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Longitudinal Care Study (LoCS)

Interim Report

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December 2010

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Table of Contents

Acknowledgements and Disclaimer	2
Aim of the interim report	5
Introduction	5
Research aims:	6
Research Design.....	6
Milestones so far	8
User and carer involvement:	8
Expert seminar	8
Site selection/access, sampling and ethical approvals:	8
Data collection instruments design	10
Methodology review and data collection tools	10
Staff survey piloting.....	11
Main changes after piloting	12
Recruiting staff for the survey:	12
Recruiting service users and carers.....	12
Fieldwork progress.....	13
Mixed-mode survey data collection	14
Early Findings	15
Expert Seminar.....	15
Literature review and intelligence gathering	17
Demographic profile and workforce intelligence	17
Gender	18
Ethnic composition	18
Age structure	19
Agency workers	19
Migrant workers	20
Recruitment and Retention	21
Motivations	22
Satisfactions and stress among care workers	23
Definitions.....	23
Overall levels	23
Links between stress and satisfaction	24
Factors associated with job satisfaction and stress	24
Factors and interventions reducing stress and increasing job satisfaction.....	25
Impacts of stress and satisfaction levels	25
Population and Care Workforce Characteristics of Selected Sites	27
Interim findings staff survey	29
Interim findings from employers' interviews	31
Recruitment.....	31
Qualities needed to work in the sector.....	31
Impact of regulation	32
Retention	32
Pay.....	32
Next steps.....	33
Discussion	33
Conclusion	35
References.....	36

List of Tables

Table 1 Distribution of care workers who piloted staff survey by job role	11
Table 2 Number of completed interviews and questionnaires in each of the four sites (as at December 2010)	14
Table 3 Selected population, health and economic indicators in the four selected sites	27
Table 4 Key workforce indicators based on analysis of National Minimum Dataset for Social Care, end of June 2010 returns	28
Table 5 Participants in the staff survey by which service user group they ‘mainly’ work with.	29

Longitudinal Care Study (LoCS)

Interim Report

Aim of the interim report

The Longitudinal Care Workforce Study (LoCS) is a longitudinal multi method study of the adult social care workforce in England. The aim of this interim report is to provide information on the progress of this study as well as to summarize some of the emerging findings. Any findings or emerging results presented reflect the early stage of this study and should be contextualized with the available data at this stage.

Introduction

The purpose of this project is to increase understanding of the factors that facilitate or constrain recruitment and retention in the social care workforce in England focussing on adult services in four sites. Since going 'live' in 2006 the National Minimum Data Set for Social Care (NMDS-SC)¹ has been gaining momentum. The NMDS-SC is providing the sector with much needed information on the profile of the adult social care workforce in England (see Eborall et al 2010). While the NMDS-SC has a number of limitations, both in terms of width and depth of coverage, for example, with the over representation of the independent sector and because the returns are provided by employers rather than employees, we are now far better able to investigate several workforce characteristics that previously were only suspected as being such. At the time of designing the current study, the NMDS-SC was still at an early stage, therefore, one of the initial aims was to establish the demographic profile of the adult social care workforce. Currently, some of these gaps in knowledge have started to close through the greater availability and more sophisticated analysis of NMDS-SC data. In 2009, the Social Care Workforce Research Unit (SCWRU) launched the *Social Care Workforce Periodical* (SCWP), a regular online publication presenting in-depth analyses of different aspects of the adult social care workforce using the latest data from the NMDS-SC. So far (December 2010), seven issues have been produced examining vacancy and turnover rates, the personal profile of the workforce, the role of young workers in the sector, the characteristics of the adult day care workforce, the role of third age workers in the sector, job shifting and the dementia care workforce. The analyses presented in SCWP are conducted by researchers at SCWRU and have been peer reviewed unless otherwise stated².

The increased availability of data, and the in-depth analyses emerging, necessitated a shift in part of the focus of the current study from drawing a detailed profile of the

¹ The NMDS-SC is the first attempt to gather standardized workforce information for the social care sector. It is developed, run and supported by Skills for Care and aims to gather a 'minimum' set of information about services and staff across all service user groups and sectors within the social care sector in England. The NMDS-SC was launched in October 2005, and the online version in July 2007; since then there has been a remarkable increase in the number of employers completing the national dataset.

² For further details see <http://www.kcl.ac.uk/schools/sspp/interdisciplinary/scwru/scwperiodical.html>

workforce to addressing gaps in the current knowledge that could not be met by the NMDS-SC. The research, still employing the original design, focuses more on issues related to factors affecting the motives of workers to join the sector or to leave, elements perceived as enhancing their career progression, and intra-work or workplace dynamics among social care staff.

Research aims:

The study aims to answer the following questions:

- What is the employment history and professional and vocational qualifications profile of a sample of social care employees, including social workers and managers?
- What are people's motivations for choosing to work in social care (for the first time and as returners)?
- What are the factors that determine whether workers may decide to remain in or to leave social care work?
- To what extent, if any, are decisions to remain/leave influenced by terms and conditions of employment, working environment, opportunities for professional /career development, and the need or wish to balance work, family and other responsibilities?
- What do employers and employees perceive as the key issues in retaining social care staff and do these perceptions differ?
- Do the above questions have an impact upon the quality of the service as experienced by service users and carers?
- Do the above questions differ by region, sector, service setting, occupational grouping, and over time?

Research Design

The study has adopted a longitudinal design with an aim to achieve a locally representative sample of social care workers in four different parts of England across the statutory, voluntary and private (independent) sectors. Sampling design is multi-staged, starting with four purposefully selected areas, to ensure geographical, population diversity and urban/rural spread.

Interviews are being conducted with managers/employers in the selected providers, including local authority managers, in the four areas and information about the staff survey and other elements of the study has been discussed and circulated. All social care staff in the selected organisations are being asked to complete self-completion questionnaires. These are being distributed by different means: online, through visits by researchers and fieldworkers, by post and in some cases are being distributed by managers in meetings. The most appropriate means of distribution is discussed with managers at the time of the initial interviews. All participants are being asked to consent to be contacted again to complete another questionnaire or take part in another interview 9 to 12 months later, depending on the time of first round completion in each of the sites. More in depth interviews are to be carried out with social care practitioners (direct care workers, for example) and we plan to interview service users and carers, to provide a different perspective on the workforce questions.

Several perspectives from the broader field of employment research have informed the design of the study and will assist in interpretation of findings. Relevant debates about the nature of careers include: the extent to which traditional hierarchical careers are giving way to portfolio or kaleidoscope careers (Arnold & Jackson 1997); expectations of employer provided guidance is giving way to a culture of career self-management (Sturges & Guest 2001) and how fulfilment of work and career plans can be facilitated or constrained by the work setting, the organization in which it is based and national policies (Arthur et al 1989, Bailyn 1989). The project will investigate factors that motivate women to join, leave or rejoin the social care workforce in to the context of theoretical debates about women's reasons for working; in particular the relative influences of structural and cultural constraints (Ginn and Sandell 1997, Crompton and Harris 1998, Davey 2002) and lifestyle preferences (Hakim 1998, 2000). The factors that motivate underrepresented groups in the social care workforce, such as men, to undertake this work will also be examined. Understanding the relative balance for workers of financial necessity and commitment to working in social care is important in contexts where local labour markets may be competing for the same workforce.

In addition, policies for the social care workforce have emphasised the importance of increasing skill levels and the availability of training courses (DH 2009). Understanding social care staff's reasons for taking courses or embarking on training will draw on debates that contrast human capital theory i.e. that individuals obtain educational credentials to improve their labour market chances (Semeijn et al, 2005) with theories that focus on commitment to an occupation and associated commitment to improve practice (Fevre, Rees and Gorard 1999). In investigating satisfaction with working conditions from the perspective of employees and employers, the study is drawing on the growing volume of health services research focusing on links between organisational contexts, staff and client outcomes (e.g. Michie and West 2004).

Milestones so far

The project started late 2008 with a number of activities and milestones achieved so far. These include:

User and carer involvement:

Service users and carers have been involved from the onset of the project, mainly through the Unit's Service User and Carer Advisory Group. The group meets regularly, three to four times a year, and dedicated time has been allowed to discuss this project. The research team presented its plans and data collection instruments to the Group and consulted members about the interview topic guides.

The research design includes a number of interviews with service users and carers in each of the sites. The interview guide and information sheet for service users and carers were discussed with a group of people with learning disabilities since this group was not represented on the Unit Advisory Group at the time. They were all members of a self-advocacy group, which was used to commenting on services and in being involved in developing plans for activities. Two members of the research team facilitated discussions with the group, which were recorded. We have since produced accessible information sheets, which will incorporate images from the Changes Picture Bank, on the basis of this consultation. We have also amended the service user interview guide in line with their suggestions, which gave good insights into the need for simplifying language and focusing on those topics most relevant to people using services.

