had moved towards block contracts at stage 2.
care: the price paid was most likely to vary by different providers, and least likely to vary by individual service users or local labour markets. Those who set a guide price usually said this included travel time and other pay enhancements, sick pay, holiday entitlements and training payments. National domiciliary care providers in the follow up study had some frustrations with variations in practice, and also some doubts about whether prices were fixed in the light of any evidence about likely effects on the supply of care workers:

Local authorities will sometimes fix in the contract what the price should be. So I suspect they haven’t necessarily market tested whether you can get care workers at some of those rates. So there are some anomalies there……some local authorities will pay mileage and visit fees, and some won’t. Some will fund all sorts of training to support you. Increasingly that’s diminishing.”

Managing Director: national provider 4 (page 267)

Once contracts were in progress, 78% of authorities said that they did monitor contracts with independent domiciliary care providers in relation to staffing and human resource policies.

In residential care, block purchasing (and cost and volume contracts) formed only a small part of contracting arrangements\textsuperscript{a}, but, for comparison, issues most likely to be specified in tendering and contracting were induction and training for new staff, and training achievement levels against national standards. Less common (around one quarter of authorities) were payments to staff for attending training and provision of sick pay. With regard to workforce-related quality monitoring, of the three-quarters (73%) of local authorities who monitored contracts with independent providers with respect to staffing and human resources policies, the majority said that they reviewed residential care in relation to policies on staff development and training (81%), and recruitment procedures (75%). Minorities reviewed in relation to conditions of service (39%); staff retention (27%); and the staff/resident interface (16%). In their periodic reviews of in-house residential provision, authorities were most likely to consider CSCI/CQC reports, and the fabric of the buildings. 53% said

\textsuperscript{a} 62% of authorities purchased less than 10% of their residential places through block contracts.
they considered the views of staff.

**Support to providers**

Support to providers took two main forms: access to training, and consultation through forums. Most authorities were in training partnerships, most frequently with independent providers\(^a\) although in-house staff had more access to training provided by the authority than did independent sector staff (table 3.1). Providers certainly valued this training, although there was a perception that its availability was decreasing, and some resentment when existing training plans were disrupted by a requirement to refresh all staff in areas (such as 'violence at work') that providers felt were not immediately relevant to them but had suddenly become prominent for commissioners because of issues in other facilities.

Almost all authorities (94%) had a provider forum, usually these met at least three times a year (sometimes up to six), but in 5% of instances they met only once a year. Previous policy guidance recommended discourse between commissioners and providers, in order to prioritise issues in shaping the market, and to support providers to reconfigure their services appropriately (DH 2007). The follow up qualitative study that was part of the Initiative suggested that providers who were contracted to provide services in a number of authorities found differences in the extent to which they experienced these consultations as genuine exchanges:

“We deal with some 30 different authorities and I see 30 different examples of local authorities. What I would call good authorities are the ones who organise regular provider forums. They consult all the providers, pretty much in advance, or at least keep them informed as to what they’re thinking. Also [they] facilitate meetings between providers, so that they can hear a consensus view. And [they] are quite happy to accept challenges from providers, and also to listen. And quite often you find that over a period of time they implement what you have said. …Then there are the authorities who pay lip service to it. Just try and do the minimum to meet up with CQC requirements. Say, ‘Oh yes we are consulting and blah, blah, blah’ - whatever.

\(^a\) 86% of partnerships. Also with NHS (49% of partnerships), and other local authorities (34%).
And then there are others who just don’t do anything. And yet at the same time they impose things without any commercial awareness as to the impact this would have on the providers.”

Managing Director: national provider 5 (page 269)

**Relationships with providers**

**Commissioners’ perspective**

Commissioners had to keep a number of potentially conflicting elements of the commissioning process in balance. They aimed to keep costs down and to encourage competition between providers, but, at the same time, it was important to ensure a sufficient supply (in terms of hours, or places) of care, as well as to keep up quality. There is a real tension here because if fees are set too low providers can, willingly or not, exit the market. In the years after the Care Standards Act 2000 had introduced new environmental standards for residential care, there was a worrying rise in the incidence of care home closures [103], with three quarters of homes that closed saying that fees not covering costs was a factor in their decision to close. This was not a market shakeout in which the poorest quality homes could not compete. The majority of nursing homes that closed were reported to have provided good quality care, but they tended to be smaller homes [104]. A recent survey\(^a\) indicated that about half of providers of care homes were not satisfied with their rate of return (along with 35% of domiciliary care providers), and that small providers were not as confident about their ability to cope with future market changes [105]. In February 2011, care market analyst William Laing said: ‘if councils are serious about some of the price reductions being proposed, then the future looks bleak for many small and medium-sized enterprises’ [106].

Possible alternatives to exit may be equally concerning for Commissioners. In December 2010 a group of care homes took Pembrokeshire County Council to court claiming they would not be able to remain open unless fees were increased. Following a review, the Council had to raise fees at an additional cost to them of £1.5 million [107]. Local Authority fee levels are not the only threat to financial viability of care home providers: the profit-taking operations of private financial institutions can

---

\(^a\) Telephone interviews with 117 providers undertaken by Opinion Leader Research for PriceWaterhouseCoopers. Response rates and sampling methods not given.
also pose a threat to the security of customers of private care homes: Southern Cross, the UK’s largest care home operator has said recently that its financial viability is threatened because of excessive rents, based on property prices at a high point in the property boom (when a private equity group sold off most of the freeholds of the homes before floating the company) [108]. Other private providers, with different business models, reported profits last year [109] but the company has 31,000 residents and 80% of revenues come from local authorities, so the possibility of its failure has wide-reaching implications.

In their discussion of relationships with providers some commissioners in the follow up study talked of partnership, others of gaining greater control. The amount of leverage that an authority had in the care home market depended to some extent on their share (that is the proportion of care home residents that they funded). In terms of their capacity for influence, commissioners were also concerned about their increasing reliance on larger providers. Some of this concern was about quality (based in one case on a perception that smaller homes that were taken over were being asset-stripped), but there was a more general unease about the impact of the growth of national providers on the local supply chain and on commissioners’ ability to foster a diversified supply of care provision. Nevertheless, most authorities in the follow up study were increasing their contracting with national chains, although some saw it as important to maintain a diversity of suppliers, and as part of that, to try and support smaller local organisations that might provide a good service but struggle with complex tendering procedures. Others however, were willing to change all providers on the basis of cost.

Can there be collaborative network relationships between purchasers and providers? Some commentators have suggested a fundamental conflict between developing long term partnerships and seeking increased efficiency by shopping around for alternative lower cost providers (see [11] for a discussion). The purchaser/provider division it has been argued, encourages competitive behaviour and short term-ism which mitigates against joint market development. Furthermore, it is difficult to establish the necessary trust for relationship building in a context where policies and organisational structures are frequently changing so that people, goals and priorities cannot be relied on to be consistent or remain constant. Research in the late 1990’s
had pointed to the negative impacts of short term macho contracting in social care [110] and, although the Labour Government replaced CCT with Best Value, aiming to improve quality through partnership, the 2009 study of commissioners [11] still revealed a range of different attitudes and actions in relation to these issues. Some commissioners felt that they had worked through these issues and now struck the right balance between cost minimisation and commissioning for quality. However in one authority in the follow up study ‘the decision to increase joint commissioning with the NHS was directly causing a problem with the implementation of the authority’s fair contracting policy. The NHS was regarded as new to the game and was requiring the authority to go through the motions of seeing if they could reduce prices, while the LA officers felt they had already explored that route and knew that they needed to do more to improve the quality rather than going for the lowest priced service. Nevertheless it was unclear whose approach would win out.’

The follow up study developed a classification of the 14 authorities based on evidence of a partnership approach in commissioning. Those who were defined as orientated more towards partnership had pricing strategies\(^a\) and policies aimed at developing and stabilising the market, and rewarding and promoting quality in care and/or employment practices. They also tended to focus more on support for providers, innovation and improving quality. At the opposite end of the scale from partnership, four authorities, described as ‘cost-minimisers’, paid low, or very low, fees for both domiciliary care and care homes, and had no quality uplifts. Interviewees from these authorities made positive comments about the flexibility and responsiveness of the market, priced residential care at a level that they knew would lead to top up fees being the norm, treated quality as a basic requirement not something that people might be rewarded for, and distanced themselves from responsibility from the HR policies of providers. Some authorities combined elements of cost minimisation with elements of a partnership approach, and at least one commissioner in a ‘mixed’ authority was conscious of the potential contradictions within the approach:

\(^a\) Pricing strategies included items like relative fee levels (high, medium, low or very low), paying quality enhancements, or payments for good HR practice.
In terms of workforce training and development, I mean, it's clear that practices we encourage because we want to keep prices down, militate against having a properly trained and maintained workforce.” (Page 106)

Wider research on the implementation of local area workforce strategies also emphasises the challenges of involving stakeholders. In a survey of local authorities published in 2009 the complexity of engaging with stakeholders was the most commonly identified barrier to implementing local area workforce strategies (77% of respondents), although here stakeholders included health partners as well as providers [111].

Providers in the study were asked what changes in commissioning practice would do most to assist them in recruiting and retaining a stable and motivated workforce. The most common responses, in order, were: higher fees; more variation in price by service user (ie a financial recognition of the comparatively greater skills and inputs required in order to assist some service users); a more integrated approach to service delivery (more common for domiciliary care providers). Also mentioned were: more scope to determine how care is delivered, higher guaranteed volumes of work and more time per service user.

