The Recruitment and Retention of a Care Workforce for Older People

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Research Findings and Policy Implications

This major research project investigated three sets of influences on recruitment and retention of a social care workforce for older adults: i) local authority (LA) commissioning practices and local labour market conditions; ii) the human resource practices of provider organisations; iii) the experiences and aspirations of the workforce. The project involved three stages of research as outlined in the box below. This summary relates primarily to stages 2 and 3 as the results for stage 1 have been reported separately.

3-stage research project:

Stage 1 – postal survey of local authorities with 90 responses

Stage 2 – detailed study of commissioning practices of selected 14 local authorities, telephone survey of 52 domiciliary agencies and 53 homes in the independent sector and ten Local Authority domiciliary care providers, all located in these 14 authorities, together with head quarter interviews with managers in ten national chain providers

Stage 3 – case studies of 20 providers (16 independent sector, four public sector, all drawn from four of the 14 local authorities) involving 98 interviews with care staff.

Here we summarise our key ten findings and consider their implications for the recruitment and retention of an expanded and higher quality social care workforce in the future. We identify the key challenges for policy if these workforce objectives are to be realised.

Key Findings

1. **LAs take different approaches to commissioning that are associated with differences in both employment practices and in user satisfaction scores.**

The 14 LAs in the study followed variable approaches to commissioning; some pursued a partnership approach, others focused mainly on cost minimising, while some followed a mixed approach. Employment practices of providers, especially domiciliary care providers, tended to be better in areas where the LA pursued a partnership approach and/or paid higher fees. However, even those following a partnership approach usually failed to provide extra fees for more complex care or for care in unsocial hours. In national surveys of users’ satisfaction with care delivery, lower scores were found in LAs following a cost minimising approach.

2. **LAs’ commissioning practices are subject to frequent changes which may limit the influence of LAs on independent sector providers’ HR practices.**
The LAs faced competing pressures on their commissioning strategies. They needed to support and develop independent sector providers but were also under pressure to use commissioning to reduce costs and secure higher levels of care service for the same price. Integrated commissioning with the NHS generated both synergies and conflicts and preparation for personalisation sometimes meant rethinking policies designed to reduce costs where these might be considered to restrict user choice. The outcome was that providers were not being offered a stable commissioning environment which may have reduced the extent to which LAs were able to influence provider practices.

3. Recruitment and retention problems were widespread, involving extensive labour shortages for unsocial hours and high staff turnover, but new recruits were often required to meet upfront costs of joining the organisation out of their own pocket and employment conditions remained poor.

In the independent sector annual staff turnover averaged 24% for homes and 31% for domiciliary care providers, 70% of whom recorded shortages for weekend and unsocial hours work. Responses to these problems by independent sector providers have been limited as employment conditions are generally poor particularly in for profit organisations. Pay levels in the independent sector were clustered within a band for the most part no more than £1 above the then national minimum wage of £5.73. A significant share of providers also passed the upfront costs of entering work (such as CRB checks, uniforms and induction training) on to new recruits.

4. Many providers failed to provide minimum employment guarantees or reasonable rewards for additional experience or qualifications or for working unsocial hours.

Over two thirds of domiciliary care providers only offer zero hours contracts to care staff and may not pay for all time spent at work due to lack of full compensation for travel time or travel costs between care visits. Across the whole independent sector not only are pay levels low but pay differentials for higher qualifications, seniority or experience often amount to no more than pence per hour. The practice of uprating pay on a regular basis was not universal; in homes uprating was more influenced by changes in the statutory national minimum wage while in domiciliary care the main factor was change in LA fee levels and profitability. Premiums for overtime were only paid by a quarter of independent sector providers and unsocial hours payments were either not made or were again more a matter of pence than a significant proportion of the hourly wage. This lack of compensation for unsocial hours is notable in a sector where almost all staff were involved in weekend work and many in early and late hours and night work. In contrast most public sector providers paid premiums for overtime and unsocial hours.

5. HR practices are better in not for profit than in private sector providers and in providers with higher Care Quality Commission (CQC) star ratings. In contrast the trend towards greater use of national chains of providers in
the independent sector is not showing any evidence of improving overall HR practices.

