# Factors that affect the recruitment and retention of domiciliary care workers and the extent to which these factors impact upon the quality of domiciliary care

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Views expressed in this report are those of the researchers and not necessarily those of the Welsh Government

**Contents**

**Glossary**

Here we include a list of the acronyms used in the report.

| Acronym/Key word | Definition |
| --- | --- |
| CfWI | Centre for Workforce Intelligence |
| CQC | Care Quality Commission |
| CSSIW | Care and Social Services Inspectorate Wales |
| CCW | Care Council for Wales |
| DBS | Disclosure and Barring Service |
| NLW | National Living Wage |
| NMDS-SC | National Minimum Dataset – Social Care |
| NMS | National Minimum Standards (of care, as specified by the Care Act, 2000) |
| NMW | National Minimum Wage |
| SCWDP | Social Care Workforce Development Programme |
| SHRM | Strategic Human Resource Management |
| QCF2 | Qualifications and Credit Framework Diploma Level 2 (formerly National Vocational Qualification Level 2) |
| WTR | Working Time Regulations |

# 1. Introduction and background

## 1.1 Research aims and objectives

The Welsh Government and the Care Council for Wales commissioned this research with the overall aim of:

Exploring the factors that affect the recruitment and retention of domiciliary care workers and the extent to which these factors impact upon the quality of domiciliary care

The specific objectives of the research are to:

- identify factors which both positively and negatively influence individuals to choose to become and remain working as domiciliary care workers

- identify the extent to which these factors impact on the quality of domiciliary care.

The research has a particular focus on the employment terms, conditions and career structures for domiciliary care workers. Specific research questions include:

- What factors encourage or deter individuals from becoming domiciliary care workers?

- What factors encourage or deter individuals from continuing to work as domiciliary care workers?

- What are the expectations of potential and existing domiciliary care workers about a career within domiciliary care?

- To what extent do the terms, conditions and career structure of domiciliary care workers impact upon the ability of domiciliary care providers to deliver quality domiciliary care?

- What do service users, their carers and families consider to be good quality domiciliary care service?

- To what extent do the terms, conditions and career structure of domiciliary care workers impact upon the quality of care experienced by service users and their families?

The findings from the research have informed a public consultation on policy interventions to improve the quality of domiciliary care through positively impacting on the recruitment and retention of domiciliary care workers (http://gov.wales/consultations/healthsocialcare/workforce/?lang=en). The research will also provide suggestions on further research and options for how Welsh Government policy can improve the quality of domiciliary care through positively influencing the recruitment and retention of domiciliary care workers.

This research draws on a conceptual framework, established through literature review (Figure 1), which is presented here for the reader's convenience.

**Figure 1: Conceptual Framework: Recruitment and Retention of Domiciliary Care Workers and Care Quality**



The report begins with a literature review of contextual and theoretical issues. Methods and findings then follow, together with conclusions around the implications of employment terms, conditions and career structures for recruitment and retention of domiciliary care workers and care quality. We end with suggestions for both further research and how Welsh Government policy might address our findings.

## 1.2 Terms used in Social Care

Here we define the terms used in this report.

*Domiciliary Care*

The term 'social care' describes all aspects of paid social care including social work. This report considers only domiciliary care, that is, personal care, protection or social support services provided to people (termed here 'service users') in their own homes (Gray and Birrell, 2013). The report is also limited to adult social care, that is, social care provided to those aged 18 and over. While the boundaries of social care, health care and other community services can be

somewhat blurred, the vast majority of social care is defined by the sources of funding, which for the significant majority of service users is financed, at least in part, by local authorities.

Recent policy developments in Wales (Welsh Government, 2015d) have encouraged a focus on re-ablement and outcomes-based care which maps a service user's current personal circumstances, encourages them to develop a positive vision of how they want these to be and takes steps, with support from family or community networks, to deliver this vision (RiPfA, 2013). The intention is to achieve the best possible levels of independence, health and wellbeing while reflecting each service user's own priorities (Welsh Government, 2015d).

*Domiciliary Care Worker*

Paid care staff are referred to as 'care workers', as opposed to 'carers' who provide unpaid care for family or friends. Various terms are applied to those who are paid to provide domiciliary care, including home care worker or support workers (CCW, 2013). Here we use the term 'domiciliary care worker' to describe those who provide person-centred support to enable service users to live as independently as possible.

*Service Provider*

'Service provider' refers to an organisation that provides social care services. Here we focus on providers of domiciliary care services particularly for older people but also including adults with a physical disability, mental health needs or a learning disability.

*Commissioning*

Commissioning of social care describes the process where (usually) a local authority purchases social care services for the population it serves. This involves a detailed procurement and contracting process.

Some social care is also purchased by individuals either privately or via direct payments, but this is beyond the scope of this report. Various commissioning arrangements exist and include:

- Block contracts: where an agreed number of hours of domiciliary care provision is purchased from a service provider regardless of whether it is actually used
- Spot and call-off contracts: where price-by-case arrangements are used and the service provider is paid only if the hours are taken up by a service user
- Cost-and-volume contacts: are combinations of block and spot contracts, where a guaranteed minimum number of hours is purchased and payment above that is made where a service user takes up hours  (see Knapp et al., 2001 for further detail).

*Sector*

Domiciliary care provided by local authorities is referred to as 'statutory sector provision' or 'statutory provision'. Externally-commissioned care is provided by the independent sector, which comprises both private and voluntary organisations.

## 1.3    The Domiciliary Care Workforce in Context

Here we outline contextual issues that inform understanding of domiciliary care provision and the domiciliary care workforce. While context is not specified as being within the scope of the project, we follow Rubery et al. (2011) in arguing that contextual insight is essential to understanding employment practice. We address three key areas of context as identified by the Care Council for Wales (2010): policy and regulation; demand (demography and expectations); and supply (skills and qualifications). We provide a broad overview that builds on the very detailed review provided by Rubery et al. (2011). In particular, we develop understanding of both the Welsh policy context and Welsh

domiciliary care and also integrate consideration of recent wider policy developments, such as the National Living Wage.

*The Policy Context*

Over the past thirty years, social care has been part of wider public sector reform, in which the state has reduced its role in the direct provision of public services. State provision has been replaced by more marketised forms of relationship (Martin, 2011) via a purchaser/ provider split in which local authorities buy services from the independent sector, comprising both private and voluntary providers (Cunningham and James, 2009). Currently, most domiciliary care in Wales is contracted out by local authorities to the independent sector, although this varies widely across local authorities with as little as 40% in some and as much as 90% in others. Welsh Government figures show that, in 2014-5, only 2.5m of 13.1m domiciliary care hours were provided by local authorities, the other 77% being provided by the independent sector (StatsWales, 2015).

Reduced state control created the need for regulation to ensure high quality care delivery and this was first introduced via the Care Standards Act 2000. This has applied in Wales for the past 15 years but, subsequent to the devolution of social care to the Welsh Government, legislation particular to Wales is now being enacted. The Social Services and Well-being Act (Wales) 2014 will take effect from April 2016 and establishes a new statutory framework for social care (Welsh Government, 2015d). Gray and Birrell (2013) suggest this aims to create a national care and support system with regionalised commissioning arrangements. Borne of a number of challenges across Welsh public services, including demographic change and increased expectations of care users, the act embodies freedom and choice for individuals using services and aims to optimise integration with health services, clarity and consistency for both service users and the workers

and organisations engaged in providing social care. At the heart of its agenda are the following aims:  promoting equality; improving inclusivity and access; and improving service performance and quality (Welsh Government, 2015d).

Service performance and quality are pressing issues for UK policy-makers generally, amidst a number of recent high profile scandals over poor care (Kingsmill, 2014, Cavendish, 2013). The Regulation and Inspection of Social Care (Wales) Act (Welsh Government, 2015c) addresses service, workforce and training regulation in Wales. Service regulation is currently conducted by the Care and Social Services Inspectorate Wales and regulation of the workforce is via the Care Council for Wales. We return to both in what follows, but note here that domiciliary care workforce regulation (other than Disclosure and Barring Service checks) is largely limited to development (CCW, 2013). The workforce is otherwise subject to only general employment regulation, key issues being the National Minimum Wage (currently £6.70 an hour) and Working Time Regulations. As we discuss later, the introduction of the National Living Wage (£7.20 an hour) from April 2016 will have substantial implications for the sector.

*Social Care Commissioning*

As noted above, Welsh adult social care is largely contracted out to the independent sector. Domiciliary care is commissioned by 22 Welsh local authorities from 336 providers (CCW, 2014). The principles underpinning the reduction of state provision presumed that the adoption of private sector principles would deliver more efficient and higher care quality (Martin, 2011). During a long period of austerity and budget cuts, however, the commissioning process in Wales has been subject to much criticism (for example, Age Cymru, 2015). For example, commissioning is activity- rather than outcomes-based; that, as the major purchaser of older people's care, local authorities have

created a monopsony, reducing competition which enables them to drive down pricing (Cavendish, 2013); and commissioning is more cost- than quality-focused (UKHCA, 2012b). Indeed, UKHCA (2012b), the body representing service providers, has conducted a survey that suggests 69% of service providers in Wales felt that local authority commissioners valued price over quality.

The emphasis on price is perhaps unsurprising given the funding constraints faced, particularly in recent years, by local authorities. In 2015-6, for example, Welsh local authorities faced budget cuts of up to 4.5% (Age Cymru, 2015). It nevertheless has substantial implications for both care quality and terms and conditions of employment and has led in certain instances to reduction in, for example, care workers' pay (ITV, 2015a). In 2015, UKHCA (2015a) calculated the minimum price for domiciliary care delivery as £15.74 per hour, rising to £16.70 per hour with the introduction of the National Living Wage. Yet, UK wide, only 28 of 203 local authorities, where data was obtained, commissioned at this rate and most Welsh local authorities paid between £13 and £16 per hour with an average hourly price of £14.24 (UKHCA, 2015c). A separate survey indicates, UK wide, 20% of local authorities pay less than £11 per hour (UKHCA, 2015b). While the UKHCA (2015a) report notes that limited data is available in respect of the Welsh domiciliary care sector, it suggests anecdotal evidence reflects a similar situation to England where local authority commissioning rates are failing to keep pace with increasing costs and regulatory burdens.

Low hourly commissioning rates do not support independent service providers in offering good terms and conditions of employment and these are typically  inferior to the statutory sector (Cunningham and James, 2009, Rubery and Urwin, 2011). Recent evidence from an English study indicates that higher fees and partnership-oriented contracting positively influence pay and other employment practice and

that better local authority commissioning may be required to support improved employment standards (Grimshaw et al., 2015). While it is possible to include terms and conditions in service providers' tenders (Hughes et al., 2009), local authority representatives in a recent Welsh study suggested seeking to dictate service provider terms and conditions could be anti-competitive, although they acknowledged tender requirements could encourage good employment practice (Burrowes, 2015). This reflects wider UK practice (e.g. DH, 2009) where there is no regulation of social care workers' terms and conditions of employment beyond standard employment legislation. While we return to this later in 'Employment Practice in Domiciliary Care', we note here that policy-makers may need to regulate social care terms and conditions (Atkinson et al., 2015). We acknowledge the process of changing care worker employment contracts could make this a protracted process (Burrowes, 2015). It is, however, an important matter. Rubery et al. (2013), for example, argue commissioning pressures may act to diminish care quality due to downward pressures on worker terms and conditions.

Funding levels have far reaching implications beyond employment terms and conditions and, in a recent Scottish survey, were cited as the biggest challenge faced by the sector (IRISS, 2015). Funding constraints have led to a general move from block to spot contracts which reduces stability in employment terms and conditions (Bessa et al., 2013). They have also led to an increase in commissioning very short care visits. For example, the UKHCA (2012a) report indicates that, in Wales, 4% of commissioned visits were 15 minutes or less and 35% were between 16-30 minutes. Nineteen per cent were 31-45 minutes, 27% were 45-60 minutes and only 12% of those commissioned were over an hour in duration. The increasing trend for visits of 30 minutes or less can have detrimental implications for care quality and has led to negative media coverage (see, for example, ITV,

2015b). As we note later, such publicity creates further difficulties in recruitment and retention in the sector.

*Size of the Sector*

Welsh Government figures indicate that local authorities work with 336 domiciliary care service providers and that the independent sector delivers 77% of domiciliary care, a proportion that is growing year on year (StatsWales, 2015). It is further estimated there were 13.1 million hours of local authority-commissioned domiciliary care provided in Wales to over 43, 000 service users in 2014-15, three quarters to older people. There has been a recent increase in the number of agencies exceeding 200 hours of provision per week and these agencies now make up around 80% of provision. As we outline below, demographic change and an ageing population mean most analysts expect demand for domiciliary care to grow over the coming decades (Age Cymru, 2015).

*Maintaining Care Quality*

Social care providers in Wales are regulated and must be registered with the Care and Social Services Inspectorate Wales (CSSIW). CSSIW produces an annual report containing an evaluation of service provider performance based on a range of evidence sources including: inspections of regulated settings, reports by other inspectorates, published performance information and a range of additional activities (CSSIW, 2014).

There are many regulations, policies and legal frameworks that have been influential in shaping development and compliance within the sector. In addition to the Care Standards Act 2000, discussed above, domiciliary care providers must also comply with the Health and Social Care (Community Health and Standards) Act 2003, Registration of Social Care and Independent Health Care (Wales) regulations, the

Domiciliary Care Agencies (Wales) Regulations 2004 and the Domiciliary Care Agencies (Wales) Regulations (Amendment) 2013. A detailed account of these is beyond the scope of this report but we draw upon them where relevant. The Care Standards Act 2000 sets out National Minimum Standards (NMS) of care which aim to ensure services are safe and provide positive outcomes for service users (CCW, 2010). These will be replaced, when the Regulation and Inspection of Social Care (Wales) Act is implemented, by an approach that will move beyond compliance with minimum standards to consider quality of services and their impact on service users (Welsh Government, 2015c). This seeks to shift emphasis to care based upon service user wellbeing and their improved outcomes, alongside maintaining required quality standards. This will require a shift away from monitoring and inspection that is time- and task-focused (Koehler, 2014) to an inspection regime which focuses on service user well-being according to an outcomes framework.

*Workforce Regulation and Development*

The Care Council for Wales (CCW) was established by the Care Standards Act 2000 to promote high standards of conduct, practice and training among social care workers (CCW, 2013). Care work is governed by the Code of Professional Practice for Social Care (which includes care workers), the revised version of which was introduced on 1 July 2015 (CCW, 2015a). This creates the opportunity for care workers in Wales to join the professional social work/care register via MyCareCouncil. Registration for domiciliary care workers is not, currently mandatory and only 417 workers were on the register in August 2015. The Welsh Government will, however, require mandatory registration of all domiciliary care workers from 2020 (Welsh Government, 2015e). This reflects calls for mandatory registration across the UK (Koehler, 2014) and many service users and their families in Wales support this (Age Cymru, 2015). CCW also provides support to service providers on training and qualifications to ensure

compliance with the Care Standards Act. The Regulation and Inspection of Social Care (Wales) Act provides for the remit of CCW to be broadened and for the organisation to be rebranded as Social Care Wales (Welsh Government, 2015c). This will be a government-sponsored body responsible for regulating and developing the social care workforce and so improving care provision.

Policy-makers have long emphasised the role of workforce development in high quality care delivery (Rainbird et al., 2011). The Social Care Workforce Development Programme (SCWDP), for example, aims to support development of the social care workforce. The Welsh Government provides 70 per cent of SCWDP's total value, over £8m in 2014-15, with local authorities responsible for the remainder (Welsh Government, 2014). National Occupational Standards for Health and Social Care have been established and adopted by CCW. CCW has also established a qualifications framework for the sector (CCW, 2013). This reflects the NMS requirement that a minimum of 50% of any domiciliary care service provider's workforce must hold a Qualifications and Credit Framework Level 2 (QCF2) Diploma Health and Social Care (Adults) Wales and Northern Ireland. QCF qualifications form the basis of apprenticeships in the sector and government funding is available for those aged under 25 for both apprenticeships and QCF2 qualifications. All new domiciliary care workers must also complete induction training within 12 weeks of undertaking a new role in social care and are encouraged to undertake the Level 2 award for Social Care Induction (Wales). QCF2 is equivalent to the standards required of UK school leavers aged 16, and does not promote high skills in the sector. We return to this later, as there is argument that domiciliary care work does not fully reflect the conventional characterisations of low-skilled work (Rainbird et al., 2011) and is complex and relational in nature (Atkinson and Lucas, 2013a).

*Workforce Size, Characteristics and Challenges*

In recent years, there has been a concerted effort to improve knowledge about the adult social care workforce in Wales. The Welsh Government has long collected basic data for those employed in social care and, in 2013 and 2014, SCWDP undertook two rounds of more sophisticated data collection (CCW, 2014, 2015b). This informed reports that provide important data around workforce demographics and the intention is that this will be an annual data collection exercise. Data collection mechanisms will need to be developed further, however, to provide more detailed and robust data on, for example, different parts of the workforce and training and qualification levels. We combine the SCWDP reports (CCW, 2014, 2015b) with other sources to provide as detailed information as possible about the domiciliary care workforce.

There are around 18,000 domiciliary care workers in Wales (CCW, 2014), with estimates that around two thirds of these are employed in the independent sector (UKHCA, 2015c). Most other data is for all care workers and is not available for domiciliary care workers specifically. In terms of profile, the social care workforce is largely female (80%), ageing (only 30% are aged 30 or under) and white (86%). The Care Council for Wales reports suggest that 90% of social care workers are on permanent contracts with an even split between full time and part time work, although domiciliary care workers are typically offered less stable employment arrangements (Rubery et al. 2015). Fourteen per cent of domiciliary care staff are reported as Welsh speakers (CCW, 2010). Recruitment, retention and development of care workers are identified as problematic across CCW reports (e.g. CCW, 2010). Local authorities provided data for the SCWDP reports and data collection difficulties mean figures in relation to qualifications, recruitment and retention should be treated with caution. However, qualification rates are relatively low (53% having a minimum Level 2 qualification) and turnover rates are relatively high (30%, UKHCA, 2015c). In 2013, this

led to the recruitment of 8,200 new care workers, with 1,100 vacant posts. There are relatively few new entrants to the social care sector, with domiciliary care workers tending to move around providers (CCW, 2014).

CCW also undertook a detailed research project entitled 'Care at Home', which profiled the current domiciliary care workforce, established a future vision for domiciliary care in Wales and devised actions to move the current workforce towards this vision (CCW, 2010). Workforce problems are identified as including: low pay and status, which reduces the extent to which domiciliary care workers feel valued and recognised as professionals, and an increasing need for different skill sets given the dynamic and multi-faceted nature of domiciliary care, meaning there are skill deficits/training needs and confusion and ambiguity regarding career pathways and qualifications. Taken together, these pressures and difficulties lead to problems in recruitment and retention and provision of sustainable high quality care (CCW, 2010).

Recruitment and retention are particularly important given the growing demand for social care and consequently social care labour. The ageing population means over a quarter of the population in Wales is aged 50 plus. Those aged over 65 are expected to increase from around 600,000 in 2013 to 900,000 in 2037 and the number of over 85s is growing at an even faster rate (Age Cymru, 2015). Wales also has a higher proportion of people aged 85 plus compared to the rest of the UK (StatsWales, 2012). While we have not been able to locate projections for growth in domiciliary care labour demand in Wales, similar patterns in England have informed projected increases of over 30% in the total adult social care workforce (CfWI, 2011). Even here, however, the pace of change is so rapid these forecasts are now out-of-date and new scenario planning is required to recalculate them (SfC, 2015). The recent CfWI (2015) report evidences, however, that

demand for social care labour is increasing faster than population growth and that growth in demand for lower levels skills, those typically associated with care work, is set to outstrip growth in demand for all other skill levels. Growth in labour demand is, therefore, an important issue for Welsh domiciliary care, even if precise forecasts are not currently available. Yet this growth may be accompanied by a shrinking labour supply. The care workforce, including domiciliary care, has an ageing profile (CCW, 2014): over a quarter are aged over 50 and over a half are aged over 40. This creates the potential for over a quarter of the workforce to exit the labour market over the next 10-15 years. There may also be a reduction of those wishing to enter social care as school leavers, especially women, become more highly educated and there is greater competition from other sectors, such as retail (Atkinson and Lucas, 2013b). Demographic and labour market trends could, in combination, have substantial implications for the domiciliary care workforce and in turn domiciliary care delivery.

## 1.4    Employment Practice and Care Quality

Before proceeding to detailed consideration of employment practice, we first present in overview the theoretical base that explains why and how employment practice/care quality relationships exist. This understanding is central to any consideration of policy interventions which aim to improve care quality by positively influencing the recruitment and retention of domiciliary care workers.

Strategic Human Resource Management (SHRM) generates understanding of the relationship between employment practice and performance outcomes, here defined as both recruitment and retention and care quality (Guest, 2011). We have adopted the term employment practice, although SHRM often uses the term human resource (HR) practice, to describe practices which design and deliver terms and conditions of employment and career structures. Traditionally,

bureaucratic employment practice focuses on routine administration of, for example, pay and is neither intended nor expected to substantially improve performance outcomes (Godard, 2010). Progressive practices, as advocated over recent decades by SHRM theorists, however, are intended to benefit both worker and organisation, a so-called mutual gains approach (Kochan and Osterman, 1994). An example is training and development, whereby workers increase their skills and perhaps qualifications, enhancing their 'human capital', and service providers benefit from a higher level of performance in terms of care delivery.

Grouping practices into 'bundles' has synergistic effects, so ensuring workers are, for example, well-paid, well-trained and have a good work-life balance has mutually reinforcing beneficial effects (Boxall and Macky, 2009). While there is ongoing debate as to which practices to include in a bundle, typical practices include fair pay and reward, adequate training and development, rigorous recruitment and selection and appropriate performance management/appraisal (Marchington and Grugulis, 2000). Other themes encompass the need for employee involvement and consultation, a focus on team working and self-managed teams and a reduction of status differentials between workers and management (Pfeffer, 1998). Flexible working has also more recently been identified as an important practice (Atkinson and Hall, 2011). Performance gains are achieved by implementing practice that positively influences worker attitudes and behaviours. A key aspect of this is worker perceptions of management's reasons for offering the practice (Nishii et al., 2008). For example, if workers believe they are offered flexible working to support them in balancing their work/life commitments, rather than as a mechanism intended for organisational benefit, they are likely to feel more motivated and have higher levels of job satisfaction. This in turn encourages discretionary effort, that is, workers going beyond the minimum expectations upon them and delivering higher performance (Purcell et al., 2003). This is referred to

as the 'causal chain' between employment practice and performance (Purcell and Hutchinson, 2007).

There is a wide body of literature that demonstrates the beneficial performance effects of progressive employment practice in high-skilled sectors (Batt, 2002), although less evidence of their effectiveness in lower-skilled sectors such as adult social care. In jobs that are routine and unrewarding, it is more challenging to develop stimulating environments for workers (Berg and Frost, 2005). As we note above, however, social care may not deserve its low-skilled label. Indeed, Gospel and Lewis (2011: p.606) argue the Care Standards Act 2000, which applied in Wales until the recent passing of the Regulation and Inspection of Social Care (Wales) Act, is premised upon SHRM:

'One way of conceptualizing the "whole systems" approach introduced by the 2000 Act, therefore, is as an attempt to establish in the social care sector a high-skills equilibrium, in which a well-trained workforce is managed by means of a complementary set of HR practices so as to deliver high-quality care.'

This approach continues in recent UK policy documents, for example, the ministerial foreword to the recent Skills for Care/Department of Health Adult Social Care Workforce recruitment and retention strategy states:

'Effective recruitment and retention of a caring and skilled adult social care workforce has a central role to play in delivering high quality care and support to people who need it. Our challenge is to ensure the workforce has the right number of people, with the right skills, knowledge and behaviours to deliver the quality, compassionate care we all deserve.' (SfC, 2014, p.3)

Skill development for care workers is thus an important agenda underpinned by policy and regulation. Complementary practice (such as pay, employment security and working time) is, also, however important and, as noted above, is not regulated in a workforce

employed in the independent sector. Gospel and Lewis's (2011) 'whole system' approach may be somewhat questionable where only certain employment practices are regulated. Philpott (2014), for example, argues that availability of low-skilled employees and public sector financial constraints set the context for pay and conditions for care workers. Job quality is typically measured in terms of development and advancement opportunities, for example higher level skills, and pay levels (Lindsay, 2005) and jobs in care work are categorised as low quality, given low skill and pay levels. Philpott (2014) provides evidence that employment, and specifically development practices, can nevertheless increase productivity, improve performance, lower absenteeism and reduce labour turnover costs and thus offer a financial return for employers in low-skilled sectors. Cooke and Bartram (2015) suggest employment practices that have the interests of the care workers at heart will likely have a positive impact for all stakeholders. They call for more cross-sectoral and cross-country comparative studies of employment practice in care work, in order to further understand how policy orientations, institutional arrangements, social norms and cultural traditions influence care regimes and quality. Heavey et al. (2013: p.136) suggest 'HR impacts firm performance, but we cannot conclude by how much, in what cases, or for whom'. Further work is needed in exploring how practices can aid improvements, particularly for social care where many organisations are small and employment practice is often rudimentary (Rubery and Urwin, 2011).

