Recruitment and retention in adult social care services

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Summary

More people are living with complex physical and mental health needs. Some of these occur later in life but others are long-standing. Many need care and support. These needs are met largely by social care services, although family carers play the major role in providing care. In England, demand for care workers is increasing but in the sector as a whole there are longstanding problems of high turnover of staff, unfilled vacancies and lack of continuity of care. Recruitment and retention of staff at all levels and in most settings are perceived to be major problems, although the scale varies geographically.

This report presents findings from research in England undertaken in 2017 to inform debates about a possible new government social care workforce strategy. It is based on 140 responses to interviews and emailed questions.

Findings

- The sector has developed many approaches to improving recruitment and retention but has limited control over the price that is paid for its services.

- There is scope for greater clarity about the extent to which local councils' responsibility for market shaping and commissioning in the Care Act 2014 also needs to consider what is needed to sustain the local adult social care workforce.

- As well as highlighting the challenges they faced in terms of recruitment and retention, participants emphasised the commitment and dedication shown by the majority of those working in adult social care – they are not 'the problem'.

- The diversity to be found among those working in adult social care was perceived to be a strength in meeting the needs of a diverse society but there is a case for further targeted efforts to attract under-represented groups, such as men, into the sector.

- Unease about the effects of competition with the NHS needs to be addressed, in particular the consequences of investing in training health care assistants and nurses who then leave to work in the NHS. Competition with the NHS for occupational therapists is another area that might benefit from further investigation.

- Many references were made to the difficulties that arose for individuals and organisations from not having enough staff but there is less clarity about the point at which these difficulties result in poorer outcomes for people using adult social care services and their families. More work is needed on the relationship between minimum staffing levels, workload and recruitment and retention.

- Apprenticeships were welcomed as having helped the sector but a skills gap appears to be developing in the number of workers with the knowledge and skills to support people with complex conditions, such as dementia and severe autism, a growing group among those using adult social care.

- The value of the National Minimum Data Set for Social Care (NMDS-SC) is considerable. Without it, and the annual reports prepared by Skills for Care about the adult social care workforce, it would be impossible to set the study findings in context.

- There is potential for more comparative work that considers recruitment and retention in adult social care alongside work in other sectors such as retail or hospitality.

Implications

This report provides an analysis of views from a range of stakeholders and interested parties on recruitment and retention in the social care workforce. While there was considerable concern about recruitment and retention in the workforce, the positive opportunities presented by social care work were also discussed. Participants considered aspects of workforce planning, tailoring skills development, and commitment to be important even if they did not know the particular strategies already in place to address these needs.

Many identified a need to improve terms and conditions, increase the status of social care work, and reduce the physical demands of care work. The majority considered there was scope for more volunteering in the sector but that it was important not to assume too much about how much paid work undertaken by care workers could be replaced by volunteers. There was limited experience of new roles. Expectations that these would result in improved recruitment and retention were low.

Limitations

The authors acknowledge the risk that participants' views may not be generalisable nor representative of the sector, nor of the public. Furthermore the study did not focus on directly employed care workers who are a small but growing part of the sector. While the risk of bias in terms of the views presented here cannot be eliminated, nonetheless data are sector-wide, participants came from different parts of England, and there were sizeable numbers of them. The views of a small number of users of social care and family carers are also included.

Acknowledgements and disclaimer

Introduction

Social care in the wider economy

Recruitment and retention difficulties in adult social care are not new (see for example, Hunter, 1998, Inman, 1998). However, there is now more interest in the topic, partly because of changes in employment practices, including the rise of the so-called 'gig economy' (Department for Business, Energy and Industrial Strategy, Undated), partly because of increasing demand for social care workers as a result of sharp rises in the number of people aged 18 and over needing social care support (Bolton, 2016, Moriarty, 2010, Wittenberg and Hu, 2015), and partly because of increased recognition that problems in recruiting and retaining social care staff have effects beyond the sector, for example in increasing the number of people no longer needing acute care awaiting discharge from hospital (National Audit Office, 2016).

Skills for Care estimates that nearly seven per cent of roles in adult social care are vacant, creating approximately 84,000 vacancies at any one time. It also reports that, at 27 per cent, average turnover rates have increased steadily and are even higher among new recruits and younger people (Davison and Polzin, 2016). There is a consensus that high vacancy and turnover rates make it more difficult to achieve and maintain good standards of care. Labour costs make up over half the expenditure on social care (Wanless, 2006) so the relationship between social care funding, pay, and vacancy and turnover rates is a close one. The 2015-2017 government allocated an extra £2 billion pounds for social care over 2017-2020, on top of allowing councils with social services responsibilities (hereafter referred to as local councils) to levy an additional social care precept of three per cent on their council tax for the financial years 2017-2018 and 2018-2019. The current government has announced its intention to consult on future social care funding (GOV.UK, 2017). In the meantime, the House of Commons Communities and Local Government Committee (2017) has asked the

National Audit Office to provide an independent estimate of any shortfall in publicly funded adult social care. However, social care employers have argued for several years that the fees local councils pay them to provide services are insufficient to enable them to invest in ways of improving employment conditions for their staff that might improve recruitment and retention (United Kingdom Homecare Association, 2015).

There is now much greater awareness of the contribution that adult social care makes to the wider economy. In 2015-2016, it was estimated that nearly 1.5 million people in England were working in the sector and that its annual contribution to the economy was about £40.4 billion. If jobs in adult social care increase proportionally to projected increases in the number of people aged 65 and over in the population, then the number of adult social care jobs will rise further by nearly a fifth by 2025 (Davison and Polzin, 2016).

Despite huge advances in the quality of data collected about the social care workforce, largely as a result of the establishment of the National Minimum Data Set for Social Care (NMDS-SC),

the volume of empirical research remains low in relation to the size of the sector and is mainly reliant upon secondary data analysis (Schneider, 2016). Two seminal publications on the direct care workforce supporting older people (Hughes et al., 2009, Rubery et al., 2011) were published before such important events as funding cuts to local councils, the introduction of the National Living Wage, and the referendum decision to leave the European Union. Even less is known about recruitment and retention in other sectors of the workforce that are also expanding, such as housing and care workers (Manthorpe and Moriarty, 2010) or personal assistants (Scourfield, 2005, Woolham, 2017).

In 2011 the Department of Health, working with Skills for Care and other sector partners, published a *Recruitment and retention strategy* that set out a vision and action plan for building the capacity of the social care workforce (Skills for Care, 2011). Following the passage of the Care Act 2014, it was agreed that the strategy needed to be refreshed to take account of the changes introduced as a result of this legislation and to incorporate lessons from the Mid Staffordshire NHS Foundation Trust Public Inquiry (Skills for Care, 2014). Both strategies were aimed at bringing together employers, policymakers and those with strategic responsibilities for planning and delivering adult social care to agree priorities for improving recruitment and retention. An evaluation of the first strategy concluded that it had been a positive achievement to bring together different organisations but that its impact had largely been at

the strategic level (Lawrie and Kearney, 2013). At the same time that Skills for Care was conducting its own internal evaluation of the 2014 Strategy, the Social Care Workforce Research Unit was commissioned by the Department for Health Policy Research Programme to undertake an evaluation of the strategy within the current policy context, including consideration of factors such as the introduction of the National Living Wage and the decision to leave the European Union, that had not been anticipated when the 2014 strategy had been written.

Aims and methods

This was a small scale project with a broad remit. A meeting was held with policy customers at the Department of Health to agree the study aims and establish the key topics on which information was requested. These were:

- What do the social care sector and others in wider employment sectors consider to be the impact of the existing 2014-2017 strategy and its fitness for purpose in meeting future recruitment challenges in the medium to long term?

- Within the limited armoury available, what are the best levers that can be used to improve the ongoing and systemic difficulties in social care recruitment and retention and which can be seen as representing the most effective approach or, colloquially, delivering the 'biggest bang for the buck?'

It was agreed that we should aim to recruit a target of around 100 participants with an interest in recruitment and retention in adult social care. As Skills for Care was also conducting its own internal evaluation, it was important to avoid duplication by not simply approaching representatives of the sector who had been involved in developing the strategy. The sampling frame was developed using the principles of maximum variation sampling (Patton, 2002). This is a type of purposeful sampling in which the aim is to maximise the diversity relevant to the research question. This means that the sample does not match the numerical distribution of the population from which it is drawn; rather, it seeks to encompass the range of variation within that population. The sample was selected in order to reflect differences in:

- roles (care and support workers, social workers, nurses and occupational therapists, team leaders and managers, and directors and other staff in senior leadership roles, family carers and those with experience of using services)

- sector (local authority adult social care departments, integrated NHS services, private sector companies, voluntary and not for profit

organisations, and social enterprises)

- organisation size (family owned businesses, regional and national chains, and multinationals)

- geography (urban and rural, different regions within England)

- different types of service user staff (working with older people, people with a learning disability, and people with mental health problems and adults aged 18-65 with complex conditions)

Contact was made with potential participants through a combination of internal and external networks such as Care England, Making Research Count, the Margaret Butterworth Care Home Forum and other Unit contacts. A total of 140 participants agreed to take part in the study. They came from a wide range of professional roles, including Human Resource (HR) directors, care workers, managers and senior managers, from different parts of the country and from different types of organisation. A small number of family carers also took part. Most of the participants answered a series of open and closed questions via email (see Appendix One) but a proportion were interviewed face to face (n=8), in focus groups (n=10) and over the telephone (n=19). More details on the sample are included in Appendix One.

Ethical permission was received from King's College London Ethics Committee (Ref: MR/16/17-280) using the Research Ethics Minimal Risk Registration Form. The Unit's Service User and Carer Advisory Group was asked to give its advice on the study.

It soon became clear that few participants were familiar with the Strategy. Furthermore, several factors reported to have an impact on recruitment and retention in adult social care, such as the National Living Wage and the decision to leave the European Union (EU), had occurred after the Strategy was published. It was decided to refocus the study to concentrate more upon the second aim, investigating the 'levers' influencing recruitment and retention and to use the Strategy primarily as a framework for analysing responses.

An interview schedule that doubled up as a survey was developed based on existing research about recruitment and retention and the topic areas that had been agreed (see Appendix Two). The

study data consisted of emailed replies to a set and hard copies of circulated at event, verbatim data transcripts of interviews and focus groups, and contemporaneous researcher notes of the telephone interviews. While contemporaneous notes clearly do not capture as much of what is said as verbatim transcripts, the process of note taking was made easier because of the way the schedule was structured. In a small scale project, the benefits of transcribing the telephone interviews would have to be set against less time on data collection.

Data were analysed using applied thematic analysis (Guest et al., 2012) which shares similarities with approaches such as grounded theory and phenomenology in the sense that themes are coded from the data but also includes aspects of quantification such as word searches and deviant case analyses. It is especially suitable for research with an applied, rather than a theoretical, focus.

Findings

All participants considered that recruitment and retention in adult social care faced unprecedented difficulties. The most frequent description was 'challenging'. Others included 'struggling', 'critical', 'dire', and 'precarious'. Many spoke of it as 'heading for' or even actually being in a 'crisis'. The most vivid analogy compared it to a 'motorway with a pothole every two yards in every direction' but other more prosaic descriptions reflected similar levels of concern.

There was universal agreement across participants - regardless of whether they were employed in local authorities, the private and voluntary sector, or with direct experience of using services - that longstanding difficulties in recruitment and retention had worsened because of the growing gap between overall levels of demand for social care and expenditure (Franklin, 2015, Humphries et al., 2016, Simpson, 2017). Participants referred to the effects of population ageing but also highlighted increases in the number of adults aged 18-65 with complex conditions needing intensive social care support. These changes meant that, unlike sectors such as wholesale or retail where increased automation is likely to mean fewer workers will be needed (Berriman and Hawkesworth, 2017), demand for social care workers would probably increase:

> With people staying alive for longer, it's an area [of employment] in society that's actually expanding. The market is growing and you have stability in terms of career choice.
> **(116, HR Director, voluntary organisation)**

However, the rise in the number of people living with complex conditions also risked creating a skills gap in terms of the number of workers able to provide the right levels of care and support:

> [People moving to nursing homes] do not just walk in. We're basically running end of life and sub-acute care.
> **(131, Chief Nurse, not for profit organisation)**

> The funding [problem] is not going away, especially with the growing demography - autism, mental health, and people with the most challenging behaviours. [It's a problem] getting staff to have the skills.
> **(010, Trustee, voluntary organisation)**

While there was recognition of the additional £2 billion for social care announced in the April 2017 budget (HM Treasury, 2017), this was not considered to be enough. Some participants also reported delays in local NHS organisations and local councils reaching agreement as to how these funds would be spent.