Expert seminar

In March 2008 we held an expert seminar to introduce the project and explain the aims and methodology to different stakeholders. This provided stakeholders with an opportunity to comment on the study's broad objectives and methods. The seminar was also designed with workshop time to gather views of stakeholders on specific issues related to the study such as:

- Their own perspectives on trends, changing demographics, motivations, career perspectives of social care staff
- Specific study methods (mixed methods with quantitative and qualitative strands)
- Recruitment methods
- Knowledge of data sources
- How the study fits with other pieces of work currently undertaken by other bodies, such as Skills for Care, for example.

Site selection/access, sampling and ethical approvals:

Four areas have been purposefully sampled based on a sampling frame and random selection, on the basis that they:

- Include different types of local authority (unitary, county council, metropolitan and London borough), which is likely to affect local partnerships and overall approach

- Cover different parts of England, to ensure geographical spread and account for different levels of affluence between different areas of England
- Include both urban and rural settings, in order to account for the different labour market issues affecting these settings
- Include authorities with a range of Comprehensive Performance Assessment ratings (both overall and in terms of social care), which will potentially affect social care provision, or be a result of different kinds of social care markets
- Are not participating in major similar research studies, to avoid research overload.

Within each chosen site (cluster) stratified sampling was used to draw a sample of social care providers from the statutory, private and voluntary sectors. Online lists of providers published by councils and the Care Quality Commission were used to produce a sampling frame for each site, subdivided by the registration category. A random sample of independent (private and voluntary) providers was selected, but the local authority was included as one single provider in each area. If a manager/proprietor declined to take part, we replaced the provider with the next in a randomly sorted list. However, as the fieldwork progressed, it emerged that the original sampling frame may not have been adequate, particularly in the use of registration categories as a means of stratifying the sample. It proved difficult to identify a proportionate sample of voluntary providers and we will also be selecting a day centre or day services in each area from other sources, because the sampling frame did not include these providers. This illustrates a disadvantage of choosing a random sample but the advantages are that many of the providers are appropriately small scale and might not have been included in this study if we had relied on contacts with providers who run large-scale services or are well known in localities.

The sampling design reflects the analytical strategy, where one of the aims of the analysis will be to establish different factors related to the study questions and to divide them into ‘employees’ factors’ and ‘employers’ factors’. To be able to distinguish these factors multilevel analysis technique will be used (Moerbeek et al 2001; Maas et al 2004).

Access to each site was by agreement with the local authority in each of the geographical areas. Three of the initial four sites we approached decided not to take part in the study. They cited a variety of reasons, mainly focusing on heavy workload and ongoing inspections. This resulted in a delay to the fieldwork, as new sites had to be identified, agreement gained to take part in the study and research governance approval achieved.

In addition to gaining full research ethics approval from King’s College London, the local authorities concerned required research governance agreement from senior managers. The research team received research governance approval in all four of the selected sites that eventually agreed to take part in the study. It has proved difficult to gather the requisite information about local authority staff in particular in two sites, again owing to pressures on site personnel. This has contributed to further delays in aspects of fieldwork at these sites. At the time of the start of this study the Social Care Research Ethics approval system had not begun. The study is registered, however, on the Social Care Research Register, administered by the Social Care Institute for Excellence (SCIE).

Local sessional researchers have been employed to conduct the fieldwork in each site, to ensure that local perspectives and knowledge of local contexts inform the study. Fieldworkers were inducted by the research team and regular meetings and telephone calls are being held to support them and to discuss any unforeseen matters.

Data collection instruments design

Methodology review and data collection tools

The main aim of the methodology review was to inform the design of the data collection tools. We reviewed international literature in the English language covering topics such as measuring workload, inter-work dynamics and career progression among others. We reviewed recent social care and social work research and aimed to use similar questions when suitable and possible to aid comparisons after the analysis. Job strain among social workers and social care staff, for example, is an increasingly important concern in relationship to employee performance and commitment to the organisation. This is particularly relevant in restructured social care settings. We decided to adopt the Karasek's job content questionnaire (JCQ), which is a well-established tool designed to measure scales assessing psychological demands, decision latitude, social support, physical demands, and job insecurity.

The JCQ is a self-completion instrument designed to measure social and psychological characteristics of jobs. We are using three scales: a, *decision latitude*, b *psychological demands* and c, *social support*- to measure the high-demand/low-control/low support model of job strain development. The demand/control model predicts not only stress-related risk but active-passive behavioural correlates of jobs. These may have direct effect on workforce dynamics in terms of retention/burnout as well as outcomes for service users. Other aspects of work demands are being assessed using the scales of d, *physical demands* and e, *job insecurity*; we are using the recommended length of 49 questions. The job demand-control model identifies two crucial aspects: job demands, the stressors existing in the work environment, and job decision latitude, the extent to which employees have the potential to control their tasks and conduct throughout the working day (Karasek 1979).

Questions related to ethnicity, educational attainment and national identity were adapted from the draft 2011 Census questions. Other questions related to job roles and different types of working have been adopted from Skills for Care studies for comparability.

The staff survey covers eight main sections:

1. Current job in social care
2. Other current paid work
3. Work history in the care sector
4. Training and induction
5. Job content, demand and support
6. Motives/reasons to work in the care sector
7. Job satisfaction
8. Demographic profile

Manager, user and carer interview guides have further been designed and cover similar topics to the staff survey enabling us to explore these issues in more detail from different stakeholder perspectives. Managers' interviews also aim to identify any problems about recruiting and retaining staff in different sectors and in different areas of work, in addition to more general information about the care provider, such as user groups and geographical coverage. These interviews are being conducted face-to-face.

Staff survey piloting

During the last quarter of 2008 the staff survey was piloted while the processes of access and research governance approval were progressing. A total of 28 pilot interviewer administered surveys were undertaken in four different geographical areas; participants held different job roles, had a range of ages, and included 5 men and 23 women. Participants were asked by fieldworkers to complete the survey, or as an interviewer assisted questionnaire, who then spent around 30 minutes discussing their views/interpretations of the questions and seeking suggestions for improvements. All participants were offered £10 vouchers for their time. While this process could not be seen as constituting a full cognitive interview (Willis 2005), this was more valuable in refining the survey than using self completion alone. Tyler and colleagues (2010 advance access) have pointed out that cognitive interviewing is rarely undertaken in surveys of the care workforce because it is wrongly assumed that everyone uses the same terms (for example, retention or turnover) in the same way so it is important to word survey questions as precisely as possible in order to avoid ambiguity.

Table 1 Distribution of social care workers who piloted staff survey by job role

Job role	Number of workers piloted the survey
Care assistant	7
Senior care assistant	3
Support worker	7
Manager	3
Social worker	2
Nurse working in social care	2
Occupational therapist	4
Total	28

In general, most found the questionnaire straightforward and easy to complete, in terms of question wording, answer options, filtering and layout. There were several positive comments about liking questions related to their job and wider satisfaction levels and many approved of such a study being undertaken.

Most respondents were enthusiastic and confident about taking part but a few seemed a little suspicious or nervous. Some were initially intimidated by the apparent length of the questionnaire but, once completed, most said it was not as bad as they first thought. Collectively, many comments were made, and each considered, but most respondents made relatively few.

Main changes after piloting

The survey originally attempted to collect detailed information relating to up to three jobs currently undertaken in the care sector. Many participants from all educational backgrounds were substantially disconcerted by the references to first, second and third job. We therefore decided to focus the questions on current 'main' job in the care sector.

We added more options related to flexible working arrangements, satisfaction, and additional training and qualifications. Following comments, we made specific reference to the 'previous week' when questions related to additional shifts. Other changes related to wording, level of instructions and layout were undertaken. The time necessitated for such changes should not be underestimated by future surveys.

Recruiting staff for the survey:

After gaining access to employers and conducting interviews with managers we requested their help in promoting participation by their staff. Different employers suggested different ways of distributing the survey to their staff, and, as might be expected, they showed different levels of cooperation and enthusiasm in helping with this task. In all settings we distributed flyers and information sheets with local contacts. The survey is being distributed in different forms, including personal visits by fieldworkers to staff meetings who wait for the surveys to be completed and take with them to post back to the Unit; distribution of paper copies by managers following which staff return the survey in pre-stamped envelopes to us, and distributing personal emails with a link to an online survey, or distributing a weblink to the survey via the employer. Each of these methods has some advantages as well as disadvantages and, of course, different groups are opting for different methods. Overall employers' cooperation remains crucial in gaining access and achieving a good response rate.

