SKILLS FOR CARE: REWARD AND INCENTIVES RESEARCH

NURSING HOMES, RESIDENTIAL HOMES AND
DOMICILIARY CARE ESTABLISHMENTS

A research project conducted for Skills for Care

Phase 2: Case studies

Authors:  Professor Rosemary Lucas, MMU Business School

Dr Carol Atkinson, Bradford University, School of Management

Joe Godden, Godden Consultancy U.K. Ltd.

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INTRODUCTION

This report outlines the findings of research commissioned by Skills for Care into the employment of care staff in the social care sector in England, with a particular focus on what helps to attract staff to and retain them in the social care sector. There have been three stages of the research: parts one and two comprised a literature search and a statistical analysis of the NMDS–SC¹ and an exploration of the statistical connections between the NMDS–SC and CSCI² ratings of quality. These stages have previously been reported upon. This document reports on the third stage of the research which consisted of in-depth face to face interviews with managers and employees of 18 social care provider establishments (for methodology and summaries of each case see Appendices 1, 2 and 3. Questionnaires for Registered Managers and employees are contained in Appendices 7 and 8). The establishments were spread across seven regions of England and comprised six domiciliary care establishments, five care only homes and five care homes with nursing³ and two nursing homes. For reasons of simplicity these two latter categories are referred to in the main body of the report as care homes with nursing. The majority of establishments provided services mainly for older people.

TABLE 1: DISTRIBUTION OF ESTABLISHMENTS INTERVIEWED BY REGION AND RATINGS

<table>
<thead>
<tr>
<th>Region</th>
<th>Domiciliary care</th>
<th>Care only homes</th>
<th>Care homes with nursing</th>
<th>Nursing homes</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>West Midlands</td>
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<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Eastern</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>South East</td>
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<td>1</td>
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<td>0</td>
<td>3</td>
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<tr>
<td>Yorks and Humberside</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

¹ NMDS – SC: National Minimum Data Set for Social Care. data base of social care providers, including information on the numbers and characteristics of staff employed by the social care sector
² CSCI: Commission for Social Care Inspection. The regulatory body for the social care sector. Performance is measured in star ratings. From 0 for unsatisfactory, 1* for satisfactory, 2* for good and 3* for excellent. Some establishments had not received a star rating at the time of the field research.
³ Within the Care Homes with nursing there were separate units, although some staff worked across both the residential and nursing home units. It became too complicated to record whether the staff were working only in the nursing home side, the residential side or a mixture of both.
The main objective of this report is to present the findings of the third phase of the research, as outlined above. The analysis aims to identify and explore relationships between: pay, other rewards and incentives, terms and conditions of employment, qualifications and other human resource (HR factors); and staff vacancy, sickness absence and turnover rates; and any relationships between these and outcomes for service users in terms of quality and continuity of care. The model below was adopted:

<table>
<thead>
<tr>
<th>Region</th>
<th>Domiciliary care</th>
<th>Care only homes</th>
<th>Care homes with nursing</th>
<th>Nursing homes</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>6</td>
</tr>
</tbody>
</table>

CSCI star rating at time of interview where known

<table>
<thead>
<tr>
<th>Rating</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>None²</td>
<td>0</td>
</tr>
<tr>
<td>*</td>
<td>1</td>
</tr>
<tr>
<td>**</td>
<td>2</td>
</tr>
<tr>
<td>***</td>
<td>3</td>
</tr>
</tbody>
</table>

TERMS OF REFERENCE

The findings derive from interviews which took place in September and October 2008.² Two semi structured interview questionnaires were used, a lengthy one for the interviews with the Registered Manager and a shorter one for interviewing staff. Interviewees were informed that the interviews would be anonymous and confidential. The establishments within the seven regions were selected on the basis of a scoring system that had been developed in parts 1 and 2 of the research. The scoring system had been created on the basis of data analysis of NMDS – SC and CSCI scores.⁶ Organisations had been rated on a scale of 1 to 5; a high score of 5

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² Not yet rated under the current system
⁵ Interviews were conducted by Rosemary Lucas, Carol Atkinson, Joe Godden and Judith Croton
⁶ Full details of the scoring system and the difficulties and limitations of the scoring system are found in a separate paper. Skills for Care Rewards and Incentives Research STATISTICAL ANALYSIS: REPORT TWO
denotes the presence of good HR practices and a low score of 1 denotes the presence of poor HR practices. High and low scoring establishments were identified in each region and at least one high scoring and one low scoring establishment was included in each of the seven regions. Descriptions of the case study establishments and a list of codes of staff interviewed are found in Appendices 3 and 4.

An additional aspect to research comprised interviews in seven case study organisations that support both people receiving direct payments and other individuals. These organisations were all in the voluntary sector and all obtained the vast majority of their funding from local authorities. Key personnel in these organisations were interviewed to ascertain their views on a range of social care workforce issues, including their perceptions of recruitment and retention issues, training, skills of the recipients in relation to their roles as employers and issues regarding the support needs of the care staff employed. The findings of this research have been provided in a separate report.

FINDINGS FROM NURSING HOMES, RESIDENTIAL HOMES AND DOMICILIARY CARE ESTABLISHMENTS

This section presents the findings from the interviews with both Registered Managers and employees.

FINDINGS FROM INTERVIEWS WITH REGISTERED MANAGERS

Interviews were conducted with the Resident Manager or Deputy in 18 social care provider organizations. In two establishments additional interviews also took place with two senior administrators but the responses have been combined to report individual establishment findings. The analysis of data from these interviews was captured in one of two ways. Closed format data was captured in tabular format, whereas open format data was captured onto a template. Given the large number of interviews, space does not permit the attachment of the full dataset. However a summary of tabular data is attached at Appendix 5. What follows in this section draws out key issues and themes emerging from both types of data and uses quotes from open format data to illustrate themes where appropriate.

DETAILS OF THE ESTABLISHMENTS

Of the eighteen establishments that comprise the case studies, twelve provided care only and care with nursing and six provided domiciliary care. Most were single site organizations, with seven being part of a small
group or large chain organization. HR activities were mainly the responsibility of the Registered Managers but in two domiciliary care organisations were shared with (e.g. recruitment) or devolved to (e.g. disciplinaries) to senior administrators. One domiciliary care organization engaged consultants for HR support at a cost of £600 per month. In addition to the day-to-day running of the business, all interviewees were involved in front line care, usually in a relief capacity, and found the dual experience both necessary and useful.

The establishments were located in seven regions and were funded by a mixture of urban and county local authorities. In the majority of cases, local authority funding was around 75% of income, with the balance made up by income from private users. Most establishments did not apply a top up rate i.e. an increased charge to the resident which is over and above the fees that the establishment receives from the local authority. Nursing homes received funding on top of the local authority funding from the NHS. There were a few examples of the NHS paying all the funding via the Continuing Care Health Funding mechanism. In a few establishments, the income from private service users and / or primary care exceeded the local authority contribution. There was considerable variation in the local authority rates, with the East Midlands having the lowest rates of those interviewed. The rate for local authority residential care for older people varied from £345 to £408 per resident per week, with varying levels for nursing care. Caution needs to be applied to these figures as it can be difficult to make direct comparisons as result of the variations in defining the basic rate. Nevertheless, there was considerable dissatisfaction with local authority rates for residential care, given that service provision is highly contingent on local authority funding and the extent to which Registered Managers or owners are willing and able to seek supplementary funding:

“... I strongly believe that homes would not be in a position to be looking at providing or having to introduce a top up if they were funded enough money to provide the facility and the care which ideally we would like to do. You may if you're in the area be talking to other homes that are members of Linca. Now Linca is the Lincolnshire Care Association which has predominantly been supportive of all homes in arguing our case with Lincolnshire County Council as to the amount that we are funded for our care. The needs of clients within care homes have changed to a certain degree over the last few years. I've been in this business 20 odd years in care homes. I have seen dramatic changes as to what was expected for looking after somebody who was elderly in a home then as to now. We have very high expectations of what we will provide, the service we will provide, the standard we will provide. If we want to maintain that at the highest possible rating then we need to have funding to do that. And it's where economically one will meet the other and this is what it's all about, isn't it? You've got x amount and what are you going to spend it on?” Registered Manager, Care Home with Nursing (NH2RL_RM).

The rate received from the local authority for domiciliary care varied from £10.50 to £16.28. On the whole, although there was some dissatisfaction with some of the rates, this appeared to be less than for the residential and nursing homes. There was one organisation that did not receive any local authority funding, but relied on Direct Payment recipients.
MANAGEMENT OF THE ORGANISATION

CSCI scores, where known, were mainly 2* and 3*. However, this is not mirrored in the ‘Good Organization’ index created in the statistical analysis in stage 2 of this research. A number of 2* organizations scored only 1, the lowest score, on this index (Appendix 6). Apart from CSCI requirements, all establishments had systems in place to monitor performance and quality. Some were self-created, while others were bought as a package from the local authority e.g. the Quality Tree in Nottingham. Most systems involved the utilization of feedback from supervisions and appraisals. Other statistics such as the number of accidents, the rate of staff turnover and complaints were quite widely used. In addition, the most comprehensive systems utilised staff meetings, surveys of patients, relatives and employees and an internal auditing process whereby senior staff were trained and required to audit departments other than their own. A few establishments had achieved liP or used ISO 9002. Benchmarking, however, was not a common practice:

“... we’ve got our own QA system; feedback from service users and employees. [Owner] bought the company two years ago gone June. Employed me for the purpose of turning the company around because it wasn’t – it was failing and our plan was to provide excellent training, excellent care and we thought well that will speak for itself and we have increased by a hundred percent in two years. It’s difficult though to benchmark against [other establishments] there’s a lack of openness as we’re all in competition.” Registered Manager, Domiciliary Care (DC1CA_RM)

Most Registered Managers believed that management and employee relations were good, although as we shall see later in the report this view was not always shared by the staff, notably where there had been a recent change in management and/or a takeover. The Registered Manager of one nursing home, for example, believed that employee relations were good. She was recently appointed and had made a lot of necessary changes but believed that staff felt she was ‘firm but fair’. This was not, however, a view shared by most of those interviewed (Appendices 6 and 7).

There was some, but minimal unionization, mainly among nurses. One Registered Manager encouraged and supported trade union membership because it enabled an employee to have someone to accompany them at a disciplinary hearing. There was no evidence that Registered Managers hold negative perceptions towards trade unions or that union membership created problems.

PAY AND PERFORMANCE

Details of pay rates and other elements of pay are summarized in Appendix 5. Basic rates reflect the rate of the National Minimum Wage (NMW) in force at the time (the adult rate increased from £5.52 to £5.73 per hour on 1st October 2008).
In these 18 establishments care workers’ pay is generally highest in the domiciliary care establishments and generally around 45p per hour or more above the NMW, with one exception in the East Midlands that paid only 2p above. In residential and/or nursing establishments, the differentials are much smaller but vary by region. The Southern and Eastern regions have the highest rates (23p to 63p above the NMW), followed by the East Midlands (18p to 23p above the NMW), although one Registered Manager stated they would pay at the level of the NMW if NVQ2 had not been achieved. NMW differentials in the 18 case studies were smallest in the North West and Yorkshire and Humberside (10p above or equal to the NMW) and the North East and the West Midlands (3p to 5p above or equal to the NMW).

The definition of senior care worker whether tended to be specific to the organization. For example, in one nursing home senior care workers were nurses and their basic pay was around £4 higher than care workers’ basic pay. As a rule the basic pay of senior care workers was not always significantly higher than that of care workers and the pay differential might be as little as 20p (see Appendix 5). Some senior care workers clearly had line management or supervisory responsibility for care workers, while others were not given this responsibility. Rather, the term was an acknowledgement of experience and or qualification.

The NMW was clearly influential in driving pay reviews and the levels at which pay could be set. There was a general tendency for annual pay reviews to be conducted in October at the time of the NMW uprating. Some organizations made reference to available funding levels and were able to work out new wage figures after the local authority review in April. One nursing home operated on a wage: sales revenue ratio of 55-60%. While a number mentioned a desire to pay above the NMW, others referred to the constraints of the local labour market and affordability:

“…we look at profit and affordability; we recognise link between pay and recruitment and retention and try to pay more than other local providers”. Registered Manager, Domiciliary Care (DC1CA_RM)

Pay scales were typically simple with reference to care worker and senior care worker differentials and the achievement of NVQ 2 or 3 but could also be quite sophisticated and reflect quite subtle variation of standard care worker and senior care worker job roles, as this example shows:

“Right, well if we look at care staff … if we look at care staff, if we recruit a care assistant that’s got no experience previously then – or no NVQ – they’ll start on £5.70. Minimum wage is £5.52. Once they get NVQ level II they go up to £6 an hour. Once they get NVQ level III they go up to £6.48 an hour. Our care coordinators who are care assistants with NVQ level III they’re also NVQ assessors so they’ve done the A1 and A2 award and they will also have done an internal auditing course plus some other courses and they’ll be on £7.20 an hour. And our registered nurses are on £10 an hour upwards”. Registered manager, Care Home with Nursing (NH1RL_RM)

Although we use the terms care worker and senior care worker in line with Skills for Care terminology, in practice employees’ job titles were more varied (see Appendix 4).
There was limited evidence pay linked to length of service.

Other elements of pay, though not universal, were the application of differential rates for unsocial hours at weekends or at night. Premium rates for public holidays were also found. There were isolated examples of individual incentives for the successful introduction of a resident or a member of staff. While a petrol allowance was made in domiciliary care organisations, issues were raised by staff about travelling and working time that might have implications for NMW compliance i.e. pay for hours worked. One domiciliary care organization leased scooters for its non-driving employees, with a lower petrol allowance, enabling them to use the scooters for personal use. This practice had facilitated one employee to learn to drive.

Non-pay benefits, including the use of scooters noted above, were quite limited, and related mainly to the provision of uniforms. Organizations did not necessarily provide a second uniform or launder them. There was very little evidence of pension provision.

Given the need for care to be available over extended periods and the concomitant complexity of working requirements and patterns, establishments demonstrated considerable flexibility towards working hours with reference to employees’ needs to ensure that staffing arrangements matched business requirements. Individual needs might have been ascertained at interview and were generally recognized e.g. domestic caring commitments to enable staff to work at times of day and on days of the week suitable to them:

“...we’re very flexible if people only want to work mornings, or they only want to work evenings we would rather keep the staff and keep them happy and I think that’s part of the reason that a lot of the staff have been here for a long time because we’re working the hours that suit them and not us. In emergencies we do change things at short notice, we’re not always over the moon about it, people have lives outside of work”. Registered Manager, Domiciliary Care (DC1JG_RM)

Most establishments enabled employees to change their working patterns at short notice, typically on the basis of swapping with a colleague. Time off at short notice was facilitated on a similar basis through the use of a bank system in some cases. Although there was limited use of being able to work different hours in school holidays, the nursing home that used a bank system also operated an annualised hours’ system to facilitate this practice and another nursing home had adjusted their cook’s start times to enable her to run her son to school during working hours. Not all Registered Manager considered that they could comment with authority on the efficacy of their approach to flexibility compared to other organisations, yet most perceived this as being helpful to recruitment and retention. Most Registered Managers considered that flexibility related to the needs of children, although one establishment recognised that flexibility was necessary to enable overseas workers to return to their home country for an extended period.

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**RECRUITMENT AND RETENTION**
The basic statistics about the number of employees and their gender, the number of volunteers and the number of care workers and senior care workers are summarized at Appendix 5. Most establishments employ between 18 and 100 employees with a mean size of 52 employees. Female employees predominate, with the exception of one domiciliary care organization which supported people with autism in tenancies. Volunteers are not often used. One residential home used them for a pre-employment trial, while another residential home used only volunteers to staff reception. The remaining examples used volunteers to help with social activities or fundraising. Temporary and agency staff are rarely used.