As we note above, there is debate as to the likely effectiveness of sophisticated practice in low-skilled sectors. Rubery and Urwin (2011) argue basic protections are lacking for care workers and an appropriate bundle may differ to higher-skilled sectors. They argue for basic employment conditions such as guaranteed working hours, stable weekly income, payment for all time spent at work (including, for example, travel time and training time), a decent level of pay and pay progression in recognition of skills and experience. These are issues

that we explore in what follows, with the important addition of training, development and careers, given policy emphasis upon these.

Building on theory presented, in the two following sections we discuss in detail first employment practice and then performance outcomes, at worker, service provider and service user levels.

## 1.5    Employment Practice in Domiciliary Care

In line with the project brief, we have a particular focus here on domiciliary care worker employment terms and conditions, including career structures. We also include discussion of worker motivations and occupational status, as these are relevant to worker decisions on taking up and maintaining employment in the domiciliary care sector. Given the limited Welsh evidence base, we draw on wider research into adult social (residential and domiciliary) care research and also on research across the UK and from similar international contexts (for example, Zeytinoglu et al., 2015 in Canada , Palmer and Eveline, 2012 in Australia, and Eaton, 2000 in America). We establish the current broader state of knowledge to inform fieldwork within the Welsh domiciliary care sector.

**Workforce Development**

We start with discussion of workforce development, given policy emphasis in both the UK and Wales upon this. Within this, we consider training and qualifications, career development and supervision.

*Training and Qualifications*

Workforce policy places substantial emphasis upon skills development (Rainbird et al., 2011) and it is generally accepted the quality of care and care workers is influenced by training, skills and qualifications (Chen, 2014). In England, Gospel and Lewis (2011) found workforce

policy increased training and qualification activity, although it did not create wider sophisticated employment practice. In a recent Scottish survey, 77% of care workers indicated they were able to attend training of interest to them (IRISS, 2015). Other research, in contrast, suggests social care is one of the weakest sectors for training provision (Arnstein, 2015) and a recent survey indicated substantial numbers of UK care workers had not received proper training in dementia, administering medication or personal care tasks (Unison, 2015). Concerns have also been raised in respect of qualifications, both level and uptake (CCW, 2010). In Wales, a service provider must ensure at least half its workforce holds a minimum Level 2 relevant qualification; all care workers taking up a new role in social care must complete an induction training programme within 12 weeks; and apprenticeships are increasingly promoted as a skills development mechanism (Kingsmill, 2014). The Qualifications and Credit Framework Health and Social Care Diploma Level 2 (QCF2) qualification requirement (originally National Vocational Qualification Level 2, NVQ2) was embedded in the National Minimum Standards established by the Care Standards Act 2000. At the time of the 2000 Act, over 80% of the UK workforce held no relevant social care qualification (Gospel and Lewis, 2011). Progress towards the 50% target has been slow in England, where around 30% of the workforce hold the QCF2 qualification (Atkinson et al., 2015). SCWDP data (CCW, 2014, 2015b) presents a more optimistic picture, although the reports note the datasets were small and cannot be generalised with confidence. The reports suggest 50% of workers hold a QCF2 qualification; nearly a quarter (22%) of organisations had 30% or more of staff with QCF3 qualifications; and that the overall proportion of domiciliary care staff holding a required or recommended qualification was 48%, compared to 44% in 2007 (CCW, 2010). In general, uptake of qualifications is somewhat limited.

This is despite the Welsh Government promoting workforce development. It encourages service providers to gain Investors in

People (IP) recognition, a UK kite mark that benchmarks certain best practice training practices (Alberga et al., 1997), citing its benefits as helping organisations to:

'make the most of your people by giving you the means to develop a positive culture and getting employees fully engaged with the aims of your business. Achieving the award sends a powerful message about how much you value your people and the part they play in your shared success' (Welsh Government, 2015b)

The broader context is, however, problematic for workforce development. There have been recent reductions in government funding for those aged over 25 wishing to undertake QCF2 qualifications and apprenticeships (Jones, 2014) which will potentially further reduce their uptake. Reports have also suggested there are many poor quality apprenticeships, including in the care sector (Arnstein, 2015), which again undermines skills development. More generally, concerns have been raised about the vocational nature of the required QCF2 qualifications: these are based on assessing outcomes of practical skills rather than developing underpinning knowledge (Gospel, 2015), albeit the underpinning knowledge required has been somewhat increased. Outside Wales, it has been argued QCF2 is too low and that policy-makers have pitched this at what is achievable by the sector rather than what is required by the work (Cameron and Phillips, 2003). Recent research has found the UK position compares unfavourably to the higher level skill development offered to and required of care workers in other Northern European countries (Cameron and Boddy, 2006).

As we noted earlier, domiciliary care work in the UK is generally depicted as low-skilled and current qualification requirements risk reinforcing this perception. Yet domiciliary care involves a range of different types of support to service users including task-based physical care, emotional support and informational support (Taris et al., 2003,

CCW, 2010). The care worker role is thus diverse and includes responsibilities not captured by current regulation, given its narrow focus on instrumental tasks (CCW, 2009). The higher-level qualification requirements found in other countries may be more appropriate in that they capture the more diverse aspects of the role (Cameron and Boddy, 2006). They may also create higher professionalism and status within the sector (Rubery et al., 2011). While there have been calls for higher level social care skills/qualifications (Atkinson and Lucas, 2013a), it must be recognised that service providers' capacity to respond to these are constrained by policy, commissioning and labour market contexts. (Gospel, 2015).

*Career Development*

The positioning of care work as low-skilled limits career opportunities. While developing skills creates the capability to work at a higher level, this depends on the effective use of these skills by service providers. For example, undertaking QCF3 requires care workers to take on extra responsibilities, which they may be disinclined to do within the same role, and this may inhibit learning. Pay structures that support career progression are also required (Philpott, 2014) and are generally lacking (Grimshaw and Carroll, 2002, Lindsay, 2005) in a sector where pay is largely at the level of the National Minimum Wage (see following section). One study found those with QCF3 qualifications earn (slightly) more than those with QCF2 (Atkinson et al., 2015) but Gospel (2015) argues, although vocational qualifications in England offer the potential for career progression, hierarchies are flat and limited financial incentives attach to their achievement. This may have implications for the age at which workers enter the sector and the likelihood of their staying within it. This of course pre-supposes that substantial numbers of care workers seek career progression. As we explore in 'Worker Motivations', some care workers may have limited interest in career progression. In general, evidence is limited in respect of career progression. CCW (2010) acknowledge career pathways are not

clearly identified and other reports identify a need for career progression opportunities (e.g. Kingsmill, 2014) and apprenticeships to formalise career paths (Koehler, 2014).


*Supervision*

The domiciliary care NMS (Welsh Government, 2004) specify care workers should receive regular supervision and an annual appraisal of performance and that these are essential to the delivery of high quality care (Chen, 2014). While there is limited research in this area, recent evidence from a Scottish survey suggests over three quarters of care workers receive effective support and supervision (IRISS, 2015) and this is confirmed in other studies  (see, for example, Atkinson and Lucas, 2013b). Supervisory and managerial support, especially for new recruits, is critically important in creating a welcoming and supportive working environment (Yeandle et al., 2006) and creating genuine employee involvement in decision-making (Philpott, 2014). Supervision can, however, be problematic in the domiciliary care sector where there is a high incidence of lone working (SfC, 2010). Performance and appraisal systems that are too focused on monitoring and control can also have negative effects on workers (Philpott, 2014).


In summary, there is substantial emphasis on training and acquisition of qualifications for the domiciliary care workforce. As we have demonstrated here, however, across adult social care there is somewhat limited achievement of qualifications and lack of career progression. Philpott (2014) argues more action is needed to promote good quality jobs in social care and we suggest workforce development is central to this. Consideration may need to be given to whether qualification levels should be raised, creating a more professionalised role as in the Northern European model, to increase perceptions of job quality.

**Pay**

Here we consider hourly rates of pay, the implications of the proposed National Living Wage and provision of benefits to care workers.

*Hourly Pay*

CCW (2010) suggests domiciliary workers should be salaried where appropriate, yet the current situation appears to be some distance from this aspiration with most care workers being hourly paid and many, as we outline below, working on zero-hours contracts (Rubery et al., 2015). Bessa et al. (2013) present one of the most recent and detailed studies of pay in the English domiciliary care sector drawing on over 265,000 records in the National Minimum Dataset-Social Care (NMDS-SC). This indicates most care workers are paid at or around the National Minimum Wage (NMW) and indeed, in 2012, around 6% were paid less than NMW. This is supported by other wide-ranging reviews in the sector (see, for example, Kingsmill, 2014) and may relate to non-payment for travelling time. Case law has recently established that care workers should be paid for travel time (Unison, 2014) and this may result in smaller numbers falling below NMW levels of payment. Evidence continues to suggest, however, that domiciliary care workers across the UK routinely do not receive pay for travel time (UKHCA, 2015c).

Bessa et al. (2013) present pay analyses by domiciliary care worker groups in England. These indicate British workers are employed on higher hourly rates than non-British workers and, while there are no gender differences for pay in terms of hourly rates, male workers earn higher pay weekly than women due to numbers of hours worked. Older workers tended to have higher hourly rates than younger workers and statutory sector rates were also higher than those in the independent sector. Finally, they evidence 80% of those being paid at or below NMW are care workers and that fewer senior care workers are paid at

this level. This supports the evidence presented above that some, limited, pay/career structures exist (Atkinson et al., 2015).

While social care work pay rates have been historically low, they are also increasingly depressed by local authority commissioning rates (Cavendish, 2013). Service providers are often unhappy about the pay rates they offer and see these as detrimental to recruitment and retention (Bessa et al., 2013). This is particularly so when considering competition with other sectors, particularly retail where pay is often slightly higher for less demanding work (Grimshaw and Carroll, 2002) and the regulatory requirements on, for example, qualifications are lower (LPC, 2007). Recent ONS data (Kirton, 2015) shows that unemployment in Wales, at 6.4%, is now around pre-recession levels and that pay has performed relatively strongly in retail as opposed to the more constrained public and associated sectors. Social care pay rates risk falling further behind other competitor sectors.

Current social care regulation does not address pay. In the statutory sector, pay rates are determined by local authority terms and conditions, whereas they are determined by competitive pressures in the independent sector. This has contributed to the low pay rates discussed above. Lack of regulation in similar groups in the health care sector, e.g. health care assistants, has been argued to be problematic (e.g. Cox et al., 2008). In Bessa et al.'s (2013) study none of the English local authorities specified payment of the NMW in their contracts nor systematically monitored compliance. Carr (2014) argues there is a disconnect between care work and pay received. Although there is no conclusive evidence that pay increases incrementally increase care quality, research demonstrates its importance in making staff feel valued and offering progression (Atkinson and Lucas, 2013b).

*National Living Wage*

The introduction of the National Living Wage (NLW) from April 2016 will add further pressures to an already financially constrained sector. No financial projections are available for the Welsh domiciliary care sector but a recent report on the financial implications for English care homes suggests a substantial increase to wage bills (including National Insurance and pension contributions) (Ingham et al., 2015). While the specific impacts of NLW cannot be known at the time of writing, insights can be gleaned from the introduction of the NMW. It was widely claimed that local authorities did not increase their commissioning rates to reflect the uprating of NMW (LPC, 2007). While this had a negligible effect on statutory provision, it had substantial impact in the independent, particularly private, sector (LPC, 2000). Here, large numbers of care workers received pay rises, causing significant compression of the lower end of the wage distribution (Machin et al., 2003) with negative implications for career/pay progression. Firm profitability also significantly reduced as wages increased (Draca et al., 2007). Similar experiences are indicated with the introduction of NLW. Lewis (2015), for example, predicts substantial wage raises in labour intensive organisations, as in social care, where a large number of employees earn less than NLW. While Lewis (2015) suggests many firms will pass on increased costs, this will be problematic given social care commissioning processes and may lead to the alternative course of action, for example, reductions in headcount, which may create capacity deficits in care provision. Falling independent sector profitability may also lead to reductions in care provision in the absence of increased commissioning rates. Both would create difficulties for delivery of the hours of care required. As with the introduction of NMW (LPC, 2005), many local authorities will need to provide additional resources required if workers' wages are to rise in line with NLW. Indeed, Ingham et al. (2015) argue additional funds are required from central government and that revenue could be raised via increases in tax and National Insurance contributions. In November

2015, the British Government's spending review gave local authorities in England the power to apply a new 2% Council Tax precept for social care that could create an extra £2billion of revenue for the sector (HM Treasury, 2015).

*Benefits*

While many sectors provide financial benefits in addition to basic pay rates, funding constraints mean these are limited in the social care sector (Philpott, 2014) and research has consistently noted their absence (Atkinson and Lucas, 2013b, Grimshaw et al., 2015).

In summary, as Philpott (2014) notes, low-skilled work and public sector financial constraints set the context for pay in social care. He argues higher levels of funding and changes to current contracting models are required to drive up pay and conditions and, ultimately, care quality. The introduction of NLW from April 2016 will bring these issues centre stage.

**Employment Security**

Employment security is an essential component of an effective HR system (Pfeffer, 1998, Rubery et al., 2015). Above we note high levels of permanent employment across the whole social care sector. Yet domiciliary care is dominated by non-standard employment relationships, with limited security (Rubery and Urwin, 2011) and characterised by high levels of temporary and casual work  (Barnard et al., 2004). Zero-hours contracts are particularly prevalent in both Wales (Burrowes, 2015) and more widely. Burrowes (2015) notes zero-hours contracts are not well defined but generally refer to contractual arrangements where the employer is not obliged to offer and worker is not obliged to accept hours of work. Alakeson and D'arcy (2014: 9) note:

'in the domiciliary care part of the sector, zero-hours contracts have become standard and predate the current period of austerity'.

Unison (2013) found 56% of domiciliary care workers in the independent sector are employed on zero-hour contracts compared to 22% in the public sector. Bessa et al. (2013) provide even higher figures, suggesting 80% of private sector domiciliary care workers are on these contracts and Rubery et al. (2011) indicate the figure is 70% for the independent sector. While no specific figures are available for Wales, other analyses call these reports into question. For example, a recent Scottish survey suggests that only 2% of care workers are on zero-hours contracts (IRISS, 2015) and an analysis of the English National Minimum Dataset-Social Care also indicates their low usage (Atkinson et al., 2015). These figures are, however, likely to be under-reporting and reflect the fact that many workers do not realise they are on zero-hours contracts (Burrowes, 2015) as they often work long hours despite insecure contracts (Rubery et al., 2011, CIPD, 2013).

Zero-hours contracts reinforce other problematic employment trends in the sector. For example, they are often, though not exclusively, used for lower-skilled roles (CIPD, 2013) and are associated with insecurity and lower pay than for workers with fixed contractual hours (Bessa et al., 2013). While typically adopted for employer benefit, workers can also refuse hours of work offered creating difficulty for service provision. These issues in combination can create substantial variation in working patterns, making it more likely domiciliary care workers will not visit the same service users and thus disrupting continuity of care (Unison, 2013). Despite these inherent difficulties, usage of zero-hours contracts appears to be an increasing trend (CIPD, 2013) and results again from commissioning practice which is moving away from guaranteed volume and increasing instability for service providers (Bessa et al., 2013). Burrowes' (2015) call for social responsibility

clauses in local authority/service provider contracts appears to be timely.

**Working Time**

The arrangement of working time is important for both service providers and care workers. Time can be organised for worker benefit, for example, term-time only or compressed working week contracts or for organisational benefit, for example, casual and temporary contracts (Atkinson and Sandiford, 2015). Arrangements can also address a coincidence of need (Atkinson and Lucas, 2013b) and indeed a recent study suggests that about 60% of independent domiciliary care service providers try to fit their rotas around worker needs (Rubery et al., 2015). Most employers emphasise the importance of flexible working arrangements and of offering part-time positions (Yeandle et al., 2006). Yet divergences between contractual hours and actual working hours are growing (Bessa et al., 2013), perhaps as a result of fewer workers and increasing workloads, with nearly two thirds of the 2,000 care staff who participated in a recent Scottish study indicating they work extra hours each week (IRISS, 2015). Indeed, opt out of the Working Time Regulations (WTR) limit on working hours is common in the sector (Rubery et al., 2015). The domiciliary care sector is thus characterised by a poor work/home equilibrium (Rubery and Urwin, 2011). Lone working is also a substantial issue for domiciliary care workers, particularly in the independent sector, and can again link to issues of poor morale or work intensification (SfC, 2010).

Rubery et al. (2015) have recently presented one of the most detailed studies to date of the role of time in the management of domiciliary care work for older adults in England and its consequences for employment conditions of workers in the independent sector. They argue insufficient attention has been paid to working time, particularly where fragmented time systems apply, as in domiciliary care, where

strict work scheduling is used to focus paid work hours at times of high demand and where periods in between are neither rewarded nor recognised. Paid hours are restricted to face-to-face contact time, meaning (until recently) no pay for travel time or other work related tasks and this creates insecurities and demands high work engagement. They demonstrate these time management practices derive from strict time-based local authority commissioning. Employment practice is again inextricably, but problematically, linked to wider contextual influences.

**Worker Motivations**

In this and the following section, we consider worker motivations and occupational status. While not employment practice, they are central to the understanding of care worker responses to these practices and thus important for the later discussion of recruitment and retention (Carr, 2014). Care worker motivations are well-documented and depict care work as a vocation. For example, one study suggests workers enter the care sector to help others, because they like care work and because of the working time flexibility (McClimont and Grove, 2004). Career progression rarely appears as a worker motivation (Atkinson and Lucas, 2013b). Other motivations include enjoying working with people (SfC, 2007) and, from a recent survey of Scottish care workers, feeling good about getting positive outcomes for service users (70%), getting positive feedback from them (64%), being driven by desire to make a difference (75%) and having work that matches personal values (54%) (IRISS, 2015). The same survey indicated, however, that care workers feel under-valued by low pay and poor terms and conditions of employment, despite which nearly 80% were happy in their jobs.

Evidence generally suggests that many care workers remain in the sector as a result of their commitment to service users (Carr, 2014) and

the intrinsic nature of the work (Blankertz and Robinson, 1997). This supports a view of care work as vocational but tends also to position it as women's work, particularly for older women who have cared for children or older relatives (Atkinson and Lucas, 2013a). This gendered perspective positions care work as low-skilled and sustains low pay in the sector (Palmer and Eveline, 2012). The need to attract younger workers into the sector and indeed to increase skill levels may make reliance upon those with traditional motivations problematic in generating an adequate supply of labour.

**Occupational Status**

As we have already noted, care work is considered to be poor quality when assessed against traditional measures of qualifications and pay (Lindsay, 2005). It is low-status as a result of both low skills and low pay (Koehler, 2014)  and also the nature of the work, often termed 'dirty work' (Bolton, 2005) in which workers offer care of a personal and often intimate nature. This is reflected in the domiciliary care workforce in Wales who reported feeling undervalued and low in status (CCW, 2010). Low status is compounded the highly gendered nature of the workforce: it is female dominated and one of the most highly gendered occupations (Carroll et al., 2009), a fact often overlooked by policy (Atkinson and Lucas, 2013a). Care work is seen as natural for (particularly mature) women (Bolton, 2005) who are often seen as 'housewifely', with relevant experience and personal qualities but typically few qualifications (Boddy et al., 2006b). Indeed, the social care workforce is aging, with slightly more older and slightly few younger workers than the workforce in general (Franklin, 2014).The perception of care as 'women's work' may create greater demand from service users for female care workers, but serves to reinforce the low-status nature of the occupation.

Care work does not, however, fit a standard classification of routine work: a focus on tangible aspects of skill, such as certified knowledge, training, accredited qualifications and career progression, misses the relational, or interpersonal, features of the job (Eaton, 2000). These relational aspects offer opportunities to exercise discretion and autonomy, particularly in domiciliary care where workers work independently and largely unsupervised (Rubery and Urwin, 2011). Indeed, domiciliary workers recognise the highly responsible and skilled nature of their role (Atkinson and Lucas, 2013a). Yet paradoxically relational care draws on so called 'soft' skills (Lloyd and Payne, 2009) and the value of these depends upon who exercises them (Grugulis and Vincent, 2009). When it is women they often go unrecognised (Himmelweit, 2007), particularly given their gendered nature and close identification with mothering (Ungerson, 2000). While vocational qualifications which accredit task-based skills may offer a partial solution, they address neither gendered perceptions nor relational skills. Higher-level qualifications which recognise and value these skills may be required (Cameron and Boddy, 2006).

In this section, we have outlined employment terms and conditions, including career structures, together with worker motivations and occupational status. While worker motivations are often positive, we have detailed the low-skilled, low-status perceptions of the care worker occupation and demonstrated that employment practice is often problematic in the sector. We move on now to discuss the implications of this for recruitment, retention and domiciliary care quality.

## 1.6 Employment Practice: Implications for Job Satisfaction, Recruitment, Retention and Care Quality

Here we explore relationships between employment terms and conditions and career structures and performance outcomes at the care worker, service provider and service user level. This is clearly

supported by research in the care sector. Kingsmill (2014, p.9), for example, notes that:

'poor working conditions often go hand in hand with poor quality of care'.

These operate in combination with policy, commissioning and labour market contexts to influence domiciliary care quality (Rubery et al., 2011). Having so far considered context and employment practice in some detail, we now turn to care quality. In line with theory, we follow a 'causal chain' (Purcell and Hutchinson, 2007) from worker performance in terms of attitudes and behaviours through to service provider level concerns of recruitment and retention and finally to service user perceptions of care quality. To underpin this, we first establish our definition of care quality.


**Defining Care Quality**

There are many definitions of performance, both generally and in social care. Here we consider performance in terms of care quality and summarise important factors in the domiciliary care context. We are consistent with wider research that considers the inter-related nature of employment practices and their impact on workers, service providers and service users. Measures of care quality can be both objective, such as labour turnover, or subjective, such as worker attitudes or service user perceptions (Marchington and Zagelmeyer, 2005). Both have merits and disadvantages and reflect the complexity of seeking to establish levels of care quality (see, for example, West et al., 2002 who measured performance based on morbidity rates and then suggested more appropriate measures might address procedures, practices and perceptions/experiences rather than particular outcomes).


We combine both process and outcomes in our definition. Outcomes reflect service user perceptions that care quality constitutes: *change*

outcomes (such as improvements in physical, mental and emotional functioning), *maintenance* outcomes (prevention of or delay in deterioration in health, wellbeing and quality of life) and *process* outcomes (that the process of care makes service users feel valued and respected) (Qureshi and McNay, 2011). While this reflects policy approaches, process outcomes are also important here as service user satisfaction often centres on the care workforce and how they are managed, trained and treated (Glendinning et al., 2008). Recognising that care quality is determined by the assessment criteria adopted (Marescaux et al., 2012), we consider multiple stakeholder views. Consistent with employment practice/performance theory, we integrate perspectives on care quality of three levels of stakeholder as identified by Lucas et al. (2009), namely:

- improved experiences for workers
- improved outcomes for service providers
- improved care for the service users.

We now consider each of these stakeholder groups in turn.

**Care Workers: Job Satisfaction and Discretionary Effort**

Here we discuss the extent to which employment practice creates the conditions for positive attitudes and behaviours and, thus, for effective performance (Purcell and Hutchinson, 2007). We focus in particular on job satisfaction, as this is frequently reported in existing research. Other attitudes, for example, motivation, commitment and happiness, are also important but their detailed examination is beyond the scope of this report. Links between job satisfaction and care quality are widely reported (Avgar et al., 2011) and its adoption is appropriate here.

*Job Satisfaction*

As we note in 'Worker Motivations', workers often undertake care work as they feel they can make a difference and this leads to high job

satisfaction (SfC, 2007). As we also discussed, understanding of the worker motivation/employment practice nexus in relation to job satisfaction is complex. Employment practice certainly has an important role. Pay and skill/career development have both been demonstrated to enhance job satisfaction in social care (Chen, 2014), as has stable employment and the provision of financial benefits beyond pay (Philpott, 2014). Informal practices which accommodate working time preferences can also reinforce positive attitudes (Rubery et al., 2015). However, social care research typically reports the failure of employment practice to increase job satisfaction. Cooke and Bartram (2015), for example, evidence that care reform and associated employment practice have reduced job satisfaction, particularly as care workers have no control over care reforms. Bessa et al.'s (2013) research demonstrates low pay is problematic for worker attitudes and Chen (2014) reports that poor training and low pay lead to job dissatisfaction and that this is higher in the UK than in other international contexts. There is, however, little research that links job satisfaction and careers for care workers. Employment terms and conditions are thus largely evaluated in terms of their detrimental impact on the quality of work life (Rubery et al., 2015). While the job satisfaction derived from an intrinsic motivation to care may to an extent buffer the detriment of these extrinsic factors, this is heavily dependent upon individual motivations for engaging in social care (King et al., 2013). Dissatisfaction from extrinsic factors may still be reported by care workers and, where employment practice works against intrinsic motivations, for example, failing to provide sufficient time to deliver adequate care, the potential for job dissatisfaction is high (Atkinson and Lucas, 2013b).