Not for profit providers pay higher wages, provide better employment conditions and have better HR outcomes but these effects are stronger for homes, possibly because not for profit domiciliary providers are still constrained by LA commissioning policies while homes have more discretion to charge higher fees to private clients. Independent sector homes rated 3* by CQC paid significantly higher wages to care workers compared to those rated 1* and 2* and were more likely to make unsocial hours payments. However, 3* homes had worse employee voice practices than 1* and 2* homes. For domiciliary care providers the evidence was more mixed. Analysis of HR practices and outcomes by type of ownership (single home or agency, local chain or national chain) suggests that the single home has better training outcomes and lower staff turnover. Among IDPs, it is local chain providers that have a better index of pay strategies than national chain providers and this combines with better HR outcomes in the form of recruitment and retention and training but unlike homes there is no association with staff turnover. Our case study evidence also suggests that even though national providers still set employment conditions, especially pay, at the local level, they only adjust pay upwards by a marginal amount in higher fee paying areas. Local pay may be used more to facilitate downward adjustment in low fee paying areas, although the national minimum wage acts as a floor to downward adjustment.

6. Better LA commissioning practices and stronger local labour market demand are associated with better employment practices which in turn reduce staff turnover and ease recruitment. This is especially the case for domiciliary care and applies even though providers’ responses to better commissioning are relatively weak.

Higher LA fees were found to be associated with higher wage levels in independent sector providers but the increase in wages per hour was very small - just 19 pence for an extra £1 per hour in fee levels in domiciliary care and 14 pence per hour wage increase for every £40 per week increase in home fees. In domiciliary care higher LA fees and /or more partnership commissioning and contracting practices promoted better HR practices including pay strategies among independent sector providers. These same better HR practices were found in turn to be associated with lower staff turnover even given the relatively low range of practices provided by the independent sector providers in our study. With either more favourable commissioning practices or more responsiveness of providers to higher fee levels, further improvements in rates of staff turnover could be anticipated. In some cases, better HR practices were associated with higher staff turnover, which may indicate that providers sometimes improve conditions when faced with high staff turnover. For homes, better HR practices are associated with both higher fee levels and stronger labour market demand. Two HR practices are associated with lower staff turnover, including the recruitment practice of recognising the value of skills, qualifications and care experience in the selection of new recruits and the practice of not requiring care workers to regularly work weekends.

7. Care staff were found to have a high level of commitment to care work, due to the satisfaction they derived from the nature of the work and despite
the majority regarding the pay as unreasonable. Scope for discretion and opportunities to form relationships with users were key to satisfaction.

Just over half of the care workers we interviewed anticipated that they would still be working for their current employer in five years time and 88% intended to be still working in the sector. Job satisfaction related to the rewarding nature of the job and the opportunity to help and care for others and, in domiciliary work, to the opportunities provided by the nature of the work for autonomy and discretion. This high satisfaction with the job was found alongside low satisfaction with key HR practices, in particular pay practices. In addition to the widespread view that pay was unreasonable for the work they did, the lack of travel pay and payment for unsocial hours were further sources of dissatisfaction. A further concern was that the spread of electronic monitoring might reduce total reward still further by restricting paid work time to time actually spent in people’s houses rather than at work.

8. Recruitment and retention of care staff was based on highly specific personal factors, that both motivated them to enter and stay in care work and made it possible to work the highly flexible and irregular hours required of them, particularly in domiciliary care. The pool of potential recruits fitting these conditions is, however, very restricted.

Employees’ motivation to enter care work was often related to their own experience of informal care or their knowledge of care work through social networks which also informed them of available jobs. Employers also tended to emphasise informal caring experiences and attitudes, in contrast to formal skills and qualifications. National providers were trying to capitalise on the potential of informal word-of-mouth recruitment methods by using bonus voucher schemes to encourage existing care workers to introduce friends and family into the sector. Retention of care workers was encouraged by the satisfaction derived from the nature of work, and for staff who had previously been in routine and low skilled work, the opportunities for training and for exercising discretion were particularly valued. In addition staff stressed their particular circumstances- the location of the work or the timing of the work in relation to their family commitments- made the job convenient, even though split shifts and working at the beginning and the end of the day were far from standard convenient hours. While we found little evidence of existing staff wanting to leave for routinised low skilled work such as in supermarkets, there was considerable interest expressed in using care as a means of entering the higher paid NHS.

9. The change in policy to personalisation was fuelling uncertainty over the future directions of care delivery, amongst both LA commissioners and providers. Among the care staff interviewed, two thirds would not consider becoming a personal assistant and only 16% expressed an interest in the role.