A sub-sample of 30 staff is currently being selected in each area, for the in-depth aspect of the research, using the following criteria:

- Type of post
- Sector
- Care groups worked with
- Age-group
- Gender
- Family situation
- Ethnicity
- Length of service.

Recruiting service users and carers

Service users and carers are currently being recruited through local authorities, and user controlled and voluntary/community groups. We have asked contacts to select service users and carers with different needs and circumstances and to pass them a letter with information about the study and our contact details. Written consent will then be sought from service users and carers taking part. Special attention will be paid to ensure a diversity of participants in relation to their characteristics and needs.

We aim to interview 10 to 15 service users and carers in each geographical area (with assistance with communication if required).

In January 2010, as noted above, we held a consultation event with a People First group in one of the selected sites about the process of interviewing service users and the proposed guide. Over 20 people with learning and physical disabilities participated. This event complemented our consultation with the Unit User and Carer Advisory Group, which includes many individuals who are particularly used to taking part in and indeed in conducting research and consultations.

Fieldwork progress

Although access was gained in four sites, the progress of fieldwork is different for each site. In one site we were requested to postpone all contact with local authority staff due to workload and ongoing inspections (Site C). We are currently in the process of communicating with this site to start fieldwork, particularly the staff survey. Meanwhile we have selected the required numbers of independent (private and voluntary) sector employers in this site, have completed the managers' interviews and are in the process of recruiting staff working for selected providers. In Site B and D, the local authorities have sought permission from their staff to participate and staff who have 'gate keeping' roles have provided the research team with a list of emails to send personalised email invitations to complete the survey. However, in Site B some members of local authority staff responded to the research team apologising for not taking part in the survey as they had been advised by their managers not to take part. The research team has followed this information up with them and has sent further information as well as assurance and copies of research governance and ethical permissions. In Site A, the local authority decided to send a weblink invitation to its staff on our behalf. The latter method may cause further complications, as the research team will not be able to follow up with the same respondents.

For the staff survey generally, we adopted mixed-mode data collection to facilitate participation among different groups of care workers and to maximise response rates. The reasons for adopting mixed-mode data collection approach for the staff survey and for targeting the use of particular methods with different groups of participants are discussed below.

Almost all interviews with managers/employers have been completed in all sites (except for local authority managers in Site D). We have conducted 7 in depth interviews with staff in one site. We originally intended to ask frontline social care workers to complete a 'diary' of their activities for five days or a week's worth of shifts. However, partly as a result of difficulties and delays in fieldwork, and partly as a result of feedback from the pilot interviews with staff, we shortened this element of the research. We have now incorporated a question into the interview guide for frontline staff asking them to give an account of their last shift. We are asking participants to describe an interaction with a service user and one with a colleague, in addition to a problem or a negative experience and a positive experience, which is in line with the original diary guide. The initial interviews implementing this approach have proved very fruitful, and look likely to provide a valuable perspective on the experience of social care work, which broadly fulfils the initial aim of undertaking this element of the research.

We have started analysing the qualitative interviews, although this work is at an early stage. Members of the research team and one of the sessional interviewers have read five interview transcripts each in order to identify themes. An initial coding frame has been developed from these initial readings, which will be used to code the interviews in full. Before coding begins, we will discuss the coding frame. Initial coding of a small number of interviews will be compared to establish agreement between coders, and further meetings will be held, to aid understanding and attempts to improve reliability, before the bulk of the interview data is coded.

Each of the separate codes will then be read, and a process of further identification of higher level coding and checking of the original coding will be undertaken, in order to identify the core themes and present a unified picture of findings.

Table 2 Number of completed interviews and questionnaires in each of the four sites (as at December 2010)

Participant group	Site A	Site B	Site C	Site D	National sample	Total
Managers' interviews	11	15	17	17		60
<i>Completed/entered staff questionnaires (total)</i>	<i>(35)</i>	<i>(161)</i>	<i>(28)</i>	<i>(209)</i>	<i>(20)</i>	<i>(453)</i>
Self-completion Online	32	136	28	55	20	271
Self-completion Paper	3	25	0	154		182
Staff interviews	0	0	0	7		7

Mixed-mode survey data collection

The social care workforce encompasses a wide range of jobs; from those requiring basic skills to specialist professions. When attempting to recruit participants from such different work, particularly to complete a written questionnaire, a mixed-mode approach has particular value. We have thus targeted different groups in different ways. For professional staff we aimed for an internet based survey with a paper option if requested, presuming that they would access a computer in work time and that they would be confident in its use. For frontline or direct social care workers (care assistants, for example), we employed two strategies, both involving completing a paper version of the same questionnaire. The first strategy involves distributing or posting enough copies to each care home selected in the study with pre-paid return envelopes. We also offered managers and employers the option that a researcher attends at a time when a number of workers are available (before, during or after a staff meeting) and distribute questionnaires and be available to answer questions, so staff can complete the survey on the spot. In all situations we also offered a choice of a weblink or the paper version. Each method has theoretical advantages and disadvantages, including, accessibility, sample representation and missing responses among others. However, combining different modes, targeted to participants, is thought to improve overall response rates and reduce non-response bias in a survey (Ekholm et al 2010). After the completion of the fieldwork we will attempt to verify and evaluate such assumptions as part of the analysis.

Early Findings

Expert Seminar

Four discussion groups were held during the expert seminar in March 2008, these discussions were very valuable in the process of designing the different data collection tools and considering the general approach to data collection. The following is a summary of some of the issues highlighted by participants as important in relation to the current project.

Age on entry to the sector was considered to be important, participants felt that motives to join the sector may vary by age, for instance people taking early retirement who seek care posts may have different motivations. Hussein and Manthorpe (2010) have investigated data related to age at entry to the sector as recorded in NMDS-SC, May 2009 release, showing that from 1983 until the end of 2008, a general trend of increased employment in the sector can be clearly observed for both young and older new workers. During the period 1983-2005, the number of entrants from the older group (26-75) far exceeded the number of young entrants (18-25). However, since 2005 the numbers of new entrants of both age groups have started to decline, with a steeper slope for the older age group (26-75). Numbers of young new workers (18-25) have also declined since 2005, but not as sharply as those related to the older age group. The staff survey collects detailed information on motivations to join the sector and will allow us investigate whether motives vary by age, particularly among the youngest groups of respondents.

Participants in the expert seminar observed variations in the way in which different groups of workers progressed in a career in social care with some personal characteristics associated with such progress. For example, interactions between age and career histories were reported where older workers may prefer to move to different posts rather than seeking qualifications. Family responsibilities and commitments may also play an important part in terms of career development and progress. Data collection tools, survey and interview guides, have been designed to explore these relationships.

Some participants indicated that the changing demographic profile in the care sector may relate to government policies particularly those related to migration. Immigration policies may also create some instability in the workforce for some migrant workers whose UK residency is related to their employment status. Recent evidence from a research project by members of the Unit has since provided evidence that migration policies are linked to changes in the profile of the care workforce, particularly in relation to age and ethnicity (Hussein et al 2010). The same research also suggested that motivations and future plans may be different among different groups of migrants and, indeed, immigration status is a crucial element in these interactions. However, it is important to note the differences between migrant workers. Most non EEA migrant workers either have leave to remain or are on non-labour 'visas' e.g. students, people married to British citizens.

Participants in the seminar emphasised the potential value of the research to explore any differences between job mobility 'within' the care sector and between different sectors. NMDS-SC data provide some information on source of recruitment to current

jobs and will be used to explore variations according to different characteristics. An analysis of source of recruitment among young workers, for example, is provided in Issue 3 of *SCWP*, and indeed some variations were observed according to job roles performed by young workers. One finding is that young workers (18-25) employed in direct care jobs are mainly recruited from within the care sector. On the other hand, young workers working in other social care jobs (predominantly non-care related), are mainly recruited from other sources, or have not been previously employed (Hussein 2010a).

Participants highlighted the importance of understanding the interactions between motivations to join as well as to stay in the care sector and a number of factors, including local and regional characteristics as well as personal and work experience. There is a lack of empirical data on care workers' motivations, with some exceptions related to particular groups. Stevens and colleagues (2010), for example, provide an insight into social work students' motivations while Hussein and colleagues (2010b) have explored migrants' motives to work in the care sector. An important element of this project is to widen the knowledge base about motivations among different groups of care workers.