Many of the reasons participants gave for difficulties in recruitment and retention would be familiar to social care policymakers. These included low levels of pay and status and a lack of leadership, problems that were seen as inter-related. Some specific concerns - such as the possible consequences of Brexit and the operation of the apprenticeship levy - reflected the impact of more recent national political decisions. Others were caused by local labour market conditions. Thus, for basic grade care workers, competition from supermarkets or other local providers meant that when one employer raised their pay rates, those whose rates remained unchanged experienced a rapid exodus of workers.

Location and the type of service provided could also influence recruitment and retention. Home care agencies in rural areas mentioned the challenges of recruiting home care workers who had their own transport while care homes located in prosperous areas to attract people who could afford to pay for their own care (self-funders) had problems recruiting care staff living within easy travelling distance.

For registered nurses and care workers with the skills and experience to become health care assistants (HCAs) in the NHS, the effects of competition were nationwide as private and voluntary sector employers struggled to compete with NHS terms and conditions of service.

Several examples of incentives to improve recruitment practice and encourage retention were given but these were often made in the realisation that they were not necessarily sufficient to attract enough people, especially those who were willing to work full time and at unsocial hours, such as weekends and evenings. The following sections describe these findings in more detail.

Pay, competition, and work intensification

Levels of pay in the social care sector have been historically low (Gardiner and Hussein, 2015, Hussein et al., 2016). For some workers, this has been compounded by underpayment of the National Minimum Wage, especially in home care because of differences in the way that travel time is paid or travel costs reimbursed (Gardiner, 2015). However, the scale of underpayment has been contested, leading to calls for further investigation (Low Pay Commission, 2016).

The 2015-2017 Conservative government introduced the National Living Wage on 1 April 2016 for all working people aged 25 and over, with some exemptions. It has been set at £7.50 per hour for the April 2017-March 2018 financial year. It will continue to rise until 2020 when it is intended that it should reach 60 per cent of median UK earnings. The adult social care sector was described as among the 'most vocal' of those expressing concern about its introduction (Low Pay Commission, 2016, p. xviii). Early evidence suggests it may have had a less serious impact upon employment than some envisaged (Giupponi et al., 2016), although there are reports of some organisations withdrawing from contracts with local councils because they consider that the amount councils are prepared to pay for their services are not financially sustainable (Low Pay Commission, 2016).

Skills for Care (2016b) estimated that in March 2016 around 40 per cent of care workers in the independent sector were paid at below the National Living Wage. By October 2016, average hourly pay for care workers had increased by three per cent, except in London where average pay rose by only one per cent to £8.14 per hour. This hourly rate is less than the £9.45 per hour that the Living Wage Foundation (Undated) calculates is needed to 'get by' in the capital and meant that the gap between care worker average pay and the Living Wage was largest in London (£0.94 per hour) and smallest in the North West (£0.25 per hour).

All the study participants recognised the difficulties in recruitment and retention that resulted from being in a low wage sector. For them, a key challenge lay in the lack of pay differentials between social care work, which they saw as more skilful and demanding than other similarly paid occupations in retail and hospitality. Competition also existed with the NHS and temporary employment agencies. The flat pay structure in which a high proportion of the workforce was paid at the National Living Wage but in which there were few enhancements for unsocial hours or levels of experience seemed to have created uneven capacity in terms of providing a 24 hour service, with it proving hard to recruit staff willing to work at night, in the evenings, and at weekends.

Introduction of National Living Wage

Insofar as participants in our study were concerned, the impact of the National Living Wage was mixed. Some providers reported that local councils were failing to pass on the additional funding from the adult social care precept added onto council tax bills (that is, local taxes) to reflect providers' increased labour costs. The failure to increase the sums paid through contracts with agencies for social care in line with the National Living Wage helped fuel the increasing gap between the fees paid by self-funders and those paying 'top up' fees with those paid for publicly funded residents (Passingham et al., 2013). One participant pointed out that staffing already accounted for 55 per cent of the company's costs and this proportion was likely to rise. She recalled that in the past, local authorities had paid proportionally more for the service that private companies provided:

> In March 1995, [I worked in a home] which charged £360 [a week for self-funders] and £360 [for people funded by] the council ... Now we get £560 from social services and it's £1,000 for private residents.
> **(011, Operations Director, private company)**

Another informant who had previously worked in retail and hospitality pointed out:

> Local authority residents don't get paid the right amount. In the retail sector, increased costs are passed on to the customer.
> **(073, HR Director, private company)**

However, unlike retail where the majority of customers were thought to realise that changes in the seasons or currency rates would lead to rises in prices, 'customers' – whether local councils or the general public – seemed not to accept that care costs needed to rise:

> Local government is not paying enough for care. We're 60:40 local authority funded and the difference [in fees] is not ethical. We're fortunate but some care organisations are not sustainable. Local government and the public need to stand up and realise that 'granny going into a home' is not like going into a hotel. They don't realise the high dependency [of residents]. People are amazed at the costs of care.
>
> **(116, HR Director, voluntary organisation)**

The main reported effect of the National Living Wage was a levelling out of the average hourly rates for basic grade jobs in care and in retail for people aged over 25. Participants were unsure about what the long term effects would be. They were concerned that some people might leave to work in retail on the assumption that the work would be less demanding for the same rate of pay. At the same time, those who enjoyed working in social care might be more inclined to stay with their employer if the rate of pay was no different to that found elsewhere:

> I think, unfortunately, the National Living Wage, because it is national and everybody's getting it, I don't know that you can see any benefit ... Whatever job [people] go into, will be paid at that rate ... I think what it has done is, where you had some employers that paid an enhancement as attraction, they've stopped paying that because everybody's gone up [to £7.50 per hour] ... The job that the [paid] carers do is really hard ... so when [supermarket] or wherever down the road advertises a job for a pound an hour more and they've got financial troubles - that often accounts for quite [a lot of decisions to change jobs] ... they'll move frequently between homes and it's quite a mobile industry. Staff, particularly at a lower grade level, will be very, very mobile between [care] homes ... So that can be quite a challenge because we invest a lot in our staff at all levels ... [and] that constant churn has quite high financial implications for us.
>
> **(118, HR Director, private company)**

The reason people leave is normally pay but with the National Living Wage, it's not so significant. The thing now is that it's a hard and difficult role when compared to stacking shelves.

> **(011, Operations Director, private company)**

People don't want the job paying minimum wage (sic) if they can work in a garden centre for the same rate of pay. All care [work] is rewarding but it's a physical job and mentally challenging ... It's hard. People get burnt out.

> **(117, HR Lead, private company)**

The theme of a segmented workforce in which there was a stable core of people who wanted to work in social care and another more mobile workforce who moved between care work and retail ran through many responses and will be discussed further in the section on values based recruitment.

In home care, which has experienced the highest turnover and vacancy rates in adult social care (Hussein et al., 2016), the problem of underpayment remained unresolved:

> In terms of operational staff there is a shortage of domiciliary care workers as their pay is less than, say, supermarket staff, so many are walking away. Some agencies only pay staff for the hours they are actually with service users, expecting them to effectively travel in their own time, which also eats into their already low pay.
>
> **(049, Business Intelligence Officer, local authority)**

One participant explained how the National Living Wage had made an imperceptible effect on her pay because she was only paid for time actually spent with service users and not for travel time. To make matters worse, her mileage rate had been cut to offset the increase in her hourly rate:

> ... the problem there was you never really got an hour's job. I was doing 30 minutes and so you would be getting £3.50, whatever, £3.60. So you'd have to have a lot of jobs in the day to make a good wage. It was hard [and the travelling] took the time up as well ... You did get mileage allowance, but that was cut ... It had gone from I think 50p a mile to, I think he [owner] cut it down to about 35p or something

... So even less money. I just thought. 'Enough is enough. I will leave.'

(013, Self-Employed Care Worker)

Competition and turnover

There is now a higher proportion of 'very old' people aged 85 and over with complex health conditions living in care homes (Office for National Statistics, 2014). This has increased the need for registered nurses to work in social care at a time when there is already a national shortage of nurses (Royal College of Nursing, 2016). While the average entry pay levels for nurses in the NHS and social care are similar (£25,000 per annum) (Davison and Polzin, 2016), nurses in the NHS acquire increments and have more opportunities for promotion, as well as being able to join the NHS superannuation scheme and qualify for non-statutory sickness pay. These differences meant that care homes have found it difficult to attract nurses from the NHS and instead tend to rely on recruiting nurses from within the European Economic Area or outside using Tier 2 visas. Nevertheless, as we discuss in the sections on status and leadership, pay levels were not the sole reasons for recruitment difficulties.

As mentioned earlier, one effect of increasing the basic hourly rate for care workers through the National Living Wage has been to reduce pay differentials between less and more experienced staff. For example, the difference in hourly rates between care workers and senior care workers declined by two per cent between 2015 and 2016. This meant that senior care workers might earn just an average of £0.81p an hour more than a care worker (Skills for Care, 2016b) but have considerable responsibility in terms of managing shifts, handing over to new staff and administering medication (Norrie et al., 2017). Many participants gave examples of experienced care staff moving to work in the NHS. In some instances, this could be a positive event - at least altruistically - if workers left to begin nurse training. More often, from the social care employer's perspective, it meant that an organisation had lost its most skilled and experienced staff to work as health care assistants in the NHS.

Social workers and occupational therapists are among the better paid workers in adult social care with average annual salaries of £34,000 and £33,700 respectively. These represent real term increases of six and 10 per cent between 2012-

2016 (Davison and Polzin, 2016). As with nurses, competition with the NHS was identified as a barrier to retaining occupational therapists (OTs) in adult social care:

In terms of occupational therapy, the problem is that the salary and progression structure is generally better in the NHS. In social care, pay may be more attractive for newly qualified occupational therapists but more experienced therapists generally get better pay in the NHS. This means that vacancies often attract newly qualified staff who then leave after they have been 'trained up' in social care ... In my local area the OT job structure [in adult social care] has changed so there are now different grades for staff – so promotion and career progression opportunities have helped. However, they haven't entirely eliminated the problem with better terms in the NHS and that therapists who have gained experience in social care may leave to work for the NHS.

(115, Research Occupational Therapist, University)

Local pay scales also impacted on social worker retention. There is no national pay scale for social workers, something that has provoked much discussion over many years (Social Work Task Force, 2009). There were reports of high levels of 'churn' as social workers – particularly newly qualified social workers who had just completed their Assessed and Supported Year in Employment (ASYE) - left for neighbouring authorities where salaries were higher:

Pay does not reflect the work you put in or are expected to put in. It is too low and there is no increase after about 3-4 years.

(087, Social Worker, local authority)

[There's] a lot of movement in our organisation. ASYEs move on to other local authorities [LA] that pay more. Our LA doesn't seem to understand that by investing more money in staff they will save in the long run.

(075, Senior Social Worker, local authority)

The median annual pay of registered managers in social care is £27,700, although it varies in different parts of the country and service setting (Skills for Care, 2016a). Several managers felt that the amount of pay they received did not reflect the amount of responsibilities they held:

Managers have low pay and are strangled by paperwork.

(130, Team Manager, local authority)

Workloads and work intensification

An even more widespread problem particularly reported by social workers participating in this study was the effect of work intensification on job satisfaction and morale. 'Work intensification' is the term developed to describe attempts to control labour costs by increasing the amount of work to be done in a set amount of time or reducing the time allowed for completing certain tasks (Boxall and Macky, 2014). Originally used to describe work on assembly lines, it was quickly recognised that it existed in other work environments. Over the last decade, work intensification has increased sharply across British workplaces as a whole (Felstead et al., 2013). However, these generalised changes seemed to have been accentuated by funding pressures in adult social care departments, as illustrated by these comments from these four participants each of whom worked for a different local council:

Social workers just aren't being recruited. No permanent social workers are being recruited. Unqualified staff are being recruited in their place. There are also less overall staff than there were. Each worker is doing three people's work. [There's] more pressure on people and we're being told to do more. In the past [our organisation] couldn't even get staff when [they were] offered an introductory incentive of £500 ... It's becoming like a factory.

(018, Social Worker, local authority)

Staff are overstretched as they are continually asked to take on more roles in response to cost improvement strategies.

(061, Independent Chair, Adult Safeguarding Board, local authority)

A noticeable reduction in the adult social care workforce due to re-organisation is putting intense pressure on the system as staff are dealing with the same level of business with a more complex client group with less staff.

(113, Safeguarding Adult Lead, local authority)

... exit by experienced social workers [in our area] due to voluntary resignation programmes.

This increases our caseloads, staff become stressed and this results in long term sickness.