While many LA commissioners and independent sector providers expressed positive views of the objective of giving users more choice over their care, they raised a large number of concerns over
how the system would work in practice. LA commissioning staff were concerned about the impact on the price charged for services, about the viability of the re-ablement services they had developed and about the implications for their geographical based commissioning which they felt had done much to alleviate problems of pay for travel time and to enable jobs to be better coordinated and planned. Providers were more concerned about the additional problems of invoicing and securing payment and of poaching of staff. The majority of care staff expressed the view that they would not even consider a job as a personal assistant but ten of the 63 who were asked did say they might be interested. The minority of care workers who would consider it mentioned that one-on-one work of this kind could potentially be more rewarding and would also have the benefit of being less rushed than their current role. However, for the majority of care workers the one-on-one nature of the personal assistant role was not appealing. Many mentioned how it would be emotionally draining to care for only one user and many felt they would become too involved and be unable to cope. They identified aspects of their current jobs they would miss if they were to become a personal assistant, including opportunities to meet lots of different people, being able to move around autonomously and have the support of managers and colleagues. Some would not consider it because they wanted the ‘back-up’ of management and working in a team and they also anticipated increased job insecurity in such a role if work was reliant on specific users. Care staff were often appreciative of the efforts their individual managers went to to try to fit work schedules to their needs, something which may be more difficult to achieve under personalisation.

10. The overall picture to emerge was of a sector in a very fragile state which was not in a position, due to current weakness and uncertainty over the future, to develop long term strategic policies and practices – either with respect to public sector commissioning or with respect to HR practice in the independent sector - to solve current and potential long-term problems of recruitment and retention.

While the current arrangements are just about delivering the current level of commissioned services, the model of delivery of social care for the elderly is in a fragile state. There is positive evidence that providers are achieving adequate levels of recruitment, albeit supplemented by recruitment of migrants and with clear shortages in some key areas. But providers of all types are experiencing relatively high levels of staff turnover and significant problems in achieving and retaining a trained workforce, particularly in domiciliary care. The sector is also very reliant both on the easing of recruitment conditions in the recession, and on a workforce that for a variety of reasons has accepted to work under poor employment conditions, primarily because of the intrinsic rewards associated with the work.

Prospects for recruitment and retention under expanding demand: the policy issues

The objective of this research and the overall social care workforce initiative funded by the Department of Health was to consider the problems facing the recruitment and retention of the social care workforce in a context where there were strong expectations of increased future demand for the social care workforce, in relation to both quantity and quality. We draw on our key findings to consider the prospects of meeting current and future demands for a
social care workforce and suggest the need for considerable changes in commissioning arrangements, the policies of provider organisations and the conditions of employment. This call for change is based on our assessment of the state of current employment arrangements in the sector and on our understandings of the characteristics of employment arrangements that are likely to be needed to be put in place to attract and retain a wider pool of potential social care workers. Our primary concern is with the need to rebalance the debate on the future of social care which currently focuses primarily on the respective roles of the state and care users in both the funding of care and in shaping the delivery of care. In our view the needs and interests of the care workers have been neglected in this debate and the contribution to be made here is to put the employment relationship back in centre stage. This approach complements a more user centred approach to care outcomes as the quality of care is dependent upon the quality and commitment of the person delivering the care. However, in line with our objective of paying more attention to the interests and role of the care worker we do not consider that a user-centred approach should necessarily imply the transfer of employer responsibilities to care users.

The current state of the social care sector.

The evidence across all stages of this research project suggests that, in the period immediately prior to the new budget conditions in 2010/11, LAs and social care providers, assisted by the easing of recruitment difficulties post the 2008 recession, were just about able to deliver the quantity and quality of care required although providers in some areas were still reliant on recruitment of migrant workers to fill gaps. Even so, clear shortages remained, particularly for unsocial hours care delivery and staff turnover remained high, such that some providers, particularly in domiciliary care, were still unable to meet modest targets for a trained workforce due in part to turnover rates. The sustainability of even this quantity and level of service would be even more in doubt in normal labour market demand conditions but there was little evidence, whatever the conditions, that the sector was in a position to realise these aims to expand the quantity of service, improve the quality of service or deliver long term strategic change. This last aim includes both movement towards a more holistic and integrated approach to the delivery of social care for the elderly and towards a more user-centred service, compatible with the development of an effective supply side of both providers and social care workers.

