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Professionalisation at work in adult social care
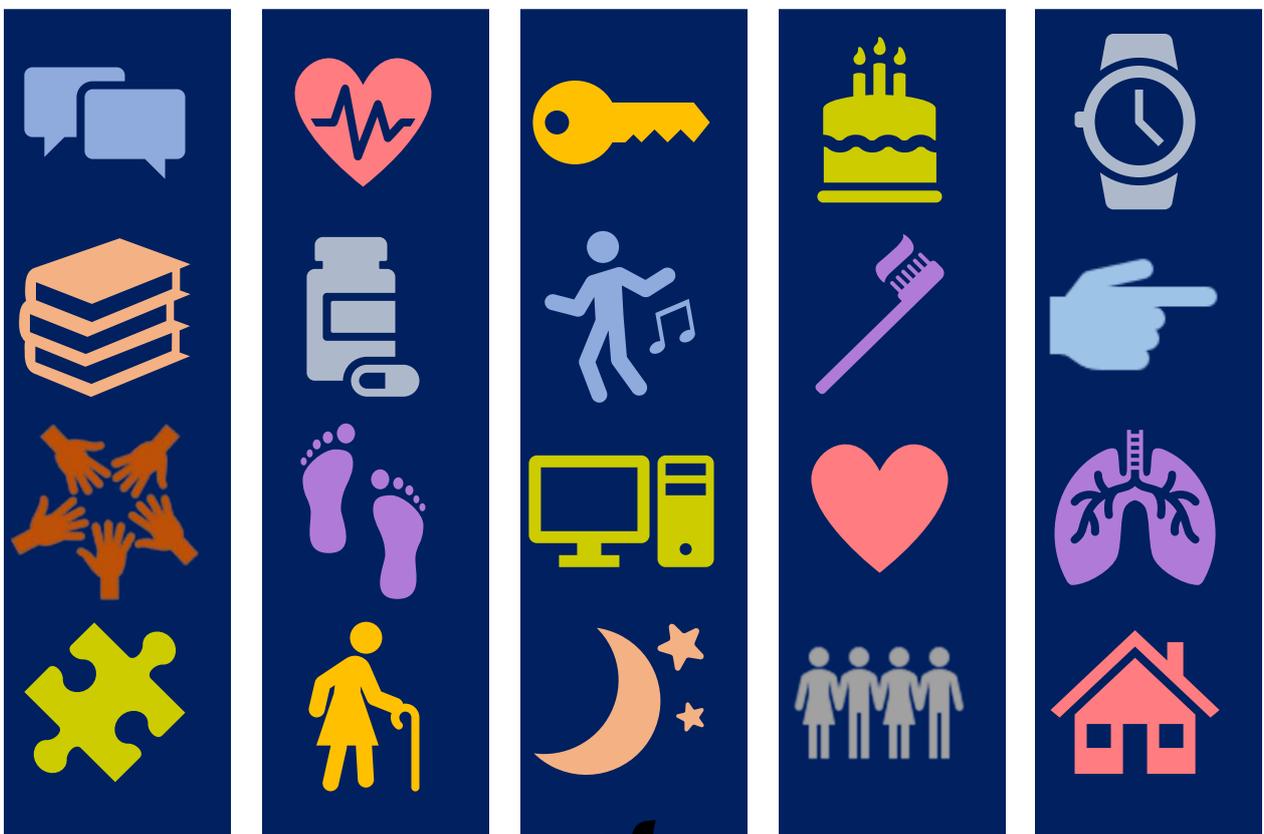
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Report to the All-Party Parliamentary Group on Adult Social Care, July 2019

Contents

Introduction

This report provides a picture of professionalisation in adult social care across the four nations of the UK. It considers policy initiatives, current skill and knowledge requirements, workforce registration, induction, training and the legal regulation of workforce standards. Our focus is the hands-on care workforce.[1] This is the largest constituency of workers in the UK adult social care sector, the overwhelming majority of whom are women and are employed to provide care in care homes or the private homes of older and disabled people. We also include in this category personal assistants (PAs), i.e. workers who are engaged directly by the people for whom they care and support (or by their family members). The hands-on care workforce is very important for the quality of life of hundreds of thousands of vulnerable adults in the UK and is very important to the future of the NHS too.

What does it mean to be part of a profession?

Many people would regard a 'professional' as having individual decision-making responsibility, as being trusted to exercise personal judgement and supported with regular training to keep their skills and knowledge up-to-date. It would be understandable if the idea of working in a 'profession' gave rise to expectations of good rates of pay, social esteem, recognition of technical know-how, ethical behaviour, job prospects and standardised practice.

At the current time, social care workers do not enjoy terms and conditions of work that are suggestive of their professionalism. They are not recruited or trained as professionals, and are not, on the whole, respected as professionals. In addition, the objective of professionalisation is controversial. There is evidence of care workers being keen to acquire formal accreditation and to be recognised as skilled professionals. Yet there

is also evidence of a significant proportion of the existing workforce being unwilling to engage with formalised accreditation, concern that the term 'professionalisation' is inappropriate, and fears of workers quitting their jobs if they feel pressured to gain qualifications. In a sector with serious recruitment and staff shortage problems, this is a genuine cause for concern.