While care workers comprise the bulk of establishments’ workforces, the position of who is classified as a senior care worker or manager is more complex, as noted above. Some nursing homes had senior care workers. Another did not, regarding nurses as senior care workers and all employees (13) above senior care worker level as managers.

Although migrant workers were not apparently employed in most establishments, those employing them were not sure how to define them, often including overseas workers from India and Africa requiring work permits (non-EEA) employed as nurses or care workers in this category. Some of these nurses had started as CAs and progressed to nurse or more senior levels. All A8 workers were Polish. Registered Managers experience of such workers was generally positive, although isolated examples of opposition from other staff and language problems were mentioned.

The measurement of staff turnover is problematic because of the presence of bank staff within these calculations. (The calculation of turnover Skills for Care uses on NMDS-SC data does exclude all non-directly employed staff, therefore bank staff are excluded. However there did seem to be a problem in the recording of turnover in some establishments as the definition that these organisations used of Bank Staff included directly employed staff. What these organisations had done was formally recruit people to work in their own organisation, but offer them a zero hours contract initially. These staff were called on as and when they were needed, many going on to become permanent staff on fixed hour contracts and it appeared that for turnover purposes these staff were included as starting and leaving every time they took on some work and subsequently finished. Including these staff in the turnover figures would create an inflated sense of turnover.). Appendix 5 shows that establishment turnover rates vary but that turnover levels in themselves are not necessarily a negative sign because they disguise a more subtle, often positive picture of internal and external career progression. Care worker turnover was often for positive reasons, for example, promotion and family commitments, rather than for negative factors such as poor performance:

“Like you say out of them 15 who left in the last 12 months, [out of a total of 40 staff], 6 went on to work in the NHS. Some of them also go on and do the student nursing which is nice. I wouldn’t say that there is one predominant reason for leaving than that there are several of them. It is because
that will include bank.... staff as well and as nurses qualify\(^8\) they are not going to work as carers so you automatically get them counting as leavers”. Registered Manager, Care Home with Nursing (NH1JG_RM)

“I’ve had a lot of staff leave to go on to do nursing. They complete their NVQ to level 3, whatever, and then they go onto nursing. Which we have no problems with. And if they want a placement for their nursing they’re more than welcome to stay and do their placements”. Registered Manager, Care Home (RH1JGRM)

The achievement of one year’s service was perceived as an important threshold.

A number of establishments reported that staff had left the establishment to go and work in another care organisation, but had found the experience unsatisfactory and had asked to come back. The Registered Manager of one nursing home allowed its ex-employees to return only once. In an exceptional case one domiciliary care organization had lost seven staff that had left voluntarily because they had been found to be claiming more petrol allowance than they were entitled to and were not prepared to continue on a less well-paid, but correct basis.

The majority of establishments identified the reasons for leaving from exit interviews, whereas others relied on good person to person communications. Compared with care worker turnover, senior care worker turnover was much rarer, reinforcing the point that achieving some level of service history was significant. Managerial turnover was not an issue although there were examples where relatively recent changes in organisation ownership / management were problematic.

There is no apparent link between turnover, CSCI and good organisation scores and divergent views on employee relations among managers and staff. There are a number of possible explanations for this. One is the problem of recording of turnover and who should be included – for example including bank staff in turnover figures is misleading. A second issue is that CSCI scores are by definition historical, with some of the scores a year old, or in some cases not available if there had been a recent change in organisation ownership / management. A third factor is the fact that the good organization scores were based on the small number of HR practices recorded in the statistical data. In any event, neither CSCI scores nor good organization scores are able to reflect more informal and less tangible beneficial or negative aspects of HR management and practice that undoubtedly exist.

Labour markets for care staff are highly distinctive according to the locality, any advantages or difficulties arising from the job opportunities available among competitors and, in a minority of cases, related to the specific cultural needs of service users. Reputation was identified as important in this nursing home that benefited from the presence of a local college as its main recruiter:

\(^8\) It was common in this establishment to employ nurses in training as care workers. They were employed on the bank and were often former permanent employees of the establishment.
“They vet a lot of the staff before they come and they get a lot of the basic training, mandatory training as well...Once we have staff vacancies we tend to have a lot of applications... A lot of it is to do with the reputation of the home and the good standards that we have and the good CSCI, people want to come and work here. We don’t have many going into factories or supermarkets, we have kept the staff you know. They have either gone off to home care for a little bit of an inflated wage but then it works the other way because we get them from home care because of the hours and the working patterns. Some go to the specialist areas, such as learning disabilities where again the wages are a little bit more attractive”. *Registered Manager, Care Home with Nursing (NH2JG_RM)*

In relation to the recruitment of care workers a number of Registered Managers mentioned low pay, poor commitment, unsociable hours, delays with CRB checks and hard work as problematic, given the demands of the job:

“If we just wanted anybody and just somebody to fill a gap we could, easily. But at the end of the day there’s a lot expected of s now you know, I know NVQ’s not rocket science but they have to be able to write reports and the medication issue’s getting a more of hot potato and they have to have a certain level of intelligence. So I suppose we could recruit if we didn’t bother what we were recruiting”.

*Registered Manager, Domiciliary Care (DC1JG_RM)*

By contrast the recruitment of senior care workers was much less problematic and a number of establishments had developed care workers to become senior care workers, a factor that clearly facilitated staff retention.

Front line s were mainly recruited through Job Centres or by word of mouth, with quite limited use made of advertising in the press. A number of Registered Managers considered that word of mouth was particularly effective. Delays in obtaining CRB check clearance were mentioned; fears were expressed that such delays could mean that staff could be lost to supermarkets although there were no actual cases of this identified. In terms of desired attributes, personal qualities scored most highly, followed by experience; qualifications were often seen as something that could be achieved while on-the-job.

Particularly desirable personal qualities mentioned by Registered Managers included maturity (i.e. ‘caring life’ experience), being good with people, enthusiasm, reliability, a caring nature, trustworthy, committed, empathy, willingness to learn, punctuality and good communication skills, which might mean the ability to speak in clear English. However, Registered Managers’ validation of such qualities was often highly subjective. More sophisticated recruitment and assessment practices were very rare. One example involved behavioural interviewing, which typically entailed a period of observation with the interviewee interacting with residents and staff.

Registered Managers’ comments also highlighted not only their strong orientation to training but also the complexities and high demands that care work entailed:
“What I’m looking for is somebody who of course has some experience, who can work well as a member of a team, can also use their own initiative and work on their own, can deliver good care, very good care and also respect your residents, give them dignity, treat them like your own grandparents, you know, you wouldn’t want anybody being rough with your grandparents or your parents and treat them well. We do an awful lot of training as well, we do in-house training, we have training brought in, we’ve got our own trainer who comes in once a week to do mandatory, we’ve just signed seven people to do their NVQ 2 and I think if, so there’s everything there for somebody, for us to support them if they are a good carer and can provide the care and to the standard that we want”.

Registered Manager, Care Home with Nursing (NH1CA_RM)

Although most Registered Managers were quite ambivalent about the need to use specific employment practices to recruit good quality front line care workers, a small number of homes provided interesting examples:

“We do get involved with care ambassadors with the local school and we do offer work experience for people at school, and one of our kitchen assistants came following doing work experience with us and because of the new change in the 16 to 18 apprenticeships we’ve just enrolled her on an apprenticeship so that she can start to get involved in personal care”. Registered Manager, Care Home (NH1RL_RM)

“We work with the universities and we use that forum as a way to get bank staff in as well so a lot of the nurses who are training will come and work on the bank within that system so we will use that forum so we will do job fairs within the university but I have to say that is primarily aimed at nurses with the silver lining that you do get students go along and you might get recruitment to your bank. I wouldn’t say that we have done anything particularly aimed at care staff. Nurse recruitment is incredibly difficult, that’s a really difficult area. Especially registered mental nurses so we do it through lots of things really. Registered Manager, Care Home with Nursing (NH1JG_RM)

Practices that worked well in trying to attract good quality front line care workers included flexibility, the reputation of the home (often spread by word of mouth) and training provision. One domiciliary care organization referred to the importance of an extended selection process over six weeks although that also had the downside that people might drop out if they found another job:

“...we invite them for an interview... to a social group and the supervisors and some staff would be watching the person interacting and seeing how communicative they are and all that sort of stuff with the clients, so, before they even go anywhere near”. Registered Manager, Domiciliary Care (D CRL_RM)

Most Registered Managers could not identify any particular practices that worked against attracting good quality care workers.
Specific measures to keep care workers were similar to those used to attract them, such as training and flexibility, with a number of Registered Managers stressing the importance and value of ‘good management style’ by setting a good personal example, such as being fair and consistent, providing the right equipment, listening and actively involving staff in resolving problems, being approachable, empowering workers and giving them a voice to influence change. Registered Managers were sure what worked well or not so well in trying to keep the staff they wanted to keep, although a number of answers mirrored the reasons they gave to keep staff. The time taken for CRBs and employment law were examples of problematics, and one Registered Manager pointed out that there was little point in trying to deal with employees that were adamant about leaving.

EMPLOYMENT AND TRAINING

Most establishments demonstrated a very strong orientation towards induction, mentoring, training, supervision and appraisal (see Appendix 3). All establishments provided induction with most stating that this followed the Skills for Care model. Issues covered included theory, fire and safety procedures, manual handling, autism, learning disabilities, and the administration of medication. The period of initial induction was normally around a week long but was typically longer in domiciliary care to enable new starters to complete a range of courses, such as manual handling and medication. A number of Registered Managers mentioned that the new employee was supported by a more experienced person acting in a formal capacity as a supernumery, buddy or mentor.

Most Registered Managers received help from local authorities regarding training, often sending employees to attend courses provided by the local authority training department. Many also acknowledged the local authority input into local workforce partnerships, for example, one Registered Manager reported that the training provided by the Black Country Partnership for Care was “phenomenal”.

“Black Country Partnership, we’re registered with them, so we have a lot of funding from them which goes down to the colleges, so they provide the NVQs. 100% staff have NVQs...They have been absolutely fantastic”. Registered Manager, Care Home (RH1JG_RM)

Although some local authorities were highlighted as particularly helpful in terms of their support and provision, experiences could be less positive:

“Intermittent. Lincolnshire is a large county and sometimes events are too far away”. Registered Manager, Care Home with Nursing (NH2RL_RM)

“Derbyshire does a lot of free courses, Nottinghamshire not much”. Registered Manager, Domiciliary Care (DC1RL_RM)
This example illustrates an innovative attempt of an establishment working with a partnership to tackle the problem of training in a large geographical area:

“Yes. Well our home is part, and it was part of – I was part of the brainchild for it - with the local authority we’re doing what’s known as the S…Pilot. The local authority identified that they had money for training but a few homes were accessing it, so I said well we’re thirteen miles from where we are based, to send our care staff to Nottingham for training is very costly. If we provide transport i.e. I was driving there and back, it takes time out of my working life, then there’s the petrol. If we provide taxi service then that’s extremely costly, if we expect staff to get there under their own steam then public transport’s very hit and miss and takes too much time so staff aren’t interested. So what we’ve proposed is there are six homes in and around S… so if we provided the training locally then staff could access that training. So there are six homes, we’ve got £6,000 for the project from the local authority and we’re putting on various training. I’ve also been able to access some training free from the Primary Care Trust, so things like infection control, wound management, continence care, we can get free from the Primary Care Trust. And I’ve managed to get a training programme put together that started in June and will run, well at least till March, where we’ve got a training day per week being put on. The difficulty that we’re having is some of the homes aren’t sending staff and what they’re saying is their organisations or their head offices are saying that they can’t afford to pay the staff for training, so out of the six homes I think there’s three that are saying we can’t pay our staff for attending this training. That could jeopardise the actual pilot, but the other homes are funding their staff. Registered Manager, Care Home with Nursing (NH1RL_RM)

Other sources of external training included the YMCA and drug representatives. A number of Registered mentioned that a NVQ assessor or training officer came to the workplace on a frequent basis.

Formal supervision was a universal practice, typically on a 6 to 8 week basis. Almost all Registered Managers regarded it as an effective mechanism to exchange information and learning, to monitor progress, to build confidence and resolve issues. In one exceptional case, the Registered Manager suggested that the work load was too great for a single person and that other staff needed to be trained to share the work. Another Registered Manager identified problems with keeping records because it was a personal discussion. The styles and methods of supervision were highly dependent on the personal approach of the supervisor:

“Definitely. It is an opportunity to be able to go through what they have done well, what they have done badly and help them and support them and enable them where they need to. Also for them just to be able to air anything and sometimes all it takes is to sit there for half an hour ranting and raving, not necessarily mean anything from it, just the ability to do that and you feel a lot better about it”. Registered Manager, Care Home with Nursing (NH1JG_RM)

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9 The pilot has been identified as S.. in order not to identify the establishment.
“I mentor the deputy and the heads of departments – your housekeeper, cook, the handyman, the
admin and the deputy managers. The deputy and the team leader, the deputy does the nursing staff,
the team leader does the senior care staff and then it cascades the nurses then supervise and monitor
the care staff and the seniors do the same with the care staff on the residential side. The cook then
does her own staff and the housekeeper then looks after the ancillary staff. So the heads of the
department are then cascaded down the front line staff. What we were finding was that the
supervisions, they were all giving the same feedback... so what we have decided to do is theme the
supervisions for that month around whatever issues we have for that month. The thing that we are
doing this time around is documentation...The personal development plan is still within the
supervision as well”. Registered Manager, Care Home with Nursing (NH2JG_RM)

Annual appraisal was also universal. Although many of the areas covered in formal supervision were included,
there appeared to be more emphasis on formal recording, staff participation through self-assessment and self-
awareness, the identification of training needs and a review of overall performance based on the achievement
of the previous year’s key objectives.

Registered Managers used a variety of means to motivate staff, often in combination. Some stated they led by
example:

  “Don’t expect anyone to do what I wouldn’t be prepared to do. Help out on floor when short staffed.
  Stressing that teamwork will achieve much more. Encourage them to work and be responsible to each
  other. Job rotation – work on different floor. Tea and coffee when needed as breaks have to be
  staggered. Split breaks if smoke”. Registered Manager, Care Home with Nursing (NH2RL_RM)

Training, communication, praise and feedback were also frequently mentioned. Although a number
encouraged the use of internal and external social activities, one Registered Manager of a nursing home
believed motivation owed more to getting the working conditions right at a time when the increasing
dependency levels of patients was not being reflected in approved staffing ratios:

  “Communication I think is the big one. Having an open door approach sometimes to your detriment
  but never mind. Training. Praise. Make sure that they are well looked after and well thought off.
  When you tell them – a pat on the back, the money’s not good but a positive feedback sometimes
doesn’t go amiss. But I think that communication is the big one through staff meetings. Keeping them
fully informed...I do an in-house monthly newsletter and in there we recognise any staff that has got
their NVQ, well done to those. It is a home thing it’s not based around staff, its staff and residents so
if we have had somebody who has celebrated their 80th birthday then that would go in there, and
staff as well”. Registered Manager, Care Home with Nursing (NH2JG_RM)

Communicating and consulting with staff was achieved formally and informally. Formal means included shift
handover meetings, notices and memos, suggestion schemes, a message or grumbles book, formal staff
meetings, supervisions and appraisals. Most Registered Managers did not miss the opportunity to take
advantage of ad hoc meetings, informal chit chats, often stating they operated an open door policy. Telephone contact was also important; two domiciliary care establishments provided their staff with free mobile phones. Registered Managers’ claims of being approachable and the above mentioned means of communicating and consulting with staff were thought to provide important opportunities that encouraged staff to ask questions and provide comments or suggestions on the running of the home. Most Registered Managers believed they had been successful in encouraging staff to be as fully involved as possible, although some considered that there were further improvements that could be made. A number expressed a willingness to take up individual suggestions for improving work practices and adopting them if they proved to be workable:

“I think, very judging by the positive questionnaires in recent liP audit”. Registered Manager, Care Home with Nursing (NH1RL_RM)

“I never get any work done while I’m here because everybody’s here is probably an indicator that they do feel involved and they do feel the front door’s open and I can never get to my desk to sit down and do the work I want to do”. Registered Manager, Domiciliary Care (DC1RL_RM)

Employees frequently popped into the office when off-duty or made themselves available by phone at any time, which raises issues about what and what does not constitute paid working time. Money was rarely mentioned as an important factor.