Our findings also suggest that the responsibility for the current state of the sector lies with a range of agents - central government, the LA commissioners and the independent sector providers. LA commissioning obviously sets the general set of conditions for both providers and for the workforce operating in the independent sector of social care and must bear considerable responsibility, together with central government, for current arrangements and the ability of the sector to move forward on the three aims of expansion, improved quality and strategic change. Nevertheless, our research also indicates that, where LAs do take the initiative to develop a more favourable commissioning environment for better social care delivery, the opportunities offered to providers to enhance their HR practices and improve recruitment and retention are not necessarily taken up. Good LA commissioning practice may thus be a necessary rather than a sufficient condition for improvements in HR practices and in
HR outcomes in the sector. Providers are in a position to exercise some choice over their HR practices, even if tight budgetary conditions and uncertainty over future funding arrangements may induce providers to act with caution. Nevertheless, they may still be too ready to take as much advantage as they can of their committed workforce by, for example, failing to offer guaranteed hours even to staff working regular full-time or even longer hours. This may be done in part because the zero hours contracts make it easier for them to demand flexibility in the number and timing of hours from their staff. Particularly significant here are the policies and strategies of the increasingly dominant national chains whose perspectives extend beyond the immediate LA and may be relatively unaffected by any specific initiatives in commissioning that are pursued only at a local level.

Both the LA commissioners and the care providers were also found to be relying upon the commitment of the current care workforce to deliver the quantity and quality of care required, without much consideration of how to expend or upgrade the workforce to meet future requirements. The commitment of the current workforce was found to derive from two sets of conditions: first from the care staff’s own personal commitment to care work which may have preceded their entry to the sector, through their own experience of informal care or may have developed through their experience of social care as more satisfying work compared to other more routinised and less meaningful jobs to which they have access; second from the tendency of providers to recruit very local staff with specific needs for particular hours schedules. Working-time arrangements in domiciliary care are far from employee friendly in any conventional sense; they are based around variable hours at unsocial times and frequently involve unpaid breaks and split shifts. However, individual employees, and primarily those located in the immediate area, may find either that either these hours fit their specific circumstances or that they are able to negotiate specific schedules within the range available that suit their current needs. All these factors may tend to reinforce commitment of the existing staff, but operate against the expansion of the pool of recruits as staff may have to be brought in from wider geographical areas, and to be attracted from groups who have a wider range of alternative jobs and training and development opportunities. If providers model their recruitment and retention strategy on what currently makes for the most committed care workers, they may not realise the need for a strategic change to recruitment, work organisation, employment conditions and career opportunities if the available pool of recruits to social care is to be expanded.

To identify the implications of our findings for policy we first of all discuss these in relation to the arrangements which were in place for delivering social care at the time of the study. We then return to the issue of the move towards personalisation and consider the implications of our findings for that policy agenda.

a) Improving recruitment and retention under current commissioning arrangements.

Improving commissioning and contracting practices
If the objective of commissioning is to set the conditions for expansion, quality enhancement and driving long term strategic change, as well as ensuring value for the public purse, then there is a need to address three main problems.

First, objectives other than meeting budgetary targets need to be allowed to influence commissioning. While clearly the aims of ensuring value for money and keeping the costs of social care within limits of affordability are in themselves vital objectives, the often overwhelming focus on short term costs may be increasing the longer term costs of care by creating barriers to strategic developments to reduce long term costs of health and residential care. Even though many involved in LA commissioning are very aware of the need to foster and develop the supply side, that is both the quality of provider organisations and the quality and size of the care work force particularly in domiciliary care, they are often unable to put these concerns into practice, or to do so only in marginal ways, through additional training support or limited quality uplifts to otherwise very tight fee payments.

Second, in line with this need for more strategic approaches, commissioning practices need to become less variable across both space and time. LAs are making different compromises between competing agendas and are thereby sending out mixed messages to key national actors such as national chains. Even within a particular LA the policy and practices are also subject to rapid changes, such that the consistency of the message even at the local level may not be strong. These considerations might suggest the need for a national care service or a national system of insurance to introduce the certainty or predictability in the systems to allow for longer term strategic development of an effective supply side.