Furthermore, the objective of professionalisation is not a panacea for concerns about poor-quality jobs and service-user safety.[2] Greater emphasis on training and skill cannot reverse the damage done to care quality by inadequate funding and low wages.[3] A policy-shift to professionalise the care workforce cannot be successful while care workers' hours of work remain chronically insecure and care homes are understaffed. Without dedicated attention to improving terms and conditions of work, appeals for professional conduct will fail to achieve optimal improvements in service-user safety. Care workers and their employers face daily challenges associated with underfunding, high labour turnover, low wages, insecurity of working hours, labour shortages, complex care packages and intense cost competition.[4] This reality has deep implications for the possibilities and practicalities of professionalisation.

Nevertheless, changes are underway in the regulation and direction of the social care workforce, these occur alongside talk of the need to 'professionalise'.[5] Whether such changes will result in a professionalisation that has meaningful and tangible impacts on relationships between care workers and service-users is something that can only be known over time. In writing this report, we have been careful not to make assumptions about professionalisation. We began with an open mind about what it might mean for social care practices and social care workers.

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[1] Thanks to GMB trade union for funding and support for the report.

[2] We use the term 'service-user' in this report to identify people who are receiving a social care service or are accessing support or care from a paid worker. However, we acknowledge that the term is contested.

[3] House of Lords Economic Affairs Committee (2019) *Social Care Funding. Time to End a National Scandal*,

https://publications.parliament.uk/pa/ld201719/ldselect/ldeconaf/392/392.pdf accessed 8th July 2019.

[4] Hayes LJB (2017) *Stories of Care: A Labour of Law. Gender and Class at Work,* Palgrave; Dromey, J and Hochlaf, D (2018) *Fair Care: A Workforce Strategy for Social Care*, Institute for Public Policy Research.

[5] Dromey, J and Hochlaf, D (fn4).

We decided it was important to set our discussion in the context of contemporary social care policies that require care to be personalised and to be increasingly available in people's own homes. Next, we looked at academic literature and policy documents to identify the skills and aptitudes that experts have identified as necessary for hands-on care work. We have organised these into six categories:

Skills and aptitudes

1. Health and Medicine
2. Values and Philosophies of Care
3. Literacy, Numeracy, Language and Communication
4. Technology and Digital
5. Employability Skills
6. Body Work

It is important to recognise that these skills are not a futuristic wish-list but rather, **they are the skills that care workers, as professionals, have or are required to have, now**.

By drawing on academic literature and policy documents we then examined how skills and aptitudes are practically developed and supported. We also undertook a small number of interviews to check facts and fill information gaps. We identified three key areas:

Professionalisation in Practice

1. Registration
2. Induction
3. Training

Our inquiry then turned to questions about law and regulation. We wanted to find out how professionalisation was expressed or shaped by regulatory instruments and regulatory bodies across England, Wales, Scotland and Northern Ireland. We have been able to make comparisons across the four nations about professional matters such as staffing levels, training, qualifications and legal compliance.

Our analysis of social care regulation tells us about professionalisation

- ✓ Identifies the professional standards, training and skills already required in law.
- ✓ Compares the substance of relevant laws across England, Wales, Scotland and Northern Ireland.
- ✓ Points to gaps between what the law requires and what is needed in practice
- ✓ Identifies how responsibility for training and professional registration variously falls on the shoulders of care workers, employers or government agencies in different ways in the different nations.

Why take a four-nations approach?

The organisation and regulation of adult social care is a matter that is devolved to each of the UK's four nations. Prior to devolution, a central feature of UK policy was to build a mixed economy of care based on market principles of cost competition and contracting. From the 1990s onwards, the role of UK local authorities has shifted from providing care and support to commissioning and arranging it. A large majority of care delivery across the UK is now undertaken by private sector organisations contracted to local authorities. There is also a sizable role for charitable and voluntary organisations and a much smaller number of workers in direct employment with local authorities or the NHS. Approx. 10% of the workforce is employed via direct payment arrangements.[6]

As a consequence of devolution, legislators and policy-makers have used statutory instruments, regulation, regulatory guidance and codes of practice to direct social care in ways that are distinctive in England, Scotland, Wales and Northern Ireland. This has implications for the workforce, for example training requirements differ across the four nations and many care workers outside England are now required to join a system of professional registration. Yet, there are also considerable similarities in the UK-wide demands placed on care workers. For example, care workers across the

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[6] Skills for Care (2018) The state of the adult social care sector and workforce in England, September 2018, Skills for Care: Leeds. Available online at: https://www.skillsforcare.org.uk/NMDS-SC-

intelligence/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2018.pdf accessed 21 May 2019.

UK are expected to work with a growing proportion of vulnerable adults with complex care needs and, in all four nations, there is an increasing emphasis on services which prevent additional needs arising and the reablement of those with support needs.

How does interest in professionalisation add to recent critiques of social care?

The House of Lords Economic Affairs Committee has very recently drawn attention to the need to focus immediate consideration of adult social care provision on failures to meet personal care needs.[7] These are needs which are basic to human existence and include washing, dressing, eating, toileting and taking prescribed medication. The Committee's report finds social care has been inadequately funded for many years and it makes an unequivocal demand for the restoration of funding for personal care to be the Government's 'top priority'.[8] It has recommended this funding come from general taxation.[9] The evidence presented to the Committee correlated funding deficits with poor job quality for care workers and the urgent need to 'restore levels of care quality'.[10] Consequently, the Committee has also recommended that personal care be made universally available free of charge at the point of access within the next 5-6 years across the UK.