However, Registered Managers’ positive statements were not always supported by staffs’ comments, particularly where ‘Chinese whispers’ were seen to perpetuate rumours and distort information rather than providing clear, direct messages.

The majority of Registered Managers felt confident enough to state that they thought their staff felt valued, although others were more cautious. This example is one of a very small number of cases where the Registered Manager rightly predicted some staff dissatisfaction:

“I would hope so, but they probably would say no”. Registered Manager, Care Home (RH1RL_RM)

Most Registered Managers considered that their staff liked working at this establishment and also preferred working there compared to other care organizations they had worked at, with a few citing examples of employees who had returned to them after a poor experience elsewhere. A number of Registered Managers referred to career-change staff that had come from non-care jobs who had ‘found their vocation’ with more rewarding work.

**SUMMARY**

Overall the findings from the interviews with managers reported a lot of positives about the sector. A lot of mechanisms were in place to support, train and develop staff. Managers were aware of the importance and benefits of good management, albeit they did not necessarily describe this in formal terms or apply it through formalised HR practices. Managers had developed strategies regarding recruitment and retention, which
generally appeared to work for their particular situation, as care worker and senior care worker recruitment and retention was not seen as a major problem. In spite of the difficulties presented by funding levels that were perceived to be inadequate, constraining Registered Managers’ ability to pay staff higher wages, they were still able to offer a wide range of non-monetary rewards and incentives that facilitated the recruitment and retention of most workers. While this was in part due to the inherent nature of care work appealing to the employees, it was also clear that a hands-on and approachable management style where problems were discussed and resolved openly and praise was forthcoming were very important to the effective functioning of the establishment. Failure to retain some staff was not always perceived as negative because it commonly meant career progression for the individual concerned. Nevertheless, high quality care is the sum of many parts. Strong leadership, vision, a commitment to training and career development and creating a committed workforce are vital prerequisites for making the right environmental, physical and social components of care work achieve high quality outcomes.

FINDINGS FROM INTERVIEWS WITH EMPLOYEES

Interviews were conducted with 67 employees. Interviews were conducted on a one to one basis and in a quiet and, where possible, private location. A semi structured questionnaire was developed in advance of the interviews and was used by all interviewers. All interviews were recorded and transcribed for analysis. The analysis of data from these interviews was captured in one of two ways. Closed format data was captured in tabular format, whereas open format data was captured onto a template. Given the large number of interviews, space does not permit the attachment of the full dataset. However a summary of tabular data is attached at Appendix 6. What follows in this section draws out key issues and themes emerging from both types of data and uses quotes from open format data to illustrate themes where appropriate.

DETAILS OF EMPLOYMENT

Employee interviews were conducted in all regions, except London and the South West, and included employees in care only homes, care homes with nursing and domiciliary care establishments. Registered Managers were asked to select front line care workers, specifically to include some with less than one year’s service, to be interviewed. In practice, care workers who could be released from their duties at the time scheduled for interviews were nominated to be interviewed. 44 Care Workers, 14 Senior Care Workers, 5 nurses and 4 ‘others’ (e.g. a domestic and a chef) were interviewed. The vast majority (58) provided front line care, albeit some had job titles (e.g. senior care assistant or floor manager) that denoted a degree of supervisory responsibility for others. Nonetheless, these employees provided hands on care to clients of the establishment in which they worked. Employees were asked to describe their job and in most cases this comprised duties such as personal and nursing care and supporting people.
Most of those interviewed were employed either in small establishments or in establishments that were part of a small chain, with only 8 working for a large organization. Those interviewed worked on a mainly full time basis, with a high proportion working in excess of 40 hours per week. While some employees in domiciliary care establishments raised the issue of a lack of guaranteed weekly hours, most employees appeared to work a consistently high number of hours and many expressed a desire to do this in order to maximize earnings.

There was a balanced age profile of those interviewed, ranging from 17 to early 60s, and a variety of lengths of service. Approaching half of those interviewed had worked in the same job for over 5 years, while nearly a quarter had less than 1 year’s service. This may, however, be skewed by the researchers’ request to see new starters in order to discuss induction training with them. 70% of employees had worked in the care sector for over 5 years, suggesting that, despite moving employer, many were committed to working within the sector.

### VIEWS ON WORK

Employees were asked to outline the aspects of their jobs that they liked most, along with those that they liked least.

#### WHAT EMPLOYEES LIKED MOST ABOUT THEIR JOBS

The strongest theme to emerge is that of the importance of working with and helping people:

“I think it’s probably the only job I’ve ever done where I go home at the end of the day and I feel like I’ve really done something. Yeah it’s quite self-satisfying you know? it isn’t like the ‘same old, same old’ where you might work in a shop and you’re just sat on a till or you know I like about its something different every day, you’re faced with new challenges every day and you know the smallest thing that you might do for somebody. You know, you might put someone’s hair in rollers and you know it totally makes their day, if they’d struggled with it themselves or they can’t get to the hairdressers or you know and I think you just kind of come out and you think ‘ah!!’ You know?” Care Worker, Domiciliary Care (DC1CA_E1)

A focus on quality of care provided and making a difference to someone’s life is also critical and many expressed the view that the role is more than about just earning money, it is about building a bond with those they care for. A number of those employed in domiciliary care expressed a preference for doing this in a client’s own home, rather than in a formal home setting. As also evidenced in the above quote, the variety of the role is important and this seems to be coupled with the opportunity to use initiative when delivering care. Flexible hours to fit with other commitments and team working also emerged as important aspects of the employees’ roles. A commonly expressed theme is that care work is a vocation and that ‘Not everyone can do it’ which led employees to be proud of their role. These themes are explored in more detail in the rest of this section.
WHAT EMPLOYEES LIKED LEAST ABOUT THEIR JOBS

It is interesting to note that a large number of employees suggest that there is ‘nothing’ that they like least about their roles. The issue that emerges most frequently, however, is the pressure caused by “inadequate staffing levels” and the detrimental effect this has on levels of care provided:

“I loved my work. I used to go home very satisfied that I’d done the best that I could on each shift that I worked. Now it’s frustration… the lack of staff. You’re lucky if you have the time to do what you need to do without just having that little bit extra to be able to sit and you know have a minute talking to them. You know. I just feel that it’s just - it’s not care.” Care Worker, Care Home with Nursing

(NH2JG_E3)

That employees have to rush and spend less time than is desirable with clients is a frequently expressed view. Employees perceive inadequate staffing levels to be driven more by budgetary constraints than recruitment difficulties, some also suggesting that client dependency levels are increasing and that this is not recognized in staffing levels. Inadequate staffing levels also led to the concern amongst those interviewed that they often have to cover for absent colleagues at short notice.

Pay is also cited as a concern, but not as strongly as might be expected. Low pay is raised by some, mainly in domiciliary care as is insecurity of income, both as a result of lack of guaranteed hours and as a result of the losing of clients leading to reductions in hours and pay. Another issue raised by a few is poor working relationships, either with management, medical staff or team members. Lack of facilities such as a staff room or lockers is also cited as a concern by a small number of employees.

In summary, employees paint a very positive picture of their roles, with a strong focus on providing a high quality of care and the negative impact of staff shortages on the ability to do so dominating the responses in this section.

SUPERVISION AND RELATIONS WITH MANAGEMENT

In this section, employees were asked some open questions about supervision and relations with management and were asked to provide answers to questions about this on a rating scale of 1-5 (see Table 1 below).

SUPERVISION

Nearly all those interviewed receive formal supervision. However, in a few establishments where a high degree of change had recently occurred, problems with a lack of supervision were reported. Supervision is perceived to be about helping and supporting employees and is generally valued as a useful way to communicate and resolve problems:

“its – well basically am I happy in my job? Am I getting all the support I need? Training? Understanding the training [laughing] and are there any problems with clients that I need to discuss or anything else I’d
need to discuss in confidence. Basically it’s a bit of an open session but we cover all areas. It’s very good. You come out and you think, oh glad you told me that.” Care Worker, Domiciliary Care (DCJC_E2)

For most, supervision takes place every 2-3 months and many suggested that it is motivating to reflect on what they do well and to have their opinions and views valued. Given the fairly recent requirement for supervision to be conducted within the sector, a very positive view of its occurrence and value emerges.

### RELATIONS WITH MANAGEMENT

Employees were asked to respond to a number of questions regarding relations with management, giving a 1-5 response or an answer of ‘Don’t know’ (see Table 2 below for an explanation of this scale and a summary of responses). They were also asked to provide comment where appropriate to explain their responses.

The responses can be seen to be largely very positive about the working relationship, which supports the points made in the section on managers’ responses above and indicates limited divergence in manager and employee views on the employment relationship.

**TABLE 2: SUMMARY OF EMPLOYEE RESPONSES**

<table>
<thead>
<tr>
<th></th>
<th>Agree strongly (1)</th>
<th>Agree (2)</th>
<th>Neither (3)</th>
<th>Disagree (4)</th>
<th>Strongly disagree (5)</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support from immediate supervisor is good</td>
<td>40/60%</td>
<td>19/28%</td>
<td>5/8%</td>
<td>2/3%</td>
<td>0/0%</td>
<td>1/1%</td>
</tr>
<tr>
<td>Managers can be relied upon to keep promises</td>
<td>25/37%</td>
<td>24/36%</td>
<td>12/18%</td>
<td>5/8%</td>
<td>0/0%</td>
<td>1/1%</td>
</tr>
<tr>
<td>Managers attempt to understand employee views</td>
<td>29/43%</td>
<td>27/40%</td>
<td>7/11%</td>
<td>4/6%</td>
<td>0/0%</td>
<td>0/0%</td>
</tr>
<tr>
<td>Managers deal with employees honestly</td>
<td>31/45%</td>
<td>27/40%</td>
<td>3/5%</td>
<td>3/5%</td>
<td>0/0%</td>
<td>3/5%</td>
</tr>
<tr>
<td>Managers understand about employee responsibilities out of work**</td>
<td>34/51%</td>
<td>26/39%</td>
<td>4/6%</td>
<td>1/1%</td>
<td>2/3%</td>
<td>0/0%</td>
</tr>
<tr>
<td>Managers encourage employees to develop their skills</td>
<td>48/72%</td>
<td>15/22%</td>
<td>3/5%</td>
<td>1/1%</td>
<td>0/0%</td>
<td>0/0%</td>
</tr>
<tr>
<td>Managers treat employees fairly</td>
<td>35/52%</td>
<td>15/23%</td>
<td>9/13%</td>
<td>4/6%</td>
<td>3/5%</td>
<td>1/1%</td>
</tr>
<tr>
<td>I share many of the values of the organisation**</td>
<td>40/60%</td>
<td>21/32%</td>
<td>2/3%</td>
<td>1/1%</td>
<td>2/3%</td>
<td>1/1%</td>
</tr>
<tr>
<td>I feel loyal to the organisation**</td>
<td>50/75%</td>
<td>12/19%</td>
<td>2/3%</td>
<td>1/1%</td>
<td>1/1%</td>
<td>1/1%</td>
</tr>
<tr>
<td>I am proud to tell people who I</td>
<td>43/68%</td>
<td>16/25%</td>
<td>3/4%</td>
<td>1/1%</td>
<td>4/6%</td>
<td>0/0%</td>
</tr>
</tbody>
</table>

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The questions used in Table 2 replicate those used in the Workplace Employment Relations Survey (WERS) 2004 (www.berr.gov.uk). The data are held in the UK Data Archive at the University of Essex (www.data-archive.ac.uk). The only known published analysis of some of these questions shows that the combined percentage of care workers’ strongly agree and agree responses is substantially higher than those of all employees in Great Britain and employees in North West England for the questions marked** in Table 2 (see Mathieson and Lucas (2008) Employment Relations in North West England, Manchester Metropolitan University and ACAS, pp.47-48). In all cases the percentages of care workers’ strongly agree responses are substantially higher than their agree responses.
<table>
<thead>
<tr>
<th>work for**</th>
<th>64%</th>
<th>24%</th>
<th>5%</th>
<th>1%</th>
<th>6%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am proud to tell people what my job is</td>
<td>55</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>81%</td>
<td>19%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

N=67

Support from immediate supervisor is perceived to be very good by most (78% agreeing or strongly agreeing that this is good). Employees suggest that supervisors and managers are always ready to help and deal with issues, those working in domiciliary care saying that there is always help available on the end of the telephone:

"Anything I need, absolutely anything I’ve even known [supervisor] where I’ve had to ring her late at night over an issue that’s been going off and she’s turned up. She’s on call 24 hours a day. If I’ve had a lot – you know, sometimes the work load gets a bit pressured, I get that support from her.” Care Worker, Domiciliary Care (DC1RL_E4)

A small number feel unsupported, but this is a minority view and sometimes arises from the staff shortages outlined above. Support from senior management is also largely positive, although a small number of concerns were raised either because of staff shortages or personality clashes.

Views on managers keeping their promises are positive (73% agreeing or strongly agreeing that this was the case):

"Yes. Well I say keeping her promises but she tries her very, very best and obviously if it can’t be done it can’t be done kind of thing. She will always try for us.” Care Worker, Care Home with Nursing (NH2JG_E1)

Some 83% also agree or strongly agree that managers attempt to understand their views, although there are some concerns around not responding to requests for increased staffing. Similarly, some 85% agree or strongly agree that managers deal with employees honestly, although a small number of employees cited examples of managers agreeing to tackle particular issues and then failing to do so.

There is general recognition that employers attempt to reconcile employees’ working patterns with their other commitments, 90% agreeing or strongly agreeing that managers understand about employees having responsibilities out of work:

"My nurses understand and the other care staff do understand that I do have responsibilities outside. This is the first place I’ve ever worked. But there’s a lot of people do say that this is one of the best places to work for people who have kids and other responsibilities outside.” Care Worker, Care Home with Nursing (NH1JG_E1)

Those employees interviewed who are care workers but with the added responsibility of managing staff rotas suggest that such flexibility is about retention and keeping staff happy so that they do a good job (e. g. Senior Care Worker, Domiciliary Care, DC1CA_E4). Flexibility can thus be seen to have mutual benefits within the employment relationship. Some discontent is expressed at the length of working hours and the impact of
having to cover colleagues’ shifts at short notice on reconciling work and other commitments, but the overall view is very positive.

94% of those interviewed were in agreement that they are encouraged to develop their skills. Employees cited the availability of off-the-job training in, for example, Alzheimer’s, dementia, autism and infection control. There is lots of opportunity to undertake NVQs and some example of controlled delegation to develop skills. This focus on skill development is discussed further below. Most, 75%, also agreed (many strongly) that employees are treated fairly by management. There is, however, some evidence of perceived injustice, for example, vouchers awarded as a mark of recognition of efforts were given to care workers but not domestics in one establishment (Domestic, Care only Home, RH1CA_E3) which gave rise to very strong negative feelings. Similarly, one employee was very disappointed when senior position was filled by external applicant and she was not given the opportunity to apply despite holding an NVQ Level 3 (Care Worker, Care only Home, RH1JC_E1).