We have seen that there is evidence that the commissioning environment can be an enabler of better HR practice by providers. However these relationships are complicated by the impact of other factors such as the nature of local labour markets, and the influence of the policies of larger national providers. Multivariate analysis revealed a complex picture of inter-related effects but three key findings were:

- LA fee levels have a positive, albeit weak, association with good HR practices, especially pay practices and working time practices; they also relate, weakly, to actual pay.

---

a Response rate 47%
b Chosen by 55% of homes and 58% of independent domiciliary care providers
c 31% of homes; 34% of independent domiciliary care providers
d Such as paying a premium for unsocial hours working, and paying extra for qualifications
• The partnership orientation of LAs has significant positive effects on both pay practices and the overall quality of HR practices for independent domiciliary care providers, but mixed effects on the quality of pay practices for homes.

• The level of local labour market demand positively influences the quality of pay levels, pay strategies and HR practices, especially for homes.

We can conclude that the commissioning environment does have some impact on workforce pay and conditions but its effects are complicated by other factors such as local labour markets, the influence of the policies and practices of national providers and the relative affluence of the local older population. A key further question must be, given these differences in commissioning practice, whether there are any noticeable differences in the quality of care provided by different authorities. Does any of this matter in terms of outcomes for users? A comparison of the responses to national home care user surveys for these different authorities showed an interesting pattern of results. The cost-minimising authorities were clustered at the bottom of the distribution of satisfaction scores, both in relation to overall satisfaction and in relation to satisfaction with different aspects of care quality. There was little significant difference between the ‘mixed’ and ‘partnership’ authorities although those classified as mixed seemed to be better at arriving on time and timekeeping generally, as well as coming at times that suit people, and personal continuity. However the ‘partnership’ authorities ranked more highly on doing the things that people want done, and having care workers who were not in a rush. This analysis should not be pushed too far, after all it relates only to home care and the number of authorities is small. However it does represent an attempt to bring in data on user views into the analysis of commissioning, which happens all too rarely.

It is important not to give too static a picture. Commissioning policies and practice were subject to rapid change. Indeed some authorities had made changes between the initial national survey and the follow up the next year. At the time of the follow up survey authorities were beginning to think about the implications of the anticipated growth in the use of personal budgets, and this was fuelling moves away from block

---

*a Analysis was based on rank scores for each of the LAs separately for the overall satisfaction question, the average ranking for the other 8 care quality related questions and a total rank score.
contracts so as to increase flexibility. The future role for the in-house workforce was also an issue. Often, the in-house workforce was seen as a valuable resource of more skilled and more experienced workers that were best used for strategic initiatives such as intermediate care and re-ablement. However, there were doubts that individual service users would be willing to pay the additional costs associated with the better pay and conditions enjoyed by these workers. Commissioners reflected that what had seemed the right strategy in the past had in some circumstances proved to be a disadvantage in a new policy climate. For example, authorities that had moved early to outsource all of their domiciliary care provision were now in the position of bearing high legacy costs for the staff who had been protected by TUPE when transferred to other employers. Commissioners who had dealt with problems in securing adequate geographical coverage by establishing patch-specific preferred providers now found that they might have to unpick these hard won arrangements should they conflict with user choices of provider. One authority had achieved a merger with the local PCT – at the time this seemed like forward-thinking progress in joint commissioning.

It is unsurprising that a further tension identified by commissioners was between the need to produce short term responses, as policies and situations changed, and the need for longer term strategic planning. Specific concerns about the future will be dealt with in the next chapter.

**Conclusion**

Commissioners are having to address a number of potentially conflicting agendas, and, in their approach to independent social care providers, they currently take varying positions on a spectrum between cost minimisation and partnership. The ability of providers to exit the market, or even to take legal action against Local Authorities, will limit the degree of cost minimisation that can take place without restricting the supply of care below desirable levels (or generating further litigation). Cost minimising authorities had lower levels of user satisfaction with domiciliary care. Fee levels and contracting conditions give commissioners some tools to influence the pay and conditions of the workforce, although there is a consciousness of the

---

*At the time of the survey there was no indication in the policy of any Party that PCT’s might be abolished.*
cost implications of improving these, which may be manifested differently depending on the attitude towards minimising costs. Collaborative working with providers through the provision of training and the use of consultation mechanisms, primarily provider forums, can in the view of providers (if done meaningfully) be of benefit to the workforce, both in terms of increasing skills and knowledge and in encouraging collaboration between providers to improve good practice, as well as giving opportunities for providers to influence commissioning practice. Commissioners influence in the market place was limited by relative prevalence of self funders in care homes, and the growth in national providers.

Joint working is evident in plans and planning processes but, with some exceptions, joint commissioning seems to have been largely restricted to intermediate care, which has often provided better paid (though arguably more skilled) work that has sustained in-house services. The greater fragmentation introduced by personal budgets, that would apparently only be affecting social care, seemed likely to increase the complexities involved in joint financial arrangements with the NHS. If NHS commissioners had different attitudes towards commissioning from the private sector this could hinder the establishment of joint arrangements.

Contracting out to independent providers continues to increase, although the greater emphasis on personal budgets, is in general leading to fewer block contracts, and to some uncertainty about the sustainability of previous changes such as patch-based commissioning. Providers prefer block contracts because they offer more stability to the workforce and, in general, they would like to see higher fees, but also, where it does not exist, more variations in fees paid in recognition of different complexity of some cases, and of higher quality of care. Some domiciliary care providers felt that restrictions on time spent with users militated against the development of relationships with care workers.

Constant change in policies and organisational structures can undermine longer term strategic planning, as well as leading to a need to unravel hard won arrangements, that may have required considerable negotiation to achieve agreement.
Chapter Seven: **Personalisation and Growth in the Use of Personal Budgets**

Our studies collected data before the most recent General Election in 2010. However policy then, as now, envisaged a growth in the numbers of people receiving personal budgets to organise their own services. Respondents had a range of perceptions about this projected growth, and, given that the pace of change is now planned to accelerate, it seems likely that their concerns remain salient today, some of them particularly so in the context of financial retrenchment. As well as a growth in the number of personal assistants, the Big Society agenda seems likely also to encourage a growth in the number of workforce members who are not specifically focused on providing assistance to individuals, but rather work more broadly as enablers in local communities [112]. However, we have no data that would bear upon attitudes to this latter change in emphasis. Therefore this chapter concentrates on views about the growth in the use of personal budgets and the numbers of personal assistants, and the implications for social care.

**The views of providers and care workers**

In common with previous studies [113] [85] providers in 2009 expressed support for the principle of personalisation, but had reservations about the practicalities. There were fears about the poaching of their staff (trained and CRB checked) to become personal assistants to people who had previously been their customers. Although there were examples of this happening, it did not seem to be a frequent occurrence, just as it had not in the individual budgets evaluation. Only time will tell if this happens widely, but there are some indications against an immediate exodus: only ten, out of 63 care workers asked, said they were interested in the possibility of becoming a PA [11]. The more detailed report of their views is illuminating:

“The minority of care workers who would consider it mentioned that one-on-one work of this kind could potentially be more rewarding and would also have the benefit of being less rushed than their current role. However, for the majority of care workers the one-on-one nature of the personal assistant role was not appealing. Many mentioned how it would be emotionally draining to care for only one user and many felt they would become too involved and be
unable to cope. They identified aspects of their current jobs they would miss if they were to become a personal assistant, including opportunities to meet lots of different people, being able to move around autonomously and have the support of managers and colleagues. Some would not consider it because they wanted the ‘back-up’ of management and working in a team, and they also anticipated increased job insecurity in such a role if work was reliant on specific users.” Page 342 Final Report

In future it may be that working as a PA through a provider will operate for care workers like agency working for some social workers. Just as the social workers are looking for a good team and work environment where they might decide to stay [41], so care workers employed by a provider might be able to try out PA work with a number of users before finding someone they wanted to work with independently. Some may find the conditions of work of a PA more congenial, in terms of possibly lower demands for extra hours, less rush and more hours guaranteed, but the longer term security of the work would probably be less, along with, as we have seen, reduced opportunities for training, peer support or gaining qualifications. National providers observed that sometimes PAs were being paid less than other care workers in the authority, and sometimes more, so this might also be a factor in decision making. Social care providers have to be registered and ensure that their workers are CRB checked and have induction and other training. Some providers regard it as unfair that in supplying PAs they have to bear the additional costs of these processes so their cost competiveness is reduced compared to direct employment of a PA. Concern was also expressed about the safety of service users if the workforce was partly unregulated [11].

Providers said that losing the security and certainty that comes from block contracts made workforce management more difficult. In addition, managing multiple invoices for payment could significantly add to their administrative load. The sheer organisation of getting the money in was also mentioned in the individual budgets evaluation, as were difficulties (also experienced by our providers) in getting the money from some service users. Providers now found they were taking the credit risk associated with bad payers. For national providers the range of different approaches to funding arrangements and agreements taken by different local
authorities was frustrating, partly because it prevented them from standardising their procedures in a way that could reduce costs.