Lack of funding means 1.4 million older people with care and support needs are unable to access services.[11] Large numbers of people of working age have given up their jobs to provide unpaid care to friends or family.[12] Every day, a reported 6,000 people take on a new caring responsibility.[13] In a recent survey, a vast majority of unpaid carers reported that providing care has had a negative impact on their mental health (72%) or physical health (61%).[14] Under-funding by government is also driving people to self-fund care. In the care home market,

this is causing a shortage of places for people who rely on public funding because prices paid by local authorities do not reflect the true cost of care provision. In the homecare market, it is leading increasing numbers of families to employ workers on an informal basis and in ways that may flout tax and employment protection legislation.[15] Across the UK, the withdrawal of public funding for social care is shaping the availability of services. There are greater shortages of care services in deprived areas because providers are concentrating their operations in affluent areas of the UK, where families can afford to pay for care privately.

The urgency and gravity of circumstance communicated by the Economic Affairs Committee suggests a professionalisation agenda faces an uphill struggle. Yet a lack of social regard for the professionalism of care workers is contributing to record numbers of care workers leaving their jobs.[16] There is an urgent need to 'invest' in the social care workforce by delivering higher pay and better conditions of work, alongside support and recognition of care workers as skilled professionals. Giving evidence to the Economic Affairs Committee, the Secretary of State for Health and Social Care suggested professionalisation was something that his department could 'just get on with', despite other issues being outstanding.[17]

However, the findings of this report show that training issues, workers' occupational registration, regulatory concern for service-user safety, terms and conditions of work, and sector funding are intricately connected. Regard for professionalisation must therefore advance on all fronts to reflect the social importance of the workforce and to remedy severe problems that have been left to drift for far too long.

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7 House of Lords (fn3)
8 Ibid, 39.
9 Ibid, 6.
10 Ibid, 3.
11 Age UK (2019) Care in Crisis https://www.ageuk.org.uk/our-impact/campaigning/care-in-crisis, accessed 8th July 2019
12 Carers Trust (2015) Key facts about carers and the people they care for, https://carers.org/key-facts-about-carers-and-people-they-care accessed 8th July 2019.
13 Carers UK (2015) Policy briefing OCTOBER 2015. https://www.carersuk.org/images/Facts_about_Carers_2015.pdf accessed 8th July 2019.

14 Carers UK (2018), State of Caring 2018 https://www.carersuk.org/images/Downloads/SoC2018/State-of-Caring-report-2018.pdf accessed 3rd July 2019.
15 Soper P and Butler E (2018) Stable Footing: Ensuring a Sustainable Future for Social Care, Adam Smith Institute.
16 Skills for Care (fn6).
17 Evidence given by Rt Hon Matt Hancock MP at Q98 http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/economic-affairs-committee/social-care-funding-in-england/oral/101566.html

Our findings in brief

➢ Training, occupational registration, concern for safeguarding, terms and conditions of work and funding are intricately connected and improvements must be made on all fronts to recognise and reward the skills and professionalism of care workers.

➢ Adequate funding for adult social care must be restored as a first step in recognising care work as a profession.

➢ Better learning outcomes for care workers and professionalisation of the sector cannot materialise in the absence of security of income, security of hours of work and protection of workers' wellbeing and health.

➢ The extensive skills involved in care work and support make it wholly inappropriate for care workers' wages to be pegged at or around the applicable statutory minimum wage rates. Recognition of the professionalism of care workers means wages must be put on a professional footing.

➢ Action is needed to reach agreements about minimum standards across the sector so that all workers are included. There is a need for sector-wide agreements on training and learning to be reached by negotiation between employers' and workers' representative organisations. Agreements on core terms and conditions of work should sit around this.

➢ The fragmentation of the care industry (with approximately 25,000 registered providers in over 50,000 locations) presents a difficulty for enforcing higher training and qualification standards within regulatory structures that enable considerable employer discretion.

➢ The basic skills (literacy, numeracy and I.T.) needs of the care workforce must be addressed with sensitivity and urgency in order to support training requirements set out in regulations and to overcome a big potential barrier to successful registration.

➢ Care workers need to be recognised for their skills in engaging and negotiating with unpaid carers as well as with professionals in other health and support roles.

➢ A lack of information about the self-funded care and support market is problematic for understanding the challenges of professionalisation. More research is needed.

➢ An absence of registration (and, to a large extent regulation) is characteristic of the PA sector and there is a need for more research and greater understanding of the interrelationships between the PA sector and other sectors of the care market.

➢ Body work is an under-recognised skill component of care work practices. To value care work properly there must be stronger regard and recognition of the skills and knowledge of body work. It should also be explicitly included as a requirement in regulation about training.

➢ The skills of care workers in respect of end-of-life care are often overlooked in accounts of their professionalism.

➢ There is a considerable gap between the promotion of personalisation in policy and care workers' knowledge, understanding and ability to put concepts into practice.

➢ Health and medically related skills and knowledge about complex conditions like dementia and diabetes are essential to hands-on care work. Many care workers are not receiving training that is specific to the health conditions and care needs of the individuals that they support.

➢ There is a substantial need for care workers to develop skills in conflict management, motivating others, team-working and organisation.

➢ There is very little information and research about on-the-job training, such as shadowing or observation shifts. This form of training is routinely used in the sector but is rarely mentioned in academic or policy literature. More research is needed.

➢ Regulation, or regulatory guidance, should ensure that time required to be set aside for training is paid time.

➢ Care workers who are shadowed should be recognised as trainers in key practices and as peer-to-peer communicators of essential knowledge.

➢ There is a marked difference in the regulation of training and workforce standards in England, and elsewhere in the UK. It seems

timely to review the decision to reject registration in England on cost grounds.