The overwhelming majority (92%) suggest that they share the values of the organization, which were perceived to be around quality of care:

“We’ve got a standard to work towards, make sure the residents are all clean at all times, safety measures, personal hygiene, respect the person, confidentiality and the privacy of each resident. And each resident is unique you see and you’ve got a one to one –, we’re always reminded that not one thing that good for everybody, that everybody is unique. So we’re going to have to deal with each individual and you get to know them and it’s nice.” Care Worker, Care Home with Nursing, (NH1JG_E2)

Again, the focus on caring for others emerges strongly, although there were some pockets of disagreement on this, particularly in establishments experiencing a high degree of change.

93% of employees felt loyal to the establishment, many citing their length of service as evidence of this, although employees in establishments undergoing change suggested a lower degree of loyalty. 88% are proud of the establishment that they work for, often as a result of its reputation locally for the quality of care provided. Some distinguished between pride in the establishment and the owning company, suggesting pride in the former but not the latter.

Every employee interviewed indicated that they are proud of the job they do, many again suggesting that it is a job that they enjoy and do well:

“I think because I’ve over the years, especially my partner’s friends and that, they look up to people like me because not everybody can do that [carer’s job], you know” Care Worker, Care only Home (NH2JG_E3)

The view of the job as vocation that only some are suited to emerges very strongly and drives pride in undertaking the role. There were a number of examples of poorly educated, low skilled women who had cared for family and taken up a paid caring role later in their lives who were extremely proud of taking up a role that
they perceived to be meaningful and responsible and one in which they gained skills and qualifications (e.g. Care Worker, Domiciliary Care, DC2CA_E3). One respondent even suggested that pride in the job is more important than pride in the establishment, loyalty being to the role not the employer (Care Worker, Nursing Home with Care, NH1CA_E4).

Despite the low pay and long hours that prevail in the care sector, an overwhelmingly positive view of relations with management is depicted in employee responses in this section.

**DECISION MAKING, INFLUENCE AND RESPONSIBILITY**

Employees indicate in response to questions about their level of involvement in decision making that this is generally good, although they recognize and accept the limits to this:

“I think that would probably depend what the decision was going to be. Because obviously sometimes we haven’t got the experience to make major decisions. But if they think they can involve us then they do try and involve you.” Care Worker, Nursing Home with Care (NH1JG_E1)

There also appears to be a fair degree of influence over how employees do their jobs, examples being provided about their opinions being sought and changes being made as a result of their suggestions. Employees indicate that they have a high degree of autonomy in deciding how to carry out their roles, particularly in comparison to other jobs they have done (e.g. hairdresser, Care Worker, Nursing Home with Care, NH1JG_E3). The importance of autonomy in the role emerges strongly, supporting the earlier findings as to what employees like most about their jobs.

The extent to which employees are informed about and able to influence significant changes varies by context, some establishments managing this better than others. Employees are generally less satisfied where the degree of change is higher, although many had fairly low expectations of being able to influence these changes:

“Yes, [influence change] if to do with residents. Not so quick if it’s running of the building.” Care Worker, Care only Home (RH1RL_E2)

A number of employees felt that change was imposed by those above the Registered Manager (i.e. the owners or a head office) and the opportunity to influence was thus very limited:

“Don’t know what to say - if it’s to do with our work hours or something we haven’t really got a choice. We’ve found that recently when our hours – our hours used to be 7.30 ‘til 3.00 and ... it came from the [head office] that now we would now work 7.00 ‘til 2.00 and the afternoon shift will do 2.00 ‘til 9.00 therefore cutting everyone’s hours down. So we felt that that was wrong... See that was beyond [Registered Manager’s] control.” Care Worker, Nursing only Home (RH1RL_E2)
Employees were asked how much responsibility they felt they had, with most suggesting that it is a very responsible job. The majority are happy to accept such responsibility, although some find it can be overwhelming:

“...It’s difficult because you go from people with dementia to people with severe mental problems and sometimes it’s a bit scary..... we have a lot of responsibility.” Care Worker, Domiciliary Care (DC2RL_E2)

Some employees noted that at times they are given additional responsibility without additional payment. Few suggested that they wanted more responsibility, indicating that they felt they shoulder significant responsibility already and that this is enough.

In summary, employees appear to feel that they have decision making and autonomy at the level of the job, and that significant responsibility attaches to this, but that changes at the wider level of the establishment are often beyond their influence.

TEAM WORKING

On the whole, employees suggest that team working is strong, almost on some occasions ‘like a second family’ (Care Worker, Care Home with Nursing, NH1CA_E4). Most suggest that everyone in the establishment forms part of the team:

“All the way round really, even the cleaning staff and everything they all muck in to help us. Like if we ever need anything doing by them they’re straightaway there and everyone” Care Worker, Care Home with Nursing NH1JG_E3

One domestic in a residential home, however, did suggest that her role is seen as less important than that of care assistants and some tensions are created by this.

There were some instances of employees working in domiciliary care feeling isolated and team work being limited:

“Because we all talk together like on our phones, we don’t really like meet up except if a few of us are out on the road and we’ve got a bit of a gap time and we maybe meet at Tesco for a brekkie but otherwise we don’t really see each other.” Care Worker, Domiciliary Care, DC1CA_E2

Some establishments, however, appear to have robust practices to deal with this, for example, usage of telephone networks, the administration office being an ‘open’ office where the carers are encouraged to call in and a network of social events taking place to build team spirit. Such events largely centred around nights out, but there were also instances of day trips and excursions with residents.
Employees feel that team members generally get on well and that work is managed so that team members can influence it. Positive outcomes to teamwork were expressed by most of the employees interviewed. There were some instances of team members not pulling their weight or tensions and conflict but these were generally limited.

Team work thus appears to be a strong and positive element of the working environment within the case study establishments.

**MANAGEMENT AND EMPLOYEE RELATIONS**

As noted throughout this section, employees have a generally very positive view of the employment relationship, for example:

“....they went to [location] and of course they hired a big, big coach and all the residents went out on day trip... and I thought to myself, that’s good, that’s – that is amazing.” *Care Worker, Care Home with Nursing (NH2RL_E3)*

Many expressed the view that there was little that management can do better, although a number referred back to the need for increased staffing levels. Other suggestions (from a relatively small number of employees) include the need to encourage more team work (especially as the establishment increases in size and work is split over floors), the need for better communication and social events and the need to improve facilities for staff, specifically a staff room. Employees in domiciliary care establishments expressed concern about not being able to care for the same clients and wanting more consistency. This was often, however, a deliberate management tactic to maintain flexibility, but was not liked by the employees.

**QUALITY OF CARE**

Almost 90% of employees feel that the quality of care offered in the establishment in which they work is high, and this is so even where they are dissatisfied with the employment relationship. Examples of this were given in terms of innovation:

“Lots of things in pipeline. We’ve got a small working group for dementia studies. [Manager]’s put on training days. We’re going to do dementia care mapping, there’s about six of us in the group. We’re in the process of changing all the corridors, we’re having themed corridors and things like that. A lot of things we are changing are for dementia clients...........for improvement for their cognitive stimulation if you like.” *Care Worker, Care Home with Nursing (NH1RL_E3)*
Some employees indicate that the quality of care is high despite, not because of, management but this is a very small number. Many employees talked about how rewarding it is to get positive feedback on the quality of care provided, which links back to the findings above about the importance of the reputation of the establishment in which they work.

One theme that emerged frequently that impacted on quality of care is inadequate staffing levels:

“Quality of care? There isn't no quality of care because you just can't give them what they need because by the time you've done with it, when you've got to go to the next one, then you've got to go to the next one.” Care Worker, Care Home with Nursing (NH2JG_E2)

Indeed, one employee suggested that inadequate staffing levels which lead to rushing residents can be considered to border on abuse Care Worker, Care Home with Nursing, (NH1CA_E4).

Not surprisingly then, the main suggestion for improving quality of care is to increase staff levels. Improved pay levels was another, less frequent, suggestion on how to improve the quality of care. It should be noted that many employees are so proud of the level of care delivered by their establishment that they suggest that it could not be improved.

MANAGEMENT SUPPORT AND TRAINING

As noted above (Table 1), employees perceive that there is a great deal of encouragement to develop their skills. Nearly all employees had had induction training and rated it as good. Only 13% do not hold an NVQ, or were not working towards one, all the other employees interviewed either holding or working towards NVQ Level 2 or 3. NVQ Level 2 and 3 in Health and Social Care is undertaken by care assistants, but there were examples of other staff also doing NVQs relevant to their roles, e.g. domestics undertaking NVQs in Support Services.

Employees expressed a strong view that training is available and that they value the opportunity to develop their skills:

“Quite a lot. I’ve done the Dementia Course; I’ve just finished that one. I’ve just – and then basically I did the Health and Safety before that. I’ve done – we get fire lectures every year. We get mandatory moving and handling, the health and safeties every three years I think – well I think they’re increasing that. Then there’s the – we’ve just finished Infection Control before the Health and Safety one, and so I’ve put my name down for the Medical Care one”. Care Worker, Care Home with Nursing (NH2RL_E4)

Indeed, one employee suggested that the amount of training available was the best thing about working in one particular establishment (Care Worker, Care only Home, RH1JG_E1). Employees also indicated that it had a motivating effect. All employee training is paid for by the employing establishments, although many
employees did observe that they are not paid for their time while undertaking training. This was not widely considered to be problematic, other than for induction training which could take up a number of days. This was less applicable to achieving NVQs, training for which was largely undertaken on the job, with assessment taking place in the workplace.

Overall, high levels of training and qualifications appear to be undertaken and this seems to be positively received by employees.

**VIEWS ON RECRUITMENT AND RETENTION**

Employees were asked their views on working within the care sector, comparing this to working in other sectors and the possibility of them leaving the sector.

Employees were asked what their job previous to this one had been. Employees had come from a range of jobs, but many had moved jobs within the care sector. There is evidence of employees moving employers to improve their terms and conditions of employment (pay, holidays and holiday pay). The reasons for employees leaving their previous jobs were varied, including: the manager, rates of pay, hours (length of or lack of flexibility in); travelling costs (domiciliary care) and for career progression.

There were a range of reasons expressed for employees having taken their current role. For those moving into the care sector, this was often motivated by a desire to help people. Moving within the care sector, word of mouth (particularly knowing the manager) is very important, as is the reputation locally of the care provided by the establishment. This may contribute to explaining why certain establishments appear to have fewer recruitment difficulties than others. Other contributory factors are rates of pay, availability of work and flexibility/being close to home.

When asked if they would recommend their employing establishment to their friends and family as a place of work, 85% suggest they would. Indeed many had and already have friends and family working in the same establishment. The reasons for this included the nature of the job, the reputation of the establishment and the team within the establishment. Over three quarters of those interviewed are planning to stay in their current establishment, again as a result of the nature of the job and the team atmosphere, but also because of their relationship with residents, the training and flexibility available and career progression offered.

When comparing care work to other sectors (e.g. retail), the comparison often favours care work and again emphasizes the vital role of autonomy:

“I think with this job and the way you’re treated, you’re not herded anywhere, you’re like left to just get on with it, you’re responsible, they give you these clients and you’re responsible whilst you there for them…. out there, you’re the boss…. I just like the job, I love the job, I like doing what I do”. *Care Worker, Domiciliary Care (DC1JG_E1)*
Few expressed an intention to leave their current job. Those who did tended to fall into two groups, one expressing positive reasons for leaving, the other more negative. In the former group, planning to leave was often associated with a desire to progress careers in other types of care work:

“No, as much as I'd love to [stay], I need to motivate and push myself further. I need to go out and get myself a highly qualified skill.... Going to uni and getting a degree, furthering my studies really. I was thinking about doing mental health nursing and I just went and sent my application off. So I am looking forward to that. I’m not saying I wouldn't like to stop here, but it would be good to push myself further”. Care Worker, Care only Home (RH1JG_E1)

This is supported by employees responses as to what their longer term work plans are. While some had given the matter little thought, many expressed a desire to develop their skills, gain qualifications and be promoted to more senior levels. Some also mentioned wanting to obtain a more highly paid role. Throughout the interviews, employees suggested that they valued training and development and expressed an interest in being able to achieve career progression. There are a number of examples of this, moving for example from care worker to senior care worker or floor manager (or similar) and the value of this in terms of retention cannot be overstated. The majority of those interviewed are motivated to stay within the sector and are positive about management, support, the job and development opportunities. When asked what might lead them to leave the sector, a number mentioned that the heavy nature of the work might make it difficult if they experienced health problems.

The more negative reasons for seeking to leave their current job mentioned above include low pay and long hours. Even then, most of those interviewed are planning to move within the sector. The small number expressing an intention to leave the sector have few plans as to what sector they might move to. They suggest they may be encouraged to stay within the sector by higher pay and better management.

Those interviewed returned repeatedly to the notion that the role is a vocation that can only be undertaken by some. As one employee in a residential home stated, care workers need compassion and patience to be able to do the job and:

“I think you have to have a caring background to want to work in this environment as well to want to do this sort of job. I think it’s either there or not there.... it's not a job that you come to for the wages... or the glamour”. Care Worker, Domiciliary Care (DC1CA_E1)

This focus on the role and its vocational nature provides insight into the stability of the workforce within the sector, despite terms and conditions that are equal or inferior to other sectors.
A separate report has been written about the Direct Payment organisations. Overall these organisations reported that there were not significant problems with recruitment and retention of care workers, although many attributed this to the relative higher pay of care workers compared with the other organisations in this study. It also appeared that recruitment was from a different labour market, with many care workers (Personal Assistants (PAs)) being recruited from circles of friends or family, or by deliberate recruitment from the non-care sector as a preference.
CONCLUSIONS

The picture emerging from this stage of the research is of a very positive employment relationship within the social care sector. It would appear, unsurprisingly perhaps, that many Registered Managers consider local authority funding rates to be inadequate and suggest that this constrains the amounts that they are able to pay care workers. While it is undoubtedly the case that hourly rates of pay are often little more than the NMW, findings from both Registered Managers and employees suggest that there are many other factors in play within the care sector that influence recruitment and retention. The key issues are drawn out below and inform the recommendations that follow as to the practices that will support recruitment and retention despite relatively low pay rates.

It is worth noting first that the findings on good management and human resource (HR) practice in the case study establishments do not correlate closely with either CSCI scores or the ‘Good Organisation’ index constructed in the stage 2 statistical analysis of the NMDS-SC. This suggests that there are many factors that lead to ‘good’ establishments and that isolating these is complex. For example, CSCI data is often 12 months out of date and organisational change, for example, change of ownership has a significant impact on staff perceptions of the employment relationship. Nevertheless, those in the sector have high expectations regarding management and HR practice, for example, supervision, appraisal, qualifications and training and this appears to be translated into high levels of satisfaction on the part of employees (see Table 2). This is coupled with robust systems in the sector for measuring and monitoring quality. One significant influence on the employment relationship, however, emerges as change and, specifically, poorly managed change which had a significant detrimental effect in a number of the case study establishments. This is explored further below.