*Discretionary Effort*

Job satisfaction typically generates discretionary effort or 'goodwill' which leads to workers going beyond the minimum required of the job (Purcell and Hutchinson, 2007). In care work, this might involve going

beyond the requirements of the care plan to address wider service user needs. While this is theoretically positioned as beneficial for both workers and service providers, the combination of worker motivations and employment practice that drives care worker job satisfaction generates particular tensions. For example, such discretionary effort is often expected and yet not valued by service providers (Cooke and Bartram, 2015). Combined with an intrinsic motivation to deliver high quality care, these same authors demonstrate employment practice reforms, such as zero-hour contracts, and associated challenging working conditions have led to reduced job quality and work intensification. This has in turn created significant, and rising levels, of stress and burnout across social care (Taris et al., 2003) and work-related stress is higher in English social care employees than other international contexts (Chen, 2014). Non-standard working hours and zero-hours contracts are key factors in high levels of work-related stress in domiciliary care workers (Zeytinoglu et al., 2015). These authors also found the reduction in the number of hours of services available for service users (i.e. shorter visits, see context section for Welsh data) brought about the need for domiciliary care workers to work at a faster pace, something that increased their perceptions of high demands being placed on them. This, in turn, impacted upon their perceptions about their ability to cope with such demands, which is a critical factor in the development of work-related stress outcomes (HSE, 2010). Zeytinoglu et al. (2015) also established direct relationships between perceptions of job insecurities/non-standard hours and the worsening of physical health, which has the potential to increase absence levels. Stress can eventually lead to burnout, which is characterised by emotional exhaustion, a low sense of personal accomplishment and a detached attitude (depersonalisation) (Leiter and Maslach, 1998).

In summary, high intrinsic worker motivations may buffer the job dissatisfaction resulting from poor employment terms and conditions.

Research demonstrates, nevertheless, that stress and burnout are increasing (Taris et al., 2003, Zeytinoglu et al., 2015) which is likely to be associated with increased depersonalisation, sickness absence and intention to or actual quitting (Taris et al., 2003). All have negative implications from both service provider and service user perspectives, as we now go on to discuss.

**Service Providers: Recruitment and Retention**

Our concern here is recruitment and retention, though as we acknowledge above, many other performance measures exist (Van de Voorde et al., 2012). Recruitment and retention occur close to the application of employment practice and are influenced by the worker attitudes brought about by these practices. As such, they are proximal indicators of performance (here, care quality) (Guest et al., 2003). Working conditions and organisational culture are essential in ensuring low-paid staff feel valued and satisfied and that recruitment and retention of staff is maximised and continuity of care is maintained (Carr, 2014). Yet there is abundant evidence that recruitment and retention is negatively impacted by, for example, low wages, poor working conditions and low job status (Rubery and Urwin, 2011, Carr, 2014, Hussein, 2014, Rubery et al., 2015). Problematic employment practice underpins the crisis of recruitment and retention that social care has been facing for many years (Boddy et al., 2006a, Barnard et al., 2004) but which is ongoing and unresolved (Burrowes, 2015, Rubery et al., 2015). Recruitment and retention figures for Wales are difficult to specify with precision, although the CCW (2015) report evidences turnover rates in domiciliary care of around 32% in 2014. Other research also puts labour turnover at around 30% (UKHCA, 2015c). This reflects turnover rates in England of around 20% across the whole workforce and 30% in recent recruits (Rubery et al., 2011, Franklin, 2014). Difficulties in recruiting to vacant posts and in retaining existing staff creates difficulties for care delivery and continuity and we now discuss these in more detail.

*Recruitment*

Here we focus on recruitment as a mechanism to generate an adequate pool of labour, rather than more detailed processes for selecting from that pool. Difficulties of both recruiting enough workers and workers of 'the right calibre' is an increasing problem (Francis and Netten, 2004, p.299). A dominance of smaller firms in the sector means a reliance on informal methods, often word of mouth  (Rubery et al., 2011) which contributes to problems in generating applications of the right quality and quantity and results, in England, in a low-skilled, untrained workforce (Chen, 2014).

Employment terms and conditions are also widely evidenced to deter entry into the social care sector. The top four recruitment difficulties in domiciliary care are (overwhelmingly) pay, the nature of care work, local labour market competition (e.g. retail) and travel costs (where workers are unpaid for these) (Rubery et al., 2011). Zero-hours contracts may also deter entry (Burrowes, 2015), as do working patterns that are fragmented and create a poor work-life balance (Rubery et al., 2015). Evening/weekend worker shortages are, for example, particularly acute in domiciliary care (Rubery and Urwin, 2011). Career structures are rarely cited as creating retention difficulties. Low status has long been acknowledged as problematic in attracting entrants to the sector, although plans for mandatory registration on domiciliary care workers in Wales (see context section) may ameliorate this.

An emerging (and somewhat anecdotal) barrier to recruitment is the sector's poor reputation. Prominent care scandals and ongoing care quality problems (Welsh Government, 2015a), both generally and in domiciliary care, have attracted high profile media attention (Williams, 2013; Watt, 2015; ITV, 2015) and serve to create a perception of a sector beset with poor practice. Further investigation is needed but this

is increasingly suggested to deter entrants. Labour shortages are clearly problematic for the delivery of high quality care and have led to suggestions that a new pool of skilled workers is required, options being immigrant or international recruitment and targeting groups such as young people, disadvantaged groups and those re-entering the labour market (Chen, 2014). Rubery et al. (2015), however, conclude that labour shortages will continue if workers are expected to accept fragmented shift patterns, work more hours than they are paid for and at pay rates around the NMW. In earlier work, these authors have called for a return to standard employment relationships in the care sector (Rubery and Urwin, 2011).

*Retention*

Employment terms and conditions also have an important role in worker retention (Patmore and McNulty, 2005). Generally, the offer of training reduces labour turnover (Avgar et al., 2011, Selden et al., 2013, CfWI, 2011), while accommodating individual's working time preferences can retain staff (Rubery et al., 2015). Low pay, however, is central to high turnover levels (Cavendish, 2013). This perhaps helps to explain why turnover is higher in domiciliary care than residential care, which offers better pay and (often) more convenient working times (see Rubery et al., 2011 for details). Leavers also often move to the statutory sector which offers better terms and conditions (Yeandle et al., 2006). Equally, issues of job satisfaction and discretionary effort are important and working practices that do not offer time to care properly are more likely to force workers out of the sector than pay (Atkinson and Lucas, 2013b), which is also true for burnout (Blankertz and Robinson, 1997). Poor quality care jobs can thus both exacerbate recruitment and retention difficulties and constrain high quality care delivery. Good quality care jobs can improve care quality *and* job satisfaction, which is essential to improved recruitment and retention (Rubery et al., 2011).

In summary, despite an overall lack of social care research (Cooke and Bartram, 2015), the evidence indicates that recruitment and retention can be improved by enhancing quality of working life, improving terms and conditions and improving job satisfaction (Chen, 2014). Effective leadership and management are also vital in providing the supervision and support workers need (Cooke and Bartram, 2015). These will only be effective in delivering an adequate workforce, however, if supported by commissioning practices (Chen, 2014). Rubery et al. (2015), for example, argue that service providers' capacity to address employment terms and conditions is constrained by their limited power in the local authority commissioning process. There are substantial barriers to service providers adopting employment practices that benefit care workers and are likely to have a positive impact for all stakeholders (Cooke and Bartram, 2015).

## Service Users: Care Quality

Here we draw first on research that examines service user perspectives as the most important source of what constitutes good quality care (Bee et al., 2008). We then move on to consider the implications of employment practice upon what we define as good care. We build on research by Iparraguirre and Ma (2015), which posits that measures of care quality should centre on self-reported quality of life from the perspective of the service user, and Shankar et al. (2013) who argue for the importance of service user centred care. Care process approaches typically view the relationship between service user and care worker as central to its success and, as we have argued earlier, the process of care is as important as the outcome itself (Beresford, 2008).

We use Francis and Netten's (2004) definition of good care from a UK domiciliary care study which indicates that good care comprises six elements:

1. Reliability: care workers arrive on time and keep scheduled appointments. This supports service user control and enables planning for their own daily schedule appropriate to their needs.
2. Continuity: receiving care by the same care worker(s) during the whole period care is received so both the care workers and service user establish familiarity, trust, rapport, understanding and knowledge of needs.
3. Flexibility: service users can ask for help with tasks beyond those stated on their care plan and an understanding that needs shift and change.
4. Communication: linked to both reliability and continuity, this includes informing service users about planned care visits and ensuring regular communication about changes or potential changes.
5. Staff Attitudes: one of the most important indicators of care quality to service users, positive staff attitudes include: respect, cheerfulness, friendliness and understanding.
6. Skills and Knowledge: demonstrable skills and knowledge are important to service users leading to development of trust in care workers' abilities.

This reflects other respected studies which define good care from a service user perspective as including, for example, the amount of contact time/length of visit and the perceived enthusiasm or motivation of care workers (Bee et al., 2008). Links between employment practice, recruitment and retention and ultimate care quality can be difficult to establish, although one study has done so using an analysis of an English social care dataset and objective Care Quality Commission (the English equivalent of the CSSIW) measures of quality (Atkinson et al., 2015). Bee et al. (2008) also suggest service users are aware of the organisational factors impacting on care quality and cite issues such as staff sickness, high staff turnover and a reliance on agency staff as factors that bring about detrimental outcomes. Such concerns are reflected in a recent English study where 5 of 9 older people

interviewed stated the care they received was sometimes inadequate and poor (Chen, 2014). Here we draw on the evidence base presented so far to infer how employment practice and recruitment and retention may influence care quality defined in this way.

Broadly, recruitment and retention difficulties are clearly problematic for many of these six elements. Reliability, continuity and skills and knowledge, for example, will all be detrimentally affected by staff shortages, poor retention and the low-skilled workforce that results from high turnover, which precludes the opportunity to complete training and qualifications. Taking reliability and continuity in a little more detail, two of the most important factors in determining care quality (Bee et al., 2008, Francis and Netten, 2004), practices such as zero-hours contracts are problematic as they increase the likelihood that domiciliary care workers will not visit the same service users (Burrowes, 2015, Unison, 2013). Labour turnover (lack of continuity) has also been shown to be related to higher service user deaths (Franklin, 2014). Time pressures also work against flexibility, as care workers have tightly prescribed visit slots which precludes delivery of tasks beyond those specified on the care plan (Francis and Netten, 2004). This may also mitigate against person-centre care; in a recent Scottish survey for example 85% of participants felt able to offer person-centred care but felt that this had not improved in the past year (IRISS, 2015). Yet person-centred care is linked to perceptions of high quality (Carr, 2008) and high quality care workers will be more easily attracted and retained by a service which facilitates creative and personalised care (Fitzgerald and Chandler, 2006). Taking also attitudes, skills and knowledge in more detail, Francis and Netton (2004) demonstrate service users are most influenced here by 'soft skills', that is, their caring motivations, rather than qualifications. Further, knowledge was described in terms of how much time care workers took to understand the individual and their needs. This is perhaps at odds with the vocational qualification led approach to
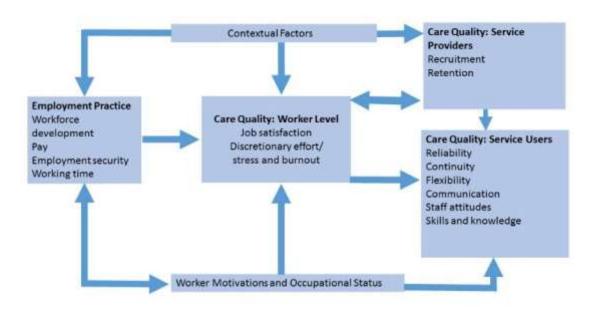
knowledge and skills in the sector. While it risks reinforcing the notion of a low-skilled sector, it does suggest a need to conceptualise workforce development in a somewhat different way to how it is currently understood.

In summary, in this section we have outlined the implications of employment practice for worker job satisfaction and discretionary effort, service provider recruitment and retention and service user perceptions of care quality. We demonstrate employment practice has negative implications for all these outcomes and that it is inextricably linked to the wider policy, commissioning and labour market contexts.

## 1.3    Conclusions from the literature review

The evidence reviewed above has informed the development of a conceptual framework (Figure 1) that underpins the data collection stage of the project. The framework outlines the inter-relationships of contextual factors, worker motivations and occupational status and employment practice in influencing performance in domiciliary care at three levels: job satisfaction and discretionary effort for care workers, recruitment and retention for service providers and care quality for service users.

**Figure 1 (repeated): Conceptual Framework: Recruitment and Retention of Domiciliary Care Workers and Care Quality**



The employment practices included are fairly rudimentary, which is informed by current research that argues sophisticated practice may not be applied in social care (Rubery et al., 2011). Nevertheless, well-established relationships are found between these practices and both job satisfaction and discretionary effort and consequently recruitment and retention. Our review suggests employment practice is generally problematic in social care with low skills and limited career progression, low pay, insecure employment and fragmented working time. Low status and negative media representations of domiciliary care work are also problematic. We demonstrate worker motivations for undertaking domiciliary care, such as wanting to make a difference, can buffer the effect of poor employment terms and conditions. While this may mitigate their negative impact to some extent, it may also create a situation in which stress and burnout increase.

Multiple perspectives are required to demonstrate the negative implications of employment practice for both recruitment and retention,

at service provider level, and care quality, at service user level. Context-specific matters such as policy, commissioning and labour market trends should be built into consideration of the impacts of employment practice and recruitment and retention on care quality. Both are contained in the conceptual framework established in this literature review. The review lends support to Cooke and Bartram (2015) who call for more research in social care arguing it is a complex sector comprising many small organisations, often with rudimentary HR systems (Rubery et al., 2013). Better understanding is required of the substantial challenges brought about by care reform programs that have reduced job quality and satisfaction and increased work intensification, stress and burnout.

## 2. Methodology

Here we outline the design and delivery of the two project phases, first, conduct of the literature review and, second, data collection processes.

### 2.1 Phase one: Literature review

We conducted a systematic literature review which started by establishing search terms to address the research aims and objectives (Table 1). We performed a detailed literature search of academic, practitioner and policy publications through the university and external library databases, including; EBSCO, Emerald, Sage Journals Online, Science Direct, Social Care online and PsycInfo. We also used our existing database from earlier projects and considerably extended this to include: recent general literature; literature specific to domiciliary care; and literature in the Welsh context. First, we searched singularly for all of the search terms in column A (context), followed by each of those terms with each combination from column B (topic) and C (stakeholder/geography/ sector). For example, one iteration of a search would be 'Adult Social Care (A) + Human Resource Management (B) + Commissioning (C)'. Each of these combinations for all of the search terms was conducted.

**Table 1: Literature Search Terms and Criteria**

| Search Criteria Term: | Search Criteria Term: | Search Criteria Term: |
|---|---|---|
| Adult Social Care | Human Resource Mgmt | Employee |
| Domiciliary Care | Strategic HRM | Organisation |
| Home Care | High Performance Work | Employer |
| Elderly Care | Recruitment | Care Worker |
| Social Care | Retention | Service User |
| Care Quality | Working Conditions | Carer |
| Care Standards | Employment terms | Wales |
|  | Skills | Sector |
|  | Low Skilled | Private Sector |
|  | Pay | Statutory Sector/Local Authority |
|  | Low Pay | Voluntary/Charity Sector |
|  | Qualifications |  |
|  | Training |  |
|  | Development |  |
|  | Performance |  |
|  | Contract type |  |
|  | Zero-hours |  |
|  | Career |  |
|  | Stress and Burnout |  |
|  | Productivity |  |
|  | Flexibility |  |
|  | Diversity |  |
|  | Regulation |  |
|  | Commissioning |  |
|  | Funding |  |

We recorded the literature search results in an Excel database which was constructed to include a number of categories including full publication title and reference and categorisation in terms of type of publication (academic journal article, policy report, etc). Relevant search terms were included as 'key words' as was categorisation of publication. In addition to the search terms used in the initial search,

we conducted a snowball search utilising the reference lists from relevant returned publications to source additional literature. Based on our existing knowledge of returned publications and reading publication abstracts, we included/excluded publications on the basis of both relevance and rigour. We did not apply a date filter but most publications were from the period 2000-2015. A total of approximately 140 publications were included in the final database. Based on this, we mapped a conceptual framework which formed the structure of the literature review and informed subsequent data collection and analysis (see Figure 1 in Section 1).

## 2.2　Phase two: Data collection and analysis

Qualitative methods were adopted as they offer a flexible approach to understanding, creating rich data and new insights into little understood issues. A series of focus groups and one to one interviews (both face to face and telephone) were conducted with local authority commissioners, registered managers of domiciliary care service providers and domiciliary care workers. Thematic analysis was undertaken. Service users are beyond the scope of the project and their perspectives are reflected through inclusion of existing research.

*Recruitment of Participants*

CCW provided us with a contact database of 22 local authority training managers and this created our first point of contact for participant recruitment. CCW provided a small number of other contacts including associated/allied organisations that had expressed an interest in the research. We drafted email invitations in English and Welsh that explained the study aims and scope and sent these to local authority training managers and other contacts. From response to email invitations, we arranged seven commissioner telephone interviews and eight focus groups across Wales, four for registered

managers and four for care workers. Where possible, focus groups were conducted as part of existing planned events (for example, provider forums) and were otherwise arranged as stand-alone events. Care worker participation in focus groups was incentivised by a £20 high street voucher. Data collection was a partially iterative process where following attendance at each focus group, we contacted providers and their associates in order to optimise participation and involvement. This resulted in additional individual telephone interviews with managers, commissioners and care workers. We also attended three CSSIW-arranged workshops at which commissioners and registered managers discussed and exchanged views on key challenges in domiciliary care.

*Participant Details*

Here we present details of the study's participants. The focus groups and interviews comprised 80 participants across Wales and of these 41 were domiciliary care workers, 32 were managers and seven were commissioners. The CSSIW workshops added a further 33 participants, 17 commissioners and 16 registered managers. There were 113 participants in total. Details of the local authorities represented by the commissioners who took part in telephone interviews are outlined in Table 2.

**Table 2: Local Authority Details**

|  | Proportion of dom care externally commissioned | Reasons for external commissioning | Plans to change | Type |
|---|---|---|---|---|
| LA1 | Less than 50% | Greater flexibility<br>Greater control<br>Reduced cost | Yes – externally commission more | Rural |
| LA2 | 90% | Greater flexibility | No | Urban |
| LA3 | 100% | Greater flexibility | No | Mixed |
| LA4 | Over 80% | Greater flexibility<br>Reduced cost | Increased focus on re-ablement | Urban |
| LA5 | Over 80% | Reduced cost | No | Rural |
| LA6 | 82% | Reduced cost | No | Mixed |
| LA7 | 70 % | Greater flexibility<br>Reduced cost | No | Mixed |

We gathered data from participants across Wales, though there was not an even distribution across its four regions as a result of ease of negotiating access. Registered managers were drawn from: the South West region (21, 66%); the South East region (4, 13%); the North region (3, 9%); the Mid region (2, 6%) and 2 (6%) were from an area not named for reasons of confidentiality. Care workers' geographical details are as follows: 23 (56%) were from the South West region; 9 (22%) from the South East; 4 (10%) from Mid Wales; and 5 (12%) from a confidential location (to protect participants' anonymity). We also gathered data from the local authority, private and voluntary sectors. We sampled 15 managers (47%) from the private sector, 9 (28%) from the voluntary sector, and 8 (25%) from the local authority/statutory sector. Our care worker population was comprised of 24 (59%) from the

private sector, 10 (24%) from the local authority/statutory sector, and 7 (17%) from the voluntary sector.

Demographic data was also captured from care worker participants through a short form that gathered information about care worker gender, age, ethnicity, welsh language usage, time worked in social care, time worked in current role, contract type and sector. This aimed to ensure that a broad range across particular categories was included. It should be noted, however, that it is not possible to have a representative sample in a small, qualitative study. Thirty-three (80%) of the care worker participants were female, which is broadly representative of the general care worker population. Participants were distributed across a full range of age categories, where ten (25%) were between the ages of 21-30, nine (22%) were between the ages of 40-50, seven (17%) were between the ages of 30-40, five (12%) were between the ages of 50-60, three (7%) were under the age of 21, and two (5%) were over the age of 60. In addition, five participants (12%) chose not to specify their age. The majority of our care worker participants did not speak, read or write in Welsh (n =31, 84%) with small proportions of our sample citing Welsh as their first (n = 3, 8%) or second language (n=3, 8%).

There was also a broad range across the length of tenure within their current job roles. Twelve care workers (29%) had worked in their current role for between 6-12 months, six (15%) had worked for between 1-3 years, with a further six (15%) working between 3-5 years. Additionally, four (10%) had worked for their current employer for less than 6 months, a further three (7%) had worked between 5-10 years and three (7%) for 10-15 years. Similarly, three (7%) had been in their current role for more than 15 years. Four care workers (10%) chose not to provide details about their length of time in their current role. Data regarding care workers' total amount of time worked in social care was also gathered. Nine care workers (22%) had worked in social care between 6 and 12 months, eight (19%) had worked between 1-3 years, seven (17%) had spent between 3-5 years in social care and four (10%) between 5-10 years. In addition, four (10%) had worked in social scare between 10-15 years and five (12%) over 15 years. Four care workers (10%)

chose not to answer this question. Care worker participants were also asked to specify their contract type. There were a large number of non-responses for this question (n=19, 46%), perhaps reflecting participants' lack of understanding of their contractual arrangements. Where the data was provided, the majority were employed on zero-hours contracts (n =13, 32%), though there was also evidence of permanent (n =7, 17%, mainly those working for local authorities) and fixed term (n=2, 5%) contractual arrangements.

The participant details for commissioners and registered managers who participated in the CSSIW workshops are outlined in Table 3.

**Table 3: CSSIW Participants**

| Location | Commissioners | Registered Managers |
|---|---|---|
| **South** | 9 | 3 |
| **North** | 3 | 9 |
| **South East** | 5 | 4 |
| **Total** | 17 | 16 |

## 2.3    Design of focus group and interview schedule

Following the completion of the literature review, the project team designed interview/focus group schedules for commissioners, managers and care workers. These derived from the project aims and objectives and the central themes in the conceptual framework (see details at Annex A). Draft schedules were shared and agreed with the Welsh Government (WG) and CCW project team before final versions were produced.

Three key areas of questioning for each group of participants included:

1.  Motivations for working in domiciliary care and links to recruitment and retention
2.  Employment terms and conditions and impact on care quality, recruitment and retention
3.  Career and Training and impacts on care quality, recruitment and retention.

## 2.4    Ethics

Ethical approval for the project was obtained via university processes and was additionally ratified by ADSS. Participant information sheets and consent forms were produced in English and Welsh and all participants gave informed consent prior to data collection beginning.

## 2.5    Data collection

We conducted semi-structured focus groups and face to face/telephone interviews around the key issues of interest and ensured voice was afforded to all participants. Focus groups and face to face/telephone interviews were recorded using digital recording equipment, ensuring that quotations in this report are an accurate representation of participant views. Recordings were transcribed verbatim via a confidential transcription service.

## 2.6    Analysis

Following transcription, we undertook thematic analysis of the data. Higher-level themes were defined by each area of the conceptual framework and an analysis template was initially separately constructed for each of the stakeholder groups (commissioners, managers and care workers). On reading the transcripts, the researchers populated each framework with relevant quotes and through a process of refinement captured and added narrative to

support the majority views and the complexities within the issues raised by participants. Following the completion of these three separate analysis templates, they were integrated into a singular account in order to illustrate similarities and differences between each stakeholder perspective and to avoid overly repetitive formatting and content. We have retained, as agreed with the project commissioner, substantial depth in this version of the analysis and provide an extensive range of illustrative quotations from all stakeholders in addition to the narrative description of the findings.

## 3. Findings

**3.1**   In what follows, we present the findings from the focus groups and interviews with commissioners, managers and domiciliary care workers, together with findings from the three CSSIW workshops. We outline our findings against the conceptual framework (Figure 1), integrating data from all stakeholders and comparing and contrasting their perspectives. Some conceptual areas are more relevant to particular stakeholders, meaning for certain themes there is greater representation of one particular stakeholder group. As per the conceptual framework, the key themes are: context, employment practice and its implications for recruitment, retention and care quality.