➢ The initiative taken by devolved nations to introduce and advance registration would be supported and assisted if England were also to develop a registration scheme for care workers because the vast majority of the U.K. care workforce are based in England.

➢ There is evidence that regulatory initiatives for the occupational registration of care workers and workforce matters are aligned with recognition of the importance of job quality to care quality (for example on zero-hours contracts in Wales, on staff wellbeing considerations in Scotland, and the density of temporary workers in N.Ireland). However, devolved nations are not able to make legislation or regulate directly on matters of employment.

➢ Professionalisation via worker registration and prescribed training standards is most advanced in N. Ireland. Sanctions on providers for engaging workers who are not fit to work in care and for breaching staffing standards appear strongest in N.Ireland.

➢ Sanctions on employers for failing to appropriately train, supervise or appraise care workers are inconsistent across the UK. It is hard to understand why it is a prosecutable offence in Scotland for providers to engage workers who are not fit to practice, but not so in England without proving avoidable harm or significant risk.

➢ A significant marker of professional status in Wales is that an unregistered person commits a criminal offence if they take or use the title 'social care worker'.

Personalisation and the professional social care workforce

A key element of governmental policy across the four nations of the UK in the past decade has been to promote personalised care delivery. The majority of people who receive local authority funded care or support from the care workforce are older people, whose needs arise from conditions that are typically age-related, such as dementia or stroke. However, the care workforce also provides support to working-age disabled people with physical, cognitive, sensory or communication impairments, who are likely to have very different requirements, expectations and demands.[18] Workers across the adult social care sector are meeting a range of different assistance needs and expectations in a very wide range of circumstances. Social care policy has responded to demands from older and disabled people for greater individual choice about how they are cared for, or supported, and by whom.[19] There is a wealth of evidence that having appropriate levels of control over care is beneficial to the physical and mental well-being of service-users, including people who lack capacity to make certain decisions.[20] In addition, the availability of choice and the ability to make choices is fundamental to the functioning of economic markets. Personalised care delivery is also a matter of respect for

> **Personalisation challenges orthodox understandings of what it means to be 'a professional' because the professional care worker is not a 'know-it-all' expert. Instead, the expertise of the care worker must be deployed to enable service-users in complex circumstances, with complex care or support needs, to co-design or direct their support and care.**

human rights and reflects a diversity of care or support needs, a diversity of communities in the UK and a diversity of individual preferences.[21] There are considerable implications for the care workforce.

In this section we consider the distinct understandings of personalisation in England, Scotland, Wales and Northern Ireland. **We then anticipate some of the challenges of professionalisation by explaining how the idea of personalisation shapes the functions and purpose of care workers' jobs.**

England

In recent years in England, personalisation has been a central focus of social care policy by successive administrations at Westminster (Labour, Coalition and Conservative). The concept of personalisation is now applied broadly within the English public services sector, but it began and is most deeply rooted in social care. Personalisation was first discussed in detail in the 2005 policy document 'Improving the Life Chances of Disabled People'[22] The concept was not clearly defined but related to the provision of support that fitted, or was tailored to, the person.[23] It has also been connected to the idea of individual choice, not just in terms of support, but in terms of the person having choice in their life and being part of the community:

> Personalisation is achieved when a person has real **choice and control** over the care and support they need to achieve their goals, to live a fulfilling life, and to be connected with society (original emphasis).[24]

Personalisation was placed at the heart of social care policy in the brief

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[18] Many people, particularly disabled people of working age, strongly reject the term 'care' in favour of 'support' or 'assistance'.

[19] The concept of personalisation originated from ideas of the disabled persons movement that asserted their need for rights to independent living. For a detailed exposition see Tarrant, A (forthcoming) Cardiff University: PhD thesis. Choice and control over life and one's own support are key elements of the idea of 'independent living', or the ability for disabled people to live the life of one's choice on an equal basis with others. See, Morris J, *Rethinking Disability Policy* (Joseph Rowntree Foundation 2011). A right to independent living is now enshrined in Article 19 of the UN Convention on the Rights of Persons with Disabilities.

[20] Scourfield, P. (2005). Implementing the Community Care (Direct Payments) Act: Will the supply of personal assistants meet the demand and at what price? Journal of Social Policy, 34(3), pp469–488; Clark H.,

Gough H. & Macfarlane A. (2004). *'It pays dividends' Direct Payments and Older People*, Policy Press.; Slasberg C. & Beresford P. 2015. Building on the original strength of direct payments to create a better future for social care. Disability & Society, 30(3), pp479–83.

[21] EHRC (2011). Close to home: An inquiry into older people and human rights in home care. Equality and Human Rights Commission. Equality and Human Rights Commission.

[22] PMSU, 'Improving the Life Chances of Disabled People' (January 2005).

[23] Ibid, p5. See also Department of Health, 'Independence, Wellbeing and Choice: Our Vision for the Future of Social Care for Adults in England' (Cm 6499, March 2005).

[24] Department of Health, 'Caring for our Future: Reforming Care and Support' (Cm 8378) p18.

cross-agency document 'Putting People First[25] and has remained at the heart of social care policy in England, emphasised in the 2012 white paper 'Caring for Our Future'.[26] It is linked to the delivery methods of direct payments and personal budgets. A personal budget is the amount of money allocated for expenditure on the care or support of an individual.[27] A direct payment occurs when a person chooses to receive the money to purchase their own support directly, often by employing one or more personal assistants.