(047, Social Worker, local authority)

For one experienced social worker, the effects of increased workloads were made worse by a reduction in peer support:

We are working less and less as a team ... [with] more lone working from home [and] in different sites through hot desking. This in turn raises stress levels with less opportunity for co-workers to check on each other's wellbeing and offer mentoring or reflective opportunities.

(024, Social Worker, local authority)

Agency working, zero hours contracts, and the 'gig economy'

Earlier research has shown that the practice of recruiting social care workers from temporary employment agencies is longstanding, although the proportion hired this way fluctuates (Cornes et al., 2012, Cornes et al., 2010). Agency working can offer advantages such as flexibility for employers and workers alike:

I've got a few support worker vacancies as well ... I don't want to fill [them] all ... because ... if you want somebody to come in just for four hours ... you can pick and choose your ... agency staff ... Sometimes you might just need a male [member of staff] ... to work with a particular person and ... it's very hard to get [permanent] male support workers.

(012, Registered Manager, local authority)

However, there was a perceived difference between the occasional, judicious use of agency staff and the tensions that could arise when agency workers outnumbered permanent staff:

There is lots of [agency staff] now ... Sometimes I think maybe [company] want that way because they don't have to pay holidays [but] I am not really sure ... Sometimes [it] will be two permanent carers [care workers] on duty. And then there will be some new person to teach and then there will be some [agency workers]. There is a load on those two permanent [care workers] ... so when they leave they blame us.

(Registered Nurse, private company)

After a period of decline, the number of short-term contracts, 'locum' or 'agency' workers in adult social care departments appeared to have increased. From an organisational perspective, the costs of employing agency social workers could be off-set by reductions in the number of people on permanent contracts. The motives of social workers choosing to be employed by agencies were not simply about take home pay but also about reducing work-related stress and achieving a better work life balance. However, echoing earlier research (Cornes et al., 2012, Cornes et al., 2010), problems with continuity of care and decision-making and a lack of organisational memory could occur when organisations became too reliant on agency workers or 'locums':

> [There's too much] reliance on fixed term contracts and agency locums. Need incentives [to retain permanent staff] like employee assistance [and] travel passes.
>
> **(094, Team Manager, local authority)**

Another participant pointed out that local authorities might be affected by the changes requiring public sector employers to subtract tax and national insurance contributions from agency workers' pay packets at source rather than allowing these workers to calculate their own tax contributions (HMRC, 2017b):

> The tax law changes [to] IR 35 will affect local authorities' ability to recruit interim staff. As interim staff have become an important stop gap in maintaining professional services

during periods of change, this could potentially destabilise social care.

> **(061, Independent Chair, Adult Safeguarding Board, Local Authority)**

The number of workers employed by temporary employment agencies is often regarded as a sign of a flexible labour market. Two other signs of labour market flexibility that have attracted widespread interest within and beyond social care are the rise of zero-hours contracts and the so-called 'gig economy' in which self-employed workers can be connected with work opportunities via digital platforms or applications owned by intermediaries (House of Commons Work and Pensions Committee, 2017). The Department for Business, Energy and Industrial Strategy (2016b) has commissioned an Independent Review of Employment Practices in the Modern Economy to consider the implications of new forms of work for workers and employers, but this report makes few specific references to social care (Taylor Review, 2017).

Social care has always had a high proportion of part time jobs, mainly because women make up over 80 per cent of the workforce. Thirty-seven per cent of the workforce work part time, 51 per cent work full time, and 11 per cent have no fixed hours (Davison and Polzin, 2016). A different picture emerges when contracted hours of work – as opposed to the actual number of hours usually worked - are considered. The number of zero-hours employment contracts in social care has risen sharply and around a third of the workforce is thought to be employed this way (Davison and Polzin, 2016).

In other sectors in which zero-hours contracts predominate, such as retail or tourism, the need for workers fluctuates or is seasonal. However, this is not true of social care. Employers argue that the way adult social care departments commission services makes it impossible to offer employees a guaranteed number of hours work (Angel, 2014). The trade union UNISON (2017) considers zero-hours contracts 'give the upper hand to unscrupulous employers'. Research by Rubery and colleagues (2011) concluded that the number of zero-hours contracts could not simply be explained by the way that services were commissioned and that some employers prefer them because it gave them additional flexibility over the workforce.

For some in the sector, the rise in the number of online platforms in which care workers can

advertise their services to people using direct payments or funding their own social care offers a chance for workers to achieve better terms and conditions than with conventional employers (Bee, 2016, McKee, 2017). There is as yet no published research that has been able to examine this systematically but a study by Woolham et al (2016) on personal assistants in social care is due to report by early 2018.

From the perspective of people participating in this study, there was a tension between the benefits to individuals of flexible working and the wider interests of the service. The 'gig economy' operated to the advantage of the participant mentioned earlier who had left her job with a home care agency because she was only paid for direct time spent with service users. She had acquired three self-funding clients through advertising and word of mouth (not through an online platform) and was looking to expand:

> I have now got my own website, business cards and everything ... [and am] trying to drum up a bit more business ... [I now charge] roughly between £11 and £13.50 [an hour]. It depends. One of my clients, it's not really care work, it's more just company, washing up, a bit of shopping, pick up prescriptions.
>
> **(013, Self-employed Care Worker)**

While this participant did not wish to work full time, others did. In one organisation taking part in a focus group, a recruitment freeze meant that a number of the regular staff were employed through an agency. The service was being reconfigured but, as agency workers, they did not have the same

employment rights as staff on permanent contracts. It illustrated how agency working could involve both choice and constraints and benefits and disadvantages.

A major difficulty mentioned by participants was the challenge of operating a 24 hour service. Organisations employing people on zero hours contracts need a larger pool of staff on whom to call than those in which the majority of staff are contracted to work full time. Arranging enough people to cover all the hours that were needed was a particular problem during early mornings, evenings and weekends (Moriarty, 2015):

> People are choosing agency work as a lifestyle choice ... People used to be embarrassed to say they worked for an agency. It was seen as a sign that you couldn't hold a job down or had bad references. Now it's the model of choice. It's also people picking their shifts ... e.g. they won't work at night ... People can get more money by working six months and then taking six months off. At one level, why shouldn't people choose that? At another, it's destroying the system.
>
> **(117, HR Lead, private company)**

The phrase 'lifestyle choice' could encompass a range of decisions, some of which were more constrained than others. One participant gave an example of personal assistant who was part of a team supporting her daughter. This personal assistant also worked part time in a shop:

> She likes the contrast. She has negotiated that she can tweak her [shop] hours if [daughter] needs her ... A lot of people are doing two or three [different] jobs. That could be a good thing. They may not want to do social care all the time. We need some acknowledgement of that ... [And] then there's the issue of benefits in terms of the hours you work – it's such a mess.
>
> **(111, Family Carer and Researcher)**

Given the gender and age profile of the social care workforce, it was not surprising that people also had to consider how to organise their paid work alongside their other family commitments. Atypical working patterns and the costs of paid child care make it less likely that care workers use formal child care arrangements (Family and Childcare Trust, 2015, Harding et al., 2017). Instead, they are very reliant on unpaid

arrangements and – where there are two parents – to work their shifts around each other:

> My children are a little bit older now and we now live next door to my in-laws, which helps with child care. So [the children] can walk back from school on their own and my in-laws are there to meet them ....[but] there is just no time for anything [else] and [my husband] and I often say we are like passing ships in the night ... [Work] are really brilliant if there is a problem with any of my children or if I've got to go to school or anything like that ... [but] I don't know how long I am going to be able to sustain the level that I am at ... I mean my house looks like a tip. My in-laws do go in and do a bit of housework and that for me as well ... [but] I don't know if this is something I will be doing ... until I retire. That scares me
>
> **(134, Team Leader, private company)**

While this participant averaged 40 hours over a fortnight, working 30 hours one week and 50 the next, the owner of a family business pointed out that there is no financial incentive for parents with children under 16 claiming Working Tax Credit to work more than the minimum hours needed to qualify for the benefit. These are currently 16 hours for a single parent and 24 for a couple where one partner works at least 16 hours and the other at least 8 hours a week. This meant that employers were often reliant on those without school age children to work additional hours. While this suited some workers, others questioned the long term sustainability of working so many extra hours per week:

> I am contracted for 40 [hours] but I do more simply because it suits me because of my personal circumstances. I haven't got any young children; they are all grown up and left home. It's just myself and my husband. He happens to work ... shifts [nearby].
>
> **(135, Service Manager, private company)**

> When I started [work] as a care worker, I worked 8-12, then 8-2 ... We had set hours and went home and that's what we did. People weren't badgering you to do more and more hours ... [Now] many work a 13 hour day with three quarters of an hour for lunch. Some work three to four [long] days on the trot ... There

are [staff] shortages now and people are leaving in droves. They get run down.

> **(007, Healthcare Assistant, private company)**

Status and rewards

The low status of social work and social care is regularly cited as a reason for recruitment and retention problems in adult social care (for example, Cavendish, 2013, Hussein and Christensen, 2017, Skills for Care, 2014, Twigg et al., 2011). Although poor pay was the most frequently reported reason for recruitment and retention difficulties, status was discussed almost as often. Both were seen as inter-related:

> [It's a] perfect storm, poor pay, low expectations, not [being] valued.
>
> **(088, Workforce Development, local authority)**

> I think [status of social care has] improved, but I still don't think it's anywhere near where it needs to be. People view being a [paid] carer as the last resort. It's the lowest-paid. They don't always see the great job and the benefits that the role does bring.
>
> **(118, HR Director, private company)**

Improving the public image of care work

Participants thought that improving the status of social care needed a three-pronged approach. The first involved outward-facing activity aimed at improving public understanding about what the work involved, including the activities undertaken by social workers and occupational therapists, in the hope that a better public image would increase the number of people wanting to work in social care, giving employers a larger pool of applicants from which to select. One participant offered an example from outside his own organisation of Devon County Council's 'Proud to Care' (Undated) programme which uses 'real life stories' to highlight types of care work and the variety of people undertaking it, including men. Others agreed with this need to focus on the value of social care work and the skills needed to do it well:

> [It] has to involve some component of addressing low prestige activity into becoming something that is treasured by communities and public systems.
>
> **(034, Policy Analyst, university)**

I guess this is a difficult thing to do because you can't do it overnight but we need people to have pride in saying, "I'm a support worker", not "I'm only a support worker". They should have their heads held high. The idea that anybody can be a support worker!

(117, HR lead, private company)

As a former homecare worker, I recognise the range of skills required to provide people with good quality person centred care whilst working independently in the community. This role is not perceived positively by society as a whole and in general care work is deemed to be 'unskilled' work – when it actually requires a range of quite complex skills to perform the role well.

(115, Research Occupational Therapist, university)

Stereotyped ideas that social care work required little skill and was a job that 'anyone could do' were thought to be widespread and to act as a major barrier to recruitment and retention. A substantial minority were concerned that negative portrayals in the media reinforced these views. Echoing findings reported elsewhere (Manthorpe et al., 2016), media coverage was criticised for focusing almost exclusively on scandals and abuse, while neglecting to cover instances where high quality care and support were being provided:

Unfortunately, the negative press about social care and the unhealthy 'blame culture' within the press and statutory services is contributing to this.

(136, Manager, private company)

It was suggested that a social care equivalent of a popular and attractive 'John Lewis Christmas advertisement' and greater use of social media might help counteract these unfavourable representations.

Careers advice

The second set of ideas for improving the recruitment and retention was based on making sure that those involved in careers advice, such as teachers and staff in job centres were better informed about social care. One participant recounted how her grandchildren's teacher had publicly told one student that if she did not do her homework she would 'end up as a care worker.' She felt that attitudes such as these were not unusual and suggested that initiatives such as Care Ambassadors (Skills for Care, Undated-b) visiting schools to talk about their work and encourage students to work in social care had minimal impact because the prevailing attitude among staff working in schools towards care work was so negative. Another wanted staff in job centres to take a more positive attitude to care work and not simply suggest it just to 'get people off their books':

It's the lack of understanding in job centres. They don't sell it in terms of value. They can't enthuse about it. They don't look at the positives – the opportunities to retrain. It's not given the profile or platform as a very worthwhile career ... [so you end up with applicants] who don't have the skills, attitudes, or aptitude to work in the sector.

(129, Chair, voluntary organisation)

The third area for action to improve recruitment and retention suggested by participants was based on incentives for the existing workforce. Although a sizeable number were pessimistic about the extent to which these worked and questioned if they really brought about long term improvements, others were more enthusiastic and described a range of approaches. These ranged from praise for the new teaching partnerships between universities and local authorities to provide social work qualifying education, to the success of small scale local events such as 'pizza evenings' aimed at encouraging team spirit and camaraderie.