**The Views of Commissioners**
Commissioners faced uncertainty over the future role of local authority commissioning in the light of the move towards personal budgets, and in the context of major cuts. One concern was that personalisation would reduce the strategic role of LAs in managing the social care market thereby leading to a major increase in the price of care services, because authorities would lose their ability to keep the lid on the price level which came from competitive tendering. The greater cost of in-house services was an issue for some. A skilled in-house team might be able to justify the higher levels of pay that could be afforded for specialist joint services such as intermediate care, but those who offered more routine assistance would probably not be able to compete in the market. The probable future ending of in-house care was accepted by some commissioners, but others saw their in-house team as a skilled and experienced workforce who would be important to support future strategic developments such as re-ablement. One commissioner expressed the view that experience as a provider improved the quality of commissioning. If all services were outsourced then, after a few years, the knowledge and experience of provision that had informed commissioning would be lost. Experience of these 14 authorities suggested that the more services were outsourced the less likelihood that the authority would be a training provider, and the less likelihood of joint provision with health services. Problems of integrating health and social care were thought likely to increase because budgetary arrangements would become increasingly different as more users had personal budgets. The lack of NHS money to support personalisation has been a recurring theme in the literature [16], although the introduction of personal health budgets, should the pilots prove them to be successful, might ease the path to joint arrangements.

Commissioners also reported that greater user choice might bring about fragmentation that could threaten some services such as extra care housing where financial viability depended on all users choosing the on-site provider (see [114] for discussion of this issue). It might also disrupt measures such as patch-based
commissioning from preferred providers, set up to ensure a good supply of care hours across different areas of the authority.

In the current context it was difficult to give clear signals to providers about future market development, and concern about overall capacity remained, unless personal assistants could be recruited from outside the sector.

**Development of the role of personal assistants**

The role of personal assistant has similarities to some other emerging front line roles in social care. A range of roles attached to formal services, for example community support worker or rehabilitation worker, are similar to the role of PAs in that: they are not professionally qualified, and they are expected to undertake generalised support roles that promote independence and may span health and social care [15]. Occasionally new workers may have specialist roles, for example assistive technology support worker. It might be argued that these workers differ from PAs in that they are not directly employed by service users. However even the title PA is becoming blurred – providers see themselves as providing PAs as part of care packages. The rest of this discussion relates to PAs who are directly employed by service users.

**The boundaries between friendship and employment**

In their review of the literature on support workers, Manthorpe et al. [15] comment: ‘it is a commonplace in the literature for this facet (the lack of a professional qualification) to be referred to as a positive advantage in the service being provided’. This lack seems to be regarded as an important part of minimising the distance between service provider and service user, in a way that contributes to emotional support. However, if there is growing informality in the relationship this can be both a strength and a weakness: we value the human ties that can form, but at the same time we are concerned about the potential vulnerabilities in the arrangement which arise precisely because of these non-contractual human ties. There is a fear that either service users, carers or PAs could exploit these ties in negotiating about the work that should be done, and the rewards that should be offered. Manthorpe et al. argue that this issue of blurred boundaries arises particularly in relation to personal assistants employed through direct payments. Certainly, where support workers are
working to professionals they (and the service user) would have someone to consult if boundary issues troubled them. Home care workers in one study cited by Manthorpe apparently observed boundaries more rigorously than PAs, but the significance of this contrast is clouded by the fact that, as we have seen, many PAs are already known to the service user. At present, we know very little about the ways in which pre-existing relationships might be changed by the introduction of payment for support offered [115].

Researchers in the skill development study pointed to the possibility that the individualisation of care work could lead to the isolation of PAs, thus meaning that they would lack access to training and collective learning experiences that were evidently valued by care workers [30]. Some service users have urged the importance of training, career development and support for PAs, arguing the importance of considering what should be provided by the service user and what needs to be delivered by others [116]. From the literature review on support workers [15] there was concern at the gaps in our knowledge of how PAs operate without support when issues of safety and safeguarding are prominent. How do they, or could they, manage risk, conflict and negotiation, or decision making for people whose capacity to make decisions may fluctuate or be diminishing? Equally, how might they get support to deal with racism or other unacceptable behaviour where we do usually, as a society, seek to place limits on people’s choices. Later literature review has confirmed that we do not have answers to these questions, particularly from UK based evidence [115], but they reflect a climate of concern about PAs as employees, taking on difficult work within a structure where there is a risk of isolation, and where employers (service users) do not have a responsibility to deal with strategic workforce issues outside of their own care, although they may feel that others should have such responsibilities.

A strategy for PAs is being developed by DH and this will need to take account of some of these issues.

---

a A large number of international workers had experienced racism and discrimination from service users and their carers. These experiences were also shared by some UK frontline workers from BME communities.
Workforce registration and accreditation – stakeholder views

Some service users reportedly argue that there should be registration of the PA workforce but that it should not be compulsory [31]. This makes logical sense if we consider how users recruit their PAs. Those who recruit people they already know and trust may well feel they have no need of the protection that registration or accreditation might afford. At the same time, they can see that those who have to appoint people they do not already know might well wish to have this protection. Equally, direct payments users are reportedly reluctant to seek references or make CRB checks on people they already know [117]. The study commissioned by Skills for Care published in 2008 [14] indicated that around half of direct payments users employed someone already known to them, but we have no way of knowing whether this proportion will remain the same as the number of people using personal budgets grows substantially. Whatever the ultimate proportion, it is easy to see why service users would like to see choice maintained in this matter, though it is important to see this as a matter of employment with the rights and obligations that this confers on all parties. With the likely abolition of the GSCC, a compulsory national register of all care workers is unlikely, although a voluntary register is planned [4] . At present, care workers who work for registered providers are subject to CRB checks, reference checks and selection and supervision by their employer. PAs directly employed by service users are not. Will service users be prepared to pay (and maybe trade off some hours of help) for the possible greater safety, as well as the lower personal bureaucratic hassle, of using a registered provider? Locally, councils who have conducted consultations are already considering possibilities such as maintaining a bank or pool of accredited PAs who will be available to service users who wish to use them, or more generally developing the personal assistant workforce [118] though the legalities of this need to be explored (for example, around duty of care and registration as an employment agency). Similar developments have also occurred in European countries that have introduced direct payments (or similar systems), although opposition was apparently expressed by some service users who regarded this as a form of ‘re-colonisation’ of the sector [119]. This kind of objection may be understandable from those who feel that they have just won their freedom from bureaucratic interference, but many respondents in our studies expressed concern about the dangers of having a regulated and an unregulated workforce [30] [11]. The unregulated workforce may be less hedged about with bureaucratic
constraints, but it could provide a haven for those who wish to escape the scrutiny of
the regulated sector: undocumented migrant workers who may exploit, or be
exploited by, their employers [20] or those with past convictions that would be of
concern if not disclosed, would be two possible examples.

Given these questions about access to support, training and collective learning for
PAs, as well as the concerns about safeguarding, there seem to be good reasons for
some intervention in this part of the sector, but this should be conducted in a way
that does not interfere unnecessarily in the arrangements that service users (or their
proxies) make with people they know, or have good reason to trust. The DH plans to
explore scope for the Health and Care Professions Council to establish a voluntary
register of social care workers by 2013 [4].

**Older people and personal budgets**

Not all service user groups have shown equal benefit from individual budgets. The IB
evaluation showed that social care outcomes for older people who were using
individual budgets were no better than those for older people using standard
services. Worse, their psychological well-being was on average significantly lower.
Nor was there any cost advantage from the use of an individual budget [85]. Other
studies have also shown older service users particularly likely to express anxiety
about the complexities of using direct payments and becoming an employer [14], and
no significant differences in levels of satisfaction with services between older people
getting direct payments/personal budgets and those receiving home care [120]. The
DH was sufficiently concerned about the IB results for older people to publish
information outlining ways in which individual budgets might be made to work for
older people [121]. This information emphasised the importance of choice in how the
money should be managed, which might include choosing that it should be managed
by the Council, as well as the importance of good support in making choices about
longer term support, that might beneficially be deferred until after the event, or crisis,
that precipitated the original referral had been dealt with in the short term. This
advice might indeed ensure that personal budgets would be a cost-effective option
for older people. However it has not been shown to do so (more research is clearly
needed), and we do not know whether the advice will be followed during
implementation, given the very clear statement in the Vision that direct payments are the preferred method of implementing a personal budget.

The evidence from IBSEN did not suggest a reduction in care management input, indeed the group using IBs consumed more care manager time than who received standard services [85]. It might be argued that this additional input would only be required in the process of setting up the service. However, unless there is an intensive case management service, it is unlikely that older people receiving standard services will receive on-going support from a care manager or social worker once assessment and care management are completed [13]. It seems unlikely therefore that a growth in the use of personal budgets will reduce the need for social work input for older people. The IB evaluators have recently speculated that the lack of positive impact of IBs on older people may be explained by the relatively lower level of per capita social care funding received by older people (for equivalent levels of impairment). They raise the question of whether it is possible to take advantage of the potential flexibilities of IBs when funding is comparatively low for the level of need [122].

If it is expected that, once personalisation is under way, service users will collectively begin to demand certain kinds of services, and jointly use their payments to secure these, then it would seem to be important to facilitate contact between service users, some of whom may be very isolated, and many of whom will be on low incomes. Not everyone has access to the internet or knows how to find like-minded people on it. Cognitive impairment and communication difficulties may, without assistance, limit the degree to which some users could participate in any kind of user network. Younger disabled people without cognitive impairment seem most likely to benefit compared with other groups, as indeed the evidence suggests they do from direct payments and individual budgets.