Participants discussed the age of care workers; noting that in social care work many can be considered 'older people' themselves. Analyses of NMDS-SC, release December 2009, presented in Issue 5 of *SCWP* focus on the contribution of older workers in the care sector. This indicated that workers in the age range 50-75 years constitute nearly two-fifths (39.3 %) of the whole social care workforce. In particular, the contribution of the oldest 'third age' group, 60-75 years, is substantial at nearly an eighth (12.2 %) of all workers (Hussein 2010b). This proportion is higher than that estimated among nurses in England, where the proportion of nurses of ages 50 or more is estimated to be around 30 percent, but similar to that found among health visitors (Drennan and Davis 2008). It is clear from several findings presented in Issue 5 of *SCWP* that the majority of workers aged 60-75 years are continuing previous employment rather than being newly recruited to the sector or to their current employers. Some observations hint at possible downward job mobility but may also be related to the specific profile of workers who retire at age 60 and whether professional workers are more likely to retire at this age. It is also possible that certain job roles, in areas such as management and supervision, may become less feasible within the more flexible work arrangements preferred by older workers (Hussein 2010b).

Participants discussed the impact of different government policies on the recruitment and retention of workers. For example, the previous Labour government's target of having 50 percent of young people in further education may affect the pool of recruits among young people. Hussein and Manthorpe (in press) found that, in comparison to older workers, younger workers in the care sector are less diverse in terms of gender and ethnicity and this highlights the possibility that young men, and young adults from Black and Minority Ethnic (BME) groups, are not often attracted to or encouraged by the sector. This may likely be linked to educational attainments among young adults, particularly women who form the large majority of care workers in England. A recent study shows that, after accounting for socio-economic variables; White British pupils from low socio-economic homes made the least progress over the

course of secondary school; while Asian pupils, particularly girls, have the best results (Strand 2008).

Literature review and intelligence gathering

The research team has compiled a search strategy and used this to conduct a review of the literature.

Demographic profile and workforce intelligence

The social care workforce is estimated to constitute from four to six percent of the total UK workforce, a smaller proportion than that found in other European Union (EU) countries such as Denmark and Sweden, but higher than that found in Spain or Hungary (Ewijk et al 2002, 69). The adult social care workforce is estimated to number 1.6 million people (Eborall et al 2010) exceeding the 1.4 million people employed in the National Health Service (NHS) (Information Centre for Health and Social Care 2010). Social care work spans several occupations, including professional staff such as social workers, care assistants; health professionals and staff employed in both the social care or health sectors (allied health professionals (AHPs), nurses, health care assistants (HCAs); ancillary staff not providing care (cleaners, catering staff, gardeners, etc); managers (at various levels, context and roles); and administration and clerical personnel (Wanless 2006, 124).

Using a combination of different sources of data, including early results from the NMDS-SC; the Information Centre for Health and Social Care's analyses of council social services workforces SSDS001 returns; the NHS Non-medical Workforce Census; the Local Authority Workforce Intelligence Group (LAWIG); the 2006 Adult Social Care Workforce Survey, and; the Commission for Social Care Inspection (CSCI) Self Assessment Survey for Councils, it is estimated that the adult social care workforce in England alone amounts to 1.75 million people (Eborall et al 2010). However, this estimate does not allow for people having more than one social care job, the same person doing different jobs will be multiply counted. In terms of actual individuals, the directly-employed workforce may be closer to 1.61 million (Eborall et al 2010). On the other hand, such estimates exclude people who are recruited and paid for privately by individuals without any support from the local authority. These include those working as self-employed or cash in hand home care workers or as live-in companions providing care, some of whom are anecdotally reported to be migrant workers. There has been very little published empirical research on this group of workers since the since the 1990s (Baldock & Ungerson 1994; Gregson & Lowe 1994; Wilson 1994), so it is difficult to know whether these reports are verifiable (a current Skills for Care study looks set to throw light on the topic of personal assistants and similar workers).

It is estimated that the independent sector (including private and voluntary) employs around 70 percent, Councils employ 16 percent, NHS around four percent and recipients of direct payments employ eight percent of the total social care workforce (Eborall et al 2010).

Gender

The social care workforce is still predominantly female – around 83 percent overall, rising to 85 to 90 percent of those undertaking direct care-providing jobs. Men account for up to a quarter of the workforce in certain areas, notably day care, support roles and management (Eborall and Griffiths 2008). The ratio of 4:1 in favour of women is consistent across the UK (Department of Health Social Services and Public Safety 2006; Scottish Executive 2006; Care Council for Wales Undated). However, men remain over-represented in senior management; accounting for more than 30 percent of this group (Skills for Care 2007a).

Such an imbalance may be due to women seeking part time employment; associated with debates about how this influences both the status and levels of remuneration that social care work attracts (Ungerson, 2000; Eyers & Bryan, 2006; Wanless, 2006). However, explanations for these gender differences are complex and attributable to a number of factors. These include stereotypical ideas about what constitutes so-called ‘women’s work’ (Christie 1998; McLean 2003; Christie 2006), structural influences upon career progression, including the higher proportion of men with professional qualifications, the higher proportions of women working part time and/or who have taken a career break (Davey et al, 2000; Davey 2002) and other less tangible ways in which men may continue to be advantaged in occupations in which women predominate, such as being more likely to affirm the professional nature and quality of their performance at work or being more conscious of the need to ‘stand out’ in the competition (Cross & Bagilhole 2002; Lupton 2006).

Ethnic composition

Social care is an employment sector in which some ethnic groups are over-represented while others are under-represented. Available data, mainly from the NMDS-SC, indicates that overall between 80 percent and 85 percent of the workforce is white, although this proportion varies in different settings; for example, it is higher in domiciliary (home care) than in residential care. The proportion of BME staff further varies in different settings and sectors, ranging from an estimated 25 percent in independent sector care homes with nursing, 15 percent in domiciliary care and nine percent in day care services. In 2009 around 85 percent of all adult social care jobs were being held by white and 15 percent by black and minority ethnic (BME) staff. In local authorities and the NHS, around 80 percent of social workers and 90 percent of occupational therapists are white (Eborall et al 2010). While these findings are based on the NMDS-SC, which mainly reflects the independent sector returns where there is substantial missing information on staff ethnicity (around 30% of employers did not provide information on their staff ethnicity), this suggests that BME people are over represented in social care compared with their proportion in the population as a whole, given that the 2001 census showed that around eight percent of the population was from a BME background. It is also consistent with data from the ONS Longitudinal Survey and the Labour Force survey (Blackwell and Guinea-Martin 2005) showing the ethnic and gender segregation in the UK labour force.

Hussein (2009a), using NMDS-SC, May 2009 release, shows that Black and minority ethnic (BME) employees comprise 17.4 percent of all care workers for whom

employers provided information on ethnicity, this is an over-representation of the proportion among the general working age population. The majority was identified as Black or Black British (8.2%), followed by Asian or Asian British (5.1%) and two to three percent Mixed and Other ethnicity respectively. Significantly more BME employees work in the NHS (29%) followed by the private sector at 19.6 percent. The lowest proportion of BME employees is reported among 'local authority - generic or other' services at 5.3 percent (n.b., data are limited in the NMDS-SC from local authorities). In terms of job roles, White employees are proportionally over represented among managers/supervisors and other job role groups, while Asian employees are considerably over represented among professional workers. Employees identified by their employers as Black or Black British are over represented in direct care and professional jobs. Cautions about this data are advised in light of the limits noted above.

Age structure

Over 60 percent of social care workers are estimated to be aged 35 years and over (Skills for Care 2007a) and, like its counterpart in health, the social care sector is often described as having an 'ageing workforce' (McNair & Flynn 2006). However, Eborall and Griffiths (2008) take a differing view, arguing that, in the case of care workers in the independent sector at least, there is a fairly even age distribution among them.

In terms of job roles and age, analysis of NMDS-SC data, May 2009 shows that direct care workers are significantly younger than other groups of workers in social care with a median age of 41 years, while the oldest group are 'managers/supervisors' at 46 years. It is worth noting that at a first stage of its analysis Skills for Care grouped social workers (median age= 45) as part of the managers/supervisors group, however, this was rectified in later versions of the data. Age also interacted with other employee characteristics such as ethnicity and gender: Asian employees have the lowest median age of 37 years, while White employees have the highest median age of 44 years. Male workers are significantly older than female, with a two-year gap in median age (Hussein 2009a). Using a more recent data set, December 2009, older workers, particularly those age 60-75 were more concentrated in the voluntary sector (Hussein 2010b).

Agency workers

In the literature, agency or temporary working is sometimes viewed as posing risks to users of social care services (Carey 2008). There has been concern that councils across the UK are reliant on agency staff to meet the growing shortages of social workers. In 2006, 'Options for Excellence – Building the Social Care Workforce of the Future' (DH/DfES 2006) set out an ambitious programme to reduce over reliance on temporary agency staff. By 2020 the policy goal was that social care employers would no longer need to rely so heavily on temporary staff to cover tasks that would be normally carried out by a permanent social worker.