In terms of pay, a clear link to the NMW is in evidence. There are some regional variations, which is to be expected, and a relatively small differential between care workers and senior care workers. Pay scales are generally limited, although some establishments do link pay to the achievement of NVQs. Other elements of pay, for example, unsocial hours’ payments, are limited and there is little evidence of much by way of non-pay financial benefits. This led to some staff working long hours to earn a living wage. Despite this, pay rates did not emerge strongly as a source of dissatisfaction. Care workers’ expectations in terms of pay do not appear to be high and many of the case study establishments are in low wage areas. More importantly, perhaps, the vocational nature of the role emerges as being very strong and seems to overrides even considerable dissatisfaction with pay. Care workers expressed a very strong view that they are proud of their role and want to help others and deliver high quality of care. Another common theme of the role as a vocation is that not everyone can do the job.
The workforce is predominantly female and employed on permanent contracts, there being little evidence of widespread use of volunteers, temporary or agency staff. Most employees work a guaranteed number of hours per work and there is limited insecurity. There also appears to be limited reliance on migrant labour. Few Registered Managers expressed serious concerns about recruitment and retention. There is little evidence of sophisticated mechanisms of recruitment, although some establishments have established links with local education providers, but those reporting fewest concerns relied heavily on word of mouth mechanisms and their reputation locally for providing a high quality of care. Employees also affirmed the importance of local reputation when selecting an establishment to work in. These mechanisms supported some establishments in mitigating the perceived barriers to recruitment of low pay and unsocial hours. Some Registered Managers nevertheless suggested that poor commitment among applicants led to difficulties in recruiting. In general, Registered Managers indicated that they were seeking firstly personal qualities and then experience over qualifications when recruiting.

In terms of retention, there was little evidence of high rates of labour turnover and some Registered Managers suggested that systems for recording labour turnover, especially in small establishments, can make turnover appear disproportionately high. There are a number or areas that managers felt could provide misleading turnover figures. These include:

- promotion of staff to senior care roles within the organisation
- positive reasons for leaving such as going on to nurse training and
- the inclusion of “bank” staff in turnover figures.

An example of the latter was cited by one of the homes which had set up its own bank system, whereby some staff were employed on effectively a casual system. An individual may work for say three weeks on the bank, be terminated and then start again on the bank system and then leave again. For this particular home that one member of staff would have left twice and be counted twice in the turnover figures in the NMDS-SC. It is not known how widespread this scenario is.

Another issue that needs considering is whether there needs to be data captured that would identify whether turnover is confined to a proportion of staff, for example higher turnover for new staff, which then reduces after someone has been in post for say more than a year. Just the small numbers involved in some establishments can be misleading. For example in an organisation with two senior care workers if one leaves then that is a 50% turnover figure. If in this scenario the senior care worker is easily replaced by promotion within the organisation that represents a very different picture than the bold statement that there is a fifty percent turnover of senior care staff.

Turnover can be for positive reasons, such as progressing into nurse training, and is thus to be encouraged. Many establishments actively sought to promote care workers to more senior levels, meaning that senior care worker recruitment was rarely problematic, and both Registered Managers and employees emphasised the importance of such career development to retention.
Flexibility of working patterns was also cited by both Registered Managers and employees as being very important to recruitment, employee satisfaction and motivation and to retention. Establishments were generally successful in delivering such flexibility. Strong evidence is presented as to the extent and impact of development practices such as supervision, training and qualifications on motivation and retention. Problems with retention appeared to be linked more often to relationships with management and staffing levels leading to intensity of work and a reduction in the quality of care provided than. There is little evidence of a significant number of employees leaving care for other sectors.

There is some dissonance between Registered Managers’ views and employee views as to the employment relationship, which is to an extent unavoidable. In many cases, however, there was a high level of agreement that the employment relationship was very good. There were some excellent examples of the importance of good quality of care being a strong driver in establishing and maintaining this. The HR practices outlined above as aiding retention also feed into establishing a good employment relationship, as does good management practice. This was felt by managers to include providing good communication, praise, feedback and social activities, but was rarely related to pay rates. Employees suggest that influence on decision making, variety, responsibility and autonomy in their role and flexibility are important in establishing a good employment relationship. There is widespread agreement that these are provided and that managers are honest and fair and attempt to understand their views. The outcome appears to be a high degree of loyalty to the establishment. Team working is also important and generally good, although there are some examples of isolation in domiciliary care settings. Problems in the employment relationship appear to emerge most frequently where good management practice is absent and where change is badly handled, often through poor communication and imposing change without discussion.

In summary, the employment relationship appears to be very positive in the majority of case study establishments, low pay and staffing establishment issues not withstanding. The contribution of good HR and management practice to this is clear.
A number of recommendations flow from the findings and conclusions presented above.

1. Local authority funding levels constrain pay rates within the sector. The vocational nature of employment in the sector means that low pay per se does not emerge as issue of great significance. The staff shortages caused by funding constraints do, however, lead to perceptions of work intensification and reduced quality of care. A review of funding to address these issues would benefit retention in the sector.

2. The emphasis on vocation and pride in the caring role could be used to build a ‘brand’ of care sector work at a sectoral level.

3. More sophisticated modes of recruitment (linked also to point 2 above) could be used to expand the pool of suitable applicants for vacant roles.

4. Registered Managers need to be aware of the importance of local reputation for quality of care when recruiting.

5. An exploration as to whether more sophisticated mechanisms for measuring labour turnover are required to more accurately reflect retention levels in the sector.

6. Registered Managers should focus on HR practices critical to recruitment and retention. These include supervision, appraisal, flexibility, career progression, training and qualifications. This is especially pertinent if selecting, as Registered Managers suggest they do, employees on the basis of personal qualities rather than qualifications. Relatively unskilled new employees highly value development opportunities offered.

7. Registered Managers should focus on management practices critical to recruitment and retention. These include communication, praise, feedback and social activities.

8. Registered Managers need to be aware of the need to manage change carefully and the detrimental effects of failing to do so.

9. There is a need to consider whether incorporating more perceptual data into the NMDS-SC could help support statistical analysis that will predict successful outcomes for the employment relationship and quality of care.
APPENDIX 1: METHODOLOGY

The sampling frame for the interviews was drawn from the NMDS-SC by Skills for Care for reasons of confidentiality. In July 2008 Skills for Care sent a letter to the Registered Managers of 104 establishments explaining the nature and scope of the research and asking them to give their consent to participate in the project (see Appendix 2). The letter was sent to all regions except for the West and South West (see Table 1), where establishments would be more difficult and time consuming to access for geographical reasons.

The ‘good organisation’ scores, derived from the statistical analysis that formed the second stage of the research, were used to select these establishments. Our main interest was in establishments with the two extreme scores denoting the presence of good HR practices (score = 5) or poor HR practice (score = 1). To achieve sufficient numbers it was also necessary to include care homes with nursing and domiciliary care organisations with codes of 4 and 2. Full details of the scoring system and the difficulties and limitations of the scoring system are found in a separate paper. Skills for Care Rewards and Incentives Research STATISTICAL ANALYSIS: REPORT TWO.

In the event only a small number of managers refused to participate and Skills for Care provided us with a list comprising 93 establishments to contact. Particular regions were allocated to each of the four interviewers. Two interviewers each conducted five interviews; the other two conducted four interviews.

We aimed to interview the Registered Manager and four front line care workers in 18 establishments - six domiciliary care organisations, six care only homes and six care home with nursing. The criterion for selecting suitable establishments was on the basis of their ‘good organisational’ scores; the objective was to target those establishments with scores of either 5 (good HR practices) and 1 (poor HR practices). However, in some regions some establishments on the list did not meet this criterion and necessitated us to include establishments with scores of 4 and 2.

The Registered Manager was contacted by telephone to arrange a convenient date and time for a visit during September or October. In many cases, setting up the interviews took some considerable time; as many as a dozen telephone calls might be required. Managers were often engaged in day-to-day activities that could not be interrupted and were unable to come to the telephone. A few establishments did not appear to exist. Although there were no actual refusals, a number of managers could not commit to a date that was convenient to them and the interviewer within time constraints. In short, an element of pragmatism was required, although the majority of the participants fitted our criterion.

Apart from themselves, the Registered Managers were asked to make four front line care workers available for interview on the basis of the letter sent by Skills for Care (Appendix 2). They were asked, if possible, to select employees with short and long service. In a very few cases fewer than four employees were available to be interviewed at the agreed time; in other cases additional interviews were offered and accepted. In a number of cases the managers saw fit to involve employees other than care workers. In most cases they were more senior staff whose retention had been facilitated by training and career development opportunities and whose experience would contribute valuable evidence to the research objectives (Appendix 3). Nevertheless, whatever job title they had been given, they were all actively engaged in the provision of front line care work. In practice, most of the interviews exceeded the times we had indicated. Some managerial interviews lasted for up to two hours rather than 45 minutes, while some employee interviews ran for 30 minutes rather than 15 minutes. The interviews were tape recorded and transcribed. Template analysis was used to analyse the findings. Closed format data was captured in tabular format and open format data was captured onto a template. These templates have been further summarised as Appendices 4 and 5.
We cannot claim that the findings are representative of establishments operating in the sector as a whole. For example, the fact that we targeted establishments to meet particular criteria meant that they were, to an extent pre-determined. There was also a selection down from the 93 establishments on the list to the 18 finally interviewed to ensure the interviews covered the pre-determined range of service providers. Although interview arrangements were easy to secure in some cases, it was not possible to ascertain why some organisations were unable to respond and organise interviews more quickly than others. However, it did appear that a lot of organisations were affected by chance factors such as the Registered Manager being on holiday or off sick, and our brief required us to interview that person. Nevertheless, we did not get any direct refusals. The establishments that we had selected where we were unable to arrange an interview were small in number. Their inability to comply with our timescale was the main explanatory factor. On this basis we might well claim that it is not a coincidence that managerial sample tells such a positive story.

The second aspect of how far our findings can be representative relates to the employee interviews. We were reliant on the Registered Managers' choice of personnel. Managers did not have advance sight of the questionnaire and none asked to see it. Even so we cannot know how far they selected employees who they thought would give the 'right' sort of responses. Much depended on who was on shift at the time of the visit and it is unlikely that managers knew the staffing roster details when the interview date was agreed. That said, there was no obvious evidence that most employees felt constrained in giving their answers, unless they felt hard done by (see, RH1RL). Managers chose to include employees other than care workers because they felt that they offered an appropriate viewpoint to the research brief that could not be obtained from care workers, such as the experience of extensive training and career development. The inclusion of others such as a domestic and chef added an extra dimension to the findings; the importance of special dietary needs to dementia patients in the case the chef. However, it was clear that managers had not primed the employees about the interviews (this was left to the interviewers) and a number quite openly expected that some of the employees might disagree with their statements. The vast majority of employees' highly positive stories were, to an extent, validated by observations made by the interviews during their visits that indicated a welcoming atmosphere, helpful staff, and a busy, functional establishment.
APPENDIX 2: LETTER TO OBTAIN ESTABLISHMENTS’ CONSENT

The Registered Manager

15 July 2008

Dear Sir/Madam

THE NATIONAL MINIMUM DATA SET FOR SOCIAL CARE: FOLLOW UP RESEARCH

Skills for Care is conducting research among CSCI-registered care homes and domiciliary care agencies which have completed the National Minimum Data Set for Social Care (NMDS-SC) in the last year or so. This research seeks to build on the information we already have by exploring in more detail what helps to attract and keep staff working in social care. We will use the research to produce guidance to employers on best practice and what works, to help minimise staff recruitment and retention difficulties and maximise quality of care.

Manchester Metropolitan University, working with a team of consultants, has been commissioned to conduct this research. Your home/agency has been sampled and the purpose of this letter is to ask if you would be willing to take part.

What would it involve?

It would involve a “case study” consisting of 5 depth interviews: one with the manager responsible for staff recruitment at your agency or care home (which may be you), and 4 with individual s at the home/agency. The interviews will be conducted face to face and preferably on the same day, although other arrangements could be made. The manager interview will ask about how staff are recruited, rewarded, motivated and retained, and should take around 45 minutes. The interviews will each take about 15 minutes and cover attitudes to the work, terms of employment and the way staff feel they are rewarded for their work. To speed up the process, interviews will be tape recorded where possible.

What about confidentiality?

All interviews will be conducted in total confidence, and individual responses will only be seen by the research team. Nothing that could be attributed to or would identify any individual manager or will be passed on to Skills for Care or to anyone else.

What’s in it for us?

The findings from all the case studies will be written up into a guide for employers. In addition a short feedback report on your case study could be produced for you. This will be worded in such a way as to preserve the anonymity of the s who participated, but should provide you with useful feedback. In addition, if you choose, this feedback report could later be published or used in publicity material by Skills for Care.

Next steps

To maintain confidentiality, the sample from the NMDS-SC is being drawn by Skills for Care. If you do NOT wish to participate in this research, please let us know either by letter, by email to nmds@skillsforcare.org.uk or by telephone to 0113 241 1241. If we do not hear from you by Friday 25 July we will pass the name, address and telephone number of your home/agency to Manchester Metropolitan University’s team of consultants. They may then contact you to explain more about the research, and, if you are willing to participate, to arrange a suitable time for the interviews.
If you are contacted by the consultants I very much hope you will take part in this project, which we think will be of benefit both to you and to social care as a whole. If you have any questions or would like further information, please contact my colleagues Christine Eborall on 020 8991 1222 or Sarah Woodrow on 0113 241 1241.

Yours faithfully

Amanda Hatton
Policy Adviser
**APPENDIX 3: DESCRIPTIONS OF CASE STUDY ESTABLISHMENTS**

**Domiciliary care Establishment, North East (DC1JG) CSC1 3* Good organisation score 2**

An excellent organisation, local charity, experienced and motivated, skilled manager. All staff thought the firm was excellent. Some complaints about terms and conditions – common issues in the sector – such as lack of guaranteed hours and lack of payment for travelling. All managerial things were in place and effective – supervision, training and all staff appreciated this. All staff loved the work with clients. Some examples of good practice – person orientated care. Money received from Local Authority reasonable and interesting to see what could be achieved with this sort of money. (e.g. couldn’t afford guaranteed hours and mileage payment).

**Nursing Home and Residential in North East (NH1JG) CSC1 2* Good organisation score 4**

Large chain establishment. Resource centre, had residential, nursing and day services, purpose built. Everything about this home positive, very motivated staff and described good quality care well. All management things in place and well done. Recruitment and retention pretty good. Very stable management team. Figures re turnover distorted as they had a bank system and every time someone left from the bank, they went onto turnover figures. In reality a large core of stability, with a proportionate turnover, some of whom going into nursing or promotion. Fee rates appear to be reasonable.

**Nursing and Residential Home, North East (NH2JG) Nursing CSC1 3* Good organisation score 2**

Large chain taken over from a small chain 6 months previously by a national company with a negative reputation in the area. This negative reputation reinforced by pay cuts, redundancies (e.g. the training providers) and reduction in domestics. Staff say that they weren’t consulted about the changes, just imposed. Staff very positive about the manager, but most stated they were hoping to leave. Lot of sickness since the take over, which a vicious circle as manager not allowed to use agency staff, so more pressure on the existing staff. Fee rates similar to NH1JG.

**Nursing Home, West Midlands (NH3JG) CSC1 2* Good organisation score 2**

One of two in the same area. High proportion of staff recruited from the ethnic minority local community. Senior Management generally well perceived. However confusion as to who the line managers of front line staff are. At moment the manager does all the supervisions, but is struggling with the numbers. Role of nurses vis a vis senior care not clear, some staff regarded nurses as their manager and others senior care. Quite a lot of strong feeling about lack of team work, and people not pulling together to support each other. Some staff expressed concerns about the poor quality of care of some staff, did say that they had reported to managers, but manager struggling to deal with it. Also concerns about basic lack of equipment, e.g. hoists. Manager aware of the problems, but seems to be struggling to deal with them.

**Residential Home, West Midlands (RH1JG) CSC1 3* Good organisation score 5**
A small residential home, owner manager. Everything about the home was positive, all HR things not only in place but well implemented. Turnover managed by close links with College and personal recommendations. Staff leaving to go into nursing.

**Domiciliary care Establishment, Eastern (DC1JC) CSCI 2* Good organisation score 2**

A small, small town Dom care service. Few recruitment and retention issues, other than always trying to expand to meet demand and that was difficult. Employees reported that they are undertaking or have completed NVQs and lots of other training and entirely positive about the management – seen as constructive, supportive, staff consulted and views valued, everyone is equal.