**3.2**   **Policy context**

Reference to the Social Services and Well-being (Wales) Act was made by a number of commissioners. Most indicated that service providers had a good understanding of the Act's requirements having undertaken substantial communication around it. Commissioners did express concerns about the new responsibilities upon service providers, particularly in respect of how they will generate the required evidence to demonstrate required outcomes. Some commissioners also recognised service providers were uncertain about what was going to happen and that much communication from local authorities was required. An outcomes-based approach was argued, however, to have the potential to enhance care quality, for example, by banking time daily so that external visits can be made on a perhaps weekly basis. Care workers were thought likely to value the autonomy offered and to value an outcomes-based approach as a more flexible mechanism for care delivery.

Many managers also expressed concerns around the Social Services and Well-being (Wales) Act and uncertainty about its requirements. Some were clearer about this and welcomed its outcomes-based

approach. It was, however, argued there are tensions between an outcomes-based approach and current contracting arrangements (and contract monitoring) which are time- and task-based. Local authority emphasis is upon call time and tasks that are easily measurable, rather than less tangible but very important aspects of care. Managers argued the Welsh Government needs to communicate a different way of working to local authorities and that service providers require greater autonomy in changing care plans in order to deliver the required outcomes. Some local authorities had a system of 'permitted variations' which created some flexibility but these were not widespread.

**Commissioning**

Here we present data on commissioning practice, whether commissioning practice can be/is used to influence employment terms and conditions and the feasibility of shared commissioning.

*Commissioning practice*

Varying proportions of domiciliary care were externally commissioned across the local authorities involved (Table 2), but only one local authority externally commissioned less than half its provision. This local authority planned to increase its external provision, arguing this would offer both greater flexibility and control. Control derived from monitoring of the external provision and a view that internal provision is not monitored in the same way. Commissioners also expected the external unit cost of provision to be lower, albeit one suggested that this margin is being eroded by the increased costs of NLW and payment of travelling time.

All local authorities commissioned external provision on a predominantly spot contract or call-off basis with limited block

contracting. Some commissioners indicated this was under review and that block contracts might be increased. All commissioners recognised the pressures upon service providers and that 'unfortunately' care is a business, highlighting care/business tensions. Many indicated a desire to support service providers and did so in different ways:

- Working with small service providers to address their high management overheads and costs by encouraging them to share services, have offices in less expensive locations etc
- Re-modelling commissioning by moving to patch areas which is more efficient and reduces the carbon footprint
- Introducing walking patches (in urban areas)
- Working in close partnership with a relatively small number of service providers
- 'Envelopes of care' (where service users can bank unused hours) were being trialled and were successful in part but some providers found them unworkable in terms of scheduling
- Using a brokerage system to link social workers/service providers
- Using a regional contract to commission care to ensure similar standards/requirements are applied across the region

Service providers, however, expressed concern over many of these suggestions and also sometimes felt some commissioners did not understand how care is delivered in practice. Many felt tendering processes lowered the level of care quality. This particularly related to spot contracts and brokerage systems, through which social workers advertised available packages of care for service providers to bid for. Neither were popular with service providers and brokerage systems were sometimes derogatively referred to as 'granny auctions'. There were also, however, concerns about block contracts. Many felt the hourly unit price offered by local authorities for these, typically lower than for spot contracts, was uneconomic. There was also a perception that local authorities were reluctant to place block contracts in the

private sector and that voluntary sector providers often won these ,
irrespective of tender quality. The increased use of block contracts
could then be problematic for private sector providers. Concerns were
also expressed over patch commissioning, in that service providers
could lose contracts in a number of geographical locations where they
currently operated.

In exploring their commissioning choices, commissioners placed an
emphasis on the stability of providers:

*"Quality of provider and obviously experience of provider through the
commissioning process. And making sure in terms of the robustness of
the provider, to make sure they are sustainable as well. We don't want
to be working with providers who are maybe not financially stable, so
it's those sort of things really, particularly when we go through a
temporary contract we will be looking at that, because we want to make
sure that these companies are going to be there and be able to
respond to demand etcetera, for the length of the contract, so those are
the things we would be looking for as we move forward".*

Commissioners expressed a desire to be fair to service providers but
many planned changes were also under consideration as spot contract
arrangements placed no obligation on service providers, which was
problematic. For example, service providers could refuse care
packages on the brokerage systems and could and did 'hand back'
service users, particularly those with complex needs (often those
passed to external providers). Some commissioners also suggested
that internal provision would increasingly focus on re-ablement with
long-term care packages being externally commissioned. Some of
these challenges were exacerbated by the changing demographic of
service users and the requirement for re-ablement:

*"There's a growing demand in terms of the demographics and particularly obviously of people with dementia. So it's really making sure the sector is geared up to meet that growing demand. But obviously working – what we would be doing in terms of new contract as well is looking at an outcomes-based commissioning process. So really we'll be looking for providers who can work with individuals to help them either maintain the skills that they've developed through re-ablement service, which is what they go through before they actually get passed through to us. So it's either maintaining them at that level or where we can develop new skills, so we can actually then reduce maybe the level of support going in, providing them with more independence. So that would be a key requirement of the new contract".*

The biggest concern that underpinned all commissioning discussions was funding. This was particularly prominent in the CSSIW workshops where commissioners and service providers exchanged views on commissioning/service provision tensions. From a commissioner perspective:

*"….in terms of sustainability as well, when we recommission the tender I want to make sure that those providers are around to deliver that service for the length of the contract. It's a balance really, because we know the contract is going to cost us more when we go to retender, I think they're facing huge pressures in the sector, and it's getting that balance right really. We have to pay obviously the appropriate rate but there's very little money out there to do it as well, which is a shame. But I think for me that's the biggest concern moving forwards".*

Service providers argued that they were being required to do 'more and more for less and less' and that allocated time was increasingly reduced, for example:

*"Government funding, that's a massive, massive issue with regards to dom care. Government funding, the way the work is put out, really. They need to drastically change the way they commission. Giving people half an hour and this is their half an hour and you have to be there at that. I think they need to come away from it, they need to look at areas, small areas, and say, right, this agency works in that area, this person has twenty hours, because everyone's different".*

Shorter visits also created extra cost for service providers in terms of travelling time. Funding rates were argued to often make care provision uneconomic. Managers in one area noted they had not had a funding increase for five years and that none were planned to cover NLW and other cost increases. Some service providers indicated they were losing money and noted an increasing trend of handing contracts back to local authorities. All had huge concerns about the introduction of NLW. Slow results-based payments from Local Authorities also created cash flow difficulties for many small service providers. There was a general feeling that current services could not be maintained at existing funding levels and would have to be reduced in the absence of funding increases. Indeed, there was a concern that numerous service providers would exit the market. Many service providers noted the essential role that social care plays in supporting the health service, but argued that it was undervalued and underfunded in comparison. Yet lack of funding and consequent shrinking care provision in the independent sector could have serious consequences for the health care system.

*Influence of commissioning on employment practice*

No local authorities required adoption of specified terms and conditions of employment in their commissioning processes/contracts. Some, but not all, local authorities had monitoring processes to enforce employment legislation, for example, that:

- recruitment processes are robust
- contracts of employment are in place
- equal pay is applied
- hourly rates reflect at least NMW and more if, for example, QCF3 qualification has been achieved
- rotas, time sheets and travel time are appropriate
- opts out of WTR (Working Time Regulations) are in place.

> *"We go through the recruitments files and check that the contract of employment is there, that they are paying NMW at least, more if they've got NVQ3, and look for equal pay. Some [service providers] don't understand this – they try to pay less if care workers have something on the DBS [check] and we go 'no, that's not fair".*

Many commissioners argued a combination of commissioning processes and funding constraints rendered them unable to substantially influence employment terms and conditions:

> *"I think like I said, it's a challenge out there moving forward, both for the sector in terms of making sure they have got good standards, but also for local authorities because to pay for that it comes at a cost, doesn't it? And with a shrinking budget, from a local authority perspective I don't think any of us would ever argue or disagree that there should be appropriate terms and*

*conditions and they should be paid the appropriate rate as well. But… [local authorities struggle to influence this]."*

More positively, the use of regional commissioning contracts was argued to support fair terms and conditions of employment and indeed some argued for a national contract. Quarterly forums were also held with service providers to discuss terms and conditions. Two local authorities also either currently use or plan in the next contracting round to adopt Unison's Ethical Care Charter to support fair terms and conditions of employment. Current local authority influence on employment terms and conditions is, however, extremely limited.

*Shared Commissioning*

There was limited enthusiasm for shared commissioning with other local and health authorities, although this was possible with, for example, safeguarding, and was in theory provided for:

> *"A big issue is whether we've got the same level of quality across the region. There's a commitment as well in our draft commissioning statement that we look at opportunities for joint commissioning so that's what we're doing. It has to be approved… but from an official level we're prepared to retender the new contract jointly".*

There were particular difficulties, however, where neighbouring local authorities had different commissioning systems e.g. block versus spot contracts. It was also felt to be difficult to work with health authorities due to incompatible systems. Health professionals were felt to be unrealistic about the needs of services users and to pay rates unaffordable to local authorities. In short, there seemed to be currently limited appetite for joint commissioning.

**Care Quality**

All commissioners defined care quality via commissioning frameworks, tender documents or contracts. Some referred to 'support' rather than care to underpin a re-ablement focus. Commissioning frameworks were seen to be helpful but not all service providers on them were able to operate in a particular geographical area and there was also a concern that care worker standards were unknown. There was again a suggestion that a Wales-wide framework could be of value. Most commissioners suggested they balanced quality and cost in commissioning care, but one argued that frameworks led to a presumption of quality with the emphasis then on cost. Outcomes-focused delivery was prominent, but care workers were often not trained on the framework outcomes and these could also be seen to be subjective.  Fifteen minutes was the shortest package of care commissioned and one local authority did not commission less than 30 minutes. Emphasis by commissioners was placed on the notion of continuity of care as being central to care quality:

> *"Well, we're looking for definite continuity in terms of the care worker going into the home. Obviously looking at appropriate trained staff as well to meet the needs of the individual, and obviously in terms of rostering the rotas, to make sure they've got enough time to actually spend that time that's been commissioned in the house as opposed to cutting the time short, so basically it's making sure they're au fait with the care plan, the support plan, and the likes of continuity of care is an issue that comes through to me quite a bit really".*

Some commissioners suggested they try to work on monitoring with CSSIW to avoid duplication for service providers but that this could be problematic and sharing was often not reciprocated. One local authority paid face-to-face visits to three in 10 of each service provider's service users on an annual basis and felt this was important in ensuring care

quality, although it was a high overhead. Financial pressures were frequently noted. For example, one local authority had had to adopt a 'one in, one out' policy for service users resolved by some additional resource but also by increasing the criteria required to access care provision. Service providers also suggested they adopted 'one in, one out' approaches, often as a result of staffing difficulties. Clear tensions around quality and funding were evident. Different mechanisms for capturing metrics around care quality were proposed but for some commissioners this was often something in the planning stage, or not currently fully operational:

> *"We've got a provider, we've bought the system already which is Work Roster, and we're working with that supplier basically to look at the contract and determine what reports we want to come out of that system. So it will look at things like making sure that people are monitored really, the actual time spent within the person's house, compared to what's been commissioned. And we'll look to see when calls are cut short, etcetera. I don't think the system will be able to give us continuity reports in terms of staff, but what we will be putting into the contract is that we expect them to have systems where we're provided with that information".*

As we note above, however, service providers perceived commissioner emphasis to be on cost rather than quality and argued that many commissioning features, particularly unit price and length of visit, were detrimental to care quality.

**Workforce regulation and development**

Commissioners had a generally positive response to mandatory registration, as it was felt this could lead to a perceived increase in care worker status and professionalism, in particular moving away from a culture that positions care workers as 'home help'. A minority view was

that registration would not enhance status (registered managers do not, for example, feel that their status has been enhanced) and would be of limited benefit. One commissioner questioned what would happen beyond the care worker's name being on the list and suggested that registration might indeed increase recruitment difficulties. Others focused more extensively on the impact for individual care workers but outlined the effort in attaining registration as a potential burden comparative to other similarly paid occupations:

> *"I think it's good in terms of quality, I think that is definitely the way to go. The only concern I would have is would that put some individuals off actually going to work in the sector….I think sometimes, you know, it's them understanding exactly what it is. I mean…, if they think they've got to sit an exam or that type of thing – again, in terms of what they would get paid there compared to maybe the local supermarkets etcetera they may decide that there's far too many requirements on them... I think it's a good thing in terms of driving quality but I just think it's just being mindful that we don't put people off".*

And:

> *"I think it will elevate the status and it will drive quality. And if you can be associated with something which provides good quality then that's going to be a good thing really. Whereas at the moment there are issues in terms of the sector and the reputation, so if they think it's going to drive up the reputation then hopefully you will get the right people coming into that sector as well. I think it's getting the balance right really, communicating exactly what that means and if it's driving the quality and the reputation I think hopefully will actually attract the right people to work in the sector".*

Managers showed much support for mandatory registration with a view that it would both create the expectation that care workers would take greater responsibility and raise the status of care work by professionalising it. Concerns were raised, however, that this would be an increased cost on either service providers or care workers and that it could be a barrier to recruitment:

> *"In principle it is a fantastic idea…we need that, to show everyone how important this profession is…and it is a profession. It would help us [to get] high quality, but with everything it would be about what comes with it, how is the process going to work and what is the administration of it going to look like in practice…and the cost of it, to them [care workers] or us, I don't get how that will impact".*

Care workers themselves were generally positive about mandatory registration, although had limited understanding of what would be involved. This reinforces the commissioners' views about the need for careful communication.

**Workforce size, characteristics and challenges**

The lack of workforce data was apparent in the commissioner and manager interviews and, in one case, was bluntly described: "we don't know about the workforce". This was not only in terms of numbers and demographics but also in terms of their motivations. For example, younger staff are entering care and whether their motivations differ to longer serving care workers is unknown. More information is required if their needs are to be addressed. Anecdotally, the workforce was suggested to be ageing and female, and difficulties recruiting Welsh speaking care workers were identified (noting service users with dementia may appreciate the opportunity to speak in Welsh).

Commissioners also noted the challenges arising from competition from other 'low skilled' sectors, namely retail:

> "One other thing as well, the providers actually say to us they're competing with large supermarkets etcetera. Obviously with them paying minimum wage and moving up to living wage, and obviously in terms of the sector and the responsibilities, in terms of the sector with DBS checks and training requirements etcetera, compared to the local supermarkets, I think sometimes that's a challenge for them as well. But obviously if there's better terms and conditions, and if we can influence that, then the more stable the workforce is really".

Managers argued these pressures translated into higher quality workers moving elsewhere, potentially creating lower quality entrants to social care. For example, there was an increase in care workers who found it difficult to work on their own initiative and those who were risk averse and scared to make mistakes. Larger service providers were perceived by many as not concerning themselves with the 'quality' of the care workers they recruited:

> "But then it's also got to be an agency that cares, that is able to do that. Because lots of big agencies that are in there for the money, that isn't cost-effective for them either. I think it could be if it was done, yeah, about the person [careworker] and what their needs are".

Workforce challenges were overwhelmingly related to recruitment and retention and we explore these in what follows.

### 3.3 Employment practice in domiciliary care

Here we report on domiciliary care worker employment terms and conditions, including career structures. We also include discussion of worker motivations and occupational status, as these are relevant to worker decisions on taking up and maintaining employment in the domiciliary care sector.

### Workforce Development

This section comprises findings on training and qualifications, career development and supervision.

*Training and Qualifications.*

Commissioners suggested most local authorities provided training, funded by Welsh Government and themselves, and such training was free to service providers. QCF2-5 was delivered in-house by one local authority. Some local authorities had waiting lists for training and suggested that service providers needed to offer training too. Indeed, in some areas, registered managers were becoming qualified and providing training in-house. There appeared to be many development opportunities available e.g. dementia, learning disability, but no clear view on whether care workers were paid to attend training. Some local authority monitoring processes required higher rates of pay for care workers who had achieved QCF3. Training vouchers were also offered to service providers to use flexibly in an effort to creatively address the pressures of attending training.

Commissioners also emphasised the difference in training provision across different provider sizes, and cited the usefulness of SCWDP in reaching out to smaller training providers who did not have their own in-house provision:

*"We've got the Social Care Workforce Development Partnership and they offer a lot of training to the independent sector. They also work with the independent sector, they actually sit in our forums to gauge what the demand is in terms of training moving forwards. So in terms of obviously the outcomes based commissioning they're looking at that really and seeing what training they can put on in order to help providers in order to meet their requirements. …They're very proactive in trying to engage with providers and get them on board in terms of training. So there's a lot of training available. Obviously a lot of the big companies don't always take up that offer of training because they use training through their own company, but definitely for the smaller ones I think it is invaluable basically".*

Management training was also identified as important by commissioners. Independent sector managers had often 'come up through the system' and were not skilled in business e.g. managing terms and conditions and managing staff. Management training would help them see the 'bigger picture' of the effect of terms and conditions as opposed to a focus on short-term budgetary pressures. It could also help them to create better employment relationships.

Service providers were generally positive about the training offered to care workers, again noting that size of organisation could have a role to play. Those who worked for larger organisations suggested a higher provision of in-house training was available, and contrasted this with other experience of working for smaller organisations:

*"Because I'm bigger, I've got more resource in-house. I mean, X's [other smaller provider] overheads in her office, there's you, one or two other people in a day, whereas I might have seven or eight in my office in a day, and some of those are trained to train, so I can use those. Also, X [provider] has a sister*

*company, a training company, so I do have a lot more ability to train in different areas because of that".*

There was attention paid to the need to promote training and to pay care workers for their attendance at it, plus reward them for their achievements in attaining training. There were difficulties noted with these issues:

> *"I pay my staff for every minute they're training and not every agency does".*

Many managers did, however, note they would like to be able to increase training provision, though differences across organisation and sector were apparent. Qualifications were more problematic:

> *"QCF – every care workers is offered it. … It's important that they have it. It should be acknowledged when they get it and we should reward them with a higher level of pay, but are restricted by commissioners".*

Managers suggested there had been little progress towards attaining the 50% of care workers in any service provider holding a QCF2, mainly due to high staff turnover levels. Recent changes in funding for QCF, meaning that funding was only available for the under 25s, were likely to exacerbate these difficulties:

> *"The issue with the qualifications now is to do with obviously the no funding for over twenty-fives, which is massive….And with all of these cost-cuttings now, you've got to pay for pensions, you've got to pay for travel time, you've got to pay the living wage and all these things, and they want us to pay for qualifications for someone who's over twenty-five".*

Retention of care workers aged over 25 years old was also argued to be potentially problematic if no QCF places were available. This was worrying given a perception that care workers in that age bracket were often more proficient and motivated:

*"And the thing is, what I tend to find is people over twenty-five are more likely to be the best staff".*

*"Yeah, and they're the ones that are going to stay because that's what they've decided to do rather than the younger staff who are under twenty-five and you train them then they leave. You're doing the same thing again and again".*

The positive commissioner and service provider perspectives on training were only partly shared by care workers, who perceived some confusion over what types of training were available and how training was funded. In general, they believed training was scarce. Induction training was argued to be variable where some care workers felt well-prepared and others felt that training was inadequate. In the private sector particularly, it was suggested care workers were sent out on first joining without sufficient training, and often asked to train others when having limited experience themselves:

*"I was out [in service users' homes] after three hours' training and on my third day I was training someone else. I knew what to do but not why, it was difficult".*

Some care workers indicated an awareness of the CCW activity in promotion of training opportunities:

*"I've seen the Care Council have put a lot of energy and effort and money into training frontline managers and leadership in care, which is rightly so, I just wonder whether they couldn't be doing something more because everybody's training budgets are stretched to the limit.*

Others explained that while they were aware that training was available in principle, in reality there were often long waits for attendance due to a shortage of funded spaces:

> *"All the spaces have gone, they've put our name down for it and before you've even had a chance to get started the spaces are gone, even though we've been waiting six months already".*

> *"And the spaces are so limited. Like we've been wanting to do a dementia course for ages, but our manager keeps saying – every time these courses come up the spaces on them are so limited that it's just first come first served. And if we can't get in there quick enough, or if she can't get in there quick enough for us, it's just like some of the dementia – like I went to a course and I think there was only eight spaces available, and that's for the whole of the area. There's just not enough, that's not enough spaces to educate people on what they need to know. So I think the spaces and stuff is important".*

Pockets of best practice were identified in terms of service provider in-house training, where those with experience working for (usually) larger organisations recognised the range of additional training available to them:

> *"Well I'm very lucky that my previous job I had an awful lot of training, with private [sector] as well, and so I've been able to carry on, but if I'd been somebody that'd come into this role with no background and previous experience, then no, it's not enough training".*

Those working for local authorities also reported good availability of training.

Attendance at training was often deemed problematic due to staff shortages and difficulties with service providers finding the time for their care workers to be released from their rotas to attend:

> "*We're struggling within our company because I feel like some of us have gone and asked for various types of training, like I've been in a few times asking if they've any courses going on at the moment including dementia, and things like – specifics to the people that I'm dealing with. They say there are courses available but they can't spare the time to let me go on the courses*".

Equally, participants explained that there were challenges in obtaining their certification following training, and that such documentation was kept by their employers:

> "*We've done all our training but we haven't got one certificate to show that we've done it, and I think it's just – like they always say at the sessions, "You'll be sent out your certificate and you will receive this and you'll have it in a book". But I've done loads of different training, and never once, even from my initial training, the four days training you do before you start, we still haven't received our certificates from that. We know ourselves that we've done it but it's a nice thing to be able to show others just even if there's another job opportunity or anything like that*".

> "*And it'd be nice for us to be able to show our clients, I have done this training, I can do it for the best of my ability for you as well. But we don't get that because we haven't received any of our training certificates*".

Other issues focused on training quality, where managers expressed concern for training methods that did not optimise learning and transfer of training, or moreover certificate evidence for training that had not been attended:

*"They'll have certificates to say they've done the training, but they've only watched a DVD. The certificate says they're trained in moving and handling. They watched a DVD on how to - that's a two-day course. But if someone's got the certificate – and it's all about companies being able to fill in documents, isn't it?".*

*"We've had staff that's come to us and said, "I haven't done this training but I've got a certificate in my file to say I have".  I report all those on to Social Services. What happens there, I don't know. But I make sure I report all those things in, but it's about what sort of comes of it and how you report and what actually gets done with that report from there really".*

Care workers were also concerned about funding restrictions that made it difficult to attain QCF and impacted equality of opportunity for those over 25:

*"I don't think there's enough opportunities. At the moment the government basically funds under twenty fives to do qualifications if they want to. And in our area it seems to be if one of our girls is under twenty-five and wants to do their NVQ [QCF] they walk into the office and they get signed up straight away. They don't get a problem with that. But if you're over twenty-five you haven't a chance".*

*Career Development*

Commissioners suggested there are no identified career pathways or not ones that are not widely recognised by care workers:

*"I think limited really. I don't know how many people actually go into that sector thinking about a career path. I think sometimes people who have got families involved in the sector may see it as a career opportunity if they've seen other people moving through the career path, but other than that, I think that people*

*probably think generally the job is the care worker and probably don't think any further than that".*

*"Some people would be happy to come in and do the job, but it would be good if you want to get the right people in to show that there could be a career pathway through the sector, for those people who choose a further career really within the sector. So probably yes, I don't think it would be a bad thing, but people don't realise they could develop a career within that area".*

National service providers were seen as more able to offer career paths, using QCF2-5 and specialist training to develop from care worker to supervisor/team leader/key worker/care co-ordinator and then registered manager, but relatively flat structures mean there is competition for limited opportunities. More work was argued to be needed in schools and colleges to promote care work as a career and some commissioners were planning to work on developing career structures in the near future as part of addressing recruitment and retention difficulties.

Managers presented differing career options, some within and some beyond domiciliary care, with mixed views as to whether these were widely recognised. Domiciliary care work was often seen as a preparation for nurse training and could be a double win: both care worker and service provider benefited as the care worker continued to work while training, so for a period became an increasingly qualified member of staff:

*"They leave to do other things that stretch them, things like nursing or university or different types of care".*

Managers generally welcomed the opportunity to support workers develop, although it could be problematic in turnover spikes at the

beginning of the academic year. There was also some innovative practice, for example, one service provider was cited as offering a cadetship from age 17. The fundamentals were learnt as a trainee before transitioning to care worker. This was funded by a combination of service provider, local authority and EU monies.