+ Transport

A key deterrent for improving social care recruitment in rural areas is the cost of travel and the lack of public transport for workers who do not have their own transport so it was not surprising that it was mentioned in several examples of successful recruitment and retention initiatives involved transport:

> A simple but effective measure by a care home company in a semi-rural area was to provide a transport service for staff to get to/from work – a sizeable number of care staff don't drive, so were deterred from applying for jobs they could not easily get to. The home has 100 per cent staffing for the first time in three years.
>
> **(068, Social Worker, local authority)**

> I have heard of some employers who employ people in rural areas, of recognising what is important to candidates in those areas, and offering free lunches at work if there are no shops nearby, or supporting with transport to and from work, or offering flexible hours where appropriate.
>
> **(071 HR Director, private company)**

However, they also highlighted differences between those employed by the public and private sector. In another example of the way in which extraneous factors can impact on social care recruitment, the owner of a family business in a rural area described how a young employee passed her driving test and bought a new car on a personal contract purchase so she could work in home care. This type of loan makes the vehicle more affordable because part of the cost is deferred until

the end of the credit agreement when a balloon payment based on the residual or guaranteed future value of the vehicle is calculated. However, they also set an annual mileage limit in order to maintain the vehicle's value. The worker soon found that the number of miles she had to travel for work was quickly in excess of the annual limit she had been given. This was a major drawback as exceeding the agreed mileage limit incurs an excess charge for every additional mile. It can also affect whether the owner is able to sell back or has to buy the vehicle at the end of the contract.

By contrast, a social worker employed by the NHS also needed to drive but had been able to get a lease car:

> I have a staff lease car which is subject to a three year contract. For this reason I would not contemplate job seeking elsewhere as I would be expected to pay a fine for early termination of the lease (I would be unable to continue the lease if I left my employment). The lease deal is very, very appealing and generous so this is a huge incentive to achieve better economic wellbeing for workers and also retain staff.
>
> **(100, Social Worker, NHS)**

+ Housing

As well as transport, housing costs were identified as something that made it more difficult to attract and retain staff. One participant found this was a particular problem for care homes that had been built in prosperous areas to attract self-funders as they were unlikely to have many local residents applying to be care workers. Another pointed out that few parts of the country were actually affordable on a care worker's salary:

> A lot of people, the younger generation getting into the workforce, this type of work isn't going to be an option. Certainly, down the south of the country, because ... whether you're renting or wanting to buy ... you'd need a pretty rich boyfriend or girlfriend working in Canary Wharf!
>
> **(124, Support Worker, local authority)**

Some employers gave examples of providing short-term accommodation aimed at helping newly appointed workers – particularly those arriving from outside the UK. However, longer term arrangements were also thought to be needed:

[Recruitment and retention] is a major concern both for social care and health and as the two are so intrinsically linked, it seems that the way forward ... may lie with the STPs [Sustainability and Transformation Partnerships]. However social care is seen as the poor cousin when in discussions ... STPs and LAs coming together to look at how they promote and support the market will be crucial ... [They also need to] focus on areas such as affordable housing.

(100, Principal Social Worker, local authority)

Although the high cost of housing is often seen as a problem affecting London and the south east, other participants pointed out that the cost of housing in places such as the West Country or Lake District was only marginally cheaper. These areas also experienced high levels of retirement migration with a consequent need for more care workers.

- Financial incentives

Although the overwhelming trend seemed to be toward an erosion of pay differentials in the sector, there were four isolated examples where organisations had sought to introduce or maintain financial incentives for loyalty or performance:

We've just done a pilot scheme with nurses, which is very similar, if it's not the same, to the NHS banding and so we reward staff for their tenure. So the longer they're with us, the more they get paid. So that's probably been our most successful initiative so far from a ... nurse recruitment point of view.

(118, HR Director, private company)

In another company, a decision had been taken to replace increments with performance related pay of up to £0.15 per hour. Taken alongside the pay rise as a result of the National Living Wage, some workers were earning £0.45 an hour more:

When you've got staff that do go above and beyond, they should be recognised. ... Back when I started, we had problematic staff and I struggled to think why we were rewarding staff that we were taking through disciplinaries. It's kind of, "You are [going through] a disciplinary, but I am going to give you a pay rise in two months' time." It didn't add up for me ... Over the year, we look at their performance ... Go

back over supervisions. Their attitude to change is very important for me, I think. If you have got a member of staff that's sort of anti-change, that's quite negative approach to have on shift.

(014, Registered Manager, private company)

Another example of a financial incentive to improve recruitment and retention was a 'finding fee' for introducing satisfactory new employees. One participant reported that workers were given £350 for every new employee whom they introduced to the company once that new worker had been in post for six months. Around one in five of the workforce had been recruited this way.

The final example of how incentives might work was of gainsharing. Unlike performance related pay, which rewards individual performance, gain sharing leads to collective benefits. Although the practice of outcomes based commissioning is well established (Moriarty and Manthorpe, 2014), this is the first example we have found of translating it into rewards for employees:

[Authority] intend to introduce a 'gain share' approach with providers, paying a bonus to providers for achieving agreed outcomes for a person, including reablement, that reduces the cost of the package. This bonus will be shared with the care staff. I am cautiously optimistic about this working in practice.

(068, Social Worker, local authority)

- Employee engagement

Employee engagement in which employees are encouraged to invest their physical, cognitive, and emotional resources towards the achievement of organisational goals is regularly included in examples of high performance work practices (HPWP) (Albrecht et al., 2015). Two participants considered that it had a beneficial effect on retention:

Staff engagement works well. We send out a staff survey and we do workshops to feed back the findings – you know, 'You said, we did'. And if we can't do something about it, we explain why. In one home we took over, turnover was 50 per cent and now it's 10 per cent. It's 13 per cent in the other home.
(011, Operations director, private company)

Our engagement survey shows we've had a 10 per cent increase in engagement ... Turnover has improved – people are staying longer.
(073, HR Director, private company)

Leadership and organisational structures

Leadership is thought to influence organisational culture strongly and there has been a steady stream of resources in adult social care designed to support social care managers in their roles (for example, National Skills Academy for Social Care, 2013, Social Care Institute for Excellence, 2006). Despite this, there has been very limited research into what makes an effective social care leader (Orellana, 2014, Orellana et al., 2017). Among those participating in this study, there was a general consensus that greater attention needed to be paid to improving the quality of leadership at all levels:

[The] emphasis needs to be on those working in social care being transformational rather than transactional in their work, i.e. changing people's lives for the better rather than going in and preparing them a meal. This can only happen through effective and passionate leadership.
(109, Chief Executive, voluntary organisation)

The quality of management is the one thing that could make a difference – treating the workforce properly and ensuring quality in the service.
(132, Self-employed Business Consultant)

Turnover is known to be high among registered managers, especially those working in care homes with nursing. In these settings, annual turnover is around a third, compared with about a fifth for registered managers in care homes without nursing and domiciliary care (Skills for Care, 2016a) so it was not surprising that so many of the comments about leadership were concerned with retention among registered managers and other nursing staff:

Out of hours, the registered nurse [RN] is the hook for everything – the building, all the staff, the residents, visitors. Should that be on the shoulders of the RN? We need a heads of department model.
(131, Chief Nurse, not for profit company)

I think the biggest challenge for nurses when they come and work in the independent sector is the lack of support around them. They're a bigger cog in a smaller wheel, whereas in the NHS if they've got an issue, they can call on any one of other nurses, doctors, any other type of service ...When they come and work for us ... they're it. They're in charge, they're solely responsible, so we sometimes find that that can be a bit of a barrier.
(118, HR Director, private company)

Some places were testing a model in which the traditional structure of registered manager and deputy had been replaced with new posts with specific roles such as clinical manager, residential manager and hospitality manager. This spread responsibility across the staff team, as well as offering new opportunities for career progression.

However, other registered managers spoke of the multiple responsibilities with which they were faced – including the impact of regulatory burden:

We live in a totally paperwork world. If it's not written down, it didn't happen. It doesn't help.
(128, Home Manager, private company)

I was shocked, because social care [administration] is so massive. The compliance and legislation and the work that goes into that

is way more stressful than I ever had in the NHS (laughs).

(138, Registered Manager, not for profit company)

Research on delayed discharges highlights increases in the number of days spent waiting for home care services to be set up (National Audit Office, 2016) but no research seems to have been undertaken into whether recruitment and retention problems are affecting arrangements once intermediate care services have ended. One participant reported the experiences of one self-funder who contacted a number of home care agencies to arrange ongoing support once his wife had left hospital only to find that, across the board, no manager was available to undertake an assessment for a fortnight. This date was after the intermediate care service was due to end.

The main disadvantage of high turnover rates among managers was that they were often replicated in high turnover rates among the other staff:

> In terms of [husband's] care home, they can't keep managers. It impacts on quality every time. If they can't keep managers, they can't keep staff.

(111, Researcher and Family Carer)

Several participants expressed concerns about the quality of leadership in local authority adult social care departments. These were mainly about a perceived shortage of good quality applicants for managerial roles and the way in which managers did not always seem to prioritise motivating and supporting the workforce:

> Second and third tier management in social care is particularly difficult to recruit to as there doesn't seem to be enough strong candidates for these roles. This has resulted in an over reliance on interim staff and a lack of stability in leadership in some [local authorities].

(061, Independent Chair Safeguarding Adult Board, local authority)

> There's a lack of validation and support from management, lack of boundaries (i.e. mobile working means working from home) so no work/life balance.

(018, Social Worker, local authority)

We must recognise [the importance of] motivational leadership. Learn from the private sector. Look at the soap shop Lush. The staff are always very nice, whatever the shop. They are annoyingly happy! Someone up in Lush is getting it!

(130, Team Manager, local authority)

Motivational skills were often seen as crucial to improving retention rates, mainly because of the importance given to managers acting as role models and mentors for the workforce:

> As a manager I have to make them [staff] believe in their own self-worth, drive the motivation. It doesn't get more important or crucial.

(128, Home Manager, private company)

> In our [nursing] home, my boss - who has no need to - does everything. She is hands on, she doesn't just give orders. If someone's missing in the kitchen, she'll cook, she'll work on the floor. People respect her because she will work alongside you. If you just stand aside and give orders, you won't be respected.

(007, Health Care Assistant, private company)

New roles, apprenticeships, training, and career development

There has been much academic and policy interest in the establishment of new roles in adult social care (Kessler and Bach, 2007, Kessler et al., 2006, Newman et al., 2008). These include hybrid or enhanced roles, such as housing and support workers (Manthorpe and Moriarty, 2010, Manthorpe and Samsi, 2012) or liaison roles, such as care navigators whose role is intended to support individuals to plan, organise and access health and social care support (Gilburt, 2016). It may have been a limitation of our sampling but it did appear that while most settings were establishing enhanced roles tailored to specific settings, community navigator posts had yet to become embedded in many adult social care departments:

> We are carrying out research on community navigators in mental health. We are seeing some positive impacts. However, I know that not all commissioners of social care are strong supporters of these roles so I am not sure whether they will expand as a workforce.

(067, Researcher, local authority)

People feel there's potential. There's lots of interest in supported housing but the problem is the lack of research evidence on this ... There is a role for place based navigation and co-ordinating care. That could span across adults and children's [services].

(034, Policy Analyst, university)

From the perspective of our participants, the most common type of new role involved additional training for care workers to enable them to fulfil an intermediate role between basic grade care workers and professional staff. For example, senior care workers and care workers were trained to become 'care practitioners' who provided more assistance to nurses in care homes with nursing. Similarly, a service for people with learning disabilities had created a 'specialist support worker' role. This involved giving support workers a combination of training about specific conditions, such as autism, and teaching them techniques to improve the way they supported people with challenging behaviours. However, there was limited potential to expand the number of people employed in this position:

In an ideal world, it would be lovely to expand these roles. They are paid slightly more [than basic grade care workers] but you can't expand their numbers without more pay and the cost of training.

(117, HR Lead, private company)

This meant that skills gaps existed between the number of people with complex health and social care needs and the number of social care workers able to support them:

In some areas, it is very difficult to find a good paid [care worker], particularly for specialised areas such as dementia and learning disabilities.

(030, Researcher, social research organisation)

Some participants were optimistic about the new nursing associate role (Department of Health, 2015), although others were concerned that it would prove to be as difficult to recruit and retain nursing associates as it was to recruit and retain nurses.