Third, LAs need to pay more attention to the employment consequences of their commissioning practices. In many respects LAs currently hide behind the notion of business to business contracting to evade the responsibility that they must share for employment practices in the sector; as our evidence shows, employment practices are not only poor, but in some areas may even be on the margin of legality. For example, LAs consider issues such as the payment of travel time between clients to be a matter for the independent providers even though they fail to include payments for travel time in their commissioning. Likewise no specific provision is made for training time and LA preference for using a simplified fee structure in the interests of minimising transaction costs in practice means that wages are unlikely to be higher for work involving more skill and intensity of care or for work outside of standard working hours. LAs are increasing their monitoring of providers’ HR practices but are treating the meeting of quality thresholds more as an additional requirement on providers and not as an indicator of what elements of their own commissioning and contracting practices may need to change.

Taking these three considerations into account, we would suggest a need to develop longer term strategic partnerships between commissioners- whether at LA or national level- and providers to create an environment in which progress could be made in developing the HR practices necessary to improve recruitment and retention in social care. This recommendation would need to take into account the need for diversity in supply, to allow scope for user choice and for the development of alternative approaches to the delivery of care and the
development and deployment of care staff. This points to long term fostering of a diverse supply, rather than repeat competitive tendering which leads to a win all or lose all outcome for the bidders, thereby creating considerable uncertainty for providers and the workforce alike. For example the one LA in our study that had changed all its providers at the last competitive tender was facing some of the most severe problems in delivering its required quantity and quality of care, and scored the third lowest user satisfaction scores in the national user survey among our 14 LAs.

Improving the HR practices of providers

The evidence from our study demonstrates both that providers in social care do not provide even the basic guarantees to employees associated with an employment relationship and that even when commissioning provides opportunities for enhancement in employment conditions, many providers, particularly the national chains, only make marginal upward adjustments in their employment conditions. Indeed it is only when local labour market conditions push turnover rates above acceptable levels that providers may be dragged into providing what many would regard as basic employment conditions and guarantees.

The policy recommendations that derives from these results are based on the premise that it is not desirable to leave it up to individual providers to ensure that employment conditions are compatible either with notions of fair rewards for the work undertaken, or more specifically with recruitment and retention of staff at levels likely to facilitate improvements in the quality and quantity of the social care workforce. Two factors do seem to have some impact on providers’ HR practices. The first is national regulations. The national minimum wage has ensured that wages in the sector do not fall below those minimum levels and uprating of the NMW is an important trigger for general uprating of pay in providers, particularly homes. Likewise holiday entitlements have been improved within the independent sector due to changes in national regulations. There is some evidence of lack of compliance with some aspects of employment regulations, for example the fairly widespread failure to treat travel time between users as paid work time, but it is also clear that without national regulations establishing minimum employment standards that conditions might be even worse in the sector. Thus the first recommendation is that it is important to maintain and improve on national employment standards. The second recommendation is that LAs should take on a more active responsibility for employment conditions by including provision for full employment costs, not simply those related to face time with users, and also undertaking more systematic monitoring to ensure that these additional resources are used to improve employment conditions and arrangements.

While providers, certainly those in the private sector, have a poor record in providing employment and income guarantees or in paying for all time spent at work, they still have an important positive role to play in shaping the employment relationship in ways that were found to be appreciated by the care workers we interviewed. Two main areas can be identified in this respect. Firstly most care workers appreciated that they were offered training beyond what they had experienced in other low paid jobs. This involvement by providers in training has been shaped by targets for training standards, although not all training is linked
to NVQs. One issue for the future is whether the removal of the training target from CQC care standards will have an adverse impact on future training provision. Likewise it is unclear where the support for training might come from in the future under personalisation. The other main area where providers’ actions are making a difference in helping to retain staff is in their efforts to fit working time schedules to staff preferences. While the managers may to some extent have exaggerated their commitment to this, the case studies did find that the care staff were appreciative of their individual managers’ efforts to coordinate work in ways that fitted their needs at least most of the time and indicated that this is one way in which the local managers were helping to recruit and retain staff in a context of overall poor employment conditions. One concern may therefore be that managers’ ability to juggle schedules to offer staff hours that fit their needs may be further constrained in the future as one of the benefits of personal budgets is the opportunity for users to have more choice and control over their care. These issues are discussed further below.

Developing the recruitment and retention of the social care workforce.

While the case studies revealed the current workforce to be highly committed and reliable, it also showed that this was a workforce with very specific characteristics; that is, it was a largely female and low qualified workforce, with many drawn into the sector through social and family networks. Moreover it was very locally based and with very specific working time preferences. If the sector is to tap into a wider pool of recruits, a number of changes to provider practices and employment conditions need to be put in place to increase the appeal of care work beyond this group. Nevertheless these changes also need to build upon those aspects of the work that the current workforce identifies as providing motivation and satisfaction.