Opportunity for progression was again argued to be dependent upon service provider size and could create turnover:

> *"I think that all depends on the size of your agency and how many posts you have. If you're a very little agency and your retention is really great, that's fantastic, but then those other staff who want to go somewhere can't because there are no positions".*

> *"I train them and then they go off, and then I have to start the whole process again. And then there's funding and money and training…".*

Other managers talked about creating opportunities for progression through different means. For example, there were instances where partial progression was identified through paying some hours at a senior carers' pay rate despite no formal or full time promotion being available:

> *"We do try and give staff progression. So there are senior positions, but what we've tried to do to try and make people feel that there is progression is they can have some senior hours. So, because obviously I can't afford to make them a senior carer and pay them a higher rate across the board, they're given a senior for a few hours a week so that they've got that level to be able to sort of progress a little bit. And then if people do move on, there is that availability there to sort of move on".*

Local authority providers also encouraged career development via in-house roles such as programmers (managing rotas) and other back office functions, where having experience of care work was felt to be a benefit.

Opportunities for progression, where they did arise, were often considered problematic for management, as great care workers were lost to a role with less caring input.

Barriers to a career linked to education and aspiration were also identified. Career progression was not seen as an aim for many (see also worker motivations section below) as the role then became 24/7 which was not attractive to all (especially with a larger female workforce who often have caring responsibilities):

> *"And again, it's not all about the money, is it? Some of these managers are on a good salary but, my gosh, they're earning it. Their responsibilities and things are massive".*

There was also some acknowledgement that care workers may not necessarily want to progress to a more senior role due to other commitments and are reluctant to relinquish a hands on, care giving role:

> *"Yeah, with working mums with children, like you say, the hours can be flexible and some people are just not happy to move on really".*

Care worker perspectives largely aligned to those of commissioners and managers. One care worker explained they worked both as a care worker and as a coordinator and the importance of this in retaining a care giving role:

*"To be honest with you, I do the both sides. I work as a care coordinator and as a care support worker, so I do see both, I see every variety, it's brilliant. The job I applied for was – it was one full-time job in the office and they were willing to split it between two people. And I wouldn't want to leave the community because I enjoy it so much and also seeing the other side, I didn't realise how much it entailed until you get there, which is fab. But you can never know enough. But I enjoy learning and it's a fab job".*

There was again a theme of using domiciliary care as a platform to progression into more highly skilled professions;

*"After the career of being a carer the next best is nursing and going further into that way, because once you're a carer or you become a manager, there's no promotions after that, I think it's just a steady line then.  And if you enjoy your job it's good, like you obviously enjoy your job to have done it – and I enjoy my job and I'd be happy – I think to myself, it'd be so nice to actually get a really good career plan, still to do with care, this job is for me and I wouldn't want to go off it, I still want to be a carer. But then there's sort of, do I look into nursing or social worker? I look more to them sort of things then".*

A distinction was made between the notion of 'caring' as a role with little opportunity or scope for progression, where if one was to progress upwards the activity of caring would diminish:

*"I don't think there is a career if you want to be a carer, so there's no progression".*

Some older care worker participants who had worked in domiciliary care for longer amounts of time cited differences between the current

system and their historical experience, where they suggested development pathways were more readily navigated in the past:

> *"Health and social care has been really good to me and has provided me with a really good career. I've gone the management route and I've done that and I've come back and I do some management work but mostly I'm a support worker. I feel so sorry for people like yourselves who haven't got the same opportunities I had all those years ago to obtain the qualifications to let me develop and grow. You haven't got the same opportunities as I was afforded in the past, and I just feel really sorry for you because I've had a good career. I've come to the end of it now, but I still work as a support worker because I enjoy it".*

A couple of care workers (male) in the voluntary sector did outline career ambitions. One, for example, wanted to open his own agency and had already gained QCF2 and 3. He spoke, however, of the difficulty of undertaking QCF5 given the long hours required in his role. Another local authority care worker was also taking QCF5 and had moved into a management role. Such examples were, however, relatively limited.

*Supervision*

Care workers spoke of the importance of supervision but most reflected that it rarely happened, usually due to time pressures and staff shortages. More depth was garnered from the manager perspective. Here supervision in a domiciliary care context brought with it a number of challenges different to care in other settings and was often seen as a monitoring and control process, rather than a developmental process:

> *"I think the problem we have in dom care we put a lot of trust in people. They aren't managed – we rely heavily on feedback from carers. Yes we do spot checks but if you've got someone*

*without the right attitude then monitoring that can be difficult. I think some things can be changed – we pass on positive feedback we ask them to come and see us if they have any problems. I've interviewed someone who had 20 years of experience and she seemed so cold and I put myself in the position of my service user…I'm not feeling great, she's coming in to my house with a bad attitude.. I'd want to see some warmth".*

A range of mechanisms were put in place by managers, though these differed in their type and frequency:

*"We do spot checks, unannounced spot checks. We do competency assessments".*

*"Yeah, and just making sure that we've got good feedback from the staff they're working with, and also from families as well. If they've got concerns, it's making sure that we ask them. But the only way you can do it in dom care is by spot checks. Supervision is great; you can pull someone into the office and say, "Are you doing this properly?" and everyone will say yes".*

*"Have you always got your badge? Have you always got your gloves?  Yeah, it's spot checks".*

*"We try and do them at least every three months. To do them any more regularly is really hard. To do them that regularly is hard sometimes".*

*"We do shadowing, spot checks and supervision. We get feedback forms. We ask other carers if there is more than one going in [to a house] to make sure everything is being done. Its 360 degree communication from the top to the bottom".*

Supervision was also discussed in more developmental terms and was seen to be very important in supporting care workers. Time difficulties

in conducting supervisions were noted, though, and some argued that, where care workers were not seeking career progression, supervision could place an unnecessary burden on them to consider training and qualifications.

**Pay**

There was a wide range of responses around pay. Local authority providers adopted local government pay scales, well above NMW or NLW, and in the voluntary sector payments ranged from NMW up to the NLW:

> *"I think pay is a massive issue, we do pay the living wage. We are commissioned for a certain amount of money, and I have concerns for next year about being a better payer. We don't have a lot to play with given how much we are paid by the LA. They [care workers] aren't recognised for the work they do – they should be paid a lot more".*

> *"I mean I start on £7.20, anything up to £8.90, so we pay quite highly compared to some. I mean some companies you'll find minimum pay and that's all you will get. We do try and pay people that little bit more, but again, we can pay someone more an hour but we always make sure that people have travel time in between calls".*

In the private sector, however, most domiciliary care workers were paid the NMW and pay was an issue of concern for service providers across the independent sector:

> *"It's a horrible phrase, but if you pay peanuts you get monkeys. I'm not being disrespectful but to get the real quality of staff we need to pay them more".*

Commissioning rates were felt to be a major constraint on pay rates. Service providers also indicated that, on the whole, they did not pay for travelling time (this was supported in care worker interviews where many suggested that they were not aware that they should be paid for this). Similarly, commissioners confirmed that many providers did not pay for travel time, though this was beginning to change:

> *"I think it's probably a mix at this moment in time, but I do think that the providers are starting to respond to the new requirements coming out. I think again in the new contracts that will change and that will be built into the cost when they tender for the contracts. So again, there will be a financial demand in terms of us actually meeting that requirement, but I think moving forward that will happen".*

There were some, though limited, links between skill and pay:

> *"And rewarding them. Our staff, once they've completed their QCF, they actually get 20p an hour [more]".*

The majority of independent sector care worker participants were not satisfied with the pay they received (although some in the voluntary sector were more positive), citing it as inadequate for the responsibility that the role entails:

> *"It's one of the hardest jobs I think, caring, and people don't realise it".*

> *"I think for some of the stuff we have to deal with, six pound seventy an hour is nothing".*

> *"Sometimes I stand there and I think I don't get paid enough to do this".*

> *"It's a lot of responsibility for a small wage".*

Local authority care workers had much higher rates of pay, already well in excess of NLW, and were far more satisfied. Some care worker participants cited dissatisfaction with their low rates of pay and the specific duties they had to undertake, which they argued were akin to more professional and highly skilled workers such as nurses. In making sense of their dissatisfaction with pay, they drew comparison between other minimum wage jobs that involved much less responsibility than domiciliary care working:

> *"And we deal with morphine and warfarin and all them sorts of things that you would expect a nurse to deal with. And when you have to do that in a fifteen minute call – like medication is such an important thing and it needs your whole concentration and then you're having to do meds, food, toileting, in that short amount of time".*

> *"It's pretty much minimum wage, isn't it? And for most minimum wage jobs you can do something where it makes no difference whether you turn up or not really, because there's always somebody there to back it up etcetera. Like stocking shelves, which they tend to be on more. But if you don't turn up it's not just yourself that's affected, it could be if you're on a double run your doubles partner, the office staff, you're affecting every single client, and calls could be late and obviously some people with dementia medication could be missed. And obviously some people for example might have dementia or they could have something as simple as OCD [obsessive-compulsive disorder], they're very set in their ways and like the call at this time, and if they don't get it, it throws them out for the day. So obviously it's important".*

In relation to hourly pay and the conditions that sit around it, there was a variety of experience, with some participants receiving higher rates

and others in receipt of the minimum wage. Importantly, independent sector participants highlighted that different agencies had different conditions for variable pay in terms of overtime, times of day worked, and weekend pay:

> *"And after seven o'clock at night you get paid more, so it balances itself out".*

> *"Ours varies, it changes, like the weekends you get paid more".*

Local authority participants, however, received enhanced payments for evening and weekend payments.

There were reports of confusion over pay rates differing from their perceived contractual content. This is also captured in further detail when we discuss employment security and different contractual arrangements:

> *"We were told – we were paid per call originally, we were asked to sign contracts and we would be on an hourly rate, but the way of doing it, they tried to say that by us signing contracts obviously you've got more security because you've got your hours and this is what you'll be doing.  So of course we signed contracts, gone onto a set wage per hour, and we're still finding people are not having their contracted hours and our wages are still down because we're not being paid as we were before per call, because the call, depending on the length of the call, as to how much you were paid for the actual call. So we've ended up losing massively. Some people, fifty, sixty pounds a week, that's a big amount to be losing".*

Linked with the notion of motivation, care workers highlighted that irrespective of poor pay and their dissatisfaction with it, many stay in their roles because of more intrinsic factors:

> *"You have the thought that you'd actually consider leaving, but then you stay because you love it. That is a big thing, though, pay".*

*National Living Wage*

Even where service providers paid above NMW, relatively few outside of local authorities paid NLW. There was real concern as to the cost implications of its introduction, coupled with a view that extra local authority funding was unlikely to be forthcoming.

Commissioners faced uncertainty over funding to support payment of NLW:

> *"We're flagging it up as a financial pressure moving forwards. Where that money will come from I don't know. But not really at this moment in time, that is something else we will have to respond to, we'll have no control over basically. Where we get that money from is something that corporately they'll have to decide".*

Managers were unsure of how NLW might impact in terms of the changes in commissioning processes and extant longer term contracts:

> *"… less than a year ago they were giving out a five year contract, even before they didn't know this living wage was going to come in, and I think that is severely going to impact on the companies [on those contracts]".*

Commissioner and service provider participants expressed concern over the extent of uncertainty around the NLW, given that at the time of data collection there was less than 6 months before to its introduction.

*Benefits*

Benefits were only offered to local authority care workers who typically received pension, paid holiday, sick pay and unsocial hours payments. No other evidence of benefits was found. One commissioner argued service providers could be more innovative in using benefits to address recruitment and retention challenges, for example, childcare vouchers or scooters for those with transport difficulties. There was limited enthusiasm amongst service providers for these initiatives when raised at CSSIW workshops.

**Employment Security**

The majority of managers noted their care workers were on zero-hours contracts, but presented this in both a positive and a negative light:

> *"I think we are restricted because we expect total flexibility and that narrows down the market for that I can aim to. We don't have 'mum runs' and moving forward with the business we need to look at that. Previously we weren't taking on anyone who wasn't completely flexible and I've just taken on two girls who each just want a day [per week] and whereas we've not been keen on that before and the nature is that when sickness occurs it hits our guys hard. I want to utilise the fact, that when people come on board it's a zero-hours contract and what I explain to them. It doesn't always work in our favour and I explain there is not a lack of hours…but we can never ever guarantee because of the nature of the business".*

> *"It's difficult because obviously because of the zero-hour contracts that we need to put in because of the way we're funded, that then prevents people from getting mortgages and it prevents them from getting finance because they don't have a fixed term contract".*

*"Trying to get staff to understand that is really, really hard, especially when you've got seventy staff because you've got huge amounts of calls between – I mean our main ones are between half six and half nine in the morning, then the lunchtime, twelve till two, and then the tea to bedtime. But in between, there's nothing. So staff are like, "Well, I'm out for six hours and you've only given me three", but then if there's only three hours and there isn't anything in between, that's really hard".*

*"The uncertainty of the work coming in [in terms of commissioning].The thing is when I ask them [existing care workers] to do more, like I've had to ask them to do at the moment, that can create sickness. And what happens then? The solid workforce who never let you down are put on again…I've now got a fortnight's work to cover. We will deal with it even if we have to go out [to visits] ourselves, and we probably will do. That impacts upon the quality [staff sickness]".*

A number of managers indicated that they were increasingly offering contracted hours to recruit and retain high quality care workers:

*"We contract some of our staff who have been with the company for over six months. So if someone wants to get a mortgage and they're a very reliable member of staff, we offer them a contract. But then it's very hard if they lose service users and things, so then I end up giving them office work and scanning".*

Some had, indeed, moved to offering contracted hours to all staff. As well as supporting recruitment and retention, this created greater security for service providers as care workers could not then simply turn down work offered:

*"Purely because the staff, if they worked on zero-hours they would leave us because they couldn't get mortgages, they couldn't get car loans, things like that. So it's better off for us".*

A number of managers argued there had been poor uptake of contracted hours as many care workers valued the flexibility offered by zero-hours contracts. Though not confirmed by the majority of care workers, during one focus group some participants explained their reasons for preferring zero-hours contracts as focusing on being able to work more hours than if they were employed on a contracted basis:

> *"Obviously at the moment I'm on a zero-[hours] contract. I was offered about an eighteen hour contract scheme, but for me there's not really much point because I work six days anyway so I'm never going to drop below eighteen hours so it'd be pretty much pointless for me to do it. I explained to the manager and said, "If you can give me thirty hours perhaps I'll take that one".*

Care worker perceptions about employment contract type dominated many of the focus group discussions, where challenges around working hours and perceived security were commonplace. Independent sector care worker participants had a variety of experiences across different contractual arrangements, some being contracted for set hours and others in receipt of zero-hours contracts. Local authority participants typically had fixed contractual hours and were paid for these whether they were worked or not. These contractual hours included travel time. Care worker opinion was divided between those who cited problems with zero-hours contracts, and others who suggested it brought them benefits in the form of flexibility and the ability to choose hours as and when convenient. Participants who worked on zero-hours contracts in the main stated they were not short of hours to work, though did suggest that insecurity was still an anxiety:

> *"You get the hours because they're there. Never, ever have I been without, but still it's just like, what if? You feel like you don't have a leg to stand on".*

> *"Well they could have no work tomorrow, could they? Nobody could live like that".*

They also discussed the way in which their regular hours were subject to change should service users become ill and require care in another setting:

> *"All or nothing though. At the moment we've got loads of hours but as soon as someone goes into hospital we lose like four calls a day and then it affects us a lot. And because we do four on, four off, so we work three days, so then you get hardly anything for the week".*

Zero-hours contracts also often translated into experiences of a much higher than expected workload and long hours, many of which were unpaid:

> *"Yeah, a hundred and twenty pound for a week's work and that's nothing really, is it, once you've paid your bills. But then we can't complain because when it is all there we're getting loads and loads of hours, more sometimes than we can handle. Sometimes we'll go from two o'clock, with no breaks, because we'll work straight through until ten. At the moment we've got loads of clients so we're not finishing until half past ten, by the time we get home it's eleven o'clock and then we're back up at half past five to start at seven".*

> *"But for me the most frustrating thing is when you look at your rota and you're starting at eight o'clock in the morning, you're going home, you make it home at ten o'clock at night, and if you tally up all the amount of hours that you work… five hours….and then you combine the amount of travelling that you've got, then you, you know, over a weekend you could be losing ten hours, you know".*

For those care workers who did have contracts, there was a perceived in how contractual terms were honoured by providers in reality, where some participants explained that less hours were available:

> *"That's the problem we're getting, we've only recently signed contracts, we've gone from zero-hour to actually having contracts, and it's very, very new, a matter of weeks. But what we're finding is that the contracts we've signed up to, I for instance have signed a forty hour contract, I'm one of the lucky ones that gets my forty hours or maybe more. There are many girls who have signed a forty hour contract that are only given twenty-two, twenty-three hours. They signed the contract because they thought they were having forty hours, but what they're saying is the hours are not there to be able to give them. And yet they're still continuing to take on new staff and it just doesn't make sense".*

Further, while some participants on contracts explained their number of contracted hours was always paid to them irrespective of actual hours worked, a number of participants cited the opposite;

> *"And we only get paid the actual hours you work, you won't get paid – if you've signed a forty hour contract, you're not going to get paid forty hours unless you've actually done forty hours work".*

In terms of the flexibility that zero-hours contracts afforded, many participants enjoyed not having to commit to set hours and days, and also acknowledged the suitability of this to a range of different personal and family circumstances:

> *"I like the flexibility you accept what you can work, so you can't say, if I'm not getting this time off I'm not getting up because you can, you volunteer for stuff".*

> *"Everyone's got different perceptions with the zero-hour contract because of like, X [other participant] just said, you know, the*

*flexibility that it brings, you know, for a lot of people it's actually a blessing, especially if you [have] children and that.*

**Working Time**

Managers suggested that most service providers tried to accommodate both care worker and service user needs in their rotas. This led to substantial complexity in developing rotas, especially given the reduction in any 'slack' in the system. Monitoring working time was a big issue:

> *"We work within the working time directive, we monitor staff hours constantly. We look at travel time as well. We look at a minimum wage trackers… if you look at some of the runs, they start at 7:30 in morning and finish at ten at night. We really look at the extent to which they are getting paid more than minimum wage".*

Managers talked about travel time as one of the employment conditions that was most dissatisfactory for care workers, and discussed the tensions between having little control over certain elements relating to it, in particular, geographical location:

> *"However some of the areas we work in are quite remote – it could be 5 or 10 miles from one house to the next. When we are commissioned we aren't commissioned for travel time… there isn't a lot of cost to put back in to the travel time…".*

> *"Ten years ago care workers relied on mileage as a top up for their wage, but not now".*

> *"Now, they're not paid for that [travel time], so they can go to another agency who gives them three calls at the same time and they get paid for three calls at the same time. People get a really poor level of care, but that member of staff earns more. So although they end up hating their job, hating the company they*

91

*work for, they still get paid more than going to a quality agency that pays them more per hour but then makes sure that there is sort of decent travel time in between. But it does cause gaps in your run, so it's a sort of double-edged sword".*

*"The reason why I'm quite selective really is, (a) the travel time, the girls getting around, and (b) the mileage allowance I pay out. If I can keep the girls in one area, or certain areas of [location], they're not bombing back and forth".*

Working time and flexibility were also cited as problematic by some:

*"…because in one way, yes, people can be flexible and say, "I want to work the morning," or, "I want to work around school," but then to be able to get - Someone can say, "I can work between nine and five," but between half past ten and twelve you might not have any calls, between two and five you haven't got any calls. They're like, "Well, I'm giving you this massive amount of availability, you're not filling my day." But if there's no calls to fill it with, there's nothing you can do".*

Other managers saw this in terms of a benefit for care workers:

*"It means they can go off and do the bank, do the shopping, do all the stuff they need to do, pick the kids up from school, take them home and then they can start the night run. So it depends on the person".*

There were also difficulties in compliance with travel time and distance versus pay rates for managers:

*"…and to be fair, out of the seventy staff, fourteen were non-compliant on my ledger, but then it was only a couple of pounds because our rates are higher. But the problem is, if you actually looked at what they earned, they wouldn't be non-compliant*

*because they're on £8.90 on the weekend, and if you flattened it out - But because HMRC only take the lowest rate they're paid and calculate all their hours on that, it then makes them non-compliant. But not to a huge amount.  I mean, what we'll do is run that and then pay them the difference. So the people who are non-compliant, we're going to top their wages up…"*

Working in the community could also be chaotic, for example, traffic jams, and there was no recognition of this. Electronic systems were increasingly used so that managers could remotely assess when care workers arrived at service user homes. Again, there was some complexity to this where the constraints of the technology could present difficulties to care workers:

*"People Planner is a rostering system. There's lots and lots of different rostering systems. Some are better than others. But with regards to the call monitoring, that's where they've got to log in and log out of calls, which in some circumstances helps and you can track where your carers are. But then there are other issues where, like I said earlier, if you've got someone with dementia and you've got to go and log in somewhere and that service user is saying, "Well, who are you?  I don't want you in my house," and you're going, "I need to log in," because they don't get paid until they start and they just want to log in, whereas that person wants to talk and wants to know what they are, or you go in the wrong floor, how do you deal with those situations when you've got to log in? And that's what I don't like about it. The same with flat complexes. If you've got someone who lives in a flat complex, that carer could be outside but then they don't get paid until the time they've actually managed to get in the flat and log in".*

A number of service providers discussed using Smartphones where a tag on the service users file is swiped on arrival and departure. This

was felt to be less problematic than a call in system, though the phones were not infallible, and also helped to monitor travel delays and reinforce safety for lone workers. Local authorities also had complex and robust electronic planning systems which improved management of care worker 'runs'.

Much of the focus with regards to working time revolved around the length of visits per service user as set out in care plans. All the care workers who had shorter visit times discussed a range of problems with this, where they felt that shorter visit times were unrealistic in attaining quality of care required:

> *"I think it's the time restrictions as well on calls, some of our calls are only fifteen minute calls, and what can you really do to improve anything in a fifteen minute call?".*

> *"And as well, in that fifteen minute call we do toileting, food and medication. To do all that in fifteen minutes and to do it to the best of your ability you need more time to do it".*

Shorter visit times were discussed in the context of pressure and stress for the care workers, and in terms of the impact it had on service users:

> *"The thing is, a lot of them can't be rushed. And they need the time, they need the couple of extra minutes to be able to stand up and steady themselves before you walk them. But you feel under pressure to be able to get them there".*

> *"It's dangerous as well, isn't it? You're trying to do everything you can, and as we all know, you can get blamed for things that are not your fault. You try and do your best but time restricts you, there's too much pressure".*

> *"You've gone into the care sector, that's what it's there for, isn't it? It's caring for that person, not to make them think that you're rushing".*

*"The last thing they want to feel is rushed, especially if you're a ninety-eight year old who gets a little bit breathless, the last thing he wants is, "Come on now, we've got to go, we've got to do meds now." And he's like, "Hang on a minute, I haven't had my tea yet".*

Participants highlighted the links between shorter visit times and impacts on health and safety as well as shorter visits as impinging on quality of care in terms of promotion of independence:

*"It's a contradiction really, isn't it, with the codes of practice of health and care workers, how can we be promoting independence, how can we be doing all the things that we want to be doing if we're kept to a twenty minute call. It's impossible, it can't be done".*

Care workers also emphasised the impact of short visit times on their own stress:

*"And especially if it is only a ten minute call and you are running late already, something might have happened and you're already running late, you now literally have like two minutes. And it can be quite stressful in that sense".*

Other care workers talked about the implementation of new systems that may help to add in more flexibility and take account of intra-individual differences in service user needs:

*"Personally I think it should be a minimum of half an hour per call. If you don't need it, then fine, because the way apparently we're going to get paid, there's a new pay scheme coming in for our company anyway, where you're going to get paid minute to minute with the log in scheme. So if you log in and you're there for twelve minutes you'll get paid for twelve minutes. If you're there for forty-five minutes you'll get paid forty-five minutes, and that's what they're trying to do. Whereas I think if everybody has*

*a minimum of half an hour call then that's fine, because if they want it it's there to be used and if they don't you'll get paid it anyway, because you're not there, so you're there for the twelve and you'll get paid the twelve. I think that would be much better".*

Length of visit times as stipulated by commissioning and care plans was thought of as problematic from the management perspective also. Interestingly, managers focused here on not only visits that were too short but also those that were too long, and discussed difference in service user views as being important:

*"But you do get – and yes, there's not a huge amount – but there's the odd one or two that don't want you in their house. Yes, you've got to go and check that they've had their medication, but as soon as you've done that, they want you out the door. You can't force someone to let you stay in their house. So yes, there are certain circumstances, and that is all they need. To say you've got to stay there for half an hour, literally five minutes is really hard with some of them. "You can leave now. Why are you still here? I don't want to talk to you". It is very uncomfortable in those situations".*

*"Because we're all different, aren't we? Like some old people embrace everybody – "Oh yeah, come on in and have a chat to me" – and then there's others who are fiercely independent – "Get out" ".*

In terms of visit times that were perceived as being too short, from a manager view this typically included reference to too many tasks being included for the length of visit allocated:

*"But then there are things where you'll see a call come up for fifteen minutes and they want that person commoded, medication, breakfast, and then that is just impossible".*

96

Managers also focused on the damaging consequences of visit times that are too short, in particular those that led to mistakes in provision of care:

> *"Wrong medication. If they're a diabetic, if they accidentally put something with sugar in. Anything like that".*

> *"Have they locked up properly… Did they record everything properly?"*

> *"Things get missed. Mistakes happen, especially if people are rushing around. But then that's the same with half an hour or hour calls. If it's a half hour with someone who's got dementia, that every time you go in you need to explain who you are and why you're there and why you've got to do what you've got to do, that can take sometimes fifteen minutes to get them to come around, and then you've still got to wash them and dress them, do the breakfast, make the bed, empty the commode. And then it becomes a fifteen-minute call because you've spent so long trying to reassure them that you're there to help them".*

Managers also outlined examples of circumstances where due to short visit times carer tasks were conducted simultaneously, having clear negative impacts on service user dignity as well as health and safety:

> *"It is so wrong, but I've heard about times when care workers have had to feed people their lunch at the same time as they are on the commode".*

Similarly, managers outlined problems in service provision after a certain time at night, typically 10.30pm onwards where service user needs were not adequately met due to rotas/scheduled visits ending too early as a function of care plans:

*"There have been times when they've put a double pad on an incontinent lady overnight, because they know one isn't enough and it will be wet by morning".*

Travel time between calls was discussed as a further challenge that impacted upon both care worker and service users in the independent sector. Local authority participants had travel time included in their contracted hours and were also paid mileage at HMRC rates. The planning of rotas and how runs were coordinated was seen to have damaging consequences where care workers missed their break times in order to try to preserve punctuality of their visit times:

*"I think the travel times can be an issue as well. Because sometimes we'll have to go from X to X in five minutes, and you just can't do it. It's a fifteen minute trip anyway, so then it sort of backlashes. Because obviously then we have to go in and do that call and be fifteen minutes late for and then for the rest of the day then we find ourselves constantly working our breaks to catch up with the calls that we're behind on. So I think travel times is a big one, because we only ever get five minutes of travel from one house to another, and they're not all the same distance, are they?".*

Travel time was further discussed in terms of equity of pay, where many independent sector care workers cited not being paid for travel time between calls as an employment practice impacting heavily upon their dissatisfaction:

*"The thing is on the system this week my travelling time was something like ten hours. If I'd been paid for those ten hours on top of the actual working hours, it would have made a big increase in my wages, and that's ten hours I've been out that I haven't actually been paid for. It's ten hours I can't do anything with either".*

Care worker participants queried whether time 'lost' for travel time resulted in them gaining a fair rate of pay:

> "You might have an hour gap, then a quarter of an hour job, and then another hour, another hour gap. The quarter of an hour job, by the time you drive there, you know, we're only on like seven pound, say, I'm on £7.40 an hour, a quarter of that, plus your petrol has got to come out of that, and plus your hours sitting around in the car with your engine, sometimes it's not worth it".