**Residential Home, South East (RH2JC) CSCI 2* Good organisation score 1**

Small residential Home for people with learning disabilities. Small home, recently taken over by a large company, with their own structures, for example centralized training. Staff seem to have adapted well to the take over. Lots of staff stability. Care seen as excellent. Training seen as excellent, achieved NVQ 2,3 and 4 in care in the organisation. All very positive, only concerns (as with the other staff were would like more resources to do more with residents)

**Residential Home, Eastern (RH1JC) CSCI 2* Good organisation score 5**

Small residential home for adults with a learning disability. Owner managed, not part of a chain. Very rural area. Low staff turn over and not difficult to recruit (Although need car to get to work) Wages £6.50 above elderly care sector, but pay concern of s who considered it low. The 3 care staff interviewed were totally committed to care work, despite the low pay. They were all holders of NVQ3 or close to achieving it. They had all heard of Skills for Care. One member of staff more critical – she had recently missed out on promotion, she also working very long hours with a second job as a single parent. Another member of staff (a man who had been a welder) also strongly saying pay must get better.

**Residential/Nursing Home, Eastern (NH1JC) 2* Good organisation score 1**

Residential / Nursing Home. 2*. 30 beds, about to double in size. One of two homes owned by same people. 75% income from private fees. Charge £600 per week, so expensive. Local Authority pay £460, (nursing) so large third party top ups. Rate seen as inadequate. Pay is £5.75 per hour with some enhancements. Have two Polish workers who are seen as very good. Turnover mainly in new staff, who may have unreasonable expectations. Staff fairly, but not very satisfied, lot of concern about expansion plans. Supervision not always happening, some stress with relations between care staff and nursing staff. Poor pay came up very strongly with two staff. This is a home built around a large Georgian house, with a more recent extension. It is slightly shabby but major refurbishment and extension programme is just beginning. Training and qualifications do not seem to be a high priority although both are available.
Domiciliary care Establishment, North West (DC1CA) CSCI 3* Good organisation score 4

A single establishment 3* organisation, covering a large geographical area including urban and rural locations. Acquired by the current owner in the past 3 years and ‘turned around’ by current manager to have good local reputation. Some recruitment difficulties arising from rapid expansion and difficulties in servicing rural locations. Money received from Local Authority was inadequate and less than the LA paid its in-house service, further compounding recruitment issues. Few retention issues. All employees were very positive about the employment relationship and the care provided to clients. All managerial things were in place and effective – supervision, training and all staff appreciated this.

Nursing Home, Yorks and Humberside (NH1CA) CSCI 2* Good organisation score 2

2* establishment, one of a small chain of 4 establishments. Registered Manager had been in place for around 8 months with a remit to ‘turn around’ the establishment. She felt things had improved significantly and that she had tackled some difficult staffing issues while retaining the support of most of the staff. Staff were much less positive about this and tensions between the Registered Manager and staff were evident from employee interviews. Staff felt they provided a good standard of care but the impact of lack of staff on this was raised by all 4 employees interviewed. Registered Manager did not perceive there to be particular recruitment difficulties. High turnover rates arose from the dismissal of certain staff for inappropriate practice when whe took up the position. All managerial things were in place and effective – supervision, training and all staff appreciated this.

Domiciliary care Establishment, North West (DC1CA) CSCI Not yet rated Good organisation score 5

A single establishment previously rated as ‘good’ (no rating on the current system). Registered Manager in place about 18 months and had managed to improve this rating, previously is had not been sufficient to obtain a contract with the Local Authority. Covered a small urban area where both clients and staff were predominantly of an ethnic minority origin. Few recruitment and retention difficulties. Funding is largely through direct payment holder clients and was perceived to be inadequate, especially given travelling costs of care assistants and size of establishment leading to significant financial constraints. All employees were very positive about the employment relationship and the care provided to clients. All managerial things were in place and effective – supervision, training and all staff appreciated this.

Residential Home, North West (RH1CA) CSCI Not yet rated Good organisation score 1

A single establishment which had previously been part of a two establishment group until purchase by current owner 12 months ago. Some of the staff had been retained by the previous owner in the other establishment which makes turnover figures look high, but the Registered Manager felt that retention was not a problem. Similarly she did not feel that recruitment was problematic. The last CSCI inspection took place under a different system and there is no overall score to report. Most employees were very positive about the
employment relationship and the care provided to clients, although there were tensions between care assistants and domestics. All managerial things were in place and effective – supervision, training and all staff appreciated this.

**Nursing Home, East Midlands (NH1RL) CSCI 3* Good organisation score 5**

This welcoming, friendly, vibrant, innovative, imaginative, well equipped and busy nursing home specialising in dementia care is owned and run by a doctor and his family that strive to achieve the highest possible standards in holistic care. The Registered Manager (daughter) is very much a mover and a shaker, as well as active fund raiser. Her highly proactive, ‘people-centred’ leadership style based on extensive training engenders very strong staff support, engagement and commitment from the team. Staff are very well supported through supervision, training and development opportunities. Residents’ needs are placed foremost, with each floor having themed corridors for cognitive stimulation with textured pictures to enable dementia patients to touch and experience everyday things such as a garden. Their special dietary needs are also attended to, such that the addition of an interview with the head Chef proved to be highly instructive. They have an excellent website.

**Nursing Home, East Midlands (NH2RL) CSCI Not yet rated Good organisation score 1**

This nursing home provides a very good example of a welcoming, friendly, vibrant and highly effective organisation from the perspectives of the management, staff and residents. The nursing home benefits from the presence of a fairly long-serving Registered Manager, who tended to stress the importance of the technical aspects of care, mentioning the completion of new, more modern accommodation, but making little reference to the wider social and pastoral features of care mentioned by the staff and cited in the brochure. Nevertheless, she demonstrated a strong HR orientation in terms of supervision and training that was frustrated in the case of access to training by geographical factors.

**Residential Home, East Midlands (RH1RL) CSCI 1* Good organisation score 5**

This residential home is part of a small chain run by a charitable organisation and was the only one to have achieved the lowest CSCI scoring of 1*. The Registered Manager had not long taken over from a very long-serving, perhaps more benevolent, manager and made tacit reference to the fact that this might not be received positively by some staff. Unsurprisingly, a rather more abrasive, matter of fact and direct HR management style clearly had some impact on some the negative perceptions expressed by staff about the way the home is run, patient care and the amount of training available. More worryingly, among such dissatisfactions was an implication of racial discrimination towards two overseas workers. Nevertheless, it was also clear that the some changes in policy direction had come from the charitable organisation that had forced the management to make cost reductions that would necessitate cut-backs.

**Domiciliary care Establishment, East Midlands (DC1RL) CSCI Not yet rated Good organisation score 5**
This domiciliary care organisation, located in a house in a suburban street also serves as a centre where clients can be brought in for meals and other recreational purposes. It is run by a highly focused, enabling, proactive Registered Manager with the able support of an Administrator, with a strong training emphasis; they also engage an external consultancy in HR matters. Off duty carers popping into the office of their own volition were evident on that day; the words ‘we’re like a family’ were used in their interviews. The staff interviewed demonstrated an extraordinary commitment to the care of their clients, which included the Registered Manager’s autistic son. Such commitment, though given willingly, could well mean that they are not being paid for ‘work’ and that the organisation is in breach of minimum wage regulations, although basic rates are well above minimum wage levels.

**Domiciliary care Establishment, East Midlands (DC2RL) CSCI 2* Good organisation score 1**

Very limited contact with the Registered Manager occurred because she was intermittently attending her terminally ill sister and had to leave during the interview, but an Administrator was able to substitute for the bulk of the remaining questions. Nevertheless, the office suggested a very well managed and efficient organisation with a visibly strong commitment to training (evidenced by the number and variety of certificates on the walls), in spite of low pay levels and high reliance on local authority funding. Staff showed a highly positive approach to their work and their clients, valuing the all round support provided by two office-based administrators and the Registered Manager.
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<td>DC2RL_E3</td>
<td>4</td>
<td>Care Assistant</td>
<td>Domiciliary care 2</td>
<td>East Midlands</td>
</tr>
<tr>
<td>DC2RL_E4</td>
<td>5</td>
<td>Administrator/relief carer</td>
<td>Domiciliary care 2</td>
<td>East Midlands</td>
</tr>
</tbody>
</table>
### APPENDIX 5: DATA CAPTURE FROM EMPLOYER INTERVIEWS

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Average</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region</td>
<td>CA&quot;&quot;(NW,Y and H,NW, NW) RL(East Mids) JG(NE,NE,WM,WM,NE) JC(E,E,E,S,E)</td>
<td></td>
<td>Good spread</td>
</tr>
<tr>
<td>Job title (RM = Registered manager, Dep Man = Deputy manager)</td>
<td>CA(RM,RM,RM,RM) RL (RM,RM,RM,RM + Administrator*, RM + Administrator**) (4 owner managers) JG(RM, RM, DepM, RM, RM) JC(RM, RM,RM, RM)</td>
<td></td>
<td>All RM except 1 Deputy (5 owner managers) * Administrator shared HR duties with RM **RM interview cut short (terminally ill relative) but Administrator able to substitute. Responses combined in both cases so that all figures relate to number of establishments interviewed.</td>
</tr>
<tr>
<td>Registration category e.g Nursing Homes, Residential Homes, RH / NH = Dual Registered, DC = Domiciliary care</td>
<td>CA(RH,NH,DC,DC) RL (NH/RH,NH/RH ,RH,DC,DC) JG(NH+RH,NH+RH,RH,NH+RH, DC) JC (NH, DC ,RH(LD) RH(LD)</td>
<td>5 RH 2 NH 5 RH/NH 6 DC</td>
<td></td>
</tr>
<tr>
<td>Status of establishment (Single, chain etc.)</td>
<td>CA(3 single, 1 S group) RL(S,S,S group, S, S) JG(L, L, S group, S) JC (S chain of 2, S, S, L chain)</td>
<td>11 small 4 small group 3 large chain</td>
<td></td>
</tr>
<tr>
<td>Local authorities</td>
<td>CA(Bury, Sheffield, Cumbria, Non) RL(Notts City &amp; County 7 Derbyshire, mainly Lincs Northants CC, Nottinghamshire &amp; Derbyshire, Derby City &amp; Derbyshire CC) JG(Middlesborough, Sunderland, Wolverhampton,</td>
<td>Mix rural and county</td>
<td></td>
</tr>
</tbody>
</table>

11 Names of interviewers CA = Carol Atkinson, RL = Rosemary Lucas. JG = Joe Godden. JC = Judith Croton
Managers were asked what percentage of their income is received from the LA

<table>
<thead>
<tr>
<th>CA</th>
<th>RL</th>
<th>JG</th>
<th>JC</th>
</tr>
</thead>
<tbody>
<tr>
<td>(70, 75, 75, 0)</td>
<td>(30, 75, 40, 50, 80)</td>
<td>(90, 80, K/N, 95, 80)</td>
<td>(25, 90, 100, 95)</td>
</tr>
</tbody>
</table>

Majority around 75% LA Two mainly private payers

1 D C Org had no contract with LA, relying on DP
Complicated because of Continuing Care Health Funding

Managers were asked the % income from private users

<table>
<thead>
<tr>
<th>CA</th>
<th>RL</th>
<th>JG</th>
<th>JC</th>
</tr>
</thead>
<tbody>
<tr>
<td>(30, 25, 25, 0)</td>
<td>(15, 25, 60, 50, 20)</td>
<td>(5, 20, K/N, 5, 20)</td>
<td>(20, 75, 10, 0, 0)</td>
</tr>
</tbody>
</table>

Majority around 25% LA Two mainly private payers.
LD all LA

Managers were asked how many residents were recipients of direct payments

<table>
<thead>
<tr>
<th>CA</th>
<th>RL</th>
<th>JG</th>
<th>JC</th>
</tr>
</thead>
<tbody>
<tr>
<td>(N, N, few, 90%)</td>
<td>(N, N, N, Y, Y)</td>
<td>(N, N, N, N, Y)</td>
<td>(N, Y, N, N)</td>
</tr>
</tbody>
</table>

Very few and then only in DC

Managers were asked for the Local authority rate for care.

<table>
<thead>
<tr>
<th>CA</th>
<th>RL</th>
<th>JG</th>
<th>JC</th>
</tr>
</thead>
<tbody>
<tr>
<td>(£482, £467 (nursing), £12.22–£14, £12.46)</td>
<td>(£370, 398, 345, £16.28, £10.80 and £12)</td>
<td>(£405, £402, £408, £457 (nursing) £10.15 hr, £6.09 _ 30 mins)</td>
<td>(£460, £15.95, £900 – £2,000, £900, £1200)</td>
</tr>
</tbody>
</table>

Considerable variation in fee rates. However the interpretation is complicated. For example some homes ask top ups, others are specialist, e.g. dementia care premium, or LD. The NE appears to pay better for residential and nursing care. DC rates vary from £10.15 to £15.95 per hour

Managers were asked if a “top up” charged

<table>
<thead>
<tr>
<th>CA</th>
<th>RL</th>
<th>JG</th>
<th>JC</th>
</tr>
</thead>
<tbody>
<tr>
<td>(N, N, N/A, N/A)</td>
<td>(Y, Y, N/A, N/A)</td>
<td>(N, N, Y, N, N)</td>
<td>(Y, N/app, N, N)</td>
</tr>
</tbody>
</table>

5 out of 13 ask for a top up, rate varies, 1 = £140 per week (few LA residents)

Managers were asked if they received health funding

<table>
<thead>
<tr>
<th>CA</th>
<th>RL</th>
<th>JG</th>
<th>JC</th>
</tr>
</thead>
<tbody>
<tr>
<td>(N, Y, Some, N)</td>
<td>(Y, Y (partly), N/A, N, N/A)</td>
<td>(Y, Y, N, N)</td>
<td>(Y, N, Y)</td>
</tr>
</tbody>
</table>

Nursing homes obviously receive health funding, wasn’t possible to get accurate figures for Health Continuing Care funding

If they received health funding the rate was asked

<table>
<thead>
<tr>
<th>CA</th>
<th>RL</th>
<th>JG</th>
<th>JC</th>
</tr>
</thead>
<tbody>
<tr>
<td>(£471, Some (&lt; LA rate), N/A)</td>
<td>(£600–1100, £103 per week for RN, N/A, £16.28 per hour, N/A)</td>
<td>(£405+, £402+)</td>
<td>(£493), N/A</td>
</tr>
</tbody>
</table>

The health rate only appeared to be paid in nursing homes. Where it was paid it appeared to vary considerably.
<table>
<thead>
<tr>
<th>CSCI score</th>
<th>JC( £600, N/A, Same as LA)</th>
<th>8 @ 2* 5@ 3* 1@1* 4 not yet rated under the current system</th>
<th>The spread broadly represents the average scores for the sector.</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Good” organisation score</td>
<td>CA(1,2,4,5) RL (5,1,5,5,1) JG (4,2,5,2,2) JC (1,2,5,1)</td>
<td></td>
<td>Appear to be no link to CSCI scores</td>
</tr>
<tr>
<td>Divergence Mg/r employees</td>
<td>CA(N, Y, No, Some) RL(N, N, Some, No, No) JG(N, Y, N,N,N) JC (Y,N,Y,N)</td>
<td></td>
<td>Appears to be no link between CSCI scores or “good org scores” Other factors may have a bigger impact e.g divergence in four situations where recent take over or major changes</td>
</tr>
<tr>
<td>Do you benchmark?</td>
<td>CA(Y, Y, N, N) RL (Own, own, No, own, own*) JG(N,N,N,Y,N) JC ( N,N,N,N)</td>
<td></td>
<td>Not on whole, but informally keep an eye on things like prices * Denotes a range of measures</td>
</tr>
<tr>
<td>TU members</td>
<td>CA(N, Y, Few, N) RL (Y, Y, N, N, N/K) JG (Y, Y, N, N, N) JC (N, N, N, N)</td>
<td></td>
<td>Very few, mainly nurses</td>
</tr>
<tr>
<td>Basic pay care worker</td>
<td>CA(£5.62, £5.52, £6.75,£6.20-£7.00) RL (£5.70, £5.52 + 18p with NVQ, £5.75 +23p, £6.66 &amp; £8.16 (more complex needs), £5.75) JG(£5.57, £5.55, £5.52, £5.52, £5.91 + 20p travel) JC(£5.75, £6.26, £6.50, £6.15)</td>
<td></td>
<td>DC higher as is specialist LD residential No consistent links between pay and good org, CSCI or divergence.</td>
</tr>
<tr>
<td>Basic pay of senior care workers</td>
<td>CA(£5.82,£5.88,£7.00, N/A) RL(£6.00 +25p after training, £9.50 +£7.25, £7.16 &amp; £8.66 (more complex needs),£5.95)</td>
<td></td>
<td>Some nursing homes had senior care and others didn’t, some DC had seniors and others didn’t. DC higher than RC and NC.</td>
</tr>
</tbody>
</table>

12 Staff more + ve than managers
Managers were asked if they had pay scales for staff

<table>
<thead>
<tr>
<th></th>
<th>CA</th>
<th>RL</th>
<th>JG</th>
<th>JC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N,Y,N,Y</td>
<td>Y,Y,Y,N,Y</td>
<td>Y,Y,Y,Y</td>
<td>Y,Y,Y,Y</td>
</tr>
</tbody>
</table>

Generally about 30 to 50 p per hour more

Mainly for achievement of NVQ’s

Variety, complicates the basic pay situation.