There was strong support for apprenticeships as a way of helping the workforce to learn 'on the job', but the introduction of the apprenticeship levy in April 2017 (HMRC, 2017a), which means that organisations with a pay bill of £3 million or more per year must pay a levy equal to 0.05 per cent of their pay bill, proved to be more controversial. Participants recognised that it was too soon to judge the effectiveness of the scheme but some felt it was an additional tax on their business. Those who felt that they already had a good track record of investing in apprentice training were concerned that providers might not provide the same quality of training as they had. It did not appear that any of the private employers taking part in this research had applied to join the register of apprenticeship training providers (RoATP) so they could deliver the training themselves.

Outside apprenticeships, some participants were using the Care Certificate (Skills for Care, Undated-a) or mapped their own training onto the Care Certificate standards. There were also examples of employers developing their own training programmes in areas such as dementia and end of life care. However, there were mixed views about the extent to which additional training was available:

In terms of a career structure, I find the more able staff tend to leave usually after a period of 4 -5 years when they have exhausted the minimal career progression. I also believe that a better level of training would enable staff to have a deeper understanding ... and therefore to work with [service users] at a more intensive level would create more job satisfaction and enable staff retention.

(133, Family Carer)

This contrasted with the experience of many participants who had often begun as care workers themselves:

The care sector has got a fantastic career path. Most of our home managers started out as care workers. It's a great place to get qualifications.

(116, HR Director, voluntary organisation)

Several participants thought that while opportunities for career progression needed to be developed, it was also important to ensure that workers who were not looking for promotion were given opportunities to develop personally and professionally to maintain their levels of enthusiasm and commitment.

Values based recruitment

The increasing emphasis on values based recruitment based upon finding and keeping people with the right values and attitude is a consequence of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Miller and Bird, 2014). A survey of social care employers found that almost three quarters of respondents who reported using a values based approach to recruitment and retention considered that it represented an improvement on previous arrangements (Consilium Research and Consultancy, 2016).

Despite the difficulties with recruitment and retention that they mentioned, participants without exception paid credit to the levels of commitment and dedication among many existing staff:

> The commitment to the people they care for and safeguard ... is beyond price.
>
> **(036, Chief Officer, voluntary organisation)**

> It's an amazing sector. [Coming in from the outside], I'm in awe of what the [paid] carers and nurses do. They do it because they care. Every other sector would be jealous if they knew!
>
> **(073, HR Lead, private company)**

Informal arrangements were often thought to help the recruitment process and sometimes people recruited via word of mouth and personal recommendations were thought to be better than those recruited via formal advertising:

> A couple of times, we've held an open evening aimed at recruiting workers in the local area. They can meet service users and get a concept of what the job is. It helps them know if they want to go forward. [Then] they won't waste my time or their time applying for a job that they don't want.
>
> **(128, Home Manager, private company)**

Other participants pointed out that developments such as this were one way for an organisation to highlight their status as a desirable place in which to work:

> [There is] increased focus on candidate experience as candidates are able to pick and choose where they can go.
>
> **(071, HR Lead, private company)**

Emphasis was also placed on ensuring that websites were attractive and easy to use – especially as most enquiries about work were now being made this way. However, despite these efforts to attract more applicants, it was not always possible to select only suitable staff likely to be at interview:

> There are two groups of people – the ones who do it for the love and the ones who just need a job. Sometimes they are only ever in it [social care] for the short term but you can't necessarily identify that at interview.
>
> **(073, HR Lead, private company)**

The biggest barrier to values based recruitment was the need to ensure that enough staff were on duty. This meant that a difficult decisions sometimes had to be made between being short staffed or employing someone who was unlikely to stay in post for long:

> There is a limited pool of people with the necessary skills and ethos to provide care at the wages offered. Care providers may have limited/no response to recruitment campaigns. At the interview stage, providers may look to compromise, and employ people who are not well suited to the job, because mediocre [or] poor staff are preferable to no staff.
>
> **(068, Social Worker, local authority)**

> It can be a quick fix to employ anyone who is looking for a job but now we have a policy that we will wait for the right staff. Two of our homes don't use agency staff at all. One uses hardly any agency staff and, if they do, they have to be the same people [who have worked in that home already]. The fourth, which we've just taken over, is on a journey. We only employ people whom we feel are right.
>
> **(011, Operations Director, private company)**

Unsurprisingly, the biggest concerns around recruitment were about safeguarding. One participant highlighted what she though was an anomaly between the requirements for employing staff in regulated settings and employing personal assistants (PAs) using direct payments. A family carer, safeguarding lead and care worker all based in different parts of the country shared similar concerns:

The big issue I've picked up is the complete contrast if you employ a PA. They don't have to have a DBS [Disclosure and Barring Service check] unless working with children.

(111, Family Carer and Researcher)

High staff turnover [is] creating poor recruitment practices as [the] drivers are around crisis resolution leading to: poor practice in DBS checks; ineffective checks on immigration status of the prospective employee; lack of assurance in place to ensure that non contracted service providers adhere to the principles of safer recruitment; staff recruited by users on devolved [direct] payments are not subjected to the same degree of scrutiny; lack of agencies working together to impose a safer recruitment culture across a transient workforce especially agency and bank staff.

(113, Safeguarding Adult Lead, local authority)

When I used to work for [company] ... they are... choosier who they employ. The lady I look after, her sister lives [elsewhere]. Now [sister] has carers in every day ... and ... this is what she tells me, they were on their 'phones all the time ... They can't wait to get out the door and they steal ... toilet rolls and body sprays and things like this. No [sister hasn't complained] and she won't. She doesn't want to upset anybody.

(013, Self-employed Care Worker)

Volunteers

Volunteering has a long history in social care and there has been increasing emphasis upon its role in delivering important services such as advocacy, peer support and befriending (Hill, 2015, Hussein, 2011, Moriarty and Manthorpe, 2017, Naylor et al., 2013). New forms of volunteering, such as the Casserole Club (Undated) have evolved in some areas to replace traditional services such as meals on wheels but there are very few evaluations of such initiatives and their sustainability.

Participants very much valued the work undertaken by volunteers but argued that there was limited potential to replace the paid workforce with volunteers for several reasons. As with the paid workforce, costs needed to be met in terms of getting DBS checks and providing training and supervision for the volunteer. There was a strongly held view that volunteering was often only one part of individuals' lives and that their capacity to provide extensive amounts of support were limited:

However, in my experience volunteers do not offer the consistency that paid workers can and need so much additional support that I question the cost effectiveness of an over reliance on them.

(114, Employer, voluntary organisation)

Volunteers tend to dip in and out and this in turn makes it difficult for service users to build trust and a rapport.

(024, Social Worker, local authority)

The existence of other commitments outside volunteering and the limited amount of time that volunteers could spend each week meant that their roles were seen as complementary, not substituting for those of the paid workforce. Providing personal care in the form of assistance with washing or bathing or undertaking statutory work was seen as an important dividing line between what volunteers should, and could, be expected to do. It was also felt that it was easier to recruit volunteers to work with some types of service user than others:

Volunteers should be doing work over and above what good social care workers are doing – they should never replace professional care – but could offer added nice things in partnership with care workers. I'm sure some volunteers do become paid – but volunteering should not be seen as the only way into paid work.

(027, Director, social enterprise)

Volunteers rarely become paid workers. They choose to do such roles for their personal reasons and are valuable to the company where they do help out. I do not think that, in general, volunteers can take on the work of the care and ancillary staff because they usually just help out with activities and wellbeing of the residents, rather than providing personal care, etc.

(071, HR Director, private company)

I don't think assessment of eligibility, mental health or capacity is the role of a volunteer. Where staff are working to a particular legal framework, this should be done by professionals or trained, paid workers. Volunteers can do

befriending, advice, mentoring or advocacy roles and provide practical support.

(029, Business Information Manager, local authority)

Some volunteer agencies that I have liaised with have advised that they are unable to work with people with dementia or mental health problems which is a shame as they may need them the most.

(072, Occupational Therapist, NHS)

An important theme was the extent to which volunteering was a route into paid work, either in adult social care or another sector. One participant had moved into social care as a result of his volunteering experiences:

I was in the private business sector before and then I did voluntary work, got my foot in the door that way. I think because I started off volunteering at a quite well-respected, forefront organisation ... working for [that organisation] and then moving into mental health was quite a good background experience.

(124, Support Worker, local authority)

Volunteering was also seen as a route back into paid employment for some people who had experienced redundancy or long term illness and to help young people build up work experience. However, caution was advised against assuming that substantial numbers of people could be recruited this way:

I have known a very few volunteers who take up a paid role or get funding to train for a professional qualification using their work experience as a volunteer to gain the next stage of their lives. However, young people need 3-4 years funding to get a qualification and older people often have family to care for so can spare only limited time as a volunteer and don't want to study at this stage of their lives.

**(016, Social Worker, voluntary organisation)**

Withdrawal from the European Union (Brexit)

While most attention has focused on the implications of withdrawal from the European Union (EU) for the NHS (Dayan, 2017), there may also be consequences for social care (Hughes, 2017, Independent Age & ILC-UK, 2016). The Office for National Statistics estimates that around 92,000 EU citizens currently work in social care, a rise of nearly a third since 2011. However, these data do not distinguish between the numbers working with adults or with children (Hansard, 2017). Based on a re-analysis of earlier Skills for Care data, Independent Age and the ILC-UK (2016) estimate that only around 5,800 EU-born workers have acquired British citizenship. They calculate that around five per cent of the adult social care workforce might be affected by changes to their immigration status. They also suggest that, because EU citizens are over-represented in professional social care roles (such as nursing or social work) and are unevenly represented across England with many more living in the south and east than in the north or the midlands, the effect of large numbers of EU citizens deciding to, or having to leave the UK, is likely to be more severe in some places than others.

The topic of Brexit is controversial so it was not surprising that participants' held varied views about how adult social care would be affected. Only a minority considered that concerns were exaggerated – or the converse – that there was going to be a 'massive depletion' of the labour force from the European Economic Area (EEA). Instead, the overwhelming majority of participants considered that much would depend on multiple factors, not just the immigration status of EEA citizens but the performance of the economy as a whole and exchange rates. Even if the overall numbers of EEA citizens leaving was low, the effect could be exaggerated because the sector was already struggling to recruit enough workers:

In an industry which is already at full capacity even a small impact could have a large effect upon the cared for person

(113, Safeguarding Adult Lead, local authority)
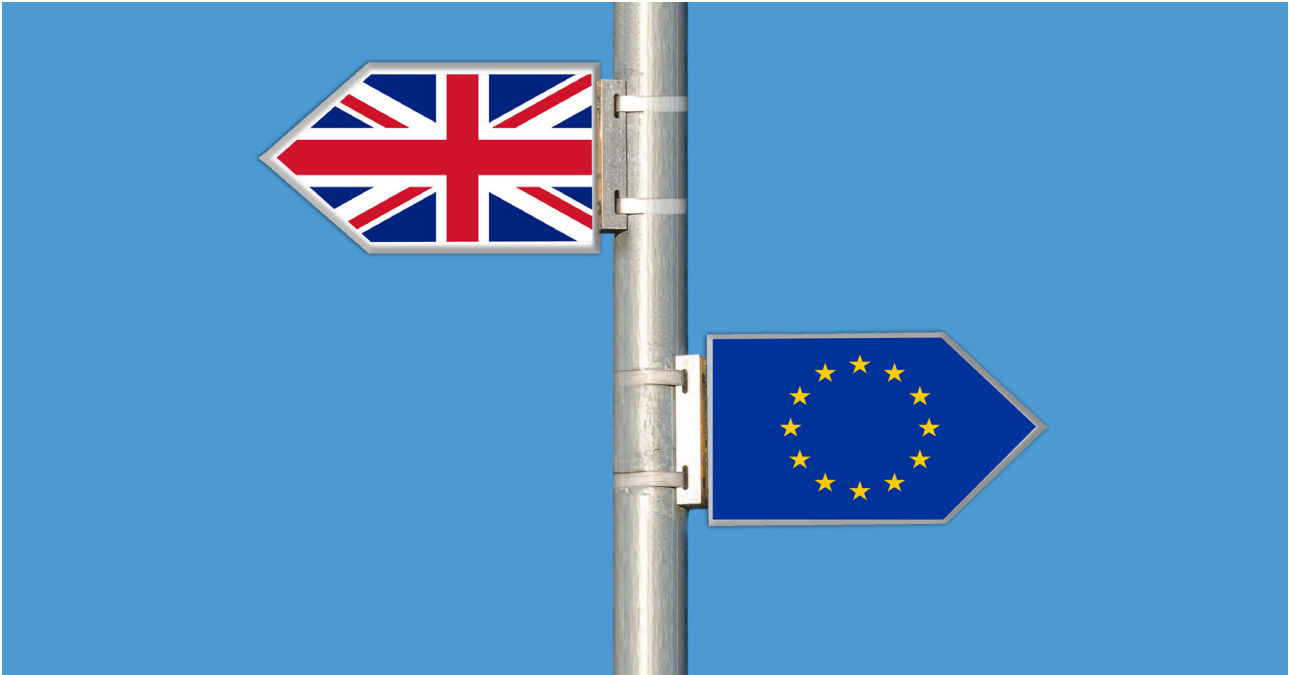
For many, a key priority was to reach a reciprocal agreement as soon as possible that would allow EU citizens already in the UK to remain here:

> Unless the UK releases a formal statement soon re visas/jobs for those living and working here, more staff will leave as they dare not risk the instability. There are further implications also for workers' rights as these policies were EU generated.
>
> **(041, Self-employed Consultant)**

> Morale is low already. Even if people decide to stay they may feel unwelcome and undervalued. If foreign workers are excluded from working in Britain, the effect will be disastrous.
>
> **(035, Nurse, NHS Care Home Support Team)**

The presence of EU citizens and citizens from countries outside the EU was seen as broadly positive and reflective of the increasing diversity of people using adult social care and within the population more generally:

> There has been a steady influx of staff from EU countries into the workforce and in my own personal experience this has been on balance both healthy and positive. The implications if people from other EU countries can no longer live and work in UK are pretty clear – fewer staff coming into the workforce and the possibility of losing existing quality staff from

these countries if they are not given remain to leave.