> "I've often, I've never really worked out, ever sat down and worked it out. But, you know, I mean it's questionable whether – if you worked out the amount of hours that you're losing, if you then worked it out overall and you subtracted it by the amount of hours, then it's questionable whether we'd be working over the minimum wage or not. I don't know if – I know a lot of companies are looking into that at the moment".

Pockets of best practice were identified where some care workers cited appropriate and careful planning from managers in order to ensure that gaps and travel time were kept to a minimum:

> "It's quite good with our company because we've got a big huge range of children and adult services, plus if we've got a gap, a three-hour gap they say, oh do you want this client, and he's your client permanently. So they fill in your gaps – because I work from seven in morning, 'til half past ten. I get an hour and a half break every day just to go, have lunch, and then half an hour then to get ready to get into day clothes, go and pick up a young boy from school. So I'm quite lucky and that's what our coordinator's doing at the moment, because we've just started up domiciliary in X. Is that, she's not just going bid, bid, bid, she's looking at packages and looking, oh hang on, that'll fall into that one, so everyone's got a whole run, we – half of our

*carers haven't got gaps. If you're full-time you haven't got gaps at all, so we're quite lucky in that"*.

It was suggested having good management with local knowledge of routes and geographical location was important in appropriate planning;

> *"Again it's, you know, a lot of these things are down to – it's a managerial thing, because if you've got a coordinator that doesn't know the areas, if they don't drive, then potentially, you know, you're employing somebody to do something which they [don't know]".*

Working time, particularly travel time and length of visits, was one of the most discussed employment practices across all data collection sessions and was widely considered to be extremely problematic for both care workers and service users. Allied to this was the practice of lone working, often at night time, which could result in care workers feeling vulnerable to harm:

> *"It can be, especially when you're doing bed rounds, if you're on a single run as we do and you're out on your own, you're driving from one place to another. Night times in some areas isn't the best. You are on your own, obviously the company know where you are because you have to tap in the numbers, they know you're on your way to your next call. But in a short space of time something can happen to you, you're not safeguarded that way, you're on your own this time of night in this position".*

This was less of an issue for local authority care workers where most calls were double-handed. Some participants cited examples of being subject to violence and suggested their providers did not appreciate the risks to their safety:

*"It's our safety as well. I been bottled in a client's house, I've been hit with a hammer and you had a serious one didn't you [to colleague], with your car, and they don't care".*

They also suggested reporting complaints to management was futile as no action was taken. Furthermore, there was concern raised for allegations of malpractice:

*"Talking to my colleagues in preparation for coming, one thing that they say as well in relation to the responsibility is the vulnerability. They feel they're not paid a great deal and they're extremely vulnerable of allegations of inappropriate practise which can often lead to a police investigation and suddenly they find themselves in an awful situation where it's proved guilty or not".*

In general, care workers reported being unsure of where to report concerns (either in respect of themselves or service users).

In terms of rural working, this presented challenges to care workers' perceived health and safety:

*"I think everybody feels a slight bit of vulnerability. I do a night shift twenty-four miles away from where I live, and the last five miles is dark single track road. And that's a bit scary, because if you broke down there there's no way you'd have signal on the mobile, so what are you supposed to do then?".*

Managers explained that they used a range of technological mechanisms to track care worker location:

*"It's hugely successful, both for call monitoring, lone working, security.  Because of the technology available on the phones it*

*means that the staff themselves can take control of what they're doing, they can send a message back that drops into this person's account, it's a permanent record. This is what's happened today. They can take a photograph – obviously with peoples' consent – if there's something they're worried about, that drops in. We've got real-time imagery".*

Managers further explained that the systems used were not able to fully mitigate against difficulties care workers or service users may face, but also assisted in the supervision of care workers:

*"Yeah. And it also means if somebody rings up and says, "My support worker is not here at the moment," we can just look at the screen and say, "Oh dear, no, they've been badly held up, we'll either get someone else out to you or do you want to wait?" And it reassures people that actually we do know. One of the biggest things that it's changed is if you have someone with a level of dementia who's got short-term memory problems and is saying, "She wasn't there, she didn't come," when the member of staff is saying, "Actually I did come, I made a record". "She didn't write that that day". And you can't prove absolutely, even though you believe your staff, but if they physically have to be there to tag in then they're there…And yes, there is the downside to it, if you do find that someone is underperforming or if you do have a problem".*

**Worker Motivations and Occupational Status**

Here we present findings on worker motivations and occupational status. While not employment practice, they are central to the understanding of care worker responses to these practices and thus important for the later discussion of recruitment and retention.

*Worker Motivations*

Commissioners suggested the intrinsic 'caring' element of the role was a primary motivator:

> *"I'd like to think it's because they are interested in that caring role and want to help people, keep them safe and well looked after. And even for some people just for social contact as well because of social isolation and they may be the only person that they actually meet. So I'm hoping they go in there for the right reasons in terms of wanting to look after and care for people well".*

Manager views broadly echoed this view. They suggested that care workers generally wanted to 'make a difference' but that there could be a substantial personal cost of high involvement when people care. Care work was seen to be too demanding to do well unless care workers did it for the right reasons and enjoyed it. Other reasons were also influential and managers spoke about their own experiences as carers themselves in capturing work motivations of home care workers:

> *"On a personal note it suited my family"* (flexibility).

Other views encompassed a progression into other occupations:

> *"People who want to become qualified as nurses or OTs and it gives them a good starting block from that".*

There was also a focus on a role for semi-retirement which was seen as an increasing phenomenon, especially for those exiting from professions such as nursing in their mid-50s:

> *"Older people working in care – it is more of a vocation than a need to work".*

Less positively, motivation could also derive from low aspiration:

*"Can't find another job – I'll do that".*

As noted above, however, managers were clear that care work was only suitable for certain types of people and that that 'not everyone can do it'.


These views were largely echoed by care workers, who cited their motivations for working in domiciliary care as centring around the satisfaction and reward gained from caring itself. They focused on the notion of accomplishment in helping service users to have a higher degree of independence and discussed the importance of the relational contact for service users:

*"It's quite a rewarding job to do as in you have an impact on the life of the person that you're helping".*


It was also commonplace that domiciliary care workers chose their role due to some prior experience of caring for a relative or wanting to improve the quality of care that they had perceived to be inadequate elsewhere:

*"I personally went into home care because I had home care for my mother. But I wasn't really satisfied with the home care she was given.  So we ended up getting rid of the home care company she had and I took over as her full-time carer until she passed away, so I went into home care after she passed away".*


Care as a career later in working life was also evident:

*"I was drawn to the job after redundancy and I had a think about it, I was going to go into computers, I was going to go into college and do a course. Then when I thought about it, I thought, ah do you know what, I'll actually give that a go, cause I, I liked*

*the thought of it you know. I worked in, I worked in recruitment for a bit as well, doing HR and nine out of ten people doing the interview process they always say, I want to be a carer because I care, you know.  That's the cliché but, you know, everybody can say it but you know it's whether people actually mean it or not.  But for me it was the thought of helping vulnerable people to live. You know, helping them with the struggles you know, people less fortunate".*

Further discussion pertaining to the consequences of motivation on care outcomes was highlighted, where participants distinguished between those who chose working in care as their role of choice as being associated with higher standards;

*"I think there's two types of people that do care work, you know, there's the ones who want to do it, and there's the ones who do it because they can, because that can't do nothing else really, you know.  Then that's sadly, that's where the standards really separate I think, you know, it's the people who want to do it for the right reasons, or there's those that just think, oh well, you know, I'll do it because it's easy and because they can't really go into nothing, any other sector. And, like I say, that's really what's separates the good between the bad I think".*

Appropriate worker motivations were thus seen as essential to good quality care.

*Occupational Status*

Managers argued care workers are ascribed low status, both by those outside care and sometimes by the care workers themselves:

*"Yeah. And they probably know more about that person they're going to than the district nurses who visit once a week, they visit every day, they probably know more. But because they don't*

*have the title "nurse" or the title "doctor", they feel, oh I'm just a carer".*

Managers argued that care work was not low skilled and that its status should reflect this. They acknowledged the complexities involved in the role and suggested that it had changed over the years with care workers undertaking tasks that once would have been the preserve of a health care professional. Higher status was felt to be essential given the high level of knowledge care workers possess:

*"I would support anything that would professionalise the care industry".*

*"I think you have to work towards professionalising the impression of the job as well as the job itself. And I think that starts very much in college, in school even, when people are having their career evenings, it took years and years to move away from the belief that nursing is a female profession…. We need to move now away from this stereotypical view of care workers as low paid, not terribly clever, female and doing it because that's what's open to them. You need to raise the whole profile of the job".*

*"And they have to have so much knowledge".*

*"They do, they have to know more than other people who are just popping in and out. They have to remember so-and-so likes this, so-and-so likes that, it's not as if they're with one person, there could be ten, twelve, thirteen different people a day, and knowing what each of those people require, it's a lot for them".*

Low status and stigmatisation also came from relatives of carers where poor treatment of care workers was seen as commonplace:

> *"Relatives can be very, very -  well, just not very nice really. Well, some of the staff don't like being called cleaners. "When does your cleaner come?" We had a couple like that, didn't we?".*

A recurring theme was the media's treatment of care work in the wake of care scandals and a view that the negative image this created was damaging to the public's perception of care work. Managers suggested creating an alternative name for the role and indeed argued for the term 'service provider' to be used rather than 'agency' with its negative connotations.

Care workers agreed their occupational status was perceived as 'low-skilled' and that this, to some extent, attracted negative stigmatisation which was at odds with the high levels of responsibility they felt their roles entailed:

> *"I think there is a bit of a stigma about caring as well – there's a small minority, because it's minimum wage or thereabouts that carers get paid, it's like, they're only cleaners, carers, de, de, de. I actually experienced not so long ago a person, nothing to do with my job or my company, saying that my job was worthless, you don't even earn anything, you don't earn much money…".*

> *"And you're seen as, you're only a carer, that's how it sometimes feels, you're not the manager, you're not the OT [occupational therapist], you're not the social worker".*

> *"I think in some calls you're more or less the servant, you're coming in and you're doing things".*

Care workers explained the multifaceted nature of work tasks encompassed a wide range of responsibilities, that were not reflected in their perceived low status and differed from other care settings:

*"I mean if you work on a nursing unit and they're, don't touch medication, you're not allowed to. But you go to the community, like any tom, dick or harry, and you know, they're dealing [it] out to us".*

*"Oh you're 'just a carer', but they don't realise what we actually do in our jobs".*

They also felt that other professionals such as nursing staff relied on care worker knowledge when they attended to service user needs:

*"It should be in line with other professionals, as nurses. I know when nurses go in the community they haven't got a clue, they're asking us what to do like, you know what I mean".*

*"Because I think we do more than district nurses even".*

The gendered nature of care work was seen to reinforce its low occupational status, that is, as 'women's work'. Some male care workers cited difficulty in being accepted into care work and discussed the difficulties in gaining acceptance and approval from the service users:

*"Because like I said, obviously some people will be quite shocked that they're having a male. Some people when they do realise they will specifically request a male, but then other people don't want a male, because a lot of elderly gentlemen are quite set in their ways shall we say and they think it's a female's job. It is a woman's job, and I don't want a man doing that sort of thing. Is he gay? Is he what? That's what they think. And they don't want you there".*

Managers also talked about potential discrimination directed at male carers from service users, which impacted on managers giving calls to males who were not welcomed by particular service users:

> *"I had six male carers out of forty-five and I only now have two, and that's because I couldn't give them the work. Because even on the male runs, even when I had a male run, the service users would ring up and say, "Don't send him again, I don't want that."*

## 3.4 Employment practice: implications for recruitment, retention and care quality

*Defining Care Quality: Care Worker Experiences*

In defining care quality, care worker participants focused once more on the importance of time:

> *"I think time, obviously, you need time to do quality care. You do need the time".*

They also talked of quality as encompassing their best efforts, and assimilated this with the impact on service users of their satisfaction and well-being, together with more operational elements of the care process:

> *"And providing the best care you can, I think that's all it comes down to, is just as long as you know you've done your best and you've followed all the rules and regulations that come along with it. And it's also the wellbeing and the happiness of the client, I think their happiness is so important for everything".*

As part of service user satisfaction, care workers also elaborated on the tensions between the rigidity of care plans and what they felt their service users might need or want from their visits:

*"But obviously then there's certain things that you can and cannot do. Like you said, cutting people's nails and stuff, we can't do that. We personally aren't allowed to do that just for health and safety hazards and stuff. But then when you go in and your client asks you to do that because it's causing a pain in their socks or something simple and you have to say no, that's upsetting for them, because we're the only people who can come in and do that, other than the chiropodist and stuff like that, which they have to book and wait for. So I think that's a big part of it as well".*

They talked of the need to be able to adapt to changing situations as they unfold, and a mindfulness for how service user needs may change:

*"I wanted to mention something with regards to quality, and I think it's something about being able to adapt to what's in front of you at that moment. Now whether it's an individual person or where they're at at that moment, but it's meeting the need that's in front of you. And that might not be what's in the care package, or it might not be what it was yesterday or what it will be tomorrow".*

In terms of their ability to deliver high quality care, participants outlined the need for them to feel valued by their employers;

*"I think feeling valued makes you give a better quality of care as well. Obviously if you don't feel valued you're not going in there with the right attitude to give quality care".*

Managers' views were similar but focused more heavily on the operational and safety focus. Definitions of care quality focused further on promotion of independence, re-ablement, and the provision of care within the home:

*"I think for us good quality allows that person to live as independently as possible and access services. We are keeping people out of residential care and that is brilliant".*

There was a further focus on promotion of safety and acknowledgment of vulnerability of service users:

*"A sense of safety, feeling safe within their home. They are vulnerable, they need to be happy and satisfied with who is coming through their door".*

Other definitions centred on the notion of empathy, personalisation as well as more operational care aspects:

*"Not rocket science, it is treating people as you would want your mum or your dad or yourself to be treated but with a huge respect for the health and safety issues such as infection control and hygiene. And also a commitment to person-centred care".*

*"person centred, making sure the service user is happy with the service that they're getting".*

Other definitions focused directly on the understanding of the care worker relative to the service users' needs:

*"A good understanding of what they're going to be dealing with".*

As noted at the outset, contracting and contract monitoring processes were task based and often seen to work against, or at least not promote, good quality care.

*Job satisfaction*

All independent sector care workers suggested the employment terms and conditions discussed earlier impacted detrimentally on their

feelings of job satisfaction. Local authority workers were more positive and, indeed, many had moved from the independent to the statutory sector for that reason and would not return to it. Nonetheless, domiciliary care workers noted a range of rewarding elements to their employment. This focused on an intrinsic benefit of helping others, where the caring itself provided a certain achievement and satisfaction for participants:

> *"It's quite a rewarding job to do as in you have an impact on the life of the person that you're helping".*

> *"Knowing we've made a difference".*

> *"Some people we go to haven't left their house in years and we're the only people that they see, so it's like the company side of it as well, they look forward to seeing us every day because they know we're just there to listen to what they have to say as well, so that's nice".*

Care workers also explained that job satisfaction derived from the relationships they build with those they care for:

> *"You become friends with the service users because you see them sometimes four times, five a day, every day and you get to know them better than you get to know your own family sometimes. You know, they do confide in you, they depend on you".*

Care workers explained that although there were many elements of their roles that had a positive impact on their satisfaction, this was in some ways offset by other problematic employment terms and conditions:

> *"But then, you know, you can't pay your mortgage with a smile on your face and that's just a sad thing really. Because, you know, if there was other factors which contributed, which made it*

*more beneficial, then you know, it would make it that much more a satisfying job".*

Managers argued that care worker job satisfaction mainly derived from helping to maintain service user independence and enjoying the caring nature of the role:

> *"Knowing they're making a difference to peoples' lives, and building up that relationship. Some of the carers from the company I'm working with now have been with the company sixteen plus years and they've got their regular clients that they've known for sixteen plus years. And the clients say, "Oh, it's like a friend popping round to see me," so they still have the professional boundaries, but they're building up those therapeutic relationships and they feel they're making a difference to that person's life".*

> *"The caring, the sense of achievement from looking after someone".*

> *"They feel they've allowed the service user to stay in their own home – there is a massive reward in that".*

In addition, managers explained that size of organisation and staying relatively small might positively impact care worker job satisfaction:

> *"It's about the service users being happy, my staff being happy. I've got a good standard of living – and I have – and I'm happy with that. I never ever wanted to get massive and have seventy carers. I want a life too".*

Care workers generally had high intrinsic job satisfaction from care delivery, despite low satisfaction with terms and conditions.

*Discretionary effort*

Care workers primarily discussed discretionary effort in relation to the inflexibility of care plans, where participants felt frustration about their rigidity and potentially negative impact on service users. They cited examples of wanting to do a range of additional tasks in order to contribute to the service users' satisfaction but this was often not part of the care plan:

> *"Or hair washing, if hair washing isn't in the care plan you can't wash somebody's hair. It's little things you know would be safe to do, but because they're not actually written down".*

Other participants nevertheless cited a range of further activities they engaged in;

> *"And it's all that, it's interaction, you've got to know your client to know what they like, then you start doing a bit of research, oh he likes jazz music, so I'll go on the computer and I'll look for jazz singers and know this song. And hum to it and he'll sing to it".*

> *"It's a huge part. Doing personal care and things around the house for them is important, but actually sitting down and just knowing that I haven't got to rush off".*

> *"The thing is it's knowing the service user. Some don't want us hanging around, some want us to come in, do our job and leave. But others would like that extra five minutes to have a chat and ask them what they're going to do with the rest of their day, it depends on the service user".*

Care workers were only able to suggest changes to the care plan (which they saw as part of their role) to management who addressed these with the social worker:

*"I think as a dom carer, that's one of the key things, is being aware of these things that the clients want. If it's not in the care plan it is reported to the office to see if it's possible to put that in there, because that is what they want. Perhaps at the time they didn't want that when the care plan was done, or they haven't told a social worker that".*

Many also noted they work much longer hours than paid for as a result of dedication to service users. 'Tired' was a word frequently used to describe how they felt, and this was also mirrored in managers' views where they described care workers as suffering from physical and psychological exhaustion. Managers also expressed concern as to the sustainability of current models of care delivery because of their negative impact on care workers.

One care worker explained that the emotional impact of caring could be problematic and that it was difficult to separate your own well-being from some of the additional tasks that one might want to perform:

*"Sometimes – well, when my mother was alive I was looking after her for years and I always felt guilty about everything, if I couldn't take her somewhere or maybe she hadn't slept during the night and she just said and I'm thinking, oh God, I should have come over. But when you're dealing with the service users sometimes they can try and pass that guilt onto you as well. So at some stage you've got to think, well, no, this is my decision now, this is best for me, so I'm sorry but I've got to say no".*

Managers also talked about care workers going above and beyond care plans. Some managers felt this was acceptable but others focused on how difficulties arose in terms of service user expectations. Rigidity of care plans was acknowledged as being problematic, but the effort of participants in doing additional duties also linked to the blurring of professional boundaries:

*"They think that the staff member should be doing the household tasks and doing the washing and doing things that - Within half an hour, that staff member is really restricted in what they do, and sometimes they take advantage really of, "I want you to do the washing." We've got some where family will leave their washing there, their ironing there, and that's taking away from the service user's time because they're expecting them to do it. They leave their dishes and things like that, so they're expecting, well, they're in the house, they're doing the dishes, they can do all the dishes. But that's not what the carer's for".*

*"And then you'll have one member of staff who will do something and they'll go shopping and they'll bring things back in their own time".*

*"Well I suppose, when you're a carer, it's hard to have those boundaries, I guess, those professional boundaries. We're going in to help people, and if they really need something and they're phoning us, then we drop everything and go".*

*"Yeah. And then they leave and someone else comes in and then it's a massive issue; "Well, my carer always did it for me." Shouldn't have done that. Or the carers, "They're ringing me at eleven, twelve o'clock at night," why did you give them your number?".*

Discretionary effort arose from the motivation to care and high levels of job satisfaction. Ultimately, however, it could place unmanageable burdens on care workers, particularly when coupled with long working hours and insufficient call time to deliver a quality of care perceived to be acceptable.

Commissioners were also aware of this challenge and the implications it had for satisfaction and care worker well-being:

*"I think sometimes families think that when a care worker goes in they have to do every single thing for them. And then when they don't meet those demands or sometimes unrealistic maybe standards, I'm not saying – I'm talking about unrealistic standards now – and I think the tensions and pressures that they face sometimes when they're in difficult situations like that. I mean, certainly those are the complaints that come through to me, across my desk, I don't get involved in every complaint but it does come through into the authority. But the ones I have it's been very challenging and I think sometimes care workers have felt quite intimidated really within some certain circumstances. I think that is a difficult part of the job".*

## Care Quality and Service Providers: Recruitment and Retention

*Recruitment*

Although the question set did not directly ask care workers about their experiences of recruitment processes, there was a suggestion from care workers that recruitment practices needed to incorporate a realistic job preview, so that potential applicants were fully versed with the range of duties expected of them:

*"I think sometimes recruitment can be an issue. As a business you can't get bigger without staff, you can't do one without the other. I deal with recruitment where I work and sometimes we have people come in and they don't seem to understand what the job is about. So someone will come in and say, "I want to work Monday to Friday, have weekends off," and stuff".*

*"Yeah. I think people should understand what care means".*

From a manager perspective, the general view was that recruitment systems could be improved, and that there were a range of circumstances that impacted on successful recruitment, such as

waiting times for employee checks that are conducted by external agencies. Local authority processes were also very slow:

> *"We don't have a brilliant recruitment process…we advertise online, however we are mindful that not everyone is IT proficient, it has had an impact. The form is quite wordy and it is something we are looking at. We use the free websites, like indeed. The time duration for the DBSs takes 12 weeks and we lose a lot of people in that time. It has a massive impact. We are asking people to wait for 3 months from when they apply to when they start… it is out of our hands. It's a massive thing for us".*

Other managers talked about attrition of applicants at various stages of the recruitment process, where potential care workers attend interviews and then do not take up the offer of a role:

> *"No. You think, well, do you want a job? We've had people come in for interview, "Oh yeah, fantastic. Really great interview. Oh, you offer so much more training than where I've been before. That's amazing. " right, sign them up for induction and they don't turn up".*

> *"Is it because they need to look like they're applying and going for interviews, that type of thing for the Job Centre? Who knows?".*

Others also talked of having inducted care workers for two weeks, only for them to take up employment with other service providers who did not provide such thorough induction.