**Conclusion**

There is widespread commitment to the idea of personalisation, involving more choice and control for service users. However, many respondents were uncertain, and sometimes wary, about the process and mechanisms through which the current system of provision (of which personal budgets, and direct payments, form a
relatively small part) would be transformed into a system where the majority, if not all, service users or their proxies (in the community) would have a personal budget.

While some providers might see it as an opportunity to grow their business, many, particularly in domiciliary care, had understandable concerns about the challenges they would face in the context of the growth of the use of personal budgets. They were wary that they might lose staff in whom they had invested resources for training and vetting, and that the additional costs that they would have to bear, compared with individual PAs, might reduce their competitiveness for new contracts with individuals. At the same time, the security and certainty for their workforce, that comes from block contracts, was under threat, and the administrative costs of collecting and processing payments were likely to increase. Commissioners, equally, had a range of concerns about how future commissioning would work in the context of major cuts and a widespread move to personal budgets, and found it difficult to give clear signals to local providers. Some saw tensions between the pursuit of strategic initiatives, such as prevention and re-ablement, and the promotion of personal budgets for all service users. Others saw arrangements for joint commissioning or patch-based commissioning that had been painstakingly negotiated, unravelling as the introduction of new organisational structures in health, and the freedom of users to choose providers from outside their patch, began to have an impact. The possible tension between individualised funding arrangements and local health and social care collaboration has been confirmed in other research [123].

With regard to personal assistants themselves as a workforce, there are questions from the Initiative about the adequacy of future supply of people wishing to work as PAs, as well as about their potential isolation from both training, and support in dealing with difficult issues. We have some understanding from research of the motivations and experiences of PAs employed during the early days of direct payments, but cannot be sure of the extent to which these results provide a guide for the future, when it is intended that the use of PAs becomes the norm. Despite the inadequate and outdated legislative framework for social care [124] it is clear that,

---

[a] The Law Commission has been working to provide a clearer, modern and more cohesive legal framework for social care in England and Wales
even where service users employ personal assistants directly using direct payments, local authorities are responsible for the quality of care and the safety of the service user. It is not clear exactly what responsibilities, if any, they will have for the PA workforce, but some already see taking on such responsibilities as likely to contribute to the quality of care and outcomes for service users. As an example, Skills for Care and ADSS have a joint initiative (Integrated Local Area Workforce Strategy – InLAWS) designed to develop effective ways to support Directors and their teams with their workforce commissioning role across the local area. Some of the case studies indicate that authorities are beginning to work with local stakeholders to identify key issues that have to be addressed. Some of those so far identified include: lack of data and information about the PA workforce, and the nature of employer and employee relations in the emerging models of care provision (Birmingham); the possibility of developing a pool of personal assistants who promote professional practice and are supported to access training, and how to monitor PAs to ensure a high quality and safe service can be provided (Poole) [118].

Clearly there is a great deal of thinking and development work to be done in rolling out a policy of personal budgets for all those who need services in the community, and it is important to learn from early experience. The research evidence that personal budgets can benefit all service users, particularly older people, is, as yet, slim indeed. It would seem important therefore to monitor and evaluate the impact of these changes, on service users as well as on the workforce (and the relationships between the two), in order to ensure that the expected benefits are delivered, and to identify adjustments that must be made where they are not achieved.
Chapter Eight: **Findings on Integrated Services, and Final Reflections**

**Introduction**

This final chapter completes the presentation of findings from the Initiative by referring to those that are relevant to health and social care integration. Following discussion of these latter findings, we will move on to outline some of the questions and recommendations that arise from all of the findings that have been presented.

**Integration**

Integration can take place at a number of levels: WHO distinguish functional, organisational, professional and/or clinical integration [125]. Our research cast light on two aspects of integration: first, on the operation of front line professionals working together in integrated teams; second, on questions related to the impact of personalisation, and NHS re-organisation, on inter-sectoral integration.

**Integrated teams**

Defining integration, in the way that one must do for research, is not straightforward. A recent report on integrated care [125] commented:

"understanding what constitutes integrated care can be difficult, with several of the managers and commissioners interviewed for this report commenting “…it's difficult to describe, but we all know it when we see it”." Page 5

Unfortunately, where concepts can have a range of meanings, what one person ‘knows’ may not be consistent with another’s ideas\(^a\). One of the studies in the Initiative focused on integrated care at the front line, as delivered by multi-disciplinary teams that included health and social care workers [13]. The study design included scoping of integrated teams; a postal survey of staff in samples of teams; in depth qualitative case studies in eight team settings\(^b\) and feedback and consultation on findings. In analysis, project data were combined with secondary data from other studies outside the Initiative. The study was designed to look at the way social care roles and responsibilities are distributed in ‘integrated’ community

---
\(^a\) Also true in the study of 'international workers'.  
\(^b\) Including interviews with 120 staff
service settings, but it became evident that the concept of ‘social care role’ was not one that was in common use at the front line, while the meaning of “integrated team” proved inconsistent and variable, both between and within organisations. With regard to roles, the researchers found that “tasks and responsibilities were distributed among team members in a way that defied fixed definitions of ‘health care’ ‘social care’ ‘professional care’ and ‘care support’.” P 22. Distinctions between professional domains (particularly nursing and social work\(^a\)) became blurred in practice as people took on work within a ‘grey area’ where the tasks required were defined by the needs of the service user and could not be unequivocally labelled health or social care. Professionals’ experience and expertise in dealing with the needs of a specific user group were important elements of their developing human capital.

In this study of integrated teams, the scoping process designed to identify teams took much longer than anticipated because of these difficulties in defining and identifying “integrated” services. The definition managers were given was “teams that include both NHS and social work staff” but such teams were not identified consistently. The researchers concluded that knowledge of “integrated” teams/services, even within organisations, was patchy, and that team structure and management arrangements were complex, variable and often changing. The scoping study found considerable variation in team size, and composition (in terms of staff discipline/roles), and on the whole far greater variation within service or country setting, than across such settings. Although identification methods differed across the studies included in the scoping exercise, one plausible observed difference was that mental health teams had a higher proportion of nurses and doctors, and teams working with older people had a higher proportion of support workers.

The follow up case studies of integrated teams did suggest that, at the front line, health and social care staff can, and do, work together well, although team members seemed to see this as happening despite, rather than because of, management and policy concerns and activities. As has been described in Chapter 5, data from England, Scotland and Wales was analysed, but it emerged that differences in models of integrated working in teams were influenced much more by differences in

\(^a\) Those who were more likely to emphasise their professional identity tended to be the minority professions such as occupational therapists and psychologists.
service user group than by policy differences across countries within the UK. However, the observed differences in the models of integration with the two different user groups were nevertheless related to policy: in mental health services integration tended to be through the use of a key worker, who was continuously involved but could draw on other team members for their expertise; in older people’s multi-disciplinary teams, integration was through a model involving people holding distinct roles and remits, such that responsibilities for different aspects of a person’s services were held by different people in the team depending on the care required, and cooperation and communication within the team were essential to provide a seamless experience for the service user. Thus the type of continuity experienced by the service user in each case would be different, one would be a continuity of person, the other continuity of care.

The influence of policy was evident in that the care management and care delivery distinction was emphasised by professionals in older people’s teams, where the work of organising care involved a considerable amount of “paperwork”, which was central to the work of assessment, residential care admission and/or organisation of care packages that would ultimately be largely delivered by others. In mental health teams in contrast, management of risk to clients and their surroundings was the main focus, and work was conducted through ongoing relationships with service users. Here, the distinction between care management and delivery was not emphasised, and the formalities of “paperwork”, although necessary, were not central to people’s everyday work the way they were in older people’s teams. Forms of dysfunctional ‘antagonistic’ working, as described by professionals, were correspondingly different – in one form a key worker might assume too much autonomy and authority in relation to the ‘their’ service users and not share with, or seek advice from, other team members; in the other, professional groups stayed with their own ‘silos’, protecting their own work domain, emphasising professional boundaries and failing to communicate. Most professionals did not describe their own teams as working in these dysfunctional ways but either had experience of them, or said they knew others who had. A need for training in the ‘soft’ skills of team building and team working was advanced by team members in the case studies [13].
Thus the different models of integrated working reflect the much greater policy focus, in relation to older people, on assessment, and gate-keeping access to residential care. As we have outlined, professionals working in integrated teams rarely used the language of ‘social care roles’ but instead spoke of work in a ‘grey area’ that was defined by the needs of the service user and could not be defined as health or social care. While team leaders were comparatively highly regarded within the team, levels of management above this were seen by front line professionals as lacking in understanding of flexible ways of working in this ‘grey area’. Although the organisation of their work was influenced by policy, this influence was not perceived to be benign: the researchers commented, “On the whole staff expressed a high degree of alienation from processes of policy making and implementation.” P 28.

This may, or may not, matter in terms of the quality of service delivered to service users, but does not suggest a fertile climate at the front line for change that is perceived to be policy driven, unless professionals can see benefits in relation to their work.

For professionals interviewed in this study, respectful and mutual recognition and understanding of capabilities, rather than the validation of individual professional roles, were what seemed to underpin good working in a team. Quantitative analysis based on Workforce Dynamics Questionnaires\(^a\) suggested that relationships in teams are important for job satisfaction and for quality of care (as defined by team members). Case studies of teams indicated that roles within teams varied across localities, being formed through relationships and depending on individual expertise and experience. Based on this evidence of the importance of relationships in teams, and of the human capital acquired by care professionals by working in the “grey area” with specific service user groups, the researchers recommendations for training included: training should be provided in building and managing relationships within teams; changing skill sets should be recognised and documented to support mechanisms such as portfolio based career progression; professional and vocational training should emphasise skills needed for ongoing learning and adaptation to a range of collaborative working models.