In social care, the agency workforce is very diverse, ranging from experienced professionals providing managerial expertise or consultancy at senior levels to part time or one off workers in care homes or domiciliary settings. Kirkpatrick and Hoque

(2006) estimated that approximately half of all agency/temporary workers in English social services are professionally qualified social workers, the majority being employed in higher profile (higher risk) services for children and families with the vast majority based in London. More recently, the Local Authority Workforce Intelligence Group (2007) found that 33.9 percent of agency staff in children's social care were field social workers, but in adult social care, 16.4 percent of agency staff were field social workers.

Cornes and colleagues' (2009) recent survey of social services directors found that the majority saw agency workers as playing an important role in 'keeping the show on the road'. Directors reported that other options for managing staff shortages would need to be exhausted before contacting an agency. Once placed, 'good' agency social workers were thought to be able to get through high volumes of work and could refresh teams by bringing in new skills and insights from other areas. Agency workers themselves pointed to the many advantages that agency working can bring, not only in terms of flexibility but also the opportunities for broadening their practice experiences. This was especially the case for newly qualified social workers who were often using agency work to give them the experience and insight they needed to find a permanent job. They also found that while staff shortages continued to be the main reason for using agency workers, agency social workers were increasingly being brought in to manage specific projects or pieces of work (for example, to tackle a waiting list) rather than just to fill a vacancy or provide cover in an unspecified way.

Migrant workers

There is an increasing body of evidence suggesting that the strong demand for migrant labour workers in the social care sector in the UK has primarily been a way of managing recruitment problems. Analysis of Labour Force Survey data has shown that the proportion of migrant care workers in the social care workforce has risen from around eight percent in 1998 to 18 percent in 2008 (Cangiano et al 2009). Since 2004, citizens from the A8 European Union accession countries have joined the care workforce. This accounts for the growth of migrant workers from these countries to the UK social care sector (Hussein et al 2008; 2010b), although the majority continue to come from countries outside the European Economic Area (EEA).

In a large-scale study of migrant care workers in England, Hussein and colleagues (2010b) found that recently arrived migrant care workers were significantly younger, more likely to have higher qualifications, more likely to be recruited to professional jobs and less likely to hold managerial/supervisory posts than English social care workers. Examining data specifically related to all non-UK qualified social workers who are registered to work in England they observed a trend towards slightly fewer internationally qualified social workers coming to work in England than in previous years. Traditionally, most come from countries with similar social work traditions to the UK's, however, recent changes in training country were also observed.

Recruitment and Retention

It is frequently observed that changing demographics and an ageing population increase the demand on formal social care providers while traditional pools of social care staff are becoming less available (Hussein and Manthorpe 2005). In addition, there is anecdotal evidence that social care employers face competition from call centres and supermarkets (Scottish Executive 2004) at the time when regulatory changes designed to improve the quality of public services were leading to an increased demand for care workers with qualifications such as NVQs (National Vocational Qualifications) (Roche & Rankin, 2004). These factors have contributed to widespread longstanding concerns about recruitment and retention in the social care workforce across the statutory, independent and voluntary sectors and across all parts of the UK, as noted by TOPSS (2003).

Only in the past decade has there been substantial scrutiny of the size of the problem of recruitment and retention. The Commission for Social Care Inspection (CSCI), the body which until recently registered, inspected and reported on adult social care services in England (at the time also responsible for children's services), described this as an area of 'chronic difficulties' (CSCI 2006, p.1) (CSCI was succeeded by the Care Quality Commission in 2009). Many vacancies in social care were becoming 'hard to fill' being generally attributed to the existence of skills gaps (that is, a shortage of suitably qualified candidates), rather than there being an overall shortage of applicants (Learning and Skills Council 2006).

The advent of the NMDS-SC further enabled detailed scoping of the problem. Eborall and Griffiths (2008) used this to estimate that in the independent sector the all-staff vacancy rate in 2006-7 was 3.4 percent, while for care workers it was 4.5 percent. Vacancy rates were at similar levels in the private and the voluntary sectors (3.4%), but higher in domiciliary care (5.5%) compared with 3.3% in care homes and 1.8% in care homes with nursing. Overall, vacancies appear to be higher in care homes and among children's social work teams (Eborall 2005; Local Authority Workforce Intelligence Group 2006). Eborall et al (2010) reported that while social care has relatively high vacancy rates, few vacancies are due to employers being unable to find workers with the relevant skills. 'The 2009 National Employers Skills Survey indicates that 12% of total social care vacancies were due to skills shortages, compared to 16% in all industrial, commercial and public sector activities in England' (Eborall et al 2010, p.8).

Identification of possible solutions to the problems of recruitment and retention emerged over the same period. Over 12 years ago, the Department of Health recognised the need to respond to shortages in the social care workforce and their relationships as set out in the *Modernising Social Services* White Paper (Department of Health 1998). The New Labour government addressed some of these concerns with the introduction of the National Minimum Standards in 2000 (these are likely to be reviewed shortly) which set out the staffing requirements across different types of service setting for the numbers of qualified staff and promoted employees' access to education and training. As one of the strategies to reduce vacancy rates and to encourage new recruits, the Department of Health launched a National Social Care Recruitment Campaign in 2001, and worked with employers to encourage recruitment and retention of social workers

(Department of Health 2004). The New Labour government also sought to improve retention by providing additional funds for training, including increasing the number of places on social work programmes and providing money to employers to enable their staff to undertake National Vocational Qualifications (NVQs) and to receive induction training (Moriarty, 2007). It produced the first adult social care workforce strategy (Department of Health 2009).

Moreover, due to the continuing shortages of social care staff, in 2007 the Department of Health published a series of report and policy documents on recruitment solutions in social care, highlighting the significance of collaboration across statutory and non-statutory sectors and the importance of including new pools of recruits (Department of Health 2007; 2009; 2010). Interestingly, the new pool of recruits appeared to come not in response to these initiatives but from other developments, particularly the free movement of labour as permitted in the European Union and the enlargement of the EU with the accession of the A8 countries. Thus recently, as noted above, social care recruitment agencies reported a growing trend of international migrants, particularly from the A8 EU accession states, seeking employment in the social care sector (Hussein et al 2010a; 2010b). The sustainability of this is uncertain. Migrants from the A8 EU accession states are obliged to register on the Home Office administered Worker Registration Scheme (WRS) if they are employed in the UK for a month or more. Analyses of these records shows that between May 2004 and September 2006, some 14,090 applicants out of a total of 364,240 people were working as care assistants and home carers, making it ninth out of the top 20 occupations in which registered workers are employed (Blanchflower et al 2007, 43). Any new cap on migration is not likely to include this group of workers.

Motivations

In relation to social care work in the UK context, the literature review revealed very little on the motivations of more qualified workers, such as social workers, and virtually nothing on those who are less qualified. However, the wish to help others, or being altruistic, is reported to be one of the main motives for working in or qualifying to work in the care sector (Stevens et al 2010). There have been many debates about the need for a theoretical framework, which conceptualises care work within both 'love and money' aspects and combines, rather than dichotomises, the two elements as motives to work in the care sector (Weicht 2010). The analysis planned for the present study will enable us to identify both 'love', as identified through altruistic motivations for family, and 'money', as indicated by perceiving care work as an easy sector to obtain work, but also other factors related to the care sector.

Motivations to work in the care sector are likely to vary among different groups of workers. Migrant workers form a particular, and significant, group of social care workers, as noted above. Hussein and colleagues (2010a) found that the set of basic motivations to work in social care expressed by migrant workers appear not to be fundamentally different to UK care workers. However, migrant workers often have an additional set of motivations, including an affinity to the country to which they have moved, a desire to take up opportunities for professional development, financial pressures or the wish to learn English. However, EU migrants, who have more freedom to work in other fields, may well have less compelling reasons to continue in the sector. Variations in their home countries' economic conditions, their developing

language skills, and skills acquisition may render them more likely to return to their home countries or to move sectors.

Satisfactions and stress among care workers

Stress and satisfaction for staff have a direct impact on overall service quality and on the retention of good workers, which may affect the quality of service delivery and outcomes (Bond 2000; Hannan et al 2001; Edwards and Burnard 2003). Furthermore, stress is correlated negatively with satisfaction (Carpenter et al 2000; Newbury-Finch and Kamali 2001). Thus it is important to understand the complex web of interacting factors that influence stress and satisfaction (Bond 2000). We aim to present messages from the literature in terms of understanding what is meant by these terms and the causes, impacts and possible ways to promote positive ways of responding to stressful situations, in order to increase staff satisfaction (and thereby improve retention and outcomes for people using services).