In terms of selection criteria and methodology, managers explained that along with capturing experience and background, they want to assess for the 'right attitude'. This was defined as having a caring nature:

*"It is caring, one of my favourite things is when I ask them for their weaknesses – when they tell me they get too attached. There is a fine line between being professional and becoming too attached but how can you care for somebody and build a relationship so that you are helping to get to really know someone…how do you build the relationship to give them the best care. So when they are all upset like this morning [a service user has died], it is a good thing, it is because I know that they are caring".*

Recruitment processes aimed to capture the right attitude through things such as situational interview questions:

*"We've got scenarios we built into the interviews, and the very first one is dealing with personal care and we talk about a lady who has never required personal care before. On this particular day you walk into the room and she's sat in her chair and has been unable to get to the toilet in time, and she's got faeces and urine on her, and on her chair… and what I ask them is what's the first thing you are going to take into consideration when you walk in to the room and see that lady there? And the first thing people say is process, clean up, clean up. Yes, that goes without saying. But what I want to hear is that you think about her – how is she feeling? She's never had any issues with personal care before. It's about dignity, and ensuring quality and I genuinely believe that quality is at the heart of everything we do. It is about stepping back and considering how embarrassed she must be feeling, and thinking about yourself – how would you feel? Someone's come in. I want them to tell me they are going to reassure her, what I want to know is that they are really going to think about her and ensuring that as far as possible when they leave there, her dignity is intact".*

Moving from process to availability of labour, recruitment was generally felt to be problematic for service providers. There was frequent reference to a 'crisis' in recruitment (and indeed retention). Local authority providers typically had fewer difficulties but were by no means immune. Managers felt the same pool of care workers tended to move around service providers and few new care workers were being attracted into the sector:

> *"It's a really transient workforce in care – people move around from agency to agency".*

Recruitment difficulties created staffing shortages and capacity deficits with service providers describing how they were unable to accept new packages of care and had often had to operate 'one in one out' [service users] systems.

The need to work with schools and colleges to make care a more attractive career was also raised. While pay and working hours were problematic for recruitment, addressing these was not the whole solution. For example, some service providers paid high hourly rates and still experienced recruitment difficulties. Status and image again were clear influencing factors.

Commissioners also expressed an awareness of recruitment challenges facing service providers:

> *"I think everybody is in the same position in terms of struggling. From a provider perspective if they're struggling to recruit staff then obviously there's going to be an issue for me in terms of actually meeting that demand. So again, there's a benefit in them having staff who are trained up and skilled with those more re-ablement skills so that they don't have to recruit additional staff because they will be working with people to either maintain*

*them or reduce them. So they will have to keep on recruiting additional staff which maybe is not available out there in the market".*

Managers and commissioners explained difficulties in recruiting care workers who speak Welsh and emphasised how important this was to meeting service user needs. There was evidence of best practice where one service provider gave Welsh lessons to their care workers, but this was also discussed in terms of challenges with cost.

Competition from the retail and health sectors, with better employment terms and conditions and working conditions, were frequently cited as highly problematic for care worker recruitment.

*Retention*

Some commissioners argued that employment terms and conditions could be optimised to enhance (recruitment and) retention:

> *"If they've got good terms and conditions, they're well looked after, in terms of quality then they'll recruit the right people and people are more inclined to stay with the organisation as well. So, if they stay supported through good quality training and allow time for training etcetera as well, in terms of payment for – which is something we're going to be obviously considering coming through the contract – in terms of the payment for the travel time between calls, allowing sufficient time. I think if you look after your workforce well and give them good terms and conditions then hopefully they'll be recruiting the right people and holding onto the right people as well".*

Many managers also suggested that retention was highly problematic, though this was not the case for all, and was influenced by the

difficulties in terms and conditions imposed by commissioning arrangements. A central theme was that of overwork and exhaustion of care workers as a result of increasingly demanding shift patterns/working hours and the demanding nature of the role as a whole:

*"It's a hard, hard job and I don't think people realise that".*

*"I think when we get leavers, obviously we do an exit interview. We get a lot that we expect a lot from them, they are very tired. Because there is a shortness of numbers. We are ten care workers down, 250 hours which is a lot. We are reliant on the office staff (also care workers) who take up extra hours. Or we are asking those out working to take up extra hours which is hard – because recruitment takes so long".*

Retention difficulties were seen to be due to care workers leaving to work in more appealing care settings, especially if the provider was diverse with other avenues of care provision:

*"We lose them to other services as we are a diverse organisation (housing support, residential care, nursing care). When you are a care worker, you have limited qualifications and you feel quite restricted in where you can go in that role. In this organisation, we tell them what is out there and push them to make decisions about what might be best for them and promote them. People are sometimes pushed in to care work as they have no other qualifications or a confidence issue, you know".*

*"Really hard.  Lots of ours, because we work with children and adults, tend to go into specialist areas, like go into autism, teaching assistants with disabilities. We've got quite a few that are doing their nursing degrees, quite a few that are doing social work degrees. So we train them to a certain level, and ours is quite a high level because we do deal with lots of challenging*

*behaviour and things, so they get very specialist training and, of course, that helps them move on elsewhere then".*

The retail sector was again frequently cited as a competitor sector, with better terms and conditions of employment and a more pleasant working environment. Zero-hours contracts could also be problematic, where the stability of the role is a factor in care workers' choosing to work elsewhere:

*"But unless we're contracted very differently by Social Services - if someone goes into hospital, then payment stops. We can't contract someone to work for thirty hours when they go into hospital. We've got no money. So if a dom care agency did contract all their staff, if people go into hospital, that dom care company then ends up being non-viable…".*

*"Stability. They're all on zero-hour contracts, whereas if they go to work for the NHS they have their thirty-seven and a half hour contracts".*

*"My staff retention is really good, and then I lose staff to the NHS. But to me, that's a massive step up for them, and I miss them, but I'm pleased to see them -  if my staff were moving around to other agencies, I'd be heart-broken".*

Providers also felt that training could be problematic as the organisation may be more likely to lose their care workers to other professions or promotions elsewhere:

*"We did want to help people to progress and improve and develop.  Now we want to hold onto them like this, don't we?".*

Working time in terms of gaps between calls was linked to retention levels as a function of earning:

*"We've had staff leave us because they don't like having gaps in their run. Then they go to an agency that literally do have back to back calls and they're continually rushing, cutting corners, and they hate it, but they get paid more, so they stay there just for the money".*

Geographical location and planning of care runs could also improve retention:

*"It just made it so much easier to retain staff because they were in the area. Whereas I've gone to X [other provider] which covers the whole of X, X and X [geographical locations], and trying to coordinate that just makes it impossible for me to retain staff and to keep the distances down. It makes it really hard".*

Other retention mechanisms included training, support and supervision:

*"Training I think is really important. A good induction is fundamental. Because when staff are trained, well trained, they feel better to cope with things".*

*"It is a very short period of time that we are interviewing them so we work very closely with our trainer who has a week with them [induction] before they go out so he is the one that knows better than me because in that short period of time in an interview they can pull the wool over your eyes. But to really get to know someone in an hour is impossible. They need to be interested and passionate. When they come out of training we communicate everything back to the coordinator and we give her a run down about confidence, how much support. It is about matching up new carers with a buddy at the beginning to help build their confidence... making sure the right person goes out*

*with the right candidate at the beginning. If I put someone out to work and don't give coordinators the right information. If we put someone nervous with someone not nurturing, it is overwhelming to start any new job – if they aren't with the right person they are going to walk".*

Management's approach was also central to retention. Important elements included being approachable and visible and seeking staff views and consulting them. Other tactics included employee awards and social events;

*"We've got Carer of the Month, so we encourage service users and staff to nominate other people for Carer of the Month and they get a £25 gift voucher and then we have a newsletter, so they'll have a little piece written about them in the newsletter. We put it on Facebook as well...".*

*"They get an email, a memo. We've got a big noticeboard in work now as well, so we put pictures of the feedback and things on the noticeboard so anyone who comes up can sort of see what they've had, and the Carers of the Month go on there and things like that. But it is hard".*

*"Yeah, I think we're quite lucky because one of our staff members, she's actually a complimentary therapist and she does hot stone massage and things. So not long back, after our usual morning meetings, we'd sort of arrange the rotas around everyone having a treatment. So that was quite nice. Everyone was quite relaxed and mellow for the day. So that was quite nice".*

*"We get to know the staff and get involved so they know there are people there… we go in to the staff meetings. We welcome the issues we want them to tell us and share. It is important to know that they do feel valued and they can air any concerns that they have".*

While terms and conditions of employment were problematic for retention, they were only a part (albeit an important part) of the story and some service providers felt that retention could be influenced in these more creative ways.

Care workers similarly saw terms and conditions as only part of the picture. There was acknowledgement that some of the more problematic employment terms and conditions were beyond service provider control and an almost implicit acceptance, at least by those still in the sector, of these poor terms and conditions. Most important to care worker retention was their feeling valued by their organisations, though terms and conditions were obviously part of this. Participants focused on the behaviours of their managers in showing them they were appreciated for the work they do as being central to wanting to remain within their employment. Here there were both negative and positive examples provided. Much of the best practice centred around managers being approachable and listening to the needs of their employees and showing reward in ways other than terms and conditions of employment:

> *"In some ways I know carers unhappy with their rotas or not working with a client, but they're more scared of the boss or the manager, that they just take it and take it, and take it until they quit. But here I know I can go into the office and go, this is my problem. It might take them a week, it might take them two but they will listen".*

> *"…it's a massive difference when you, when you go to a company which, alright you've got all the root causes that we're talking about, the pay, the travelling, all the root causes. They'll never change because of the nature of the industry. But it does make a massive difference when you work for a company who are using a half decent management you know, they do listen".*

126

Participants explained their choices as to what provider to work for as deriving from a sense of trust in the management team:

*"In X [geographical area] alone there's got to be at least forty different care companies and you can pick and choose, you know, some of them do pay better money than we're getting now. But it's – because we've got a great management team with this company it is one of those that I'd prefer to stick with at this point at the moment. I'm hoping that, like you know with things like that and the government are always on about, they're going to look after carers and support those better, that they might give us a decent wage, or pay us an hourly rate eventually, so that's why I'm going to stick with it for the time being".*

Some participants explained that a lack of appreciation from their managers was problematic and may encourage them to apply for work elsewhere:

*"I think showing carers appreciation too. We do a job that nobody else wants to do and you never get a thank you – from the clients you do, but you don't get a thank you from the powers that be".*

And others cited that positive appreciation from their managers was central to them wanting to stay within their roles:

*"I do feel valued by my employer and my employer does a great deal to let us know that we're appreciated. Today there's a buffet going on, we're given chocolates, we're given phone calls, we're really appreciated. I work in a small area, my employers, my managers, are really supportive, so I've got a different experience from yourselves [other focus group participants]. I do think it's important to give that balance".*

In stating positive factors that impacted upon wanting to remain in their roles as domiciliary care workers, the distinction between domiciliary and other types of care provision was highlighted where participants cited flexibility and a sense of freedom in going about their work tasks within a community setting:

> *"It's the flexibility of it as well… I find that I can give more to the community and to the people that I go and see. Whereas if I was somewhere in a nursing home for instance, I wouldn't be able to do as much as I do".*

Similarly, participants provided examples of good practice, which heightened their likelihood of staying:

> *"They all come in, they have a big massive day of cakes, drinks, games and you've got the eighteen year olds coming in for a bit of a disco in our office. And we've got the elderly now, and like this week now, or next week, Wednesday, we're picking all our clients up, taking them to our office, we've got a jazz singer come in. It's the little touches to our team and just – it just brightens your day and I think, hang on, I've done something good, I can go to bed now, I've done something good today".*

Some participants discussed working in other job roles as well as being employed as a care worker, and cited that despite poorer pay in care work, they chose to work more hours because of how rewarding the work was for them:

> *"And I've cut my hours – I get paid more money as a doorman in the night time and I could give up my door – I gave up seven days of the doors just down to one to just do more hours of care and that's why I love the job and I've always taken the job".*

Care workers also explained their movement from and to different agencies and drew on a range of experience to explain the factors that impacted on their likelihood to stay. For example, length of visit time was seen as central to retention:

> *"The one thing that drew me to this was, we don't do less than an hour calls. Yeah, you know, cos there's no way in the world could I work, well I would work but I'd fight it. You can't do someone's breakfast in half an hour and get them up and dressed".*

Much of the discussions on retention issues focused on the planning of working patterns and visits, including travel time. Care workers felt they would be more likely to stay working in domiciliary care should there be better provision in this domain:

> *"If you look at our role and our job and at the hours that we work, if the calls are needed from seven o'clock in the morning until two o'clock in the afternoon, why can't we just work from seven until two? Get paid from seven until two, and have as many calls that are feasible, possible, in that time. And then the evening shift, from three until ten.  And then incorporate all the calls that we can – we're guaranteed six or seven hours pay, we get the clients done, you're less rushed, you know exactly where you are".*

Best practice was identified by some care workers, where for example a system that matches care worker to service user interests was seen as something that optimised retention and was central equally to the promotion of care quality:

> *"You know you said about the quality of care, I think one of the biggest things with the company I work for again is the matching up of personalities. It is such a huge thing. Just because you're not the best personal care carer, because that person trusts you*

*more they open up more and things get done better, I don't know. That is one of the best things about it, is the personality matches".*

Other care worker participants cited that recruitment processes should take into account home location and proximity to the home worker community in order to minimise the problems associated with travel time:

*"I think also as well it is the recruitment thing - but when, if you employ people that live outside a certain radius then that's got to be improvement issue, because you know, if you're a domiciliary provider and you've got all these issues, then you should only really be recruiting people within a five or ten mile radius, because otherwise you're just, you know, you're setting yourself up for problems".*

Furthermore, there was reliance placed on the iterative nature of the employment terms and conditions on recruitment and retention issues and their interplay with care quality outcomes (in particular continuity):

*"It's chicken and egg though, because like all the reasons we spoke of earlier, they all contribute the core tension levels, which are - you know, because our company one year we had forty-six percent retention hours. Now that's, that's one of the reasons why I left the job, you know recruiting care workers and the - you know, you talk about continuity being such an important thing to service users, yeah that is a massive issue within the sector. So you know people come, we get people come, they work one day, they're like, nah I don't want to do it".*

In one local authority service that we visited, five new care workers had recently joined and gave terms and conditions and care quality as a key reason for moving from the private sector. They also painted graphic pictures of poor private sector provision where long hours and

low pay lead to high levels of staff turnover and poor quality as a result of limited induction and ongoing training.

**Care Quality: Service User Outcomes**

Commissioners and service providers noted the changing landscape of care, with emphasis shifting to incorporate a broader range of outcomes centred around the need for a greater understanding of what service users really need and want. They mentioned the need for skilled communicators to ascertain service user perspectives of care quality and how these map to the ambition of supporting more holistic well-being and independence. This was, as noted previously, argued to be at odds with current commissioning and contract monitoring processes. Managers suggested that individuality of service users and how they viewed the notion of 'care' was paramount:

> *"Everybody's view is different, some service users just want you to sit with them for five minutes to make them feel special".*

> *"person-centred, making sure the service user is happy with the service that they're getting".*

A further distinction was made between meeting the 'needs' and 'wants' of service users:

> *"and it is hard because we're only contracted to support someone with their needs and not with what they want…say somebody might want to go to bed at half past eleven, they can't meet those needs. They can't because carers will only work till ten, half past ten, eleven".*

> *"But they need to go to bed and they need assistance to get into bed, so therefore they have to have a call".*

Continuity of care was a central theme and the challenges around this were discussed in the context of recruitment and retention problems:

*"But then if you have a massive turnover of staff, how can you guarantee continuity? You can't, with holidays, sickness. But I think we all do our best with continuity".*

*"We try really hard and our continuity is awful compared to what it should be because of constant sickness and then having someone that knows someone and then you've got to take them out of that package to put them into another package because there's no one else that knows person, and then that person's continuity changes. It is really, really hard".*

*"There are lots of the bigger agencies that cover calls. So as long as there's a name on there, to them, they cover the call and it doesn't matter. And that's when it comes back to actually being an agency that cares about what you do or whether you're an agency that's run by someone who just wants to make money".*

*"When you're toileting people, showering people, I would be mortified if I had a complete stranger…".*

Care continuity was also discussed with reference to the challenges that it could bring in managing professional boundaries and where familiarisation could result in a raised expectation of care provision and increased discretionary effort from care workers:

*"I think there's got to be barriers really, professional barriers. You know when you're sending someone in to see somebody five mornings a week? They do become familiar, they do become complacent, and again, that's when things happen. It just takes one little thing and then it all goes horribly wrong….yeah, because complacency does come with familiarity".*

*"It's just some people do get too complacent or too familiar if not complacent. They may do the job thoroughly to a T but they*

*could be that little bit too friendly where there's that – and it is hard obviously in this job when you are with somebody on that run for so long. I've had a client since I've started, so four and a half years, and it is hard not to create that friendship and that bond. But obviously to try and then keep separate and keep professional is difficult. And some people can't do it".*

Managers explained the challenges in providing continuity with the high prevalence of zero-hours contracts:

*"…we've talked about zero-hours contracts and the issues that has for people, and then people move around, they don't want to stay in that job; that affects consistency. It's just like a big circle really, isn't it?".*

Overall, care quality was felt to be compromised as a result of commissioning practice that created poor terms and conditions of employment which were widely linked to recruitment and retention difficulties. Some managers were positive about their ability to influence this. Others were much less so and cited substantial concern over increased funding constraints, regulatory changes and ongoing financial pressures:

*"No one sets out to provide bad care, but you're dragged to it, dragged into the gutter".*

In the extreme, one manager argued that service providers could reduce in number creating capacity problems in the system and with detrimental consequences for quality and the possibility of:

*"Lonely and immoral deaths".*

Care workers also linked terms and conditions of employment to care quality and suggested that service users were aware of these, through

a variety of mechanisms. First, they suggested an awareness through television and other media reports:

> *"I think they are becoming more and more aware, through the press".*

Care workers also suggested that services users had a sense of sympathy with the challenges that they faced:

> *"I do, yes, think they are aware [of pay and working hours] and sometimes, many clients that I go and see will say about some of the dom [domiciliary care workers]…they'll say you know it's terrible, they've had to rush in here to rush off there. Not fair on them".*

Care worker participants highlighted a number of things that they perceived to impact upon service user satisfaction. In particular, they voiced concerns about punctuality difficulties as a function of travel time issues and shorter visit times:

> *"But one of our clients is very time conscious, she won't let you in early, she won't let you in late, and that brings a stress then because you need to do everything you need to do for her in that call and the constant conversation is, "I don't understand why you're late".*

> *"And a lot of the older clients are very time conscious. If you walk through that door two minutes late they want to know why".*

There were also examples of where care worker frustration with visit time length could impact on their attitude and ultimately the standards of care they were able to provide:

> *"Yeah, because you've got to drive here, you've got to drive there, so then you've got  -  then you start considering the logistical impact as well, financially and you just think, what is the point, what is the point.  And then when you start thinking, what is the point, then that contradicts every reason you're here. Because you start getting a little bit disgruntled".*

There were, in some cases, suggestions that lack of time to care could be tantamount to abuse. In terms of defining quality of care from the service user perspective, care workers cited a range of factors that centred around the relational element of care and how that was determined by continuity of care:

> *"Relationships with your clients. Because not everybody at that age wants five different people in one week to go and have a wash. They would want to have a wash with the people – and it's hard to build up that relationship with somebody to have them naked in front of you so you can put them in the shower and then all of a sudden you've got that confidence and then they're moving you on now to somebody else.  And then you're walking in and you've got that same problem, trying to gain their trust so to speak, to be able to carry on their personal care, you know?"*

> *"This woman has become so much more confident now she knows who I am, she can trust me in her home and she doesn't have to worry about it. And her dementia is really strong as well. For me, it's quite worrying to have other carers going in there, not for any bad reason, just because she doesn't know who they are".*

Care workers provided some examples of why continuity was important, stating that higher levels of familiarity with service users impacted on a greater ability to understand their needs and symptoms and therefore enabled them to provide higher levels of care:

> *"But if somebody new walked in, it's like people in hospital, the nurses leave them, "Oh, she's an old lady with dementia." No, she's not, she's not normally like that. That's what is making her confused, it's nothing to do with – so continuity is a big part….and the eating habits as well, because obviously she has dementia, sometimes she just forgets to eat.  It's little things like*

*that we pick up on because we know her. Now other carers will just put the food back in the fridge, she hasn't eaten that, they'll assume that she's eaten something earlier on in the day, but it takes us who know her well to know that she's just forgotten to eat".*

Other perceptions focused on the relational element as being more significant than the operational or physical care provision:

*"Yeah, but people think it's a lot about caring is wiping their bum but actually most of it is actually speaking to your clients and talking".*

Similarly, when addressing manager views the acknowledgement of the challenges in promotion of quality care were addressed in terms of the constraints from challenging employment terms and conditions:

*"If we are expecting care workers to work long hours, if we are expecting them to put in extra calls, it is going to have an impact on the care that they provide, naturally. Not through being neglectful but because they are so tired. They can become complacent due to tiredness".*

## 3.5    Summary

Here we have presented commissioner, manager and care worker perspectives on the research objectives. While complex, we have demonstrated a high degree of consensus across these stakeholder groups that employment terms and conditions and career structures are problematic for both recruitment and retention and care quality. We have outlined mechanisms through which service providers can alleviate these difficulties and note that funding levels and commissioning practice are central to these.

# 4.    Conclusions

The aim of this project was to explore the factors that affect recruitment and retention of domiciliary care workers and the extent to which these factors impact upon the quality of domiciliary care. The specific objectives of the research were to:

- identify factors which both positively and negatively influence individuals to choose to become and remain working as domiciliary care workers
- identify the extent to which these factors impact on the quality of domiciliary care.

The research focused on employment terms, conditions and career structures. In particular, we explored workforce development, pay, employment security and working time. We also considered worker motivations and occupational status as important influences on care worker recruitment and retention.

## 4.1    Context

We begin by considering the domiciliary care context. While this was not specified as within project scope, as we noted above, it influences the matters under consideration to such an extent that its inclusion was required to develop understanding of terms and conditions, career structures and their wider implications. Detailed analysis of contextual matters was, however, beyond the remit of the project and we confine ourselves here to outlining key issues that arose during data collection and recommending any further investigation required. We discuss challenges for domiciliary care in three key areas identified by the Care Council for Wales (2010): policy and regulation; demand, that is demography and expectations of care; and supply, that is skills and qualifications.

**Policy and Regulation**

A consistent and important theme across all participants was inadequate funding for domiciliary care provision. Most provision is externally commissioned and local authority commissioners perceived it to be more flexible, have a lower unit cost and (for some) be of higher quality than internal provision. Commissioners emphasised quality and cost in their commissioning processes, whereas service providers felt these were primarily cost-focused. This resulted from funding pressures, which were of particular concern given the imminent introduction of the NLW. Most commissioners were unclear as to whether they could afford to increase the unit price offered to service providers to accommodate the NLW and a number said they were lobbying Welsh Government for additional funds. All service providers expressed concern about the current unit prices and the implications of NLW, arguing many independent sector providers risked ceasing to trade and that this would create substantial capacity difficulties in the domiciliary care market. A re-current theme was the dependence of health care on an effective social care system and the attendant potential risks to health systems.

Allied to funding levels were the commissioning models adopted by local authorities. A range of models were evidenced, all with advantages and disadvantages, but there was substantial reliance upon spot contracting as cost-efficient and flexible for commissioners. Coupled with generally low unit prices, these contracts had substantial influence on the issues of specific focus in this project, that is, employment terms and conditions. Low pay and zero-hours contracts were, for example, argued to derive from insecure contracting arrangements with extremely tight margins. Commissioners did not seek to influence employment terms and conditions in current contracts, although some monitored compliance with general employment legislation, but a number indicated a desire to adopt Unison's Ethical Care Charter in subsequent contracting

rounds. A national contract was also suggested as a way of enhancing terms and conditions. The financial implications of both were noted as a concern. While it is not within the remit of this project to make recommendations on domiciliary care funding and commissioning processes, these are inextricably linked to employment terms and conditions and career structures and we note here the need for their further investigation.