Three types of recommendations can therefore be made with respect to policies to extend recruitment and improve retention. The first essential action is to extend the recruitment net beyond the informal and localised recruitment process that is currently the main means of filling vacancies in the sector. This is the only way the sector will be able to expand and appeal to under-represented groups, such as men or indeed women with higher levels of qualifications. The current pool that providers tap into is not easily expanded due to the focus on the immediate locality. Moreover, as the educational levels of women rise and more remain continuously in employment and committed to their initial choice of occupation or sector, there may be fewer women seeking flexible work in their immediate locality. While the sector needs to retain its word of mouth and informal recruitment, it also needs to diversify its recruitment practices and sources of recruits.

Second, in order to achieve this diversification and to retain these new hires, employment and working conditions need to improve. While we do not know how many people are deterred from entering because of the low pay levels on offer, it is clear that even most current staff consider the level of pay to be unreasonable and that the ‘pull’ of better pay in the NHS is one of the most frequent reasons given by care workers for intentions to leave. However, improvements to the extrinsic quality of work need to be complemented by policies to maintain or enhance the intrinsic value of the work to build upon the evidence in our case
studies of the importance of the experience of undertaking meaningful work in the retention of staff. The consequence may be a need to reassess the long term effects of some current trends, including those towards electronic monitoring, to ensure that new practices designed to ensure better value for the public purse and also in some respects for the care user do not result in deterioration in both the quality of work and the quality of care provided. Opportunities for advancement for care staff without requiring their withdrawal from hands on care work also need to be created.

Third, while workers were generally satisfied with their hours, the research revealed the idiosyncratic nature of the hours worked by care workers. The hours were unpredictable and variable, fragmented across the day, and did not fit standard notions of family friendly flexible working. The hours suited care workers with very specific needs and circumstances who often needed to work locally. This sort of working time would not constitute flexible working to many and to the extent that more standard notions of family-friendly flexible working are now available in many organisations, the sector cannot rely on its image as ‘flexible’ as a way to expand the sector in the future. There is thus a need to work towards new working-time arrangements that still provide some flexibility for employers but which provide staff with more guaranteed hours and less unpaid time spent in travelling or in gaps between user appointments. These developments would also need to take into account user needs and might require LAs to move away from commissioning in prescribed short visit times to provide more scope for planning care at the provider level.

**Summary of key policy recommendations.**

The key policy recommendations to achieve better recruitment and retention outcomes include the following.

- Stronger partnership arrangements are needed with providers, either at LA level or through a national system of care commissioning, involving increased obligations on both sides. Longer term guarantees of contracts or of preferred provider status need to be offered to enable providers to make a step change in their employment practices (but these arrangements should be designed to foster and not reduce the diversity of supply).
- LAs or a national care commission should promote better and reasonable employment conditions through both better resourcing and more stringent requirements on providers to meet higher HR standards.
- Attention also needs to be paid to maintaining or improving the intrinsic rewards from the work, potentially calling into question the practice of fragmented commissioning of care packages, backed up by electronic monitoring.
- Likewise there needs to be a more partnership approach to developing working time arrangements that meet both user and care worker needs, perhaps by moving away from the fragmentation of care commissioning by task and narrow time periods.
- These recommendations should together provide the environment in which providers can start to extend their recruitment pool and begin to attract and retain staff beyond
the immediate vicinity and to provide both better employment conditions and more opportunities for advancement within social care work.

- Attention should also be paid to how to facilitate the development of high quality re-ablement and specialist services to ensure that users are not unnecessarily placed in residential care. The delivery of specialised and short term care could require consideration of a return to more guaranteed employment conditions and higher paid employment, possibly within the public sector or under more stable and higher paying contracts with specialist providers. The further development of specialist services could also provide the important missing elements of opportunities for care workers to progress without loss of involvement in hands on care.