Personalisation is the core animating principle of adult social care policy in England (for example, it is even used as a definitional principle in respect of end-of-life care-giving and 'a good death'[28]). It is consistently connected to the importance of service-user choice and control. This extends to individuals who lack the capacity to make certain decisions,[29] and it is also connected to ideas about how best to keep vulnerable adults safe, with a particular focus on how risk is understood and treated. An individual's autonomy may include choices by them to take risks – a matter that must be balanced with the need to support some individuals to stay safe.[30] This has significant implications for the workforce and the way care workers engage with those they assist, as noted in the 2012 white paper on social care, which stated:

> The principle of personalised care will be embedded within the way that local authorities, care providers and care workers deliver care and support.[31]

Control, and to a lesser extent choice, are now included in the definition of 'wellbeing' in the Care Act 2014. A general requirement to promote the wellbeing of individuals forms the core underpinning duty of that Act.

Wales

In Wales the Welsh Government has sought to move away from the development of a market in public services and to instead highlight the idea of 'voice' rather than individual choice.[32] The term 'personalisation' is not currently used,[33] and the mechanism of personal budgets has not been placed into law. The essential idea is that social care – and other elements of public sector provision – should not be fragmented into support which is driven and purchased by individuals on marketplace principles but should instead respond to, and be moulded by, the voice and desires of the broader public. The Welsh Government states, however, that it is committed to the principle of individuals having control over their support, and the use of direct payments has been expanded under the Social Services and Wellbeing (Wales) Act 2014. As in England, control forms part of the definition of 'wellbeing' in the 2014 Act, and the accompanying legislative framework creates an 'outcomes-focused' approach which gives scope for individuals to state their intended outcomes from care. A particular feature of social care in Wales is a strong focus on the 'co-production' of support and services between the state and other agencies and those who use (or will use) support. This is reflected in the 2014 Act, which requires local authorities to promote the development of

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[25] HM Government et al, 'Putting People First: A shared vision and commitment to the transformation of Adult Social Care' (HM Government, 2007).

[26] Department of Health (fn24).

[27] In England, service-users must be allocated, and informed of, a personal budget (see s26, Care Act 2014). Their personal budget can be spent on their behalf by the local authority or allocated directly to them in the form of a direct payment (see s31-33, Care Act 2014). There are also options for a personal budget to be managed by third-parties Department of Health and Social Care, 'Care and support statutory guidance' (updated 26 October 2018) https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#Chapter11 accessed 9 July 2019.

[28] Department of Health (2014) *New Priorities for Care.* London: Department of Health and Social Care.

[29] Department of Health, 'A Vision for Adult Social Care: Capable Communities and Active Citizens' (2010) para 4.4. '… people who lack the mental capacity to make some decisions should also be offered the same opportunities for choice and control as anyone else'.

[30] Ibid para 6.10. 'Risk management does not mean trying to eliminate risk. It means managing risks to maximise people's choice and control over

their services. True empowerment means that people might make decisions service providers disagree with. But as long as the outcomes are part of the care plan and all risks have been fully discussed and understood, this can lead to real choice and control and a better quality of life for the individual.'

[31] Department of Health (fn24) p56.

[32] One of the principles of 'progressive universalism' outlined by Mark Drakeford AM in 2006. Accordingly, 'policy should be guided by the collective voice of civil society institutions rather than by individual choice'. [32] Mark Drakeford, 'Progressive Universalism' (2006-7), reproduced in: Institute of Welsh Affairs (IWA), 'Unpacking the Progressive Consensus', IWA 2008. 'Progressive universalism' is no longer stated to be the driving ideology of the Welsh Government, but the idea of citizen 'voice and control' remains central to social care development. See Welsh Government, 'Social Services (Wales) Bill: Consultation Document' (12 March 2012).

[33] This term is considered to be too closely connected with the marketisation of support. Welsh Assembly Government, 'Sustainable Social Services for Wales: A Framework for Action' (2011) para 3.16.

social enterprises and cooperative arrangements, as well as 'the involvement of persons for whom care and support or preventative services are to be provided in the design and operation of that provision'.[34]

In Wales, as in England, there is recognition of the importance of the workforce in bringing these plans for social care to fruition. The white paper prior to the 2014 legislation, stated:

> We will prioritise building a stronger workforce, more confident in its own professional judgement, reducing the volume of guidance we issue to create the space needed.[35]
>
> … citizen-focused, sustainable services will not be possible without placing the professional contribution of social workers and social care workers even more at the heart of services. Whilst leadership, collaboration, integrated services and a focus on performance make a huge impact, it is the way in which frontline staff deliver the day-to-day work with citizens that ultimately makes the difference.[36]

The need for new information and skills in the workforce is reflected in information recently developed by Social Care Wales, relating to direct payments and the employment of personal assistants.[37]

Scotland

Since devolution, the Scottish Government has also demonstrated a determination to develop a social care system based upon distinct principles. As in Wales, these have inclined towards those of social solidarity, collectivism and universalism.[38] The most notable policy distinction in Scotland is the provision of free personal

care for older adults.[39] Scotland has also recently become the first nation in the UK to place the principles of self-directed support into primary legislation. The Social Care (Self-directed Support) (Scotland) Act 2013 gives individuals choice in how support is provided, namely the choice of a direct payment; or funding allocated to the council or another agency to be used as directed by the individual; or for the council to decide upon and arrange support.