Domiciliary care provision in Wales is subject to various policy and regulation. The introduction of the Social Services and Well-being (Wales) Act in April 2016 was prominent in our findings, as it will create a substantial shift in approach from minimum standards of care that are largely task-based to outcomes-based care. This was broadly welcomed by our participants but raised a number of issues. First was the tension between an outcomes-based approach and current commissioning and contract monitoring processes that rely upon examination of time and task. Registered managers in particular noted that alternative monitoring processes would be required to support its successful implementation. Allied to this were concerns over gathering the required evidence by service providers and a need for further guidance on this. Second was the requirement for greater education of service users and their families as to what constitutes care given a shift to outcomes-based care with an emphasis on re-ablement. There were perceptions that this may not be seen as 'good care' by those who wanted a more traditional delivery. Third was the extent to which outcomes-based care would offer the necessary autonomy. While broadly welcomed, there were concerns that care plans are unduly restrictive and inflexible and do not facilitate autonomy. Many participants called for greater flexibility without always needing to involve Social Services in care plan changes. Some local authorities operated permitted variation systems that were felt to be helpful. These issues again require further investigation.

Finally, there appeared to be limited appetite for joint commissioning across health and social care and there was concern over duplication of effort across local authority contract monitoring and CSSIW inspections. A more joined up approach across agencies could be encouraged by Welsh Government.

**Labour Demand**

Workforce data collection is improving but still lacks detail and there is little modelling of projected labour demand over the coming decades. Given Wales's aging population and the likelihood of increased demand for domiciliary care, more robust workforce data collection mechanisms are required, together with a clearer understanding of future labour demand to support workforce planning in the domiciliary care sector.

**Labour Supply**

During the data collection phase of this project, the Welsh Government announced the introduction from 2020 of mandatory registration for domiciliary care workers. The commissioner and manager response to this was largely positive, as it was seen as an opportunity to raise the status of care work (we explore this in more detail below). There were some concerns expressed as to its cost and whether it might be a barrier to entry to the sector and argument that it will be important to position registration in a positive way. There was very limited understanding of mandatory registration amongst care workers. Detailed communication will be required and Social Care Wales will have an important role in this. Further, a number of participants argued that the motivations and aspirations of new entrants to the sector were unknown and potentially different to those of longer serving care workers and it is important to develop understanding of these. We cover other labour supply issues relating

to training and qualifications in the following discussion of employment practice.

## 4.2    Employment Practice

We first discuss findings for specific employment practices, before drawing these together into an overview of factors that positively and negatively influence individuals to become and remain domiciliary care workers and the implications of these for care quality.

### Workforce Development

While commissioners and service providers suggested training was widely available, many care workers did not support this. Despite evidence of some good training practice, a number of care workers reported having started working with service users following inadequate induction training. Many also noted a lack of ongoing training opportunities, particularly in specialist areas such as dementia. Funding influenced this, both in provision of training places and release of staff from caring duties to attend training. Commissioners also argued that there was a need for more management training for service providers themselves. As we discuss below, effective management by service providers can to some extent mitigate problematic terms and conditions of employment, yet effective management practice was not evident in all service providers. Commissioners also argued that managers would benefit from training in the financial aspects of running a business.

Although it was not possible to establish precise numbers of care workers holding QCF2, most managers indicated that their organisations had not met the 50% NMS target and that only around a quarter of their workforce held the required qualification. High levels of staff turnover were partially responsible for this. Both service

providers and care workers expressed substantial concern around the removal of government funding for those aged over 25 to obtain these qualifications. There were also some who felt that QCF was overly task-based and did not develop the right skills, arguing that higher-level qualifications and specialist training were more appropriate to service provider, care worker and service user needs.

There were mixed views on the availability of domiciliary care career paths, but general agreement that (even where they existed) they were unclear to those both within and outside the sector. There were, however, small pockets of innovative practice, for example, one service provider ran its own cadetship programme. Removal of funding for apprenticeships for those aged over 25 was again cited as problematic. Prior to this study, there was limited evidence in respect of domiciliary care careers in Wales and our findings indicate there is much work to be done in this sphere. Many suggested that greater interaction with schools and colleges was required to present care work both as an attractive career and a career in its own right, rather than as a stepping stone to, for example, nursing. Positioning care work as highly skilled, rather than a job which required limited qualifications, was also argued to be essential.

Supervision was thought to be important by all participants, although there was a general recognition that time and logistical difficulties meant that it happened less frequently than was required or desirable.

**Pay**

Care workers were hourly paid and, in the private sector, mainly received the NMW. Those employed by local authorities and some in the voluntary sector received higher pay, although the latter was still usually below NLW rates. Outside of local authorities, care workers uniformly expressed dissatisfaction with low pay and were also of the

view that it did not reflect the levels of responsibility in the role. Service providers recognised and regretted this but argued commissioning rates did not allow them to pay more. As we note above, there were widespread concerns amidst both commissioners and service providers about the introduction of NLW and the implications of the cost increases associated with paying it. Other than those employed by local authorities, care workers did not receive payment for travel time, although some commissioners argued their unit prices should support its payment. Benefits were again limited in the independent sector and while some argued for innovative low cost options, for example, scooters and childcare, there was limited wider enthusiasm for these. Low pay rates were allied to the (perceived) low skill and low status nature of care work and were argued to be problematic by all participants.

## Employment Security

Zero-hours contracts dominated in the independent sector, with only those care workers employed by local authorities routinely having guaranteed contracted hours. While it has been argued that care workers favour zero-hours contracts, we found limited evidence to support this, although some care workers did cite flexibility as a benefit. Most care workers regretted the insecurity they created and cited difficulties with obtaining mortgages as, despite often working long hours, these were not guaranteed. Many service providers argued spot contracting by local authorities meant that they were not able to offer more secure contracts. A small number of service providers were, however, increasingly offering at least some guaranteed contracted hours. This was largely to counter difficulties created by zero-hours contract workers turning down work offered, which then led to problems with service delivery. Employment insecurity was, however, typically experienced by those working in the independent sector and was often linked to labour turnover as care workers moved jobs in search of more secure employment.

**Working Time**

The long hours worked by independent sector care workers was a common theme. We also frequently heard that, as they are paid only for contact hours and not travel time, they often work full time hours for part time wages. Opt out of the WTR maximum weekly hours was common. Long hours were mitigated to a certain extent in some service providers by the organisation of rotas for mutual benefit so, for example, care workers could collect children from school. Long working hours, however, led to fatigue and strain and this was exacerbated by practices such as very short visits to service users. Here care workers were under pressure to work quickly which was stressful and they also expressed substantial dissatisfaction over the impact of this on care quality. This was typically of greater concern to care workers than pay levels and other employment practices. Many also expressed concern over lone working and vulnerability and service providers argued that electronic monitoring systems were helpful in supporting lone care workers. For a number of reasons, working time was one of the key sources of dissatisfaction for care workers.

**Worker Motivations**

A range of worker motivations were cited, the most common being the desire to help and a make a difference to the lives of others. This included those who had retired from other caring professions, such as nursing and wanted to work on a part time basis. Some also argued that flexibility and, less positively, lack of alternative options motivated people to join care work. A small number argued the profile of care workers was changing and there was a lack of understanding of the motivations of those who had more recently entered the sector. The need to attract those with caring motivations was prominent, linking back to promoting care as an attractive career. It was also argued that

not all care workers wanted a career but were motivated by caring itself and valued the conditions required to deliver good care.

### Occupational Status

Occupational status was widely cited as problematic. While those in the sector recognised the skilled and responsible nature of care work, it was argued to generally be considered as low skilled with an out of date label of 'home help'. This fails to reflect the substantial changes in the nature of the role in recent years, for example, that care workers regularly administer medication. Reputational issues arising from negative media coverage were frequently cited as problematic. It was argued to be essential to promote the skilled nature of the role and to move it away from being routine 'women's work'. Difficulties around this were noted as service users can prefer female care workers, which reinforces the gendered nature of the occupation.

### 4.3    Addressing the key project objectives

We now draw together the findings in respect of employment terms and conditions and career structures to address the key project objectives.

Identifying factors which both positively and negatively influence individuals to choose to become and remain working as domiciliary care workers

All participants argued that attraction and retention was related in large part to worker motivations and the nature of care work. Care workers derive high intrinsic satisfaction from caring and the relationships they build with service users. This satisfaction was clearly linked to discretionary effort with care workers often going beyond the requirements of the care plan to address service user needs. Care workers suggested that employment terms and

conditions had a relatively limited role to play in attraction and retention and they seemed largely resigned to poor terms and conditions. While they expressed dissatisfaction with development, pay and employment security, the greatest concern arose around working time. This related in part to its adverse impact on themselves, but also substantially to its detrimental impact on the quality of care they were able to deliver. Working time flexibility was nevertheless important and service providers often sought to reconcile their requirements with those of care workers when devising rotas. General dissatisfaction with employment terms and conditions tended to be buffered by high levels of intrinsic satisfaction derived from caring but this often created strain and fatigue amongst care workers. Care workers also saw trust and feeling valued by service providers as critical to their retention, particularly in the face of many of the difficult working conditions they experienced. Poor terms and conditions did, however, contribute to a perception of being under-valued and a number of care workers had moved service provider to improve these, particularly from the private to local authority sector.

Our care worker data relates, however, only to those who have been attracted to and retained in the sector and managers expressed a very different view. They argued that there was a 'crisis' in recruitment and retention in the sector and that employment terms, conditions and career structures were central to this. There was perceived to be a fairly stagnant pool of labour that moved around service providers rather than new entrants being attracted to the sector. Managers evidenced high vacancy rates and turnover levels and frequently spoke of being unable to accept care packages as a result of labour shortages. Managers believed that pay, working hours and working environment were critical in this. Retail was argued to offer higher rates of pay, (sometimes) more secure employment contracts, less onerous working hours and more pleasant working conditions. Health care settings were equally often seen to be preferable. Labour

shortages also created a vicious circle of labour turnover as care workers then worked increasingly long hours with resultant strain and fatigue. Managers also noted the need to create a larger and more diverse pool of care workers, particularly in relation to gender and those able to speak the Welsh language. All participants agreed that the perceived status of care work and its negative image, regularly portrayed in the media in the wake of recent care scandals, were problematic for recruitment, retention and morale in the sector.

While managers felt they had limited control over many of the issues that created recruitment and retention difficulties, there were suggested actions to alleviate retention difficulties via enhancing care worker satisfaction. These included:

- Adopting an approachable and consultative management style

- Offering support to care workers where they had particular difficulties, for example, with the families of service users or where care plans required amendment

- Demonstrating that care workers were valued through praise, recognition, social activities etc

- Addressing isolation from lone working through meetings both social and formal

- Addressing care worker needs for flexibility via careful rostering

- Buddying and mentor systems for new care workers

- Careful matching of care worker and service user.

Service providers successfully adopted many of these practices, albeit recognising they were not a substitute for improved terms and conditions.

**Identifying the extent to which these factors impact on the quality of domiciliary care.**

Our definition of care quality for service users comprised: reliability, continuity, flexibility, communication, staff attitudes and skills and knowledge. We have evidenced how employment terms and conditions influence recruitment and retention and that recruitment and retention difficulties are problematic for care quality. Here we expound in more detail the implications of employment terms and conditions for the six aspects of care quality in our definition.

*Skills and Knowledge*: demonstrable skills and knowledge are important to service users leading to development of trust in care workers' abilities. Central to this is effective induction training and provision of ongoing training and qualification. We have evidenced substantial problems with training and qualification provision, which is likely to impact on skill and knowledge levels and thus reduce care quality. Further, we have demonstrated wider difficulties in care worker retention. High levels of turnover mean a constant flow of new staff requiring induction and ongoing training. Where this is inadequate, skills and knowledge and care quality are again likely to be compromised.

*Flexibility*: service users can ask for help with tasks beyond those stated on their care plan and care workers understand that needs shift and change. Training is again central to developing the skills, knowledge and confidence to support care workers in offering the required flexibility and where this is lacking, care quality may be reduced. Adequate time to deliver the required flexibility is also essential and can be compromised by poor work scheduling. Care workers need autonomy to deliver flexibility and contextual issues which create rigidity in care plans are problematic, particularly given a shift to an outcomes-based approach to care.

*Continuity*: receiving care by the same care worker(s) during the whole period of care is important so both the care workers and

service user establish familiarity, trust, rapport, understanding and knowledge of needs. Use of zero-hours contracts is particularly problematic for continuity of care. The majority of domiciliary care workers do not have guaranteed hours, and can be required to work a wide variety of patterns, and can also refuse work offered. Both create difficulties for continuity with service users. High levels of turnover also create lack of continuity as there is a constant churn of care workers working with a given service user.

*Reliability*: care workers should arrive on time and keep scheduled appointments. This supports service user control and enables planning for their own daily schedule appropriate to their needs. Zero hours contracts again mitigate against reliable working patterns, meaning they change frequently and disrupt schedules. Lack of payment for travel time can also contribute to scheduling difficulties. Important here also is length of commissioned visits, which derives from contextual influences as opposed to terms and conditions of employment. Short visits which afford inadequate time to deliver the required care can often lead to disruption of care worker schedules causing them to run late. This creates both strain and dissatisfaction with the quality of care delivered. Both are closely linked to high turnover with its attendant difficulties for care quality.

*Communication*: links to both reliability and continuity and includes informing service users about planned care visits and ensuring regular communication about changes or potential changes. Where employment practice such as zero hours contracts compromises continuity, negative consequences for communication and care quality will result. Effective training is also central to effective communication and, where this is lacking, will reduce its quality.

*Staff Attitudes*: this is one of the most important indicators of care quality to service users. Positive staff attitudes include respect, cheerfulness, friendliness and understanding. While these may derive from positive worker motivations and the intrinsic satisfaction derived from caring, they may also be negatively impacted by employment

practice. Low pay and insecure employment were commonly cited, for example, as making care workers feel under-valued. Lack of training can undermine confidence in the ability to do a job well and short visits/lack of payment for travel time can create strain and fatigue. All these factors are likely to negatively impact on staff attitudes and consequent care quality.

In summary, recruitment of care workers with the right attitudes and providing workforce development that underpins the required skills and knowledge is essential. We have, however, evidenced that opportunities to access training and qualifications can be limited and that, even when offered, these do not always deliver the required level of skill development. Continuity and reliability are also often comprised by high labour turnover, the use of zero-hour contracts and working time practices that offer care workers insecure and inconsistent working patterns which create fragmented care delivery. Working time and short visits were commonly cited as the most problematic practices. Communication and flexibility are also often hampered by restrictive care plans and a lack of autonomy for care workers, albeit these often derive from commissioning practices rather than terms and conditions of employment.

A well-trained, well-paid and secure workforce with appropriate working patterns is required to recruit and retain care workers and to deliver high quality care. Our findings suggest these are not conditions widely experienced outside of local authority employment in the current domiciliary care workforce. Our findings support Philpott (2014) who argues changes to current commissioning processes and higher levels of funding are required and that more should be done to promote good quality domiciliary care jobs.  We also suggest that regulation of employment terms and conditions will be required to achieve the required changes.

## 5.      Further Research and Policy Options

Here we suggest both further research needed and policy options through which the Welsh Government can improve the quality of domiciliary care by positively influencing individuals to become and remain working as domiciliary care workers.

### 5.1      Context

We suggest further research is required in respect of a number of contextual issues that have arisen during the course of this project, but are beyond its scope. Investigation is required in respect of:

1. Funding levels and commissioning models that will underpin high quality domiciliary care
2. The introduction of the Social Services and Well-being (Wales) Act in April 2016, particularly how to:
   - resolve tensions between outcome-based care delivery and commissioning and monitoring processes that are focused on time and task
   - educate service users and families on an outcomes-based care approach
   - create greater autonomy for care workers in delivery of outcomes, particularly in relation to greater flexibility in care plans
3. The potential for joint commissioning of health and social care services and how to create a more 'joined up' approach across social care agencies
4. The delivery of more robust workforce data and modelling of future labour supply and demand, together with understanding of the (potentially) changing motivations and aspirations of new entrants to the sector
5. Mandatory registration, to position it as enhancing the status of care work, rather than as costly and a barrier to entry to the sector.

## 5.2     Employment Practice

We have explored employment terms, conditions and career structures in detail and demonstrated their key role in both recruitment, retention and care quality. We outline a number of policy options for Welsh Government:

6. Creation of more robust regulation to ensure delivery and uptake of induction and specialist training, QCF qualifications, supervision and apprenticeships, ensuring that these are available to all age groups

7. Identification of an appropriate qualification level, which may be above QCF2, to underpin skilled care work

8. Enhanced management training for service providers to cover both business/financial and leadership matters

9. Development and communication of clearer career paths to create recognition of care as a skilled and viable career option

10. Development of pay structures (and supporting regulation) that reflect the skilled and demanding nature of care work and underpin a career structure. Further research is required to benchmark pay against appropriate comparator occupations

11. Regulation or commissioning practice to ensure adoption of secure contracts of employment, with zero-hours contracts offered to create flexibility at the margins rather than routinely used

12. Regulation or commissioning practice to ensure that all working time, including travel time, is paid

13. Regulation or commissioning practice to ensure that care workers have sufficient time during service user visits to deliver good quality care and are not placed under undue strain

14. Creation of a more diverse workforce, particularly across characteristics including gender, age and speaking the Welsh language.

## 5.3    Implications for recruitment and retention

Welsh Government policy could address recruitment and retention in the following ways:

15. A larger labour pool is required. In addition to policy options 6-14, the labour pool could be enlarged by:

- Campaigns to enhance perceptions of the status of care work, emphasising the skilled nature of care work and countering the negative media image of both care work and care quality
- Positive communication and promotion of mandatory registration
- Engagement with schools and colleges to attract younger people to a career in care and also engagement with those retiring from other caring professions, e.g. nursing, who are seeking a bridge to full retirement

16. Policy options 6-14 are central to improved retention. These could be supported by:

- Management training to develop understanding of creating employment relationships based on mutual trust, respect and value.

Many of these policy options are aspirational and have substantial cost implications. Some will be more quickly achieved than others; a more diverse workforce is, for example, likely to be long term in nature.  However, we reflect the voices of our participants in arguing that delivery of high quality domiciliary care risks being compromised and that required changes will not be achieved without addressing current funding levels for domiciliary care provision. Regulation is also important in ensuring that funding increases flow to improvement of terms and conditions.

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**Annex A**

**Focus Group/Interview Schedule: FOR COMMISSIONERS**

*Section 1: Commissioning High Quality Domiciliary Care*

1. What proportion of domiciliary care is externally provided- what are your views on that?

2. How are commissioners are able to use their commissioning powers to ensure that domiciliary care workers are employed on legal and fair terms and conditions of employment. Does this happen in your experience and what barriers are there (if any) to this?

3. How do you define care quality? What does good quality care look like? How helpful is the commissioning framework guidance?

4. To what extent are cost savings possible via joint commissioning e.g. health boards and neighbouring authorities?

5. What are your priorities when commissioning domiciliary care?

6. What pressures do you face when commissioning domiciliary care?

*Section 2: Working Conditions and Care Quality*

1. *To what extent do you think employment terms and conditions for domiciliary care workers are satisfactory? (Probe all of the following areas: pay, training and qualifications, working hours/workload/work rotas, flexible working/WLB, career structures, diversity management, low status, lone working, contract type)*

2. What opportunities and barriers do you feel there are regarding implementing satisfactory employment terms and conditions for domiciliary care workers?

3. Do you feel the employment terms and conditions for domiciliary care workers impact on the quality of care provided? If so, in what ways might they influence care quality? (nb: can be both positive and negative)?

4. To what extent you do think service users are aware of the working conditions of domiciliary care workers? What are the implications of this?

*Section 3: Career*

1.  To what extent do you feel there are opportunities for domiciliary care workers to develop/progress their career in domiciliary care?

2.  Do you think domiciliary care has a defined career path that would allow care workers to progress to other roles? What might be the enablers or barriers to career progression?

3.  Do you feel care workers in your/provider organisations receive enough training and development in their current work? What sorts of training do they receive/what training do you feel would be beneficial for them (explore: constraints, resources, impact on care quality etc). How can workers be encouraged to take up training? What barriers are there to this?

*Section 4: Motivations, Intentions and Recruitment*

1.  For what reasons do you think people choose to work as domiciliary care workers?

2.  What do you think domiciliary care workers enjoy most about their roles and why?

3.  What do you think domiciliary care workers enjoy least about their job and why?

4.  How effective are the processes your organisation/providers use to recruit domiciliary care workers? Are there any barriers to effective recruitment? *(probe: funding, commissioning, whether recruitment systems assess required personal attributes vs qualifications, skills etc.) Are these issues organisation specific or sector wide?*

5.  To what extent do you think domiciliary care workers want to remain within their job roles, and what things impact upon their decision? How easy/difficult do you/your providers find it to retain domiciliary care workers? Why do you think this is? How can you/your providers tackle retention difficulties?

*Section 5: Other*

Is there anything else that you would like to share about domiciliary care that you think is important when researching this topic (link to aims of study)? Thank you for your time in participating in this focus group/interview.

**Focus Group/Interview Schedule: FOR MANAGERS**

*Section 1: Motivations, Intentions and Recruitment*

1.  Why do you think people choose to work as domiciliary care workers?

2.  What do you think domiciliary care workers enjoy most about their roles and why?

3.  What do you think domiciliary care workers enjoy least about their job and why?

4.  How effective are the processes your organisation uses to recruit domiciliary care workers? Are there any barriers to effective recruitment*? (probe: funding, commissioning, whether recruitment systems assess required personal attributes vs qualifications, skills etc.) Are these issues organisation specific or sector wide?*

5.  To what extent do you think domiciliary care workers want to remain within their job roles, and what things impact upon their decision? How easy/difficult do you find it to retain domiciliary care workers? Why do you think this is? How can you tackle retention difficulties?

*Section 2: Working Conditions and Care Quality*

1.  To what extent do you think employment terms and conditions for domiciliary care workers are satisfactory? (Probe all of the following areas: pay, training and qualifications, working hours/workload, flexible working/WLB, career structures, diversity management, low status, lone working, contract type)

2.  What opportunities and barriers are there regarding implementing satisfactory employment terms and conditions for domiciliary care workers?

3.  What does good quality care look like to you? What does it look like to care workers? And service users? What differences exist and why?

4.  Do you feel that the employment terms and conditions for domiciliary care workers impact on the quality of care provided? If so, in what ways might

they influence care quality? (nb: can be both positive and negative). Do terms and conditions impact on the organisation's service quality?

5.      To what extent you do think service users are aware of the working conditions of domiciliary care workers?


*Section 3: Career*

1.  To what extent do you feel there are opportunities for domiciliary care workers to develop/progress their career in domiciliary care?

2.  Do you think that domiciliary care has a defined career path that would allow care workers to progress to other roles? What might be the enablers or barriers to career progression?

3.  Do you feel your care workers receive enough training and development in their current roles? What sorts of training do they receive/what training do you feel would be beneficial for them (explore: constraints, resources, impact on care quality etc). How do your encourage workers to take up training? What barriers are there to this?

*Section 4: Other*

1.  Is there anything else that you would like to share about domiciliary care that you think is important when researching this topic (link to aims of study)?

### Focus Group/Interview Schedule: FOR CARE WORKERS

#### Section 1: Motivations and Intentions

1. Please can you tell me about your reasons for choosing to work as domiciliary care workers?

2. What do you enjoy most about your job and why?

3. What do you enjoy least about your job and why?

4. Do you see yourselves continuing to work as domiciliary care workers in the future? What factors impact on your decision? What would stop you working in a domiciliary care? What could prevent you leaving?

#### Section 2: Working Conditions and Care Quality

1. To what extent are you satisfied with your employment terms and conditions? *(Probe all of the following areas: pay, training and qualifications, working hours/work rotas/workload, flexible working/WLB, career structures, diversity management, low status, lone working, contract type – ask specifically about zero hours)*

2. Thinking about the care you provide, what does good quality care look like for you? What does it look like for service users? How important is continuity of care?

3. Do you feel that your working conditions impact on the quality of care you can provide? If so, in what ways might they influence care quality? (nb: can be both positive and negative). Probe around pay, time, flexibility, working hours/work rotas/workload etc.

4. To what extent you do think service users are aware of the working conditions of care workers? Probe around pay, time, flexibility, working hours/work rotas/workload etc.

#### Section 3: Career

1. To what extent do you feel there are opportunities for you to progress/develop your career in domiciliary care?

2. Do you think that domiciliary care has a defined career path that would allow you to progress to other roles? Do you want career progression? What might help you get or prevent you from getting career progression?

3.  Do you feel you receive enough training and development in your current work? What sorts of training have you received/what training do you feel would be beneficial for you (explore impact on care quality etc). How good is the training?

*Section 4: Other*

1.  Is there anything else that you would like to share about your role as a domiciliary carer that you think is important when researching this topic (link to aims of study)?