**b) Implications of our findings in the context of the move to personalisation**

There are several ways in which our findings would support a move towards a more user centred system of care as a means of recruiting and retaining a larger and more skilled social care workforce. In particular, to the extent that this offered care workers more opportunities for developing relationships with users and more opportunities to exercise discretion in the ways in which they provided care, then this change in direction could promote the intrinsic value of the work and enhance retention. However, these benefits may not necessarily be achieved under current proposals for the mode of implementing personalisation. This applies in particular if the proposals result in the user being the direct employer. In this latter scenario even the above listed potential benefits of enhanced discretion and more opportunity to form relationships would not necessarily be realised as the dual role of the user as the person receiving the care and the employer of the care giver could inhibit the formation of a good relationship. Care workers mentioned concerns about the lack of back up from managers in their decisions on care provision, about their discomfort at the idea of being paid by the user and about the potential problems of how they would be able to cope with a user who was difficult or aggressive.

An important concern is how work would be scheduled and organised without the role of the intermediary, the employer; this was a critical factor in care workers’ job satisfaction. Although opportunities to schedule care to meet their own needs is an important positive attraction of personalisation for users, it is not clear how the difficult trade-offs between the ideal time for a care visit and the competing demands from many users would be met. The scheduling problem in principle could be eased by care workers caring for only one or a smaller number of users but this would increase the need to expand the available workforce and reduce the possibility of the job providing for full-time employment for those in need of a full salary. Care workers we interviewed were concerned that caring for only one user might prove less fulfilling compared to their current involvement with many users or might lead them to be too involved, making it difficult to retain some distance from the user. They were also concerned about job security if a user were to die or to move into residential care. The ending of the job with the loss of a user could also enhance the risk of loss of skilled workers to the sector as a whole; when workers are displaced from employment there is no guarantee
that they will confine their job search to the same field of work and having just been made 
unemployed they might be unwilling to risk this happening a second time by entering into 
another contract with an individual user.

Beyond these concerns over the move to directly employed personal assistants, our research 
also pointed to a number of more institutional and budgetary concerns over personalisation as 
currently proposed. Those most commonly raised by providers related to the poaching of 
their staff and the increased difficulty in securing payment for services. For LAs the most 
common concerns were over the impact on costs, the possibility that users would choose not 
to purchase the more expensive re-ablement services, even though their long term costs of 
care might then increase, and the problems user choice posed for organising care provision 
by geographical area to minimise travel time and guarantee supply. The general uncertainty 
over the future role of LAs and providers in the provision of services was also inhibiting 
more strategic thinking and development, particularly with respect to integration with health. 
Finally there was the problem of adding to the existing ambiguity over who had the 
responsibility to provide training. Under personalisation three sets of agents might be 
involved- the LA, the provider (if the PA were hired through an agency) and the user who 
might be asked to pay for the training or the time spent training. In general it seems unlikely 
in a sector where public funding inevitably shapes the market that strategic aims will be 
achieved, or even the current quality and quantity of care maintained, without some 
continued planning of provision at either LA or national level. If policies are not put in place 
to enable strategic developments to be maintained and strengthened, the outcome could be 
moves away from re-ablement and care in the users’ homes and back to the more expensive 
and less desired outcome of residential care.

There thus seems to be an urgent need for further consideration of the appropriate modes of 
implementing greater user choice in social care. Greater clarity is needed in the future roles of 
LAs and existing providers in acting as commissioners, brokers or intermediaries with the 
users and detailed consideration needs to be given to appropriate forms of employment 
relationships and employment organisation in a caring profession. More clearly needs to be 
done to enable users to have more say over how and when their care is delivered but there is 
little evidence that the full consequences for the employment relationship of a move towards 
directly employed personal assistants or even personal budgets have been considered. A 
comprehensive study of the experiences of personal assistants is urgently required, together 
with more policy thinking on how care staff are to be provided with adequate training and 
some form of employment security under the new budget holding arrangements.

**Conclusion: towards a rebalancing of the care debate**

A key premise of this research has been that, in order for the quality of care to be maintained 
and enhanced, it is vital to do more to recruit and retain skilled and committed care workers. 
What has been missing in current debates over social care is any serious consideration of 
employment. While there has rightly been an increased recognition that the voice of the care 
user needs to be heard more, the voice of the care worker is still silent when one examines the 
main policy debates and documents. The consequence is that the implications of social care
policies, whether towards competitive outsourcing or user-centred care delivery, for the quality of employment relationships in social care are often ignored or hidden. This is a surprising feature of public policy in this service area where the quality of care cannot be divorced from the quality and commitment of the person delivering the care. Thus, whatever direction social care policy moves in, we would argue for the need to give greater consideration to the employment arrangements that could be reasonably expected to deliver the committed and skilled workforce that the care users in turn deserve and need.