These options are available also to individuals who may lack the capacity to make certain decisions, such as those with dementia, and those with fluctuating capacity, and the guidance makes clear that a potential lack of decision-making capacity is not a reason to deny self-directed support. [40] The 2013 Act is also underpinned by general principles that are intended to guide practice and require the supported person to be involved in a collaborative way in the process of assessment and the provision of support; and for them to be assisted to express their views and make an informed choice. In respect of self-directed support, guiding principles emphasise service-users' rights to dignity and to participate in the community. The practitioner guidance notes that the treatment of risk is a difficult area because care workers need to balance the empowerment of individuals with regard for their safety and safeguarding.[41]

As in England and Wales, the Scottish Government is aware that the ongoing reform of social care and the increased focus on self-directed support will create different needs and pressures on the workforce. The Scottish Government National Health and Social Care Workforce Plan states that the vision for social care in Scotland will require:

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[34] Section 16(1)(c).
[35] Welsh Assembly Government (fn33) para 1.14.
[36] Ibid, para 3.56.
[37] Social Care Wales, 'Employer Toolkit for Supporting the Learning of Personal Assistants' (undated) http://www.paemployertoolkit.wales/ accessed 1 July 2019; and Social Care Wales, 'Using Direct Payments to Employ Personal Assistants' (undated) https://socialcare.wales/service-improvement/using-direct-payments-to-employ-personal-assistants accessed 1 July 2019.
[38] Keating, M (2003) 'Social Inclusion, Devolution and Policy Divergence', *Political Quarterly*, 74(4), pp. 429-39; Stewart, J. (2004) *Taking Stock: Scottish Social Welfare After Devolution*, Bristol: Policy Press; see Birrell D

(2007) Devolution and Social Care: Are There Four Systems of Social Care in the United Kingdom? https://www.sochealth.co.uk/national-health-service/devolution-in-health/devolution-social-care/ accessed 7 July 2019
[39] Section 1, Community Care and Health (Scotland) Act 2002.
[40] Scottish Government, 'Self-Directed Support: Practitioner Guidance' (2014) https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2014/08/self-directed-support-practitioners-guidance/documents/self-directed-support-practitioner-guidance/self-directed-support-practitioner-guidance/govscot%3Adocument/00458234.pdf accessed 5 July 2019.
[41] Ibid, p30.

a compassionate, autonomous workforce that is skilled at having good conversations with people, can support them to live as independently as possible for as long as possible, is confident in supporting people to set and make progress towards their own goals and can help people manage risk in their lives.[42]

It also notes that one of the challenges is:

How to support the workforce in responding to policies which demand greater autonomy for the social care workforce and more innovation in models of support that are personalised for individuals.[43]

The workforce plan notes the importance of the regulatory system in supporting these changes. Notably, each of the Scottish Government,[44] the Care Inspectorate,[45] and the Scottish Social Services Council provides information on self-directed support, including on the role of personal assistants.[46]

Northern Ireland

Recent policy developments on social care in Northern Ireland have focused – similarly as to England, Wales and Scotland – on the development of increasing community-based support that is tailored to the individual. A 2011 review of health and social care in Northern Ireland proposed a future model based upon 12 principles which included, 'placing the individual at the centre … by promoting a better outcome for the service-user, carer and their family' and 'promoting independence and personalisation of care'.[47] Similarly, the 2016 policy, Health and Wellbeing 2026: Delivering

Together', set out a vision for greater prevention of need, more community-based support and 'a new model of person-centred care focussed on prevention, early intervention, supporting independence and wellbeing'.[48] Self-directed support (SDS), including the use of both direct payments and personal budgets, is being expanded in Northern Ireland, with individuals offered the same choices over support as are available under the 2013 legislation in Scotland.[49]

As elsewhere, the capacity for these changes to come to fruition depends on the work performed, and the skills of, the workforce in Northern Ireland. The Domiciliary Care Workforce Review Northern Ireland 2016–2021 states:

In line with the principles of personalisation, the role of the professional and the care worker within SDS will become less about being a 'fixer' of problems and more about being a co-facilitator of solutions working in collaboration and co-production based on power sharing and mutual respect. Doing things '**with people'** rather than '**to them**' (original emphasis).[50]

Workforce implications

Despite national differences, all four nations of the UK have set out rights, responsibilities and expectations that require social care support to be delivered in community settings, to be focused on prevention, and to be driven and *controlled* by those using support or needing care (not simply individually tailored to their needs). The ratification by the UK of the UN Convention on the Rights of Persons with Disabilities requires policy commitments to support and assistance that is controlled by the

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[42] Scottish Government, 'National Health and Social Care Workforce Plan' (December 2017), 22.

[43] Ibid. See also, NHS Scotland, 'Everyone Matters: 2020 Workforce Vision' (2017) https://www.workforcevision.scot.nhs.uk/wp-content/uploads/2017/12/Everyone-Matters-2020-Workforce-Vision-Implementation-Plan-2018-20.pdf accessed 1 July 2019.

[44] Scottish Government, 'Personal Assistant Employer's Handbook: What you need to know' (March 2014) https://hub.careinspectorate.com/media/2546/sg-personal-assistant-employers-handbook.pdf accessed 1 July 2019.

[45] Care Inspectorate, 'Self-directed Support' (undated) https://hub.careinspectorate.com/national-policy-and-legislation/policies/self-directed-support/ accessed 1 July 2019.

[46] Scottish Social Services Council, 'New Resources for Personal Assistants and their Employers' (undated) http://ssscnews.uk.com/2016/05/10/new-

resources-for-personal-assistants-and-their-employers/ accessed 1 July 2019.