\(^a\) Based on 1187 responses to surveys that were conducted as part of the project, combined with secondary data from other studies outside the Initiative
Joint Working and Personalisation

We have seen in Chapter 6 that local authority commissioners were concerned about their collaborative arrangements with health in the context of the move to widespread use of personal budgets [11]. Previous research on individual budgets showed how the contexts of local collaboration created problems for the implementation of the personalisation pilots, jeopardised inter-sectoral relationships and threatened some of the collaborative arrangements that had developed over the previous decade. On the basis of this work it has been argued that the personal health budgets will need to build upon the experiences of social care individual budget pilots so that policy objectives of personalisation do not undermine previous collaborative achievements [123]. The history of health and social care collaboration in which social care has frequently been regarded by health as the junior partner [16] makes it seem doubtful that this will happen without some central direction. A report from the evaluators describing early experiences of implementing personal health budgets has indicated the high degree of cultural shift needed to gain acceptance of this mechanism in the NHS. Currently the pilots, planned to end in 2012, are being implemented by PCTs, and although Chief Executives involved were reportedly enthusiastic about the personalisation agenda in health care, middle managers and healthcare professionals were less likely to be so. In particular, it was felt that "engaging with GPs seemed to be a huge hurdle that some sites had yet to overcome" [126]. This finding does not bode well for the speedy implementation of personal health budgets by GP-led consortia, should the pilots be deemed successful.

REFLECTIONS AND RECOMMENDATIONS

SOCIAL WORK

The Diversity and Progression study,

This study investigated the particular circumstances of minority groups of students to understand what factors affected their experiences and progress on social work programmes. It identified both barriers to progression and opportunities that could harness difference and diversity as a source of learning in order to contribute to better progression rates. The study found that monitoring of progression rates on
social work programmes was limited and that many staff were often unaware of the extent of the problem. It was suggested that programmes should introduce more reliable systems for monitoring the factors in the learning environment that may be contributing to differential outcomes for student progression and that more effective use could be made of existing institutional and national data in order to do this. In examining the learning environments of several university providers of social work education, a key finding was that a whole organisational approach appeared to have a very positive impact on student progression.

Though an exploratory study, the overall conclusion of the study was that areas of inequality in social work education could still be identified, despite the introduction of a range of initiatives and policies designed to counteract them. This is an important message for all stakeholders in social work education and suggests that organisations should regularly evaluate how far their equality and diversity policies are achieving their objectives at different levels of the organisation.

The Into the Workforce study
Earlier chapters outlined key concerns about the social work workforce and the responses made by the Social Work Reform Board and the Munro Review to set the conditions which it is hoped will improve the functioning of the workforce and the quality of service. The Into the Workforce study in the Initiative concurred with many of the concerns that were identified in the process of the two reviews but also provided some detail about the expectations and perspectives of those at the interface between qualifying training and professional practice. This part of the chapter summarises some key findings and perspectives presented in the study to discuss issues about the current social work workforce and the role of the social worker. We then outline some recommendations to contribute to workforce reform.

The central question of the study was about the perceived relevance of the social work degree qualification for the posts graduates assumed and the extent to which they and their employers felt they were ‘ready’ or ‘prepared’ for practice. As mentioned earlier, the question was formulated in 2003 in relation to the degree evaluation, the view being that the question could only be fully investigated when the graduates entered the workforce. In the intervening period, concerns have grown
about the state of the social work workforce (hence the setting up of the Social Work Task Force) whilst at the same time, comments were commonly reported in the field of social work and to the Task Force that new social workers were often not properly prepared for the demands of the job [51]. What the Into the Workforce study found was that overall, three quarters of the graduates in their first year felt well prepared for their current job by their degree programme, a significant majority. Furthermore, how well prepared they felt was affected by the workplace context into which they went. Whilst this may not be surprising in a direct sense, it was a much more complex picture than might have been assumed. A number of job-related factors were analysed and the ability to apply values (most significant) and to engage with the job, which included opportunities to learn and develop and emphasis on working in partnership with service users and carers, were the most significant factors in how well prepared graduates felt. These factors suggest that the type of work available to, or expected of, new graduates may not always meet their expectations in helping service users. Perceptions of preparedness were also affected by how supportive a team graduates were in, the more supportive the team, the less ‘preparedness’ was an issue.

However, only half of new graduates were satisfied with ‘The amount of contact time with service users or carers’ in their current job in social work, and a third were dissatisfied, dissatisfaction being higher among those working mainly with children. The graduates identified gaps in knowledge which were causing them some anxiety about their practice and they wanted more help in supervision in applying theoretical approaches to their practice. The study reported findings about high workloads, a performance management culture for supervision and a reduction of good work/life balance in graduates’ second year. There was also an increase in the number of respondents reporting that they found it difficult to cope with the stress of their job. The overall picture for many was one of increasing pressure and dissatisfaction with the nature of the work available. Thus, the study concurred with the views reported earlier about the erosion of the social work role. It has highlighted the importance to graduates of being able to put their values into practice and to get help in supervision with using theory to understand their work with service users.
The study found that there were several issues causing new graduates some level of anxiety about their practice:

- Knowledge of mental health conditions (among very many more graduates than work specifically in mental health)
- Knowledge of Child Protection
- How to deal with hostility, aggression or conflict
- Assessing risk
- Preparing reports for legal proceedings

The latter three also emerged in the West Midlands project [88] as development needs indicating that they are not particular to newly qualified workers. They appear to be long standing [34] and seem to present a clear need that is not being addressed in training – qualifying or post qualifying.

**The current culture**

The current culture of the social work workforce which has driven services in recent years has been shown to be managerialist, target oriented and geared to performance management. This culture is not only ineffective for the service needed by service users but is inefficient for the workforce. It has produced a highly bureaucratic system which, in the view of social workers, impedes a person-centred approach [26] and prevents social workers using the skills, knowledge and values for which they were trained. This culture presents significant barriers to effecting change in social work and social care. It was also shown in Chapter 3 that there is a high rate of departure from social work in the first five years after qualifying and this is wasteful of the time and money spent in educating and training social workers. However, there are also considerable opportunities for change in proposals for workforce reform. Messages emanating from the Into the Workforce study can contribute to this process and recommendations are set out here. Some messages also link with other studies in the Research Initiative and are presented later.
**Recommendations from the Into the Workforce study**

*Person-centred work and values*

The study showed that new graduates wanted to work with their values and apply them to their practice. It is important that new arrangements ensure that this happens if the workforce is not to lose newly qualified recruits in their early years in the job. Social workers want to have professional autonomy and to offer a service they are trained to do, not be confined to narrow tasks which prevents them working holistically with situations. This is completely in line with the principles of the Personalisation agenda and ‘A Vision for Adult Social Care’.

*Supervision*

The study suggests that a key area to consider is how theoretical understanding of service users’ situations develops through supervision. This is important so that as effective a service as possible is offered which may be of more help to users whilst also likely to be more efficient in the long run. Within this context, the current frequency proposed by the SWRB in the Employers Standards seems very minimal and unlikely to facilitate this aspect of supervision.

*Knowledge and skills gaps*

Opportunities should be provided for workers to have training at both qualifying and post qualifying levels in the areas listed above which were identified as causing some level of anxiety.

**SOCIAL WORK AND ADULT SOCIAL CARE**

**Recommendations concerning team and organisational culture, and the impact of external regulation and targets**

*Teamwork and the supportive team*

The Into the Workforce project found that team support was an important issue for how prepared graduates felt, how likely they were to identify knowledge gaps, and for staff retention in the long run. The finding that having a supportive team was the most significant factor in deflecting graduates from looking for another job is a key issue. Employers need to consider carefully how team building can take place to produce successful team working and how teams can be supported in the workplace. The study of integrated teams [13] also emphasised the importance of
good teamwork, indicating that the supportiveness of the team continues to be an important issue for experienced social workers: hence the latter study’s recommendations for training and support in teamwork and team building.

*Learning through participation*

Findings, from a range of studies [13] [30], have emphasised the amount of learning that occurs informally (but within formal organisations), through experience of the work itself, relationships with service users and colleagues, taking part in communities of practice, and learning from practice within the organisation or team. New roles could be based on learning through participation, for example within new processes to take forward policies on Personalisation and also community development skills. Employers should consider how informal processes for learning can be fostered and maintained.

The West Midlands project [88] identified the need for social workers to develop greater professional confidence as adult services became more multi-disciplinary. The study of integrated teams, as discussed, shows not only how people learn from each other in this type of work but also how the service can develop, even when workers are alienated from policy making processes. This study found that “Learning appears as inseparable from service change and role re – configuration…… a lot of learning took place when staff worked together “in the grey area” to problem solve together and find solutions to challenges arising. This process also drove service transformation.” ([13] pii Case Study). This study gives pointers for the development of professional roles in the changing context.

*A learning culture*

The concept of an expansive/restrictive continuum of learning environments, as outlined in chapter 4, can contribute to a shift away from the restrictive environments of the current culture to move to a learning culture (also a recommendation of the Munro Review).