Definitions

Stress has been characterised as an emotional and/or physiological response to pressure or stressors of various kinds (Balloch et al 1998; Lloyd et al 2002). Exposure to prolonged levels of high stress can produce 'burnout', a serious condition involving various physical and psychological symptoms: emotional exhaustion, depersonalisation and reduced feelings of personal accomplishment (Lloyd et al 2002; Evans et al 2005).

Cameron and Moss (2002) identify dimensions of satisfaction in terms of promotion prospects; relations with supervisor; job security; the actual work itself; hours of work. All of these dimensions, in addition to a global satisfaction question, make up many of the measures used in satisfaction research. Thus, most of the issues identified may be thought of as extrinsic to the actual work itself and be related more to the particular circumstances of the worker.

Overall levels

A complex set of findings is evident from research over the past ten years. Some studies have produced evidence that satisfaction levels have been high, but are worsening (Cameron and Moss 2002). For example, Coffey et al (2004), report generally lower levels of satisfaction and higher stress levels in social services staff compared with studies undertaken in the 1990s (McLean 1999; Fleming and Taylor 2006). Specifically, Evans et al (2005; 2006) found that mental health social workers scored highly on the General Health Questionnaire (GHQ) measure of emotional exhaustion and had low levels of job satisfaction.

However, other studies (Billings et al 2003; ADSS Cymru 2005; Cameron and Moss 2007) have found that levels of satisfaction among social workers and social care are fairly high compared to other professions, particularly in terms of social care workers' satisfaction with intrinsic aspects of the job. Further, several studies have indicated that motivations to work professionally in this field include job satisfaction (Craik and Naphthine 2001, in respect of Occupational Therapists). Cameron and Moss (2002) point out that stress levels in the general population were rising over the 1990s and

job satisfaction levels in other professions have been falling. Intrinsic satisfaction with the work, particularly the quality of relationships with service users (Cameron and Moss 2002; Ryan et al 2004; Huxley et al 2005), has remained higher than satisfaction with other elements, such as workload (Cameron and Moss 2002).

Links between stress and satisfaction

Unsurprisingly, many studies have found a direct link between levels of stress, measured in different ways and job satisfaction (Carpenter et al 2000; Redfern et al 2002; Gulliver et al 2003; Carpenter et al 2003; Coffey et al 2004; Evans et al 2006). Interestingly, however, a complex relationship between levels of distress and positive relationships with care home residents was found in one study, in which more distressed staff were more likely to have fewer negative and more positive interactions with care home residents (Hannan et al 2001). Redfern et al (2002) also found that highly dissatisfied staff in one nursing home still had high levels of commitment to the work. Furthermore, Fleming and Taylor (2006) reported that while home care workers experienced high levels of stress, they also had high levels of job satisfaction. These authors argued that home care workers had high levels of intrinsic job satisfaction, in the sense that they believed the work was important, despite identifying a range of areas of dissatisfaction.

Factors associated with job satisfaction and stress

Men and staff from Black and Minority Ethnic (BME) groups have been found to be more stressed at work and to have lower levels of job satisfaction (Cameron and Moss 2002; Gulliver et al 2003; Evans et al 2006a). However, there are differences between BME groups; for example, Black African and Black Caribbean workers had lower levels of burnout in one study (Billings et al 2003). Racism from staff and service users has been identified as an extra source of stress for BME workers (Prevatt-Goldstein 2002; Brockmann 2001).

Types of post and task have both been associated with differing levels of stress and job satisfaction in several studies. Frontline social care workers (home care workers or care home staff) have been found to be less stressed and more satisfied than social workers and managers (Balloch et al 1998; Coffey et al 2004). Carnaby and Cambridge (2002) found that performing intimate care tasks was disliked most and produced lower job satisfaction, while Carpenter et al (2000) found that staff working in a long stay hospital derived more satisfaction from direct patient care. However, after the hospital closed and staff moved to working in community based settings, patient/user related activities, such as working with relatives, gave more satisfaction. Balloch et al (1998), reporting on the NISW longitudinal study of social services staff, found that satisfaction was generated by different aspects of work for different kinds of worker. For managers, sharing skills and in having a well functioning team were most important; while social workers were more satisfied by 'helping people' or making progress on a difficult case. Home care and residential workers were more satisfied by keeping people clean and comfortable and from expressions of gratitude from service users.

The ADSS Cymru study of recruitment and retention of social workers in Wales found that a majority of the sample of social workers surveyed (74.1 %) did not feel

that their current pay and benefits package fairly reflected their duties and responsibilities (ADSS Cymru 2005). However, Balloch et al (1998) reported that low pay was only a major source of dissatisfaction at work for home care workers (unsurprisingly): higher paid staff, such as managers, social workers and residential workers, reported being less concerned about pay. Other non-financial rewards, particularly the value of direct work with service users, have been found to be of more importance in overall satisfaction (ADSS Cymru 2005, DH/DfES 2006).

High workloads and lack support have been linked to higher levels of burnout in social care staff (Hannan et al 2001; Billings et al 2003; Coffey et al 2004; Evans et al 2006; Fleming and Taylor 2006). Unsocial and unpredictable working hours have also been identified as a burnout or stress factor for home care workers (Fleming and Taylor, 2006). Violence and conflict at work are sources of stress for social care staff (Balloch et al 1998; Brockmann 2002; Fleming and Taylor 2006). Role ambiguity/clarity, the extent to which where staff are clear about their remit and role conflict and the extent to which staff face mutually incompatible or personally distasteful demands, have been identified as particular sources of stress (Balloch et al 1998; Carpenter et al 2000; Redfern et al 2002; Carpenter et al 2003; Gulliver et al 2003).

Major structural change (such as integration of services) has been linked to reduced role clarity, lower job satisfaction and increased levels of stress (Gulliver et al 2003). However, management and leadership have also been shown to be important factors mediating the impact of change on stress and satisfaction (Carpenter et al 2000; Gulliver et al 2003) and furthermore, the impact of change has been found to be variable (Freeman and Peck 2006) and the importance of different factors, such as role clarity, varies over time (Gulliver et al 2003).

Factors and interventions reducing stress and increasing job satisfaction

Support for social workers and other professionals in the field (e.g. occupational therapists) has been emphasised as a moderating factor in protecting against the negative outcomes of stressors in the workplace (Fletcher and Jones 1993; Carpenter et al 2000; Edwards and Burnard 2003; Ryan et al 2004; Collins 2007). Hannan et al (2001) reported studies that found a link between relevant education and training and increased satisfaction and positive attitudes. Specific training on conflict and abuse management in working with aggression from service users was found to be of particular benefit (Hannan et al 2001).

Alimo-Metcalfe and colleagues (2007) studied the role of leadership capability and style on staff working on wellbeing and attitudes in mental health Crisis Resolution Teams. They found that leadership style and capability positively affected staff attitudes and wellbeing at work. They stress the importance of 'engaging leadership', which involves respect for staff; the ability to unite different groups around a joint vision; and well as supportive delegation (Alimo-Metcalfe et al 2007: 26)

Impacts of stress and satisfaction levels

There has been no certain evidence of a direct link between pay and rewards and recruitment and retention (DH and DfES 2006). However, lower pay is regarded as a

factor in the high turnover of staff in some occupations, and better management and training are unlikely to address all of the issues around pay and rewards identified in the research (DH and DfES 2006, p17).

Key reasons for leaving social care posts are reported to be high workloads (Skills for Care 2007b; ADSS 2004), lack of leadership, supervision, training, and lack of appreciation (ADSS 2004), and poor relations with colleagues or managers (Skills for Care 2007b), all of which have been associated with increased stress levels. There is much evidence that stress and burnout are causes of high staff turnover in human services professions (Edwards and Burnard 2003). Conversely, job satisfaction and intrinsic enjoyment of the work have been associated with reasons for staying in post (Skills for Care 2007b).

The links between stress and satisfaction and turnover of staff and overall outcomes, coupled with the evidence indicating that levels of stress are generally relatively high (despite the mixed evidence about overall satisfaction levels), indicate the importance of developing specific programmes to address these issues. The evidence reviewed here suggests the importance of supporting staff in terms of good leadership, training, developing strong teams and considering levels of pay in working to reduce stress and increase job satisfaction.

Population and Care Workforce Characteristics of Selected Sites

The selected four sites provide a diverse mix of geographical locations, population structure and social care workforce size and profile. Table 3 presents key demographic, health and economic indicators for the four selected sites. Site A is a large and relatively affluent shire county, with an estimated population of around 1.5 million. Nonetheless, unemployment rates and the proportion of benefit claimants are higher than average. The majority of the population of this area (90%) are of White British ethnicity, with a mean age of 39.2 years; however, the mean age of people from BME communities is considerably lower at 26.1 years.