[47] Health and Social Care Board, 'Transforming Your Care: A Review of Health and Social Care in Northern Ireland (2011) http://www.transformingyourcare.hscni.net/wp-content/uploads/2012/10/Transforming-Your-Care-Review-of-HSC-in-NI.pdf accessed 1 July 2019.

[48] Department of Health (Northern Ireland), 'Health and Wellbeing 2026: Delivering Together (2016), 11.

[49] Health and Social Care Board, 'Self Directed Support' http://www.hscboard.hscni.net/sds/ accessed 1 July 2019.

[50] Department of Health (Northern Ireland), 'Domiciliary Care Workforce Review Northern Ireland 2016-2021' (2018) 30.

Personalisation requires care workers to:

> Be open to direction by service-users instead of prioritising managerial instruction.

> Be confident in making their own professional judgements.

> Respect and understand human rights.

> Support people who lack capacity in making some decisions.

> Balance risk-taking with the need to help some people stay safe. Support others to understand, and manage, risks.

> Know how to achieve outcomes that individuals want to pursue.

> Involve service-users in the design of their care and support as appropriate.

> Help others make complex, as well as straightforward, decisions.

> Assist others to express their views and facilitate choices by people who find it hard to communicate with others.

> Be highly skilled at conversation.

> Engage in complex negotiations about matters of personal health and wellbeing.

> Be innovative.

> Be flexible in order to adapt care plans in response to service-user requests, sometimes diverting efforts to tasks that are not on a care plan.

> Manage time and adapt established ways of doing things.

> Be a co-facilitator of solutions, not a fixer of problems.

service-user, including a right to independent living.[51] Changes in social care are being driven by shifting demographics and are underpinned by different political motivations and principles, but 'personalisation' has considerable implications for care workers across the UK.

For personalisation to be effective it must be evident in the day-to-day interactions between care workers and service-users. Workers must understand and embrace the principle of autonomy and self-determination of the individuals they assist and recognise how it fundamentally changes their own role. For example, facilitating service-user directed support might take the form of listening to directions from the individual they are supporting instead of prioritising their own or their employer's beliefs as to how care should be provided. It might mean undertaking different tasks rather than routine, pre-established 'care'. In domiciliary care, it raises the prospect of time conflicts if a person wishes to receive care in a way that is more time consuming than the planned length of the visit permits. It may raise practice conflicts where a person wishes to undertake an activity that places them at physical risk – such as a risk of falling. Care workers must have a sophisticated appreciation of how to balance the right of individuals to take risks, with the duty that they and their employers have to safeguard individuals if necessary. As professionals, care workers must engage with service-users as managers of, and partners in, the caring support they receive. Care workers' terms and conditions of employment are important factors. Their ability to clearly express their professional opinions, or to engage in whistleblowing, to raise safeguarding issues, and to assert the legal rights of their service users or indeed their own legal rights, is impeded if their contract is insecure or if they do not earn an income that is sufficient to support their own wellbeing.[52]

The ability to manage boundaries between care packages and service-users' requests is a key skill that care workers must learn and exercise.[53] For example, when older service-users have been asked about care quality, they have attached importance to care workers'

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[51] See footnote 19.

[52] J Rubery and P Unwin, 'Bringing the employer back in: why social care needs a standard employment relationship' [2011] Human Resource Management Journal 21: 122. See also S Ramirez, 'Raising Concerns in the Workplace' (2012, Older People's Commissioner for Wales); C Atkinson, S Crozier and R Lucas 'Workforce Policy and Care Quality in English Long-term Elder Care' (2018) Public Performance & Management Review 41(4),

859-884; SC Bolton and G Wibberley 'Domiciliary care: The formal and informal labour process' (2014) Sociology 48(4): 682-697; J Lewis and A West 'Re-shaping social care services for older people in England: Policy development and the problem of achieving "Good Care"' (2014) Journal of Social Policy 43(1).

[53] Hebson G, Rubery J, Grimshaw D (2014) FairWRC Research Briefing No 1, p6.

willingness to be flexible and to work beyond the boundaries of their contracts and the confines of the tasks in the care plan.[54] Service-users frequently want care to be provided in a family-like way, they want care to be delivered according to their wishes, preferences, foibles and predilections as individuals.[55] Facilitating user-led support is a skill in itself. It gives rise to a range of training requirements and the ability to make decisions and negotiate also depends upon care workers having a stable employment environment.[56]

In addition, there may be skill requirements that are particular to the part of the UK in which the care worker is located, For example, in Wales the focus on collective and cooperative support set out at section 16 of the 2014 Act includes the combining of care arrangements to service-users' mutual advantage. This might mean that workers, especially PAs and other care workers who do not have external supervision, need particular skills and knowledge to work confidently in situations in which they need to support a group activity in a residential situation or help individuals to engage in community activities as a group.

The role of workers providing support, assistance and care to older and disabled people is changing across the UK. The implications are of care workers being better able to work independently of direction that is external to relations of care and support, of care workers having significant decision-making abilities and being confident in exercising personal judgement. While decision-making and judgement are already exercised by many care workers, changing policy implies a need to recognise the value of these abilities, and to extend them to workers who may currently see their role as 'routine' caregiving or conducting tasks under employer or agency supervision.

[54] Francis J and Netten A (2004) Raising the quality of homecare: A study ofservice-users' views. *Social Policy and Adminstartion* 38(3), 290-305.
[55] Stacey, C. L. 2011*. The caring self: The work experiences of home care aides*. Industrial Labor Relations (ILR) Press, Cornell University; Nare, L. 2011. The moral economy of domestic and care labour: Migrant workers in Naples, Italy. Sociology, 45(3), 396–412; Johnson, E. K. (2015) The business of care: The moral labour of care workers. Sociology of Health & Illness, 37(1), 112–26; Hayes LJB (fn4).
[56] Francis and Netten (fn54) p5.