Managers were asked if employees could change working patterns

<table>
<thead>
<tr>
<th></th>
<th>CA</th>
<th>RL</th>
<th>JG</th>
<th>JC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Y,Y,Y,Y</td>
<td>Y,Y,Y,N,Y</td>
<td>Y,Y,Y,Y</td>
<td>Y,Y,Y,Y</td>
</tr>
</tbody>
</table>

Nearly all prided themselves as flexible employers, felt it aided retention

Flexibility aids retention

<table>
<thead>
<tr>
<th></th>
<th>CA</th>
<th>RL</th>
<th>JG</th>
<th>JC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Y,Y,Y,Y</td>
<td>D/K,Y,Y, D/K, Y</td>
<td>Y,Y,Y,Y</td>
<td>Y,Y,Y,Y</td>
</tr>
</tbody>
</table>

Number of employees, by size of organisation

<table>
<thead>
<tr>
<th></th>
<th>CA</th>
<th>RL</th>
<th>JG</th>
<th>JC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>28,45,90,18</td>
<td>68,26,72,40,38</td>
<td>75,63,15,30,100</td>
<td>55,39,14,(excludes managers 13, excludes managers)</td>
</tr>
</tbody>
</table>

3 homes less than 16 employers, 2 LD and 1 small RH. Rest range in size 18 to 100

Average no of employers (excluding those with less than 16 = 52 employees

Male %

<table>
<thead>
<tr>
<th></th>
<th>CA</th>
<th>RL</th>
<th>JG</th>
<th>JC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>14,13,0,17</td>
<td>6,19,3,50,10,</td>
<td>0,3,0,0,3</td>
<td>0,0,13,14</td>
</tr>
</tbody>
</table>

Very low, with exception of 1 (Autistic unit)

Nurse pay?
<table>
<thead>
<tr>
<th></th>
<th>CA (86,87,100,83)</th>
<th>RL(94,81,97,50,90)</th>
<th>JG(100,97,100,100,97)</th>
<th>JC(100,100, 86, 87)</th>
<th>Very high</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female %</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volunteers</td>
<td>CA (N,Y,N,N)</td>
<td>RL(Y,Y,Y,Y,N)</td>
<td>JG (N,N,N,N,Y,N)</td>
<td>JC (N, N, N, Y)</td>
<td>Very few</td>
</tr>
<tr>
<td>Care worker numbers</td>
<td>CA(17,19,63,16)</td>
<td>RL(43,16,40,23,33)</td>
<td>JG(40,33,12,27,90)</td>
<td>JC(24,33,8,9)</td>
<td>Average 33 (excluding 3 homes with less than 16 staff)</td>
</tr>
<tr>
<td>Senior care worker numbers</td>
<td>CA(6,4,25,0)</td>
<td>RL (7 RNs, 7 RNs (inc RM),10,7,3)</td>
<td>JG(6,6,3,3,2) (nurses not included)</td>
<td>JC, (0,excludes nurses) 4,4,4</td>
<td>Complicated because some NH had Senior Care and others didn’t and some DC didn’t have SC. LD had higher proportion of SC (and managers)</td>
</tr>
<tr>
<td>Numbers of management staff</td>
<td>CA(5,7,2,2)</td>
<td>RL (13,2,3,3,23)</td>
<td>JG(3,3,2,2,3)</td>
<td>JC (2, 2,1,2)</td>
<td>Nothing of significance</td>
</tr>
<tr>
<td>Numbers of temporary staff</td>
<td>CA (N/A, 0, 0, 0)</td>
<td>RL(0, 0*, 0, 0, 0)</td>
<td>JG(5*, 0, 0*, 0, 0)</td>
<td>JC (0, 0, 0, 0)</td>
<td>* 3 orgs have their own pool</td>
</tr>
<tr>
<td>Number of agency staff</td>
<td>CA (N/A, Y, 0, 0)</td>
<td>RL (0, 0, 0, 0)</td>
<td>JG (0, 0, 0, 0)</td>
<td>JC (0, 0, 0, 2)</td>
<td>Only one org had agency staff</td>
</tr>
<tr>
<td>Number of migrant workers?</td>
<td>CA(0,0,0,0)</td>
<td>RL(0,2,7,0,0)</td>
<td>JG (0,0,0,1,0)</td>
<td>JC (0,2,0,0)</td>
<td>4 orgs had migrant workers, numbers not great except 1 home where 7 out of 72. Most were non-EEA employees with work permits</td>
</tr>
<tr>
<td>Number of care workers with longer than 12 months service</td>
<td>CA (12 (of 17), 90%+, 70%, 14 (of 16)</td>
<td>RL (Most, Most, Most, 11 (of 23), 27 (of 33)</td>
<td>Overall numbers with more than 12 month service were high</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| What is the % turnover of care workers in last 12 months | CA(14,7,20,22) RL(19,13,15,9,21) JG(35,15,33,8,12.5) (Bank system exaggerates figs) JC(25,10,0,23) | Turnover pretty low, slightly higher in DC, some distortion because of use of bank staff in some RH and NH. Also some small figs. E.g. small home with 8 CW with 2 staff leaving = 25%.
Several places commented on stable core of 70 to 80% with turnover taking place in 20 to 30%. Also lots of natural progression included in the figs.
No apparent link between turn over and Good org scores, CSCI or with divergence of views between management and staff. |
<p>| Numbers of senior care workers with longer than 12 months? | CA (All, All, 90%, N/A) RL (All, All, All, All) JG (Most, Most, All, Most, All) JC (N/A, Most, Most, Most) | High numbers with more than 12 months in post |
| What is the %turnover of senior care workers in last 12 months? | CA(0,0,8,N/A) RL(0,0,0,0) JG(16,20,0,0,N/A) JC( N/A, 25,25,25) (turnover of 1 person) | Generally very low, small numbers can distort e.g. in 3 homes 1 SCW leaving is 25% turnover |
| What is the % turnover of managers in last 12 months? | CA (0, 25 (1 person), 0, 0) RL (0, 0, 0, 0, 0) JG (33, 0, 0, 0, 0, 0) JC (0, 0, 0, 50,) | Very low turn over of managers |
| Has the registered manager left in last 12 months? | CA (N, Y, N, N) RL (N, N, N, N, N) JG (N, N, N, N, N) JC (0, 0, 0, 1 RM left) | Very low turn over |
| Numbers who had received Skills for Care induction | CA (Y, Y, Y, Y) RL (Y, Y, N, N, N) JG (Y,Y,Y,Y,Y) JC (Y,Y,Y,Y) | All do induction, most Skills for Care |
| Do you have a mentor system? | CA (Y, Y, Y, Y) | All have mentor system, mainly for new |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>CA (F, F, F, F)</th>
<th>RL (F, F, In, In)</th>
<th>JG (F, F, F, F)</th>
<th>JC (F, F, F, F)</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have a formal mentor / informal system?</td>
<td>(Y, Y, Y, Y, Y)</td>
<td></td>
<td>JG (Y, Y, Y, Y, Y)</td>
<td>JC (Y, Y, Y, Y)</td>
<td>Mostly formal linked to induction</td>
</tr>
<tr>
<td>Does the LA help with training?</td>
<td>(Y, Y, N, N)</td>
<td>(Y, Y, Y, Y, Y)</td>
<td>JG (Y, Y, Y, Y, Y)</td>
<td>JC (Y, Y, Y, Y)</td>
<td>Most help from LA with training</td>
</tr>
<tr>
<td>Do you do appraisals?</td>
<td>(Y, Y, Y, Y)</td>
<td>RL (Y, Y, Y, Y, Y)</td>
<td>JG (Y, Y, Y, Y, Y)</td>
<td>JC (Y, Y, Y, Y)</td>
<td>Universal</td>
</tr>
<tr>
<td>Do staff feel valued?</td>
<td>(Y, Y, D/K, Y)</td>
<td>RL (Yes, Hope so, Hope so, Yes, Sometimes)</td>
<td>JG (Y, Y, Y, Y)</td>
<td>JC (Y, Y, Y, Y)</td>
<td>Mainly positive, one comment re if don’t like it tend not to stay</td>
</tr>
<tr>
<td>Do staff like working here?</td>
<td>(Y, Y (on balance), N/K, Y)</td>
<td>RL (Y, Y, Most, Y, D/K)</td>
<td>JG (Y, Y, Y, Y)</td>
<td>JC (Y, Y, Y, Y)</td>
<td>On the whole yes</td>
</tr>
</tbody>
</table>
## APPENDIX 6: DATA CAPTURE FROM EMPLOYEE INTERVIEWS

<table>
<thead>
<tr>
<th>Question / issue</th>
<th>Aggregate figs</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region</td>
<td>North East = 12, West Mids = 6, East = 10, South = 2, North West = 12, Yorkshire and Humberside = 4, East Midlands = 21</td>
<td>Covered all regions except London and SW</td>
</tr>
<tr>
<td>Categorisation of staff interviewed</td>
<td>Care Assistants = 44, Senior Care = 14, Nurses = 5, Other = 4 Total = 67</td>
<td></td>
</tr>
<tr>
<td>Organisation type that staff worked in</td>
<td>NH\textsuperscript{14}/RH = 31</td>
<td>30 were s working in dual registered nursing /</td>
</tr>
</tbody>
</table>

\textsuperscript{14} NH = Nursing Home, RH = Residential Home, NH/RH = dual registered, DC = Domiciliary care
| RH = 13 | residential care. |
| DC = 23 Total = 67 |
| Numbers of staff employed in various sizes of the organisation. (Large = part of a large company, or chain. Small chain = part of a small chain of companies Small = single company organisation |
| Large = 9 |
| Small chain = 24 |
| Small = 34 |
| Total = 67 |
| Reflects national profile of the industry |
| Local Authority |
| Sunderland, Middlesbrough, Wolverhampton, Norfolk and Suffolk, West Sussex, Cambridgeshire, Bury, Sheffield, Workington |
| Notts city, Notinghamshire, Derbyshire, Lincolnshire, Northhamptonshire |
| Good mixture of urban and county |
| CSCI Score |
| 0 * = 0, |
| 1* = 1, |
| 2* = 36 |
| 3* = 17 |
| Not yet scored = 12 |
| Unusually there were no 0 * and only one 1 *, however 12 not scored at time of interviews. \(^{15}\) Ration of 2 * to 3 * within or slightly above national norms |

\(^{15}\) This was for two reasons: a) not all establishments had yet been allocated a star rating by CSCI as the scoring system had only been introduced in April 2008 and b) if an organisation had changed ownership then a new CSCI score had to be allocated.
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
</table>
| “Good Org score”, where known                                           | 18 = score 1  
15 = score of 2  
8 = score of 4  
20 = score of 5                                                                                                                                 |
|                                                                         | Have range of high score and low score. Do not appear to relate to CSCI scores, or views of staff. Discontent low, but pockets of discontent, three pockets to do with organisational change |
| Divergence between Manager and Employees regarding a range of issues    | No divergence = 49  
Divergence = 18                                                                                                                                                                                          |
|                                                                         | Divergence not high, divergence concentrated in four establishments (14 out of 18)                                                                                                                      |
| Full time, or part time                                                | Full time = 56  
Part time (less than 30 hours) = 10  
Not known = 1                                                                                                                                 |
|                                                                         | Mainly full time,                                                                                                                          |
| No. of hours worked per week                                            | 28 work 40 hours plus per week  
38 work 30 to 40 hours per week  
Only 1 works less than 20                                                                                                                        |
|                                                                         | Hi proportion work 40 hours plus (Some of these stated it was to earn enough money. Shift system – e.g. 12 hours in some homes mean that staff like to be able to work say 3 shifts and then done weeks work.  
Some mention of lack of guaranteed hours in DC, however all seemed to have consistent high number if hours |
| Age profile                                                             | Under 30 = 18  
Age 30 to 39 = 14                                                                                                                            |
<p>|                                                                         | Age profile fairly evenly spread                                                                                                           |</p>
<table>
<thead>
<tr>
<th>Age Range</th>
<th>Count</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 40 to 49</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Age 50 to 59</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Age 60 +</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Not known</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Length in current job</th>
<th>Count</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 years +</td>
<td>29</td>
<td>Good proportion worked in same job for 5 years plus, relatively high proportion worked less than 1 year, however we asked to see a high proportion of people who were new starters, so not surprising</td>
</tr>
<tr>
<td>More than 1, less than 5</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Less than 1 year</td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Length in social care</th>
<th>Count</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 years plus</td>
<td>47</td>
<td>Large majority had significant length of work in social care</td>
</tr>
<tr>
<td>14 = more than one year, less than 5</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>6 = less than 1 year</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employees were asked if they received formal supervision</th>
<th>Count</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>62 = yes</td>
<td>62</td>
<td>Nearly all had formal supervision. Examples where did not occur – two in one home where staff were discontent</td>
</tr>
<tr>
<td>4 = no,</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>1 no data / not clear</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employees were asked if they felt the organisation had a good or poor philosophy of care</th>
<th>Count</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 = good</td>
<td>60</td>
<td>Very high proportion, even where staff not happy many felt happy about the quality of care (several attributed this to the excellent work that they and colleagues did, inspite of the management)</td>
</tr>
<tr>
<td>6 = fair / mixed</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>1 = need more staff</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Scores</td>
<td>Notes</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Interviewees were asked about their induction</td>
<td>1 = non 1= poor 1 = didn’t apply when started 64 = good</td>
<td>Very high rate of “good” induction</td>
</tr>
<tr>
<td>Interviewees were asked about whether they had achieved and NVQ in care, or were working towards one.</td>
<td>Achieved NVQ 3 = 12, Doing NVQ 3 = 3 Have NVQ 2 = 27 Doing NVQ 2 = 10 Not got = 9 (3 from NH1JC) Not applicable = 5</td>
<td>Very high rate of qualifications overall. One home (NH1JC) three staff not doing NVQ who wanted to and this home had a queuing system. Staff in that home not happy. Other homes / DOMICILIARY CARE did not appear to put limits on numbers.</td>
</tr>
<tr>
<td>Interviewees were asked to rate the training and</td>
<td>Good = 60 Fair = 3 (2 from NH1JC) O.K = 3 Poor = 1</td>
<td>Very high proportion, 2 of the “fairs” from the home where lot staff not satisfied and not doing NVQ’s</td>
</tr>
<tr>
<td>Employees were asked if they would recommend their workplace to friends</td>
<td>Recommend to friends yes = 57 Not recommend to friends = 6 Maybe = 3</td>
<td>Very high proportion would recommend their workplace. 4 of the “no’s 2 were from two homes experiencing change</td>
</tr>
<tr>
<td>Question</td>
<td>Response Options</td>
<td>Analysis</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Employees were asked if they were planning to stay in their current job?</td>
<td>Planning to stay = 52  Not sure = 9  No = 2  Did not answer / would not answer = 4</td>
<td>Very high proportion planning to stay. (4% not planning to stay) or if include don’t knows, not sure, did not answer = 66% planning to stay</td>
</tr>
<tr>
<td>Employees were asked if they were planning to leave?</td>
<td>Planning to leave / maybe / don’t know = 16  Planning to stay = 48  Did not know = 2</td>
<td>High proportion planning to stay (66%)</td>
</tr>
<tr>
<td>Employees were asked if they were planning to stay in care work?</td>
<td>Stay in care work = 53 (4 included care in hospitals)  No / don’t know = 14 (includes 6 planning to go into nursing)</td>
<td>75% planning to stay in social care (but includes further 12% planning to go into nursing) and other 13% includes no / don’t know. Overall high commitment to social care</td>
</tr>
</tbody>
</table>
APPENDIX 7: REGISTERED MANAGER QUESTIONNAIRE

Questions for interviews for rewards and incentives research

**Introduction.** Explain the reason for the research –

“There has been a lot of concern about attracting staff to work in social care and then keeping them, especially as demand increases and more people will need care in future. We are trying to get a picture of the “reality” of the situation, the degree of the problem, and how employers are coping and coming up with solutions / things that help”.