Table 3 Selected population, health and economic indicators in the four sites

Indicators	Site A	Site B	Site C	Site D	All England
Population	1.5 M	0.68 M	0.3 M	0.13M	
% Not White British	10.3%	4.9%	55.1%	3.3%	9.7%
Unemployment rate	6.8%	4.2%	3.9%	5.6%	5.4 %
% Claiming a Key Benefit	16.0%	9.0%	14%	15%	14%
Mean age (years)	39.2	38.5	35.6	43.2	38.6
Median age (years)	39.0	38.0	33.0	44.0	37.0
Life expectancy – Males	77.7	79.3	78.7	78.8	77.9
Life expectancy- Females	80.8	81.6	83.1	82.7	82.1

Site B, a shire county, is less ethnically diverse than average, with BME people forming just under 5 percent (compared to around 8% nationally). Both unemployment rates and the percentage of benefit claimants are lower than the national average. Site C is a very diverse inner city local authority, with a relatively young population but a high population of very elderly people. Site D, a unitary authority, has predominantly White British population. Site D's population average age is considerably higher than the national figure at 43.2 years (compared to 38.6 years).

Table 4 presents key workforce indicators in the four sites as calculated from the NMDS-SC returns by the end of June 2010. The number of social care providers in each site reflects the size of the area and its population, with the largest number of providers in Site A and smallest in Site C. Directly related to this is the size of the workforce itself. Turnover rates are particularly low at Site C at 9 percent, and highest in Site B at 27 percent. Site B also saw a large percentage of staff joining in the previous 12 months at 30 percent; this is compared to only 16 and 17 percent in Sites C and D. Reliance on agency staff is highest in Site A and C, while voluntary sector staff are very evident in Site D.

At 17.6 percent, the employment of temporary staff is considerable in inner city Site C compared to a range of 3 to 6 percent in the other three sites. Similarly vacancy rates are highest in Site C. Over half of the staff in Sites C and D have completed an induction compared to around a quarter in Sites A and B.

Table 4 Key workforce indicators based on analysis of National Minimum Dataset for Social Care, end of June 2010 returns

Key workforce Indicators	Site A	Site B	Site C	Site D
Total number of social care provisions	537	306	60	120
Employees				
Total Number of Staff Employed	12,092	9,997	1,414	2,806
Permanent Staff (%)	93.8%	96.2%	82.5%	96.6%
Temporary Staff (%)	6.2%	3.8%	17.5%	3.4%
Vacancy Rate	4.1%	2.7%	5.0%	1.6%
Employed Staff Starting in the last 12 months	2,817	3,028	226	487
Employed Staff Starting in the last 12 months (%)	23.3%	30.3%	16.0%	17.4%
Employed Staff Leaving in last 12 months	2,995	2,670	131	642
Turnover Rate	24.8%	26.7%	9.3%	22.9%
Total Workers (employees + others)	14,048	11,091	1,562	3,027
Bank or Pool Staff (%)	4.6%	6.3%	4.5%	3.4%
Agency Staff (%)	3.1%	1.4%	2.6%	0.1%
Student Staff (%)	0.1%	0.2%	1.0%	0.2%
Voluntary Staff (%)	0.1%	1.4%	0.4%	3.3%
Other Staff (%)	6.0%	0.6%	1.0%	0.3%
Gender				
Not recorded	8%	9%	20%	7%
Male	17%	18%	18%	18%
Female	73%	74%	63%	75%
Unknown	2%	0%	0%	0%
Ethnicity				
White	64%	47%	22%	77%
Mixed	0%	1%	2%	0%
Asian	3%	3%	18%	3%
Black	2%	7%	19%	0%
Other	1%	1%	4%	2%
Not known	19%	27%	3%	8%
Not recorded	12%	14%	32%	11%
Employment Status				
Full time	35%	27%	36%	44%
Part time	22%	30%	24%	32%
Neither of these	27%	24%	4%	5%
Not recorded	16%	19%	36%	19%
Induction				
% Completed induction	24%	27%	55%	61%

In terms of social care workforce diversity, no variations are observed in relation to gender except for Site C where only 63 percent are reported to be women (note that unknown and not recorded figures are included in the base). Surprisingly, only 22 percent of the workforce in Site C are reported to be of White ethnicity, however, over a third of workers in this site had their ethnicity missing in the NMDS returns.

Interim findings staff survey

The analysis presented in this section based on returns to the study staff survey by the beginning of June 2010 (303 completed questionnaires) The majority (41%) have been completed by direct care workers, followed by 27.7 percent by care managers/supervisors, 17.7 percent by other workers and 14.3 percent by professional staff. Participants currently work with a variety of service users, with almost equal proportions of 46 percent working with older people, people with learning disabilities, people with dementia, and other older people (workers can state that they work with more than service user group). Nearly a quarter, 24 percent, works with ‘carers’ but only 2 percent work with refugees and asylum seekers (see Table 5).

Table 5 Participants in the staff survey by which service user group they ‘mainly’ work with.

Service User group	%	N
Other older people	48.3%	141
People with learning disabilities	46.6%	136
People with dementia/Alzheimer’s disease	43.5%	127
People with physical disabilities	40.1%	117
Older people with other mental health problems or illnesses excluding learning disability	34.2%	100
People with mental health needs	32.5%	95
People with sensory impairments (e.g. sight or hearing)	32.2%	94
Carers	23.6%	69
People who misuse alcohol or drugs	16.8%	49
Young adults (16-25)	10.6%	31
Other (please specify)	6.5%	19
Asylum seekers/refugees	1.7%	5
Total questionnaires returned*	100%	303

*Numbers do not sum to the total, as many people were working with more than one group

Nearly half of respondents work in care homes (including care homes with nursing), followed by a third who carry out most of their work in service users’ homes and 30 percent who are office based. Over half, 55 percent, are employed by a local authority, 30 percent by private or for profit companies and 13 percent by voluntary/not for profit organisations. The high proportion of respondents employed in local authority services is probably an artefact of the sampling strategy whereby local authorities circulated details of the survey to all staff while workers in the private sector have to be recruited sequentially, employer by employer. Overall, 85 percent of respondents work full time and 72 percent did extra hours during the month prior to the survey. Out of those who worked extra hours, 30 percent, did so unpaid in their own time. A small proportion, 8 percent, holds an additional paid job to their main job in social care. Such additional jobs appear to be within the care sector as well. The reported reason for having an extra job, not surprisingly, is the need for additional income.

Slightly more participants have family/friends also working in social care than not (55% vs. 45%). This supports anecdotal evidence from within the sector that people are more likely to be attracted to social care through personal contacts than from advertising or advice from careers' services or job advisors. Only 15 percent were not in paid employment prior to their current job in social care. Just under half (48%) of those who were in full or part time work prior to their current job were working in social care, while 35 percent were working in jobs not related to social care. The latter indicates a possible high degree of inter-sectoral mobility, but also the possible attraction of social care work to those outside the sector. These will be investigated further for different job roles when the full data at Time 1 are collected.

The vast majority of respondents (92%) had received some form of induction when they began their current job. Of these, 59 percent felt that their induction fully met their initial training needs while 38 percent felt that such needs were partially met and only 3 percent indicated that their induction did not meet their initial training needs at all. When asked about training needs, participants highlighted some areas where they thought they needed further training. At the top of the list were welfare benefits/rights, mental capacity issues, dementia awareness and communication skills, where a third or more of participants felt a need for further training.

In terms of motivations to work in the care sector, the majority (71%) identified altruistic motives, namely helping people to improve the quality of their own lives. However, good career prospects, high job satisfaction, interesting and stimulating work were also identified by a considerable number of participants but not as their first motivation. Among those who participated in the survey so far, nearly 80 percent, reported that they are either satisfied or very satisfied with their current jobs. Moreover, 77 percent said that they would 'definitely' or 'probably' advise a friend to work in social care.

Interim findings from employers' interviews

Earlier work (Eborall and Griffiths 2008) emphasised the diversity of social care employers, ranging from small family run businesses to major national and multinational companies and this diversity is reflected among the employers interviewed in this study. Initial analyses suggest that there are some common themes that cut across all the employer interviewees, such as the status and motivations of those who choose to work in the sector or the impact of regulation, while others, such as recruitment and retention, levels of pay and access to training tend to be more variable.