*Regulation and Targets*

Our research has shown that, despite their many negative impacts in relation to social work, regulation and targets had a positive impact on the amount and quality
of training received by care workers. Such training was much valued by these workers. It is particularly important, where employers are not willing or able to institute improvements, that forms of incentives be considered to ensure consistent quality across the workforce. For example, the Diversity and Progression study makes such a case for requiring all social work programmes to monitor targets and rates of progression, to better assess the achievements of diverse groups of students.

Overall we would argue that there is a case for regulation and appropriate targets, devised with service users and practitioners, that are relevant to the purpose of the service. However targets alone may not be able to achieve desired changes: it is important to note that the availability of some central funding to support training was significant in assisting organisations to meet targets. Such funding also had positive impacts in providing an impetus for collaboration through the development of regional consortia, originally formed to facilitate the acquisition of funds but subsequently taking a broader collaborative focus. Despite their positive role, without funding these collaborative arrangements were identified as institutionally fragile. Without additional funding, either provided through central or local Government, or through higher fees and charges (many of which are paid ultimately from the public purse), it is difficult to see how aspirations can be met for a workforce that can deal with predicted future demands (such as the growth in the numbers of people with dementia), as well as provide a transformed service.

A whole systems approach
The overall policy recommendation of the Social Work Task Force was the creation of a single national reform programme for social work and therefore, a whole systems approach to the various sectors that contribute to developing a skilled social work workforce. Munro likewise takes a systems approach to her reforms: she has stated that there should be no ‘cherry picking’ of her review’s recommendations. Both the SWRB and Munro view the organisational context for social work as crucial to the effective implementation of their proposals. Therefore, some of the issues to do with whole organisational approaches as discussed in the Rainbird study and set out at the end of the Chapter 4 are relevant for the reform process as a whole. This is also confirmed by the Diversity and Progression study.
**ADULT SOCIAL CARE**

This overview and synthesis has covered many issues of current prominence in adult social care. Two large issues affecting social care are currently under wider fundamental review: how long term care is to be funded \[127\]; and how to construct a coherent legal framework for social care \[124\]. While these issues are not directly the subject of workforce research, the ways in which they are ultimately addressed and resolved will undoubtedly have an impact on the workforce in terms of pay, conditions of service and work organisation. Chronic underfunding of the social care sector is already recognised, but, in the short term, the funding prospects are not encouraging: a survey of local authority budget setting for 2011-12 showed £991M cut from social care budgets in England, leading ADASS to urge the Government to include the findings of the Commission on the Funding of Care and Support in its review of NHS legislation \[128\]. Given that wages for the majority of the workforce are already so low, it is clear that there is little scope for savings to be made on staff costs unless numbers of staff are reduced, or undesirable cuts are made in, for example, support for training. A recent report by a user-led consortium identified chronic underfunding of the sector as a key barrier to person-centred support, along with, among other factors, the lack of a well-supported, skilled and well-trained workforce, and the poor terms and conditions of service of workers \[129\]. Workforce issues do matter to service users. Of necessity, this report has been written before the Government has responded fully to the outcomes of these reviews of law and funding, but it is to be hoped that the Commissions’ reports will act as a spur to produce much-needed change.

The remainder of this chapter raises questions and makes recommendations on the basis of reflection on our research findings relating to adult social care in general, and to the frontline workforce members who are not social workers. Most of these recommendations relate to the development of personalisation and personal budgets, but, since it is our argument that residential care\(^a\) has been relatively neglected in the discussion of personalisation, that is where we will begin.

\(^a\) Particularly for older people
Residential care

Relative policy neglect of an invaluable service?

More than half of social care expenditure [50] is devoted to residential care\(^a\), but during the past few years personalisation in residential care has received less attention from policy makers than personalisation in community care. There are times when residential care seems to be seen primarily - indeed only - as 'something that must be avoided'. The Vision [1] certainly states that the principles of personalisation should apply to people in residential care, but there is little guidance as yet on the mechanisms by which this should be achieved, although there are important existing efforts to improve quality of care in care homes such as My Home Life [130], as well as developments in research on how to assess outcomes in care homes [131]. It is to be hoped that the White Paper on social care will address the topic of residential care and personalisation in a positive way that recognises the interests of the residents of care homes, as well as their workforce.

The evidence is that care homes and nursing homes will remain a much needed service. Future projections suggest that increased numbers of people with advanced dementia will require residential care and, given the complexities of this work, this growth will mean a requirement for improvement in staff ratios and training. Estimates vary, but between 1/3 and half of people with dementia are in care homes, and 2/3 of care home residents have some form of dementia [132] [67]. It is recognised in the National Dementia Strategy that care of people with dementia requires improvement both in care homes (where the focus has been on reducing the levels of inappropriate prescription of antipsychotic drugs, and improving staff training) and in the community (where the focus has been on early diagnosis and intervention, and help for carers). Our research, and other studies cited, suggest that levels of compulsory training for staff are not yet as high as we might like, and we cannot cast any light on the quality of such training. The Dementia Strategy has involved a scoping study and gap analysis [133] that are intended to prepare the way for a workforce development action plan covering health and social care, but this is not yet published, so we do not yet know how the necessary levels of training are to be resourced, whether through incentive funding, regulation of the sector or an

\(^a\) 9/16.1 billion pounds (2008/9 statistics)
expectation that fees paid by LAs and private customers will rise. The Dilnot commission’s literature review on public opinion [134] makes it clear that the cost of residential care is (or would be) a shock to many members of the public, as is the discovery that relatively low levels of saving preclude them from financial assistance if they need such care. It remains to be seen whether the Government’s action in response to the Dilnot Commission’s proposals [135] will adequately address these long standing issues.

Could providers become too big to fail?
As we have seen, dependence on larger private (and voluntary) providers is growing. Local authorities can exert some downward pressure on care home and nursing home fees but, as a recent court case has demonstrated, there may be a limit to this, particularly if it is done without due consideration of providers’ actual costs. As we have seen recently, the private sector business model can affect the fees needed for financial viability. The cost of, and fees for, residential care are inevitably related to property prices, but companies may therefore be vulnerable to being asset stripped when the property market is booming. The financial problems that follow may have little to do with the operational cost of providing care, but nevertheless may put at risk the care of people supported by public resources. As we have seen recently, the extensive use of larger private providers carries the risk of creating organisations that are too big to fail. Perhaps there should be limits on market share, or restrictions on acceptable business models?

Training and Qualifications
Valuing formal and informal learning
Our studies have demonstrated not only the importance and value of formal training, but also the key role of informal participative learning. The latter takes place on the job and involves learning over time, from colleagues, from the workplace and its organisation, and from experience with service users. There is a risk that PAs might be isolated from some of these learning opportunities.

Supply of care workers and personalisation
We have seen that there is a shortage of supply of care workers, and that one of the ways that people have previously dealt with this (direct recruitment of workers from
outside the EU), will no longer be available. Recruitment is more difficult in the domiciliary care sector than the care home sector, and so will it be for personal assistants (except for those already known to the user). Recession will only ease the situation in the short term, and it may reduce the number of migrants from within the European Community who come to the UK for any kind of work and subsequently take up care work. If staff shortages are to be addressed it will be necessary to be able to recruit additional workers from outside the traditional pool, whilst ensuring that new recruits do not lack the personal qualities that employers and service users value above all. If basic wages for new entrants cannot be raised in the short term then maybe wider recruitment could be achieved by encouraging better rewarded promotion/progress opportunities for people who might otherwise be deterred by poor prospects. For example: by rewarding qualifications, training or years of experience with noticeably higher pay; and by offering relatively higher pay for seniors. Of course such possibilities exist only within the context of formal organisational employment structures. It is difficult to see how they could be implemented for a workforce of personal assistants employed by individual service users. We have seen that work as a personal assistant does not appeal to the majority of existing care workers, and the complexities of work scheduling, as well as the difficulties of accessing training and support, both play a role in deterring people from taking up such posts. As the use of personal budgets spreads, the situation should be monitored to determine how patterns of recruitment and churn within the social care workforce have an impact on the ways in which services can be delivered.

**Personalisation and personal assistants – recommendations for development**
Chapter 7 considered the implications of the projected growth in the number of personal assistants that would be expected to go along with the intended expansion in the numbers of people supported by personal budgets. The following section based on that chapter sums up recommendations that might facilitate the development of personalisation through the use of personal budgets, and the employment of personal assistants.
Service users as employers and commissioners

The need for support for service users in their role as employers is already accepted, and there is a great deal of information and assistance available to them in relation to the employer role. As the use of personal budgets grows, other support that might be needed could include:

Ways to support service users in developing networks of contact with each other, otherwise important opportunities for people to recognise common interests and jointly commission services might be lost. This is particularly important for people who do not use the internet or who have communication difficulties and or cognitive impairments.

A dispute resolution service might be of value to both service users and PAs to help settle differences, and to avoid more costly use of tribunals or the courts.

A strategy for PAs would valuably include:

- Mechanisms to ensure a supply of workers accredited, checked and suitably inducted for service user employers who need this. This could be partly achieved through the proposed voluntary register, depending on the conditions of registration. However someone has to supply (and pay for) induction training and CRB checks. If potential recruits had to pay, this could prove a deterrent to entering this form of employment, given the low wages on offer.