We are interviewing managers and front line care workers because they may have different perspectives and research shows that the “reality” as seen by staff is important in developing any solutions.

We will produce a full report of all the research, which will be on the Skills for Care web site and we will let them know when it will be available, there will also be summary reports.

We have been commissioned by Skills for Care to undertake this research to inform Skills for Care and the sector.

There are four parts of the research. Literature research, statistical analysis of CSCI and NMDS data, consultation with Skills for Care regions and this work.

Ideally we would like to interview one manager and 4 care workers: 2 who are newish in post and 2 who have been in the organisation longer. Stress importance of trying to get a cross section of staff – for example it would limit the work if the manager only gave us access to staff who they think would say positive things. It is unlikely that we will be able to interview night staff, however if this is possible then would be good to do so.

**Confidentiality**

All information will be treated in strictest confidence. The only people who will know what interviewers say will be the researchers. The interviewers will collate information from the selected sites and then produce an anonymised report.
If however the manager wants we could provide a synopsis which we would send to the manager for information. We would not identify what individual staff had said, or give any indication of what staff said that could be attributed. The manager could then decide whether they would want the example to appear on publicity, for example the Skills for Care web site. If we were to do that we would need some photos of the organisation and if the photos included service users their permissions. We could also use photos from a photo gallery. (This can not include views of staff).

**Service users**

We are not interviewing service users because that raises ethical issues, which would be too complicated to tackle for this work. We do however recognise that the views of service users and carers are important.

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**Name of interviewer**

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**Section 1 Biographical information**

1. Are there issues on the day of the interview that might affect the interviews? Is today a typical day, or is there something important that might affect the interviews?

2. Name of organisation

3. Address

4. Region
5. Name of manager being interviewed

6. Job title of manager

7. Role of manager

8. Date of interview

Section 2 Details of the firm

1. Check Registration category/ies and whether other services provided – use questions on services and service users from NMDS-SC

(Residential older people, residential with nursing, nursing home, domiciliary care, specialist categories e.g. dementia)

2a) Are you part of a large chain, or small group, or a single establishment?.
2b) What is the name of the chain/group?

3. Which local authorities do you commission with?

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16 N.B. The questions that we ask will be about the single unit that interviewing e.g. staff numbers relate to the unit.
4a) What proportion, approximately of your income is derived from commissions from local authorities?

4b) And what proportion from private service users?

4c) Do you have any direct payment / individual budget holders paying you?

5a) What is the local authority rate?\textsuperscript{17}

5 b) Do you charge a top up (applies only to residential care)? If so how much?

6. How adequate do you feel the local authority rate is/are?

7a) Do you have service users who are funded by health?

\textsuperscript{17} For residential this will be expressed in an amount per week for domiciliary care it will be expressed in rate per hour, e.g. £12 per hour, £7 per half hour etc.
7b) What is / are the health rate? (May not be applicable).

7c) If you receive health funding what is your perception of the health rates?

8. Who is responsible for Human Resources management/personnel management here – including recruitment?

Section 3 Management of the organisation.

1. What is your CSCI score now?

2. Apart from CSCI scores how do you monitor performance and quality? (Keep records, set targets, involve staff, service users, relatives, benchmarking with other organisations?)

3. Do you evaluate the quality of the service to service users in relation “similar local providers”? If so how?

4a) Are any staff members of a trade union?
4b) Does this help or hinder employee management relations?

4c) Does this create any problems?

5. How would you describe management/staff relations?

Section 4 Pay and performance

1a) What is the basic pay of front line care staff? [record as gross hourly rate if possible]

1b) What is the basic pay of first line managers / supervisors e.g. Senior care workers? [record as gross hourly rate if possible]

2. How often is pay reviewed?

3a) How are pay levels set? [prompt re relevance of local economy and wage rates]
3b) What are the criteria for any increase in basic pay?

3c) Do you have pay scales? If so what are they?

4a) Are there any other elements of pay / reward in addition to basic pay? E.g. shift payments, bonuses, etc.?

4b) What are they?

4c) Who gets them?

4d) How are they determined?

5. Are there other non-pay benefits for staff e.g. free uniforms, travel, childcare, pension scheme?

6a) How do you try and enable work life balance e.g. do you try and alter shift patterns, or hours worked to enable people to take account of other commitments?
6b) Can people change their working patterns at short notice?

6c) Can people work different hours in school holidays?

6d) Can people take time off at short notice?

6e) Do you think you are more or less flexible than other employers? If more flexible do you think that this helps with recruitment and retention of staff?

Section 5 Recruitment and retention issues

1a) How many paid employees are there in total?

1b) How many male and how many female employees?

1c) How many volunteers are there and what do they do?

2. How many front line care staff are there?
3. How many senior care staff are there?

4. How many management staff? [Above senior care]

5a) How many temporary staff?

5b) How many agency staff?

6a) How many migrant workers? ¹⁸

6b) If you employ migrant workers which countries do they come from? What jobs are they doing?

¹⁸ ‘Migrant’ workers are generally considered to be in transition between countries for the purposes of employment, and a worker who has been in the UK for more than 5 years is no longer considered to be a migrant.
6c) Is turnover of the migrant workforce higher / lower than the rest of the staff? If so why?

6d) How do you rate the migrant workers compared with the indigenous workforce?

6e) If you employ migrant workers what are your general experiences?

6f) Are you being affected by the new restrictions on migrant worker? – E.g. outside the EU only skilled workers in shortage areas eligible to work in UK? If so how?

7a) How many care staff have been working here for 12 months or more?

7b) How many front line care staff have left in last 12 months?

7c) Do you know why these staff left?
7d) How do you know?

7e) What were the reasons?

8a) How many senior care staff have been working here for 12 months or more?

8b) How many senior care staff have left in last 12 months?

8c) Do you know the reasons for senior staff leaving?

8d) How do you know?

8e) What were the reasons?

9a) How many managers have left in the last 12 months?

9b) Has the Registered Manager left in the last 12 months?
10a) What is the local labour market for care staff like?

10b) If it is difficult? what makes it difficult?

11a) What are the main problems / issues re recruitment of care staff

11b) What are the main problems re recruitment of senior care?

12. For front line care workers, what sources of recruitment do you use? E.g. word of mouth, job centre, advert, direct approach.

13. What are you looking for when recruiting front line care workers? and then ask for importance of:

   a) experience
   b) personal qualities
   c) qualifications
d) What else? etc.

14. Are there any specific things you have done to attract good quality front line care workers?

15. What works well and not so well in trying to attract good quality front line care workers?

16. Are there any specific things you have done to keep the care workers you want to keep?

17. What works well and not so well in trying to keep the staff you want to keep?

Section 6 Employment issues and training

1a) What induction methods do you use for front line care workers?
1b) Do you use the Skills for Care induction training?

2. Do you have a mentoring system for front line staff? (formal or informal)²⁰

3. What training do you provide in house?

4a) Do you use external training for staff, and if so for what training?

4b) Do you get help from the local authority regarding training? For example, funding, or the local authority supplying training?

4c) How useful is the help from the local authority?

5a) Do staff receive formal and informal supervision? (Formal where a manager / supervisor meets with care worker on a regular basis to discuss performance and

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²⁰ From here on for the rest of this section I’d suggest we focus on front line care workers, including senior care workers, only. Otherwise I think it will get very long, because responses to these questions are likely to be different for managers and supervisors.

²ⁱ Maybe help comes from employer partnership, which may be part funded by the local authority. Managers may not know about who funds the partnerships.
5b) Do you find supervision helpful for the staff and if so in what ways?

6a) Do staff get an annual appraisal?

6b) How formal is this?

6c) What is included in this?

7. How do you motivate staff?

8a) How do you communicate and consult with staff? (Meetings, suggestion schemes, informal etc.)

8b) How do you encourage staff to ask questions/provide comments and suggestions on the running of the home / organisation?
8c) How successful do you think that you are at encouraging staff to be as involved as fully as possible and come up with ideas?

8d) Do you think that your staff feel valued?

9. Do you think that your staff like working here?

10a) How do you think your employees feel about working here, compared with other care organisations they have worked at?

10b) How do you think staff feel about working here compared to other non care work in the area?

Thank the manager, stress again the confidentiality.

Any comments the interviewer wants to make about the interview or the establishment?
APPENDIX 8: EMPLOYEE QUESTIONNAIRE

Name of interviewer

Date of interview

Explain regarding confidentiality and that nothing will get back to management. Interviewing staff across the country so we can better understand the issues and problems of working in the care sector.

We will write up the case studies, will not identify regions, names or anything.

Will destroy information when it has been all brought together.

First establish context –

Is this a typical day or has something happened that might affect the interview?

Section 1 Biographical information
Date of interview

1. Name

2. Job title

3. Are you full time / part time? How many hours per week do you normally work?

4. How old are you?

5. How long have been working in this job?

6. How long have been working in social care work?

Section 2 Views on the work

1a) What exactly is your job? (for example if the person – day time care worker, a specialist, or works nights)
1b) What do you most like about your job?

(Try and separate out comments about the organisation – I like the place, management, flexibility, convenience, colleagues, from the nature of the work with service users)

2. What do you least like about your job? (Again try and separate out comments about the nature of the work with service users from working for this organisation).

Section 3 Supervision and relations with management
1. Describe the day to day support that you get from your immediate supervisor (probably senior care worker)?

2. Do you think the support you get from your immediate supervisor is good?\(^\text{21}\)

(1. Agree strongly, 2. agree, 3. neither agree nor disagree, 4. disagree, 5. disagree strongly, 6. don’t know)

Any comment?

3. Do you get formal supervision? Can you describe what form this supervision takes? For example, who is this with, how often, what things are covered?

Any comment?

4. Describe the support your get from the senior manager(s)\(^\text{22}\) For example do you see them / meet with them, do they consult with you?

5. How good are managers at involving you in the decisions regarding day to day work? (e.g. – seeking your views, responding to your suggestions, allowing you to influence final decisions?)

\(^{21}\) This section particularly there needs to be privacy – if impossible to get then they could self complete this section.

\(^{22}\) (For many this would be the registered manager, but go with the interviewees definition of senior manager – and record this.)
5b) How much influence do you feel that you have over day to day decisions about work?

6. How good are managers at keeping you informed about significant changes to work (e.g. changes to the way things are run, changes in staffing, changes to the way you work, changes to shift patterns?)

6b) How much influence do you feel that you have over significant changes?

7. Can managers here be relied upon to keep their promises? (1. Agree strongly, 2. agree, 3. neither agree nor disagree, 4. disagree, 5. disagree strongly, 6. don’t know)

Any comment?

8. Managers here sincerely attempt to understand employees’ views? (1. Agree strongly, 2. agree, 3. neither agree nor disagree, 4. disagree, 5. disagree strongly, 6. don’t know)

Any comment

Any comment

10. Managers understand about employees having responsibilities outside work (1. Agree strongly, 2. agree, 3. neither agree nor disagree, 4. disagree, 5. disagree strongly, 6. don’t know).

Any comment

11. Managers here encourage people to develop their skills? (1. Agree strongly, 2. agree, 3. neither agree nor disagree, 4. disagree, 5. disagree strongly, 6. don’t know).

Any comment


Any comment?

13. To what extent do you agree/disagree that – “I share many of the values of the organisation”, (1.Agree strongly, 2. agree, 3. neither agree
nor disagree, 4. disagree, 5. disagree strongly, 6. don’t know).

Any comment?

14. I feel loyal to the organisation? (1. Agree strongly, 2. Agree, 3. neither agree nor disagree, 4. disagree, 5. disagree strongly, 6. don’t know.)

Any comment?

15. I am proud to tell people who I work for? (1. Agree strongly, 2. agree, 3. neither agree nor disagree, 4. disagree, 5. disagree strongly, 6. don’t know).

Any comment?

16. I am proud to tell people what my job is?

(1. Agree strongly, 2. agree, 3. neither agree nor disagree, 4. disagree, 5. disagree strongly, 6. don’t know).

Any comment?

17. How much responsibility do you feel you are given?
18. Would you like more say in how things are run around here?

19a). How much do you feel part of a team?  

19b) Who is the team?)

19c) How do you get on with others in the team?  

19d) How much influence do you feel you have over work of the team that you work in?

20. What could the management here do better?

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23 (This is to find out if people are in teams – say covering a particular location within a home, or domiciliary care area and work as a team – if such teams do not exist then ignore rest of question 19)
21. How would you describe management and employee relations here?

Section 4 Quality of Care

1. What do you think about the quality of care here?

2. Do you have any suggestions for improving the quality of the care?

3. Do you think that management have got a good / poor philosophy of care towards residents / service users?

4. If the philosophy of care is poor what could be done to change this?

Section 5. Management support and training
1. When you started work here did you get a good / OK / poor induction?

2. How far have you been encouraged to take up training? / qualifications?

3. Do you have an NVQ in Care? Which one (s)

4. Please describe the encouragement that you get to take up training / qualifications

5. Who paid for the qualification?

6. Has the support from your management regarding training and qualifications been good, OK, poor?

Section 6 Views on recruitment and retention?
1. What did you do in the last job?

2. What were your reasons for leaving?

3. Why did you move to this job?

4. Would you recommend to friends to come and work here? Why, or why not?

5. If you are planning to stay here what it is it that encourages you to stay?

6. Are you planning to leave, if so when and why?

7. What are your longer term work plans?
8. Do you intend to stay in care work?

9. If you don’t intend to stay in care work what would encourage you to stay?

10. If you are intending to stay in care work what would make you decide to move out of care work?

Thank the interviewee and reassure re: confidentiality

Interviewer’s comments. (If any)