> **(015, Team Leader, private company)**

For one participant, an EU citizen who had worked in the UK for over 20 years, the situation had created some uncertainty for her:

> How do we know? I don't have [a] British passport so I am just a little bit thinking, even though I've been here for so long ... from 1994 - that is almost 23 years.
>
> **(137, Registered Nurse, private company)**

Reflecting existing research (Franklin and Brancati, 2015, Independent Age & ILC-UK, 2016), participants were of the view that different parts of the country would be more affected than others:

> The most significant [potential effect] relates to the south east where non UK EU citizens who are social care nurses (i.e. in nursing homes) make up one fifth of the workforce.
>
> **(036, Chief Officer, voluntary organisation)**

It was suggested that the effect would be greatest in areas of high employment where employers had found it particularly difficult to recruit UK citizens into care work. However, one participant suggested that it might be too simplistic just to consider geographical regions as a totality. Instead, it was important to take account of smaller villages

and towns where there were high 'pockets' of EEA citizens working in social care:

> The geographical area that I work in has a high unemployment rate and few job opportunities. It is evident when I visit care homes that there has been an influx of eastern Europeans, particularly in coastal areas and the city. They always present as efficient and professional and my fear is that there may well be a shortage of skilled professional workers in care homes when we leave Europe.
>
> **(129, Manager, voluntary organisation)**

Another factor highlighted by participants was how the mix of UK, EU and other citizens differs between social care employers. The HR Director of a large national care home chain reported that EU citizens made up 20 per cent of its workforce so the company would be severely affected if large numbers of the workforce decided to leave.

Other participants noted that as migrant workers (EU and non EU) were more likely to be men and to work full time, the gender distribution of the adult social care workforce could become even more unbalanced and employers might find it even harder to recruit enough workers.

It is thought that an increasing number of self-funding individuals and families are hiring live in care workers whose accommodation is provided as part of their employment. This is an area in which we have almost no reliable data but one participant commented that many workers employed this way are from the EU.

The final potential consequence for adult social care of Brexit was what would happen if large numbers of retired British citizens living abroad returned home. It was not clear how many of these might have social care needs.

Some participants were of the view that it might prove necessary to change the immigration rules to make it easier for workers from outside the EEA, particularly nurses, to work in the UK. It was suggested that the uncertainty over EEA citizens working in the UK was not helped by the new Immigration Skills Charge that came into force in April 2017 (Department for Business, 2016a).

The 2014 Strategy and the role of central government

Few participants were familiar with the 2014 Recruitment and Retention Strategy (Skills for Care, 2014). Of those who remembered it, a minority were critical:

> Almost unreadable. Didn't even really define what was meant in terms of who they wanted to target to recruit and retain.
>
> **(109, Chief Executive, voluntary organisation)**

More typically, there was a sense that the strategy was constrained by wider influences that were outside its remit:

> There is nothing wrong with the strategy – although it doesn't fully explore the fact that in pure numbers terms we are fighting a losing battle. Values based recruitment and recruiting new types of workers are fine but the practicality of supply is not fully explored.
>
> **(046, Operations Director, local authority)**

> Good strategy which highlights the areas and aspects that can be targeted when looking at ways of pulling people into the sector. However the fundamental issues that are stated above such as pay, perception, austerity make implementation a real challenge and it is still then left to individual organisations to manage, as to tackle a wider footprint is extremely difficult.
>
> **(100, Principal Social Worker, local authority)**

There was wide agreement that while certain decisions were better made locally, there was an important role for central government in making decisions about funding for social care and providing leadership:

> Local knowledge and responsibility is key and that's better provided locally.
>
> **(034, Policy Analyst, university)**

> It's kind of about leadership, really, setting the agenda ... National Government set the tone and the framework and priorities. They do have a really important role. The guidance coming from central government is what the local authority pay attention to. Taking a lead.
>
> **(106, Independent Social Worker)**

However, there was a striking absence of views about how this national guidance could best be implemented locally. Apart from one participant who referred to the potential to consider aspects of workforce planning in Sustainability and Transformation Partnerships (STPs) (see earlier), it seemed as if, at a local level, recruitment and retention was seen as a matter for individual employers even though – as participants emphasised – aspects such as affordable housing, public transport and community safety – especially at night or in the evenings – affected all the social care employers within a particular district.

Overall, participants' views about the challenges to recruitment and retention in social care and the best way of resolving them were captured in this final comment from one HR Director:

I think anything that raises the profile of the industry and puts the emphasis on delivery [should be a priority]. The emphasis seems to be laid at the feet of the likes of CQC [Care Quality Commission], 'Let's regulate, let's monitor'. That's great, but if we're not actually fixing what happens down here, it doesn't matter how often you regulate, nothing's going to change. Improvements can't be made unless something goes into the front end first. So it would be great to see a strategy that actually just doesn't look at the recruitment and retention, it actually looks at what the feed-in is, and the fact that to have a successful recruitment and retention strategy ... there has to be money in social care. Social care needs to be made attractive, it needs to take priority. We're an ageing population; social care is only going to increase, it isn't going to decrease.

(118, HR Director, private company)

Discussion

It is important to begin by acknowledging the limitations of this study. It was small scale and undertaken over a short period so it is possible that participants did not represent the full range of views and experiences within the adult social care workforce. Reference is often made to the number of people leaving social care to work in other sectors and this study could have been strengthened had it been able to capture more about recruitment and retention in other sectors such as retail or hospitality. Nevertheless, the study design also had its advantages. In large scale studies, particularly those based upon secondary data analysis, information about sectors of the workforce that are small in number, such as people employed in adult social care departments or the learning disability workforce, is often either excluded or muted.

Private companies providing services for older people are by far the largest provider in adult social care and they rightly receive a good deal of attention in terms of recruitment and retention. However, while social workers and occupational therapists are a much smaller group numerically than care workers working with older people, the consequences of recruitment and retention problems among these professions can be considerable, for example, in the rate of delayed hospital discharges. By including as diverse a range of participants as possible, we aimed for a more fine grained approach that highlighted differences as well as similarities.

The 2014 Adult Social Care Recruitment and Retention Strategy set out three priorities, the first of which was to raise the profile of adult social care and the career opportunities it offers to help attract people with the right values into the sector (Skills for Care, 2014, pp. 22-25). While few participants in the study were aware of the strategy, there was a strong consensus among them that adult social care was damaged by its poor image. Apprenticeships and care ambassadors were generally seen as positive developments but

their influence had to be offset against the negative image of social care that resulted from scandals (Manthorpe et al., 2016) and the perception of social care as a byword for low pay and poor terms and conditions of work. The diversity of the workforce was seen as one of its strengths but it was felt that further, more targeted work, was needed to attract under-represented groups into adult social care, such as men.

Several participants personally exemplified the career opportunities available in social care, having achieved senior positions after starting out in care work or as a volunteer. The availability of a range of vocational social care qualifications helps those who may have entered with workforce with limited educational qualifications. However, there was a strong sense that funding constraints limited the number of workers who received additional training and certainly meant that increased skills could not be reflected properly in higher pay. This led to many of the most experienced members of the workforce being tempted to leave adult social care to work in the NHS.

Opportunities should be taken to learn from other sectors and to ensure that best use is made of other funded research in terms of how it can inform what is known about the social care workforce. The advent of the Firstline (Frontline, Undated) prototype to train managers in children's social care could help inform our understanding about career progression in adult social care and to consider further the leaderships skills that are needed. Researchers undertaking evaluations of community navigator roles should be encouraged to collect information on navigators' employment backgrounds. Many of these posts are time limited so it is also important to consider workers' employment plans should they be made redundant.

Results from this study also highlighted gaps in our knowledge about recruitment and retention in some sectors of the adult social care workforce. A high proportion of adult social care expenditure is now spent on support for people aged under 65

with very complex needs (NHS Digital, 2016). This includes a high number of people with a learning disability and very high support needs but there appears to be very little published information on recruitment and retention among those working with these service users.

The second priority of the Strategy was to 'encourage and enable good recruitment practices' (2014, pp. 26-29). It was clear from the interviews that participants were familiar with values based recruitment and that the concept was supported. A range of practices, such as open evenings, were employed to maximise recruitment. Within the constraints of limited opportunities for pay rises, incentives, such as better employee engagement, were used to encourage retention.

As well as highlighting the challenges they faced, participants emphasised the commitment and dedication shown by the majority of those working in adult social care. Nevertheless, the notion of a dual workforce that consisted of people with the requisite values and commitment to work in social care and another more mobile workforce whose prime consideration was to have a job was dominant. Values were generally seen to be innate (Manthorpe et al., 2017) and it was not clear if, and how, participants' considerable knowledge and experience about adult social care was being fully utilised helping others deepen and maintain their values and avoid burnout.

In some cases, factors such as the use of temporary recruitment agencies and the anomaly between the employment and Disclosure and Barring Service (DBS) checks needed for social care workers when compared with personal assistants (directly employed care workers) were seen as additional complications to values based recruitment. Participants were often left with a dilemma in terms of who to employ because it was not always possible to wait until the 'right' candidate applied and if they were only able to work with a temporary employee there was often little they could do about values or mentoring. A continuing tension also exists between the DBS checks required to appoint staff in regulated settings and what happens when they are employed by self-funders or people on direct payments.

The third Strategy priority was to 'address the issue of above average turnover rates that exist in the sector' (2014, pp. 30-35). It is now widely accepted that turnover rates vary across the social care workforce and are higher among nurses, registered managers and home care workers (Davison and Polzin, 2016). Much of the discussion about turnover is dominated by discussions about pay and the National Living Wage (GOV.UK, Undated) and the 'real' Living Wage (Living Wage Foundation, Undated). There seemed to be a consensus among participants that the introduction of the

National Living Wage had flattened pay levels in social care and similar sectors, such as retail, and so reduced the 'churn' that happened when employers in the locality increased their hourly pay. However, it was too soon to see whether these effects were long term. Concern was also expressed about the effect of competition with the NHS for nurses and health care assistants which, as mentioned earlier, was seen as another disincentive to investing further in training.

The study highlighted that while participants sought to manage turnover rates, many factors were outside their control. These included affordable housing, public transport, community safety (especially at night or in the evenings), the relationship between paid work and other family commitments (most notably child care), and the links between paid employment and in-work benefits. Concern was also expressed that a small number of workers were responsible for working a large number of hours and that this might lead to increased rates of burnout. The preponderance of zero-hours contracts needs to be seen in the context of other factors, such as the availability of child care and the number of workers holding more than one paid job. There were many references to the difficulties that arose for individuals and organisations from not having enough staff. These highlighted how little is known about the point at which staffing difficulties begin to result in poorer outcomes for people using adult social care services and their families. There is potential for more exploration of the relationship between workload, minimum staffing levels, and recruitment and retention.

At a national level, better 'joined up thinking' around welfare reform, paying for child care, housing and transport could all improve recruitment and retention in adult social care. At a local level, there is scope for greater clarity about the extent to which local councils' responsibility for market shaping and commissioning in the Care Act 2014 also needs to consider implications for the adult social care workforce. For example, some local councils have committed to being Living Wage employers and to commission services only from social care providers who pay their employees the Living Wage.