- Mechanisms to tackle isolation of PAs through:
  - Mutual support (mechanisms to keep in touch with other PAs and also service users). Could be e-networks, telephone contacts and/or meetings.
  - Access to advice and support (if and when wanted) from other people with expertise. The kinds of issues would include:
    - Employment issues
      - Contracts, holidays, pay issues
- Care-related issues
  - Relationship issues
  - Technical issues
- Personal development issues
  - Training and/or qualifications
  - Job finding
  - Career building

The above organisational support and advice giving functions would require resources, as would the provision of training. Conceivably they might be funded by subscription, or by service users, but, given that pay is likely to be close to the minimum wage, and users, not unreasonably, do not often feel a broader general responsibility for training or career development of care workers, it is realistic to expect that some investment of public resources would be needed.

For workforce planning, local authorities would need routine information collection about PAs, perhaps by a survey linked to NMD-SC.

**Further Research and Information Gathering**

The following suggestions for further research and information gathering have been mentioned in the report and are drawn together here.

1. Relationships between training and/or qualifications and service quality and outcomes. Exploring this topic requires a scientific research programme that will break the question down into what content and style of training delivers what outcomes for whom in what circumstances (ie taking account of workplace influences on practice). Research needed using comparative methods, preferably controlled trials, and/or, where possible, large scale quantitative modelling. Such knowledge is essential if we are to understand how best to invest in workforce training and development.

2. Impacts of pay and conditions of the workforce (and HR practices) on quality of care and outcomes. Controlled trials might present more difficulty here, so
comparative analysis using primary or secondary survey data would be one way forward.

3. In relation to PAs:
   Regular gathering by survey of routine information about pay, characteristics and deployment to complement NMD-SC and assist local area workforce planning. This should preferably include information on those working for self-funders.

   Research on: how PAs deal with issues such as the management of risk, abusive customers, becoming over-involved, how, when and whether they can access support, learning and/or training.

4. How to encourage/enable service users using personal budgets to work together to develop ideas of services they would like to purchase collectively. (Research and development needed here)

5. On-going monitoring/evaluation of the roll out of personal budgets to determine the best arrangements for different user groups, the impacts on collaboration with health, and how work scheduling operates as the number of people employing personal assistants increases.

6. The effectiveness of social work supervision on outcomes. Our research indicated the importance to social workers of having supervision that helped them apply theoretical approaches to their practice. Further research in this area could contribute to understanding the nature of theoretical understanding of service users’ situations through types of supervision and what impact this may have on the outcomes for the service users. Included in this should be the frequency and form of supervision required to enable this process to be effective.

Reflections on the future

Chapter One outlined the key features of ‘A Vision for Adult Social Care’, including a key role social workers will play in community development. The aims of the policy are “to make services more personalised, more preventative and more focused on
delivering the best outcomes for those who use them” (p6), particularly relevant to social work. The ‘Personalisation’ agenda was already bringing about significant changes in social workers’ roles in Adult social services, as discussed earlier, with some parts of the role being undertaken by non-qualified staff in some areas. In relation to building the Big Society, the move to taking a key role in community development signals even more change for social work, although this role has been undertaken in the past. While a more preventative and community-orientated role might in principle be welcomed by many social workers, including those in Children’s services, current services tend to deal with people with the greatest needs. Eligibility criteria have been rising as funding cuts have made it difficult for some local authorities to provide funding for all assessed needs, and social workers may have little confidence that working practices will be able to change in this context. The development of Social Work Practices may also bring a plurality of employers of social workers in the future and a reduction of the local authority role. Some coordination of services may be necessary if a possible fragmentation of services is to be avoided. Proposals for the reform of social work and new policy developments in social care could bring well needed change, but it will be important to monitor changes if unintended consequences, as has happened with the target culture, are not to impede progress.

The desire that support should be ‘person-centred’ is not new, although the language used to describe the kind of assistance that is tailored to the individual may have changed over time. As we have seen in relation to older people, without sufficient resources, mere re-arrangement of service delivery methods is unlikely to be transformational. A substantial growth in the use of personal budgets, mainly in the form of direct payments, is a central aim of current policy. Indeed, the aspiration is to provide this for everyone eligible for social care, although the specific implications of personalisation for residential care have received relatively little attention. The workforce implications of such a change are substantial. Our research suggests that this vision for the delivery of social care needs to be carefully thought through, not just in terms of the very challenging practicalities, although these are many, but also in the light of evidence about service users’ experiences of personal budgets, and the impact on frontline workers, in order to avoid imposing another ‘one size fits all’ solution that suits only a few.
References


Available from: 
http://www.kcl.ac.uk/content/1/c6/03/89/22/SupportWorkerroleandtasksFINAL1.pdf


43. McGregor, K. *£70m extra cost of hiring agency social workers*. Community Care 2010 1 September; Available from: http://www.communitycare.co.uk/Articles/2010/09/01/115206/70m-extra-cost-of-hiring-agency-social-workers.htm.


70. Meyer, J., Keeping the workforce fit for purpose, in My Home Life: Quality of life in care homes, National Care Homes Research and Development Forum, Editor 2007, Help the Aged.


84. Williams, C., Personalisation: Is the social worker role being eroded?, in Community Care, 2009.


100. Fighting Monsters AMHP. *Social work education and the Munro Report*. Fighting monsters AMHP: life and thoughts of a British social worker 2011 [cited 2011 20 June]; Available from:


PSSRU. *Closures of Care Homes for Older People: Summary of Findings*, No. 1, 2002; Available from: http://www.pssru.ac.uk/pdf/rs021.pdf.


Pitt, V. *One-fifth of social care providers expect to close next year*. Community Care 2011; Available from: http://www.communitycare.co.uk/Articles/2011/02/16/116286/one-fifth-of-social-care-providers-expect-to-close-next-year.htm.


## APPENDIX 1

GSCC Social Work Registrants by Organisation
Sector at 7th March 2011

<table>
<thead>
<tr>
<th>Sector</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency - Private</td>
<td>3267</td>
<td>3.74%</td>
</tr>
<tr>
<td>Competent Authority</td>
<td>8</td>
<td>0.01%</td>
</tr>
<tr>
<td>Education</td>
<td>2</td>
<td>0.00%</td>
</tr>
<tr>
<td>Educational Establishment</td>
<td>35</td>
<td>0.04%</td>
</tr>
<tr>
<td>Employment Agency</td>
<td>81</td>
<td>0.09%</td>
</tr>
<tr>
<td>FE/HE Education</td>
<td>4</td>
<td>0.00%</td>
</tr>
<tr>
<td>Government</td>
<td>6</td>
<td>0.01%</td>
</tr>
<tr>
<td>Health</td>
<td>11</td>
<td>0.01%</td>
</tr>
<tr>
<td>Health - Public</td>
<td>3088</td>
<td>3.53%</td>
</tr>
<tr>
<td>Higher Education Institute</td>
<td>125</td>
<td>0.14%</td>
</tr>
<tr>
<td>Hospital</td>
<td>8</td>
<td>0.01%</td>
</tr>
<tr>
<td>Local Authority</td>
<td>14</td>
<td>0.02%</td>
</tr>
<tr>
<td>Local Authority - Public</td>
<td>47621</td>
<td>54.50%</td>
</tr>
<tr>
<td>Local Authority - Social Services</td>
<td>2026</td>
<td>2.32%</td>
</tr>
<tr>
<td>National Health Service</td>
<td>1</td>
<td>0.00%</td>
</tr>
<tr>
<td>Other</td>
<td>15568</td>
<td>17.82%</td>
</tr>
<tr>
<td>Other - Private</td>
<td>4214</td>
<td>4.82%</td>
</tr>
<tr>
<td>Other - Public</td>
<td>1785</td>
<td>2.04%</td>
</tr>
<tr>
<td>Private</td>
<td>183</td>
<td>0.21%</td>
</tr>
<tr>
<td>Recruitment Agency</td>
<td>45</td>
<td>0.05%</td>
</tr>
<tr>
<td>Recruitment/Employment agency</td>
<td>40</td>
<td>0.05%</td>
</tr>
<tr>
<td>Self Employed</td>
<td>1</td>
<td>0.00%</td>
</tr>
<tr>
<td>Trust</td>
<td>21</td>
<td>0.02%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>5</td>
<td>0.01%</td>
</tr>
<tr>
<td>Unknown</td>
<td>6675</td>
<td>7.64%</td>
</tr>
<tr>
<td>Voluntary</td>
<td>2550</td>
<td>2.92%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>87384</td>
<td>100.00%</td>
</tr>
</tbody>
</table>
APPENDIX 2

Social Work Reform Board – One Year On proposals

Submission from:

Into the Workforce research project

This is a study funded by the Department of Health under the Social Care Workforce Research Initiative which is being undertaken in partnership by Sharpe Research and the Social Care Workforce Research Unit, King’s College London.

31st May 2011

Contact:

Sharpe Research
7 Broadhinton Road
London SW4 0LU
Tel: 020 7627 3143
Email: sharpe.research@btinternet.com
INTRODUCTION

*Into the Workforce* is a study funded by the Department of Health under the Social Care Workforce Research Initiative which is being undertaken in partnership by Sharpe Research and the Social Care Workforce Research Unit, King’s College London. The research has three aspects:

- whether graduate social workers believe themselves to be well prepared;
- the nature of their progress in the workplace over time; and
- how newly-qualified social workers’ own beliefs about their abilities and preparedness compare with the needs and expectations of employers.