Recruitment

A key theme from the employers' interviews has been the existence of a skills gap, which means that, while they may receive a substantial number of applications for a post, the number of people who are appointable is much lower. Many of the employers interviewed reported increases in the number of people seeking work in the sector, partly as a result of the recession and partly as a result of initiatives to help people who are long term unemployed, but they pointed out that very few of these were people whom they thought were suitable for work in the sector. However, lack of experience was not in itself a barrier to employment provided the applicant was thought to possess the right attitudes and personal qualities.

Employers used a range of methods to advertise their posts. As well as conventional ways of advertising vacancies, such as the local job centre or advertisements in the local newspaper, they found that word of mouth was an important way of attracting people to work in their organisation. This seems to resonate with findings from the survey with high numbers of respondents reporting that they had family members or friends working in social care. The internet was increasingly used as a way to advertise posts. Some employers gave examples of imaginative steps they had taken to recruit people such as putting cards in local schools and nurseries to attract parents.

Qualities needed to work in the sector

A strong theme among employers was the need to attract staff with the right combination of 'soft skills' such as motivation, commitment, and flexibility alongside formal qualifications and experience in the sector. Phrases such as having it 'in you' to care or 'vocation' were not unusual. These qualities were not seen as incompatible with supporting service users' independence but essential to it. At the same time, there was an increasing need for staff to be flexible in terms of what tasks they did or the hours they worked. For example, a manager of small home for people with a learning disability pointed out that employees might need to be prepared to work from 6pm-12am rather than the usual 3-10pm shift so as to accompany a resident who wanted to go out. This is consistent with the new vision for adult social care which envisages workers taking on new, creative, and person-centred roles in order to provide tailored support to individuals (Department of Health, 2009; 2010).

Impact of regulation

The impact of regulation was a dominant theme. This could be seen in terms of the impact of the *Common Induction Standards* on the development of induction programmes for new staff, the effects of the *National Minimum Standards* on the number of staff with NVQ Level 2 or 3 qualifications and the operation of Criminal Record Bureau and vetting and barring checks. On the whole, changes to induction and opportunities to acquire NVQ qualifications were viewed positively and employers commented that expectations about training were now higher among both employers and employees. While everyone accepted the necessity for CRB and vetting and barring checks, experiences were more variable. There was an acknowledgement that the speed at which CRB checks were completed had improved but some employers were concerned that they might lose workers to other sectors if applicants needed to start paid employment immediately. Other employers asked potential applicants to pay the fee themselves. However, the area of regulation that caused employers most concern was their responsibility to prevent illegal working by immigrants who do not have permission to work in the UK. Some employers were worried that they did not have the skills to identify where people had assumed a false identity or where applicants were using forged documents and passports.

Retention

Retention in social care is often seen to be problematic, as noted above, and one of the most striking findings from the employer interviews was the variation in retention rates reported by employers: one employer who had been in post for eight years reported that quite a number of her staff had been there longer than she had. By contrast, others had experienced far greater difficulties. Many employers who were interviewed saw their role as creating a supportive environment and phrases such as ‘family’ or ‘team’ were used frequently.

Pay

Unsurprisingly, levels of pay were an important theme. On the whole, employers’ views about the levels of pay they offered depended both upon the type of service they provided and their source of funding. Where older people made up the majority of people using the service, reported pay levels were generally lower in organisations reliant upon block contracts from the local authority. This may also affect the sustainability of the business. On the whole, those employers who reported that retention was good in their organisation identified higher rates of pay as one, but not the only, reason for their success. By contrast, where care workers were paid at levels around the minimum wage, then retention levels tended to be poorer and it was harder to attract workers. There was evidence that some employers were trying to link pay and performance. In some instances, staff who achieved NVQ qualifications were awarded pay rises. One employer had tried to reduce unjustified sickness and absence by linking pay to attendance. Another rewarded exceptional performance by taking the worker out to lunch and giving him or her a voucher.

Next steps

During the next six months we will be working on a number of elements of this study:

1. Qualitative data analysis of round one of managers' interviews. A coding frame has been developed for this and interview transcripts have been entered into N-Vivo and coding will commence shortly after this report goes to press (December 2010)
2. For the purpose of the staff survey we aim to access local authority staff in two sites, we are currently in the process of this
3. Start users' interviews in four sites. Interview guides have been developed and access is being negotiated
4. Staff in-depth interviews in four sites will continue
5. Preparations will be made for the second round of managers' interviews in two sites
6. Once the first round of the staff survey is completed, in the first quarter of 2011, further quantitative analysis will be undertaken.

Discussion

The research is a relatively early stage in terms of data collected, although a great deal of detailed preparation work has been completed. A number of interesting and suggestive findings have emerged, even at this early stage.

In terms of recruitment, there was a suggestion from the early findings of the survey that social care attracts a relatively high proportion of employees from other sectors or from people who were not previously in paid employment. Research on migrant care workers (Hussein et al 2010) indicated that many migrant care workers chose social care work because of the relative ease of finding work in this sector, because of the availability of jobs and the fact that it is possible to start work with few qualifications. This fits too with the theme emerging from the manager interviews relating to a skills gap. However, there was also a common view that personal qualities were more important than qualifications and to a lesser extent skills. Managers tended to be confident that they could train people up if they had the right sort of personal qualities; such a perception chimes well with evidence about the preferences of people employing their own care workers (Flynn 2005). These two themes of a skills gap but also a preference by employers to teach 'on the job' may be in tension, and further analysis will explore this in more detail.

The finding from the managers' interviews of increases in the numbers of people seeking work in the sector may reflect the impact of the recession and higher levels of unemployment. Clearly in times of high unemployment, there are usually more people interested in applying for work, although the impact on the availability of people with

the right kind of skills is less clear. This is a topic that the second round of interviews will explore in more depth.

Word of mouth recruitment is seen by managers as at least as important as advertising, which supports the survey finding that a high proportion of people have family members or friends working in the sector, thus making it likely that they heard about jobs through word of mouth. Again this reflects the experiences of migrant care workers, who also often heard of jobs through friends and family, either before or after coming to the UK (Hussein et al 2010b). This may be connected to the perception of care work as being easy to get into. It is interesting that while care work is typified by high levels of stress and mixed levels of satisfaction, people seem likely to recommend that family and friends work in the sector. Further analysis both of the survey and interviews may throw some light on this apparent inconsistency.

Motivations to work in social care appear to be a mix of altruistic, and more self oriented concerns about career prospects and having work that is interesting and stimulating, although altruistic motivations dominated. This kind of mix was very similar to that found in social work students by the Evaluation of the Social Work Degree team (Stevens et al 2010) and that of migrant care workers (Hussein et al 2010a). This also suggests a commonality in the motivations to work in social work and social care more widely. More in depth analysis of the survey and interviews with social care staff will enable an exploration between motivation, experience and future plans.

This particular mix of motivation to work in this sector has implications for employers wishing to enhance retention. Focusing on and acknowledging the positive direct caring elements of the work may feed the dominant motivation to work in the sector, which provides intrinsic satisfaction (Cameron and Moss 2002). This may also have a positive some impact on stress and burnout in the sector (McLean 1999; Fleming and Taylor 2006), which there is some evidence to suggest is inversely related to satisfaction. However, of similar importance might be the more difficult element of managing workload, which is a major source of stress (Hannan et al 2001; Billings et al 2003; Coffey et al 2004; Evans et al 2006; Fleming and Taylor 2006) Whilst good support can limit the impact of workload problems to an extent, they are still a major factor contributing to stress and burnout. This may well become more difficult as public spending cuts are implemented, which may have a knock on effect on all providers as local authorities' budgets reduce and therefore the resources they can expend on social care are restricted. This, in turn, may be likely to increase workloads and stress levels.

The most common areas of training need identified by participants were welfare benefits/rights, mental capacity issues, dementia awareness and communication skills, where a third or more of participants felt a need for further training. Demand for these kinds of skills and knowledge is likely to increase over time, both because of the demographic changes but also because of the skills gaps in the pool of new recruits identified above. However, again because of pressure on finances, funding these subjects may become difficult.

Conclusion

This reported has presented a flavour of the kinds of findings that the research will produce in the coming months and the final report. A more comprehensive interim report will be produced when the first round of data collection is complete, from which more definite conclusions may be drawn. This will represent a snapshot of recruitment and retention issues, and the motivation, experiences and career intentions of social care workers.

The findings that have already emerged chime well with other research, whilst showing how this study will add to the evidence in this field. For example, while the motivations reported are similar in mix to previous studies, the link between social work and social care motivations is less commonly addressed. We have already begun to see findings emerging in answer to several of the research questions, particularly in relation to the employment history and profile of social care workers and motivations and employers' perceptions of key issues in retaining social care staff. Clearer and stronger findings will be reported after the first round of data collection and analyses have been completed. This report has pointed to likely areas of further exploration for that stage and for the second round.

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