As with nurses and registered managers, recognition also needs to be given to what appear to be high levels of 'churn' among local authority employed social workers and occupational therapists where pay levels are in excess of the Living Wage but which may be perceived as incommensurate with experience or workload. In this sense, 'enough pay' was seen as just one factor influencing turnover that would be traded off against other considerations such as job satisfaction or feeling valued.

This is one of the first studies to have systematically collected data on the UK's decision to leave the European Union. There was strong support for reaching an agreement with other EU countries that would enable social care workers from the EU already resident in the UK to remain here, should they wish. There was considerable uncertainty about the implications of this decision for social care recruitment and retention but it was thought that the effects would be more apparent in some parts of the country and among some sectors of the workforce (particularly nurses) than others. There was also a suggestion that it might prove necessary to revisit the Tier 2 visa requirements for people from outside the EU.

Overall, while there were calls for better funding for social care, an important conclusion from this study is not just the need to review the adult social care recruitment and retention strategy to take account of changes in adult social care policy but also the need for future strategies to consider the impact of changes in the economy and the labour market as a whole for social care. Both are intertwined. Without this, it will prove harder to develop long term effective solutions to the longstanding problems of recruitment and retention in social care.

References

ALBRECHT, S. L., BAKKER, A. B., GRUMAN, J., MACEY, W. H. & SAKS, A. M. 2015. Employee engagement, human resource management practices and competitive advantage: an integrated approach. Journal of Organizational Effectiveness: People and Performance, 2, 7-35.

ANGEL, C. 2014. The use of zero hours contracts in the homecare sector. ACAS HR Masterclass [Online]. Available from: http://m.acas.org.uk/index.aspx?articleid=4901 [Accessed 29 May 2017].

BEE, M. 2016. How the 'gig economy' could revolutionise social care. Community Care [Online]. Available: http://www.communitycare.co.uk/2016/11/07/gig-economy-revolutionise-social-care/ [Accessed 5 June 2017].

BERRIMAN, R. & HAWKESWORTH, J. 2017. Will Robots Steal Our Jobs? The potential impact of automation on the UK and other major economies. London: PwC UK.

BOLTON, J. 2016. Predicting and Managing Demand in Social Care. Discussion paper. Oxford: Oxford Brookes University, IPC (Institute of Public Care).

BOXALL, P. & MACKY, K. 2014. High-involvement work processes, work intensification and employee well-being. Work, Employment and Society, 28, 963-984.

CASSEROLE CLUB. Undated. Doing something great with an extra plate [Online]. Available: https://www.casseroleclub.com/ [Accessed 13 June 2017].

CAVENDISH, C. 2013. The Cavendish Review: an independent review into healthcare assistants and support workers in the NHS and social care settings. London: Department of Health.

CONSILIUM RESEARCH AND CONSULTANCY 2016. Study into the Impact of a Values Based Approach to Recruitment and Retention. Leeds: Skills for Care.

CORNES, M., MANTHORPE, J., MORIARTY, J. & HUSSEIN, S. 2012. The experiences and perspectives of agency social workers in England. Social Work and Social Sciences Review, 16, 67-83.

CORNES, M., MORIARTY, J., BLENDI-MAHOTA, S., CHITTLEBURGH, T., HUSSEIN, S. & MANTHORPE, J. 2010. Working for the Agency: the role and significance of temporary employment agencies in the social care workforce. Final Report. London: King's College London, Social Care Workforce Research Unit.

DAVISON, S. & POLZIN, G. 2016. The State of the Adult Social Care Sector and Workforce in England. September 2016. Leeds: Skills for Care.

DAYAN, M. 2017. General Election 2017: Getting a Brexit deal that works for the NHS. London: Nuffield Trust.

DEPARTMENT FOR BUSINESS, ENERGY AND INDUSTRIAL STRATEGY. 2016a. Press release 24 March 2016: Government's new Immigration Skills Charge to incentivise training of British workers [Online]. London: Department for Business, Energy and Industrial Strategy. Available: https://www.gov.uk/government/news/governments-new-immigration-skills-charge-to-incentivise-training-of-british-workers [Accessed 15 May 2017].

DEPARTMENT FOR BUSINESS, ENERGY AND INDUSTRIAL STRATEGY 2016b. Press release 30 November 2016: Taylor review on modern employment practices launches.

DEPARTMENT FOR BUSINESS, ENERGY AND INDUSTRIAL STRATEGY. Undated. Review of employment practices in the modern economy [Online]. London: Department for Business, Energy and Industrial Strategy. Available: https://beis.dialogue-app.com/matthew-taylor-review [Accessed 15 May 2017].

DEPARTMENT OF HEALTH. 2015. Nursing associate role offers new route into nursing. Media release 17 December 2015 [Online]. Available: https://www.gov.uk/government/news/nursing-associate-role-offers-new-route-into-nursing [Accessed 13 June 2017].

DEVON COUNTY COUNCIL. Undated. Proud to care [Online]. Available: https://www.proudtocaredevon.org.uk/ [Accessed 6 June 2017].

FAMILY AND CHILDCARE TRUST 2015. Childcare for London parents with atypical work patterns: what are the problems and how should we fix them? London: Family and Childcare Trust.

FELSTEAD, A., GALLIE, D., GREEN, F. & INANC, H. 2013. Work Intensification in Britain: First Findings from the Skills and Employment Survey 2012. London: Institute of Education, LLAKES (Centre for Learning and Life Chances in Knowledge Economies and Societies).

FRANKLIN, B. 2015. The End of Formal Adult Social Care. A provocation by the ILC-UK. London: ILC-UK (International Longevity Centre - UK).

FRANKLIN, B. & BRANCATI, C. U. 2015. Moved to Care: the impact of migration on the adult social care workforce. London: Independent Age & IlC-UK.

FRONTLINE. Undated. Firstline approach [Online]. Available: http://www.thefrontline.org.uk/about-frontline/our-approach/firstline-approach [Accessed 19 June 2017].

GARDINER, L. 2015. The Scale of Minimum Wage Underpayment in Social Care. London: Resolution Foundation.

GARDINER, L. & HUSSEIN, S. 2015. As If We Cared. The costs and benefits of a living wage for social care workers. London: Resolution Foundation.

GILBURT, H. 2016. Supporting integration through new roles and working across boundaries. London: King's Fund.

GIUPPONI, G., LINDNER, A., MACHIN, S. & MANNING, A. 2016. The Impact of the National Living Wage on English Care Homes. Interim report. London: Department for Business, Energy and Industrial Strategy.

GOV.UK. 2017. Queen's Speech 2017. Her Majesty's most gracious speech to both Houses of Parliament [Online]. Available: https://www.gov.uk/government/speeches/queens-speech-2017 [Accessed 22 June 2017].

GOV.UK. Undated. National Minimum Wage and National Living Wage rates [Online]. Available: https://www.gov.uk/national-minimum-wage-rates [Accessed 19 June 2017].

GUEST, G. S., MACQUEEN, K. M. & NAMEY, E. E. 2012. Applied Thematic Analysis, Thousand Oaks, CA, SAGE Publications, Inc.

HANSARD 2017. Social services: migrant workers: Answer to written question - 63833. 22 February 2017. London: Web based publication.

HARDING, C., WHEATON, B. & BUTLER, A. 2017. Childcare Survey 2017. London: Family and Childcare Trust.

HILL, M. 2015. Evaluation of the Volunteering in Care Homes Project. Interim Evaluation Report: executive summary. London: Institute for Volunteering Research.

HM TREASURY 2017. Spring Budget 2017. London: HM Treasury.

HMRC 2017a. Policy paper: Apprenticeship Levy. London: HM Revenue and Customs.

HMRC 2017b. Policy paper: Off-payroll working in the public sector: changes to the intermediaries legislation. London: HM Revenue and Customs.

HOUSE OF COMMONS COMMUNITIES AND LOCAL GOVERNMENT COMMITTEE 2017. Adult Social Care. Ninth Report of Session 2016–17. HC 1103. London: Web based publication.

HOUSE OF COMMONS WORK AND PENSIONS COMMITTEE 2017. Self-employment and the Gig Economy. Thirteenth Report of session 2016–17. HC 847. London: Web based publication.

HUGHES, J., CHESTER, H. & CHALLIS, D. 2009. Recruitment and Retention of a Social Care Workforce for Older People

HUGHES, R. 2017. Brexit may be the story of the day, but the chapter on social care is missing. The Blog: Huffington Post [Online]. Available from: http://www.huffingtonpost.co.uk/rhidian-hughes/social-care-brexit_b_16151534.html.

HUMPHRIES, R., THORLBY, R., HOLDER, H., HALL, P. & CHARLES, A. 2016. Social Care for Older People: home truths. London: King's Fund.

HUNTER, M. 1998. Recruitment crisis looms for home care. Community Care, 19 August 1999, 8-9.

HUSSEIN, S. 2011. Volunteers in the formal long-term care workforce. Social Care Workforce Periodical 13. London: King's College
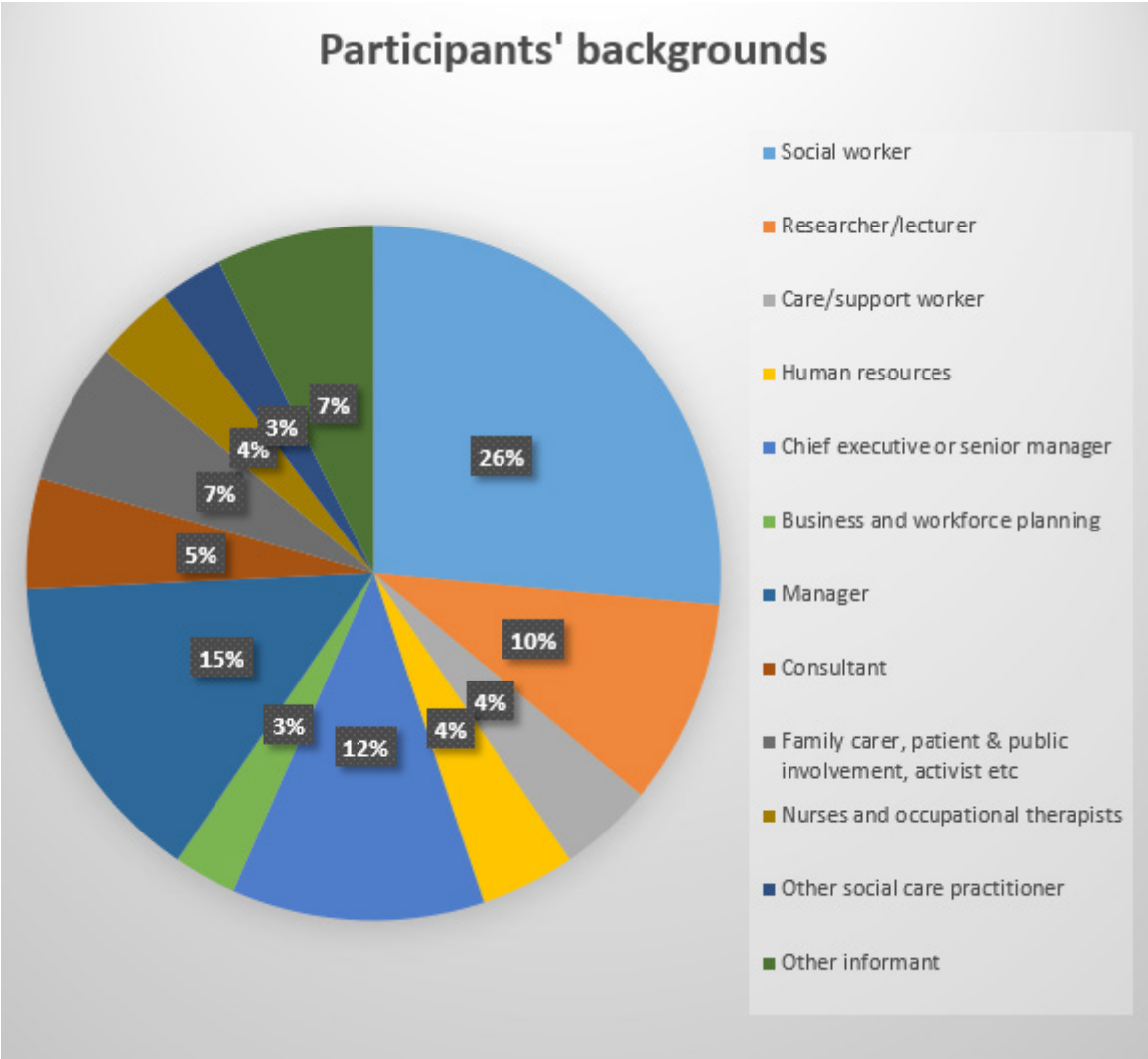
London, Social Care Workforce Research Unit.