This submission uses results from three surveys of graduates from two cohorts of the social work degree, from face-to-face interviews with line managers of new social work graduates, sampled independently, from two surveys of Directors in Children’s and Adult services, from focus groups with service users and carers and an advisory group and from five regional meetings with 30 Higher Education Institutes (HEIs). The final report is due to be completed in June 2011.

The sample of new graduates is a follow-up from surveys of students starting their social work degree studies in 2005-6 and 2006-7 (Evaluation of the New Social Work Degree Qualification in England (SWDE), 2008). In the first cohort, undergraduate students taking part in this present ‘Into the Workforce’ survey will have completed their studies in 2008, but postgraduates a year earlier; this sample also contains a small number of postgraduate students completing their studies in 2008, having begun in 2006-7. The second cohort consists only of undergraduates, beginning their studies in 2006-7 and completing in 2009.

Respondents to the ‘Into the Workforce’ survey include graduates who were not currently employed in social work, though they might have been looking for a social work position. However, the results reported here are based mainly on 317 graduates currently employed in social work. The ‘Into the Workforce’ survey was designed to be completed online, and was emailed in November 2008 and 2009 to all those on the database of previous SWDE survey respondents from the relevant
cohorts. The 2009 graduates were also followed up through Social Work Programmes as this cohort had been surveyed originally as students via HEIs.

Line managers were recruited by purposive sampling in order to include managers from a range of services in both Adult and Children’s services. As well as those involved in day to day management of social workers, they also include those with responsibilities for training, and recruitment consultants placing agency social workers. Geographically, managers have been located in the north, midlands, and south of England and in London boroughs. The two rounds of manager interviews took place in 2009 and 2010. The HEI surveys took place in 2010.

General

The findings from the research tend to confirm many of the issues in need of reform as discussed in the One Year On report and endorse the SWRB proposals in general. This submission has been presented to set out key messages emanating from the research rather than the five areas identified in the One Year On Report. Particularly, they include information relevant to the Curriculum and to the Assessed and Supported Year in Employment (ASYE), as newly qualified graduates were the main focus for the research.

The Social Work Task Force in its interim report in July 2009 noted as one of its six key themes of enquiry that “We have been told that new social workers are often not properly prepared for the demands of the job…”

The data obtained in this study confirm the need for good preparation and opportunities for ongoing development mentioned by the Task Force. While graduates, line managers, employers and HEIs in the ITW study all had ideas about ways in which qualifying training could be improved, their experiences suggest that issues about the extent to which professional qualifying programmes prepare social workers to be effective practitioners are much more complex than has been presented in some media reports. The study found that the workplace context into which newly qualified workers go has a considerable bearing on whether they feel appropriately prepared, or not.

Employers Standards and Supervision Framework

“1.1.Evidence submitted to the Social Work Task Force demonstrated that the nature and demands of social work mean that it is essential for a number of key working conditions to be in place. These were enough time to spend working directly with children, adults and families, the right working environment, appropriate ICT systems
and equipment, meaningful professional support and access to learning and evidence. The Task Force was clear that it should be the responsibility of all employers to put in place the conditions in which well trained social work professionals can work confidently and competently to help children, adults and families.” (OYO report page 19)

The ITW study fully concurs with the above statement and found that many of these key working conditions were not in place. However, in the study the effect of perceived manageable workload on job enjoyment and retention was shown to be a lower priority for new entrants to the profession than their ability to adhere to their social work values – identified as a key factor influencing job satisfaction. The lack of opportunity to implement their values was also a factor in graduates’ propensity to look for another job. It suggests that the type of work available to, or expected of, new graduates does not always meet their expectations in helping service users. Not being able to put their social work values into practice or transmit them to others was also found to be correlated with not feeling well-prepared. Thus, beliefs about how well their degree has prepared social work graduates for working life are to some extent a function of their actual job experiences.

Graduates also wanted more help in supervision in applying theoretical approaches to their practice – three-quarters of second-year graduates picked this as top of the list (followed by reflection and self-awareness) of what they most wanted from their supervision. Only one in five respondents reported that supervision was used to help them in this area. Taken together with answers to attitudinal questions about theory, the findings suggest that insufficient attention is given to helping graduates to apply theory to practice in their working lives.

When this information is combined with data on the frequency of supervision, the potential problems caused by the diversity of the content of supervisions becomes most apparent. Managers and newly qualified social workers taking part in this study described a process by which the frequency of supervision tapered as participants became more experienced. However, a sizeable proportion – more than one in ten in their first year of practice and one in five in their second year – received supervision less often than once a month. The proposed frequency in the Supervision Framework is low with only a minimum monthly supervision suggested after six months. This is particularly limiting for newly qualified workers. Formal supervision once a month is very little to facilitate the range of tasks stemming from a month’s work and to try to enhance professional development.

The study found that the key factor that made respondents want to stay in their jobs was having a supportive team. Better use of peer networks for the supervisory processes is proposed in the Framework – which the study would endorse – but formal group supervision is not. This is a potentially important vehicle for theoretical development, especially if individual supervision is limited.
Key messages

Manage caseloads so that individual workers are able to undertake work which is consistent with social work values of helping service users.

Ensure supervision pays explicit attention to helping supervisees apply theoretical approaches to their practice.

Reconsider the frequency of supervision to shorter intervals than proposed, especially for newly qualified workers.

Propose formal group supervision at monthly intervals to supplement individual supervision.

Identify the effectiveness of different models of supervision, including such issues as their timing, content, and whether they are delivered by line managers or other experienced practitioners.

Curriculum

There was a view from HEIs that programmes were not building a rigorous enough social and behavioural science base to teaching and input could be fairly narrow. This could result in students not being sufficiently equipped to understand some of the complex situations they would encounter or to become critical practitioners. It was felt that there should be agreed core knowledge, as there is in other professional training, which should be the basis for practice. Another area that was thought to be limited was in the theory underpinning work with relationships – dealing with the more emotional content and context of practice – which could also result in graduates being less equipped than they needed to be. It was recognised that a stronger process was needed that better integrated theory and skills. Messages were also given about the lack of time available to include all the content desired in the academic curriculum and that consideration needed to be given to what was feasible and desirable at qualifying level and what at further stages of the career structure – material that is better absorbed at a later stage of professional skill.

Key messages

Ensure guidance on the curriculum includes rigorous attention to the social science area as outlined in the Capability on ‘Knowledge’.

Agree core knowledge that is fundamental to all social work education.

Ensure theory underpinning work with relationships – dealing with the more emotional content and context of practice – is embedded in the curriculum.
Establish a stronger process to better integrate theory and skills.

Give guidance on what content is feasible and desirable at qualifying level and what at further stages of the career structure.

Address the following issues identified by graduates as causing them some anxiety about their practice:

- Knowledge of mental health conditions (among very many more graduates than work specifically in mental health)
- Knowledge of Child Protection
- How to deal with hostility, aggression or conflict
- Assessing risk
- Preparing reports for legal proceedings

These areas relate to the previous message and it will be important to establish what is appropriate and feasible at qualifying level and what for later stages of professional development.

Partnership working

The idea of more shared working and shared responsibility for the future social workers was welcomed by HEIs. It was thought important to work at partnerships in order to develop a workforce that has the requisite knowledge and skill to function at the appropriate level that was expected. Several examples of partnership working through programme structures were cited, mainly with training and development personnel but it was thought to be more difficult to engage managers at a senior level in agencies. Reference was made by HEIs to the importance of keeping up to date with current practice and for staff in agencies to keep up to date with learning – both sides of the equation.

Key messages

Ensure the guidance on ‘partnerships’ encourages managers at a senior level in agencies to become ‘partners’ in an active way.

Assessed and Supported Year in Employment (ASYE)

There was strong support from line managers for the policy of NQSW transition schemes, which are to inform the setting up of the ASYE. Most of the line managers generally concurred with the idea that newly-qualified social workers needed additional support during their first year of practice. However, it was noted that line
managers should be able to use their discretion in deciding when new workers were ready to undertake certain activities, and also pointed out that other skills took longer than a year to acquire. Most managers considered that they themselves had only felt confident about their abilities around two years post qualification.

HEI respondents saw the ASYE as an opportunity for HEIs and employers to work together to share responsibility for graduates’ readiness for practice and subsequent development over the year. It was experience in a job that helped graduates apply their learning and fully develop. However, there was some doubt about whether the NQSW schemes as currently operating would be the best basis for developing the year. It was stated by one respondent whose HEI was involved in the schemes that analysis and critical perspectives were not being mapped in the Outcome Statements. Given the findings from this study, it seems important to ensure that the AYSE gives newly qualified workers opportunities to develop their theoretical understanding in order to provide the most effective service to meet the needs of service users. Whether theoretical understanding develops will very much depend on the quality of the supervisor/mentor and the opportunities the NQSWs have to further their qualifying training.

Key messages

Ensure that the AYSE gives newly qualified workers opportunities to develop their theoretical understanding from their qualifying training through supervision and further training.

Recommend that HEIs and employers work together to share responsibility for graduates’ readiness for practice and subsequent development over the year.
APPENDIX 3

Outputs from the DH Social Care Workforce Research Initiative at June 30 2011

Journal articles and published papers


Rainbird et al. (submitted) “‘A self-managed, self-motivated workforce’: can management make a difference to job quality in care work?” Human Relations special edition on the relationship between training and job quality


Conference Papers


**Final Reports currently available (direct links)**

**Commissioning, Recruitment and Retention**


**Skill Development, Training and Qualifications**


Changing Roles