HUSSEIN, S. & CHRISTENSEN, K. 2017. Migration, gender and low-paid work: on migrant men's entry dynamics into the feminised social care work in the UK. Journal of Ethnic and Migration Studies, 43, 749-765.

HUSSEIN, S., ISMAIL, M. & MANTHORPE, J. 2016. Changes in turnover and vacancy rates of care workers in England from 2008 to 2010: panel analysis of national workforce data. Health & Social Care in the Community, 24, 547-556.

INDEPENDENT AGE & ILC-UK 2016. Brexit and the Future of Migrants in the Social Care Workforce. London: Independent Age.

INMAN, K. 1998. Profession faces recruitment crisis. Community Care, 5 November 1998, 8-9.

KESSLER, I. & BACH, S. 2007. The Skills for Care New Types of Worker Programme: Stage 1 Evaluation Report Oxford: University of Oxford, Said Business School.

KESSLER, I., BACH, S. & HERON, P. 2006. Understanding assistant roles in social care. Work, Employment and Society, 20, 667-685.

LAWRIE, M. & KEARNEY, J. 2013. Evaluation of the Adult Social Care Workforce Recruitment and Retention Implementation Plan. Final report. London: ICF GHK.

LIVING WAGE FOUNDATION. Undated. What is the real Living Wage? [Online]. Available: https://www.livingwage.org.uk/what-is-the-living-wage [Accessed 22 May 2017].

LOW PAY COMMISSION 2016. National Minimum Wage: Low Pay Commission Report Autumn 2016. Cm 9272 London: Department for Business, Energy and Industrial Strategy.

MACBEITH, I. 2016. Why Hertfordshire is out to pay care workers above the living wage. Community Care [Online]. Available: http://www.communitycare.co.uk/2016/04/01/hertfordshire-pay-care-workers-living-wage/ [Accessed 20 June 2017].

MANTHORPE, J., HARRIS, J., SAMSI, K. & MORIARTY, J. 2017. Doing, being and becoming a valued care worker: user and family carer views. Ethics and Social Welfare, 11, 79-91.

MANTHORPE, J. & MORIARTY, J. 2010. Workforce Issues in Housing with Care for Adults with High Support Needs. In: GARWOOD, S. (ed.) A Better Life for Older People with High Support Needs in Housing with Care. York: Joseph Rowntree Foundation.

MANTHORPE, J., NJOYA, E., HARRIS, J., NORRIE, C. & MORIARTY, J. 2016. Media reactions to the Panorama programme "Behind Closed Doors: Social Care Exposed" and care staff reflections on publicity of poor practice in the care sector. Journal of Adult Protection, 18, 266-276.

MANTHORPE, J. & SAMSI, K. 2012. Improving practice in communication with older people and support networks living in housing with care schemes: aspirations and ambitions. British Journal of Social Work, 42, 1495-1512.

MCKEE, S. 2017. The gig economy and social care. Care Management Matters [Online]. Available from: https://www.caremanagementmatters.co.uk/feature/gig-economy-social-care/ [Accessed 5 June 2017].

MILLER, S. & BIRD, J. 2014. Assessment of practitioners' and students' values when recruiting. Nursing Management, 21, 22-29.

MORIARTY, J. 2010. Competing with myths: migrant labour in social care. In: RUHS, M. & ANDERSON, B. (eds.) Who Needs Migrant Workers? Labour shortages, immigration, and public policy. Oxford: Oxford University Press.

MORIARTY, J. 2015. Commentary: the adult social care workforce in England. In: WALDEN, D. (ed.) Reimagining Adult Social Care. Dartington: Research in Practice for Adults.

MORIARTY, J. & MANTHORPE, J. 2014. Fragmentation and competition: voluntary organisations' experiences of support for family carers. Voluntary Sector Review, 5, 249-257.

MORIARTY, J. & MANTHORPE, J. 2017. The diversity of befriending by, and of, older people. Working with Older People, 21, 63-71.

NATIONAL AUDIT OFFICE 2016. Discharging Older Patients from Hospital. HC 18 Session 2016-17. London: National Audit Office.

NATIONAL SKILLS ACADEMY FOR SOCIAL CARE 2013. Leadership Starts With Me. The why, what and how of leadership in adult social care. National Skills Academy for Social Care.

NAYLOR, C., MUNDLE, C., WEAKS, L. & BUCK, D. 2013. Volunteering in Health and Care: securing a sustainable future. London: King's Fund.

NEWMAN, J., GLENDINNING, C. & HUGHES, M. 2008. Beyond modernisation? Social care and the transformation of welfare governance. Journal of Social Policy, 37, 531-557.

NHS DIGITAL 2016. Personal Social Services: expenditure and unit costs. England 2015-16. Leeds: NHS Digital.

NORRIE, C., LIPMAN, V., MORIARTY, J., ELASWARAPU, R. & MANTHORPE, J. 2017. How Do Handovers Happen? A study of handover-at-shift changeovers in care homes for older people. London: King's College London, Social Care Workforce Research Unit.

OFFICE FOR NATIONAL STATISTICS 2014. Changes in the Older Resident Care Home Population between 2001 and 2011. London: Office for National Statistics.

ORELLANA, K. 2014. Care Home Managers: a scoping review of evidence. London: NIHR School for Social Care Research.

ORELLANA, K., MANTHORPE, J. & MORIARTY, J. 2017. What do we know about care home managers? Findings of a scoping review. Health & Social Care in the Community, 25, 366-377.

PASSINGHAM, A., HOLLOWAY, J. & BOTTERY, S. 2013. Care Home Top-up Fees: the secret subsidy. London: Independent Age.

PATTON, M. Q. 2002. Qualitative Research & Evaluation Methods, Thousand Oaks, CA, SAGE Publications, Inc.

ROYAL COLLEGE OF NURSING 2016. Unheeded Warnings: health care in crisis. The UK nursing labour market review 2016. London: Royal College of Nursing.

RUBERY, J., HEBSON, G., GRIMSHAW, D., CARROLL, M., SMITH, L., MARCHINGTON, L. & UGARTE, S. 2011. The Recruitment and Retention of a Care Workforce for Older People. Manchester: University of Manchester, European Work and Employment Research Centre (EWERC).

SCHNEIDER, J. 2016. Paid carers: a new research challenge. Aging & Mental Health [Online]. Available: http://dx.doi.org/10.1080/13607863.2016.1156049.

SCOURFIELD, P. 2005. Implementing the Community Care (Direct Payments) Act: will the supply of personal assistants meet the demand and at what price? Journal of Social Policy, 34, 469-488.

SIMPSON, P. 2017. Public Spending on Adult Social Care in England. IFS Briefing Note BN200. London: Institute for Fiscal Studies.

SKILLS FOR CARE 2011. Adult Social Care Workforce Recruitment and Retention Strategy. Leeds: Skills for Care.

SKILLS FOR CARE 2014. Adult Social Care Workforce Recruitment and Retention Strategy 2014-2017. Prepared by Skills for Care on behalf of the Department of Health's recruitment and retention group. Leeds: Skills for Care.

SKILLS FOR CARE 2016a. NMDS-SC Briefing 26. Registered managers in adult social care. January 2016. Leeds: Skills for Care.

SKILLS FOR CARE 2016b. NMDS-SC Trend Briefing 4: Pay in the adult social care sector. Leeds: Skills for Care.

SKILLS FOR CARE. Undated-a. Care Certificate [Online]. Available: http://www.skillsforcare.org.uk/Learning-development/Care-Certificate/Care-Certificate.aspx [Accessed 13 June 2017].

SKILLS FOR CARE. Undated-b. I Care ... Ambassadors [Online]. Available: http://www.skillsforcare.org.uk/Recruitment-retention/I-Care...Ambassadors/I-Care...Ambassadors.aspx [Accessed 6 June 2017].

SOCIAL CARE INSTITUTE FOR EXCELLENCE. 2006. Leadership and management [Online]. Available: http://www.scie.org.uk/workforce/peoplemanagement/leadership/leadmanage/ [Accessed 6 June 2017].

SOCIAL WORK TASK FORCE 2009. Building a Safe, Confident Future: the final report of the Social Work Task Force. London: Department for Children, Schools and Families.

TAYLOR REVIEW. 2017. Good Work - The Taylor Review of modern working practices. London, Department for Business, Energy & Industrial Strategy.

TWIGG, J., WOLKOWITZ, C., COHEN, R. L. & NETTLETON, S. 2011. Conceptualising body work in health and social care. Sociology of Health & Illness, 33, 171-188.

UNISON. 2017. Press release, 15 March 2017: Zero-hours contracts give the upper hand to unscrupulous employers, says UNISON [Online]. Available: https://www.unison.org.uk/news/press-release/2017/03/zero-hours-contracts-give-the-upper-hand-to-unscrupulous-employers-says-unison/ [Accessed 30 May 2017].

UNITED KINGDOM HOMECARE ASSOCIATION 2015. UKHCA Briefing: A Minimum Price for Homecare. Version 3.1, November 2015. London: United Kingdom Homecare Association.

WANLESS, D. 2006. Securing Good Care for Older People: taking a long term view. London: King's Fund.

WITTENBERG, R. & HU, B. 2015. Projections of Demand for and Costs of Social Care for Older People and Younger Adults in England, 2015-2035. Canterbury.

WOOLHAM, J. 2017. What do we know about social care personal assistants? RIPfA Blog [Online]. Available from: https://www.ripfa.org.uk/blog/what-do-we-know-about-social-care-personal-assistants/ [Accessed 14 June 2017].

Appendix One: Background of sample

Participants' backgrounds

- Social worker — 26%
- Researcher/lecturer — 10%
- Care/support worker — 4%
- Human resources — 4%
- Chief executive or senior manager — 12%
- Business and workforce planning — 3%
- Manager — 15%
- Consultant — 5%
- Family carer, patient & public involvement, activist etc — 7%
- Nurses and occupational therapists — 4%
- Other social care practitioner — 3%
- Other informant — 7%

Appendix Two: Interview schedule

The Social Care Workforce Research Unit based at King's College London has been asked by the Department of Health Policy Research Programme to find out about recruitment and retention in adult social care and the impact of the 2014-2017 Adult Social Care Recruitment and Retention Strategy. We would like to telephone you to ask you a short set of questions or, if you prefer, you can answer them using the form below. Before you decide whether or not you want to take part, please read the information sheet attached to this email.

(1)   If a journalist asked you 'off the record' to describe the current situation in the adult social care workforce in a sentence, what would you say?

_____
_____
_____

(2)   What are the main problems in recruitment and retention, if any, faced by the sector?

_____
_____
_____

(3)   What are the main strengths of the workforce, if any, within the sector?

_____
_____
_____

(4)   What are the implications for the sector, if any, resulting from the United Kingdom government's decision to negotiate leaving the European Union (Brexit)?

_____
_____
_____

(5)   Are there any other factors affecting recruitment and retention in the adult social care workforce at the moment?

_____
_____
_____

(6)   A number of new social care roles have developed, such as community navigators who help individuals and their families find out about what support is available to them? Does your organisation employ any of these new types of worker?

Yes ☐   No ☐   NA: not social care employer ☐

(7) What are your views about these roles within the sector? Do you think their numbers and areas of work will expand? What are the advantages and disadvantages of these roles?

_____
_____
_____

(8) Can you think of any instances where activities currently undertaken by paid workers could be undertaken by volunteers? If yes, what are the circumstances? If no, why not? In your experience, do volunteers ever go on to become paid social care workers?

_____
_____
_____

(9) What is the role of central government, if any, in managing recruitment and retention in adult social care?

_____
_____
_____

(10) In your experience, what has been the most successful example of an initiative to improve recruitment and retention in social care?

_____
_____
_____

(11) Have you heard of the 2014-2017 Adult Social Care Recruitment and Retention Strategy which was prepared by Skills for Care on behalf of the Department of Health's recruitment and retention group? If yes, what do you think about the Strategy?

Yes ☐   No ☐

_____
_____
_____

(12) What do you think should be the priorities for recruitment and retention within the adult social care workforce over the next two years? Is there anything else you want to add about recruitment and retention?

_____
_____
_____

Job title: _____

Employed by:

☐ Local authority adult social care department   ☐ Employer private company

☐ Employer voluntary sector   ☐ Manager/deputy care home

☐ Manager/deputy home care agency   ☐ Care worker (home care)

☐ Care worker (care home)   ☐ Employer/manager in other sector
   (please specify)

☐ Other informant (please specify)

_____