Skills for hands-on care workers

Skill requirements for the adult social care workforce are shaped by demographic change, such as the ageing of the population and increasing levels of disability, as well as by political and social factors, technology, and the changing needs and expectations of service-users.[57] Approx. 19% of employers across the health and social care sector report a 'skills gap' in their current workforce, that is, they have employees who are unable to do their job to the required level.[58] The extent of the 'skills gap' varies by geographical area, for example, it is more frequently noted by employers in Scotland (29%) than in Northern Ireland (13%).[59]

In what follows, we outline a series of skills needs and 'skill gaps' that have been identified in the social care workforce. We have organised the information into categories of health and medicine; values and philosophies of care (personalisation and enablement);

literacy, numeracy, language and communication; technologies and digital capabilities; employability skills, and; body work. We discuss each of these below with reference to academic literature and a series of reports focusing upon social care in England, Wales, Scotland, and Northern Ireland, as well as information gathered from interviews with employers and workers' representatives, officials from sector inspectorate bodies or regulators and policy-makers.

Health and Medicine

The ageing of the UK population, alongside narrower eligibility criteria for accessing care services (particularly homecare) has resulted in an increased acuity, complexity, and multiplicity of service-users' needs.[60] Alongside the drive towards joined up working between (and the integration of) health and social care, this is placing pressure on care workers to develop specialist skills and knowledge.[61] As the care worker role is increasingly mirroring health-related occupations, such as nursing,[62] **health or medical-related skills and knowledge of complex conditions are more often seen as a requirement for hands-on care workers**.[63]

Across care settings, workers are commonly expected to administer medications or prompt service-users to take medications, to hold a knowledge of dementia,[64] and to possess the ability to provide sensitive end-of-life care.[65]

Poor terms and conditions of work can impede access to training

We were told that there is demand amongst care workers to attend additional training courses and update their skills. But significant barriers to this include long working hours, insecure employment contracts, and workers not being paid or allowed time off to complete or attend training. In addition, few chances of career progression and a minimal wage difference between care worker and senior care worker roles means that there are few career-oriented or financial incentives for workers prioritising training.

[57] Centre for Workforce Intelligence (2013) Big Picture Challenges: The Context, October 2013. Centre for Workforce Intelligence: London. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/507359/CfWI_Big_picture_challenges_context.pdf. Commissioned by the Department of Health; UK Commission for Employment and Skills (2015) Sector insights: skills and performance challenges in the health and social care sector. Evidence Report 91, May 2015. London: UKCES.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/430137/Skills_and_Performance_Challenges_in_Health_and_Social_Care.pdf
[58] UK Commission for Employment and Skills (fn57)
[59] Ibid.
[60] Ibid; Kingsmill, D (2014) The Kingsmill review: Taking care. An independent report into working conditions in the care sector https://www.policyforum.labour.org.uk/uploads/editor/files/The_Kingsmill_Review_-_Taking_Care_-_Final_2.pdf
[61] Social Care Wales (no date) Consultation On The Review Of The Social Care Induction Framework Summary Report And Next Steps https://socialcare.wales/cms_assets/file-uploads/Consultation-on-the-

review-of-the-Social-Care-Induction-Framework-Summary-report-and-next-steps.pdf ; Scottish Social Services Council (2017) Workforce skills report 2016-17. sssc.uk.com/about-the-sssc/multimedia-library/publications/workforce-development/workforce-skills-report-2016-17; Atkinson, C, Sarwar, A, and Crozier, S (2019) Greater Manchester Independent Prosperity Review, Adult social care technical report, March 2019. Manchester University: Decent Work and Productivity Research Centre.
[62] UK Commission for Employment and Skills (fn57); Kingsmill (fn60).
[63] Scottish Social Services Council (fn61); Care Quality Commission (2012). The state of health care and adult social care in England in 2011/12. accessed online Feb 2013: www.cqc.org.uk/sites/default/files/media/documents/cqc__soc_201112_final_tag.pdf
[64] Social Care Wales (2016) Developing Improvement Priorities for Social Care Wales – summary report. Available Online at: https://socialcare.wales/resources/developing-improvement-priorities-for-social-care-wales-summary-report; Scottish Social Services Council (fn61).
[65] Scottish social services council (fn61).

Activities reportedly undertaken by homecare workers in Scotland, for example, include PEG feeding (feeding service-users through a tube in their stomach), identifying 'vital signs' (clinical measurements, specifically temperature, blood pressure, respiration rate, and pulse rate) and complex conditions/needs, and undertaking stoma care.[66] Care workers working in care homes in Scotland are also identified as requiring specialist training in stroke awareness, installing catheters, using a hoist, and incontinence care.[67] However, there have been suggestions that care workers are performing this labour without the appropriate training, with the UK Homecare Association (UKHCA) reporting that its helpline was 'inundated with workers asking whether they are allowed to do invasive procedures, giving insulin or assisting with medication'.[68]

With the drive to reduce admissions to hospital and to support people to stay at home for longer, care workers across the sector now have a crucial role to play in preventative care and in the promotion of public health and wellbeing, which increasingly require specialist skills and training.[69] Staff in care homes, for example, may require training in how to prevent pressure sores.[70] Homecare workers may also be expected to know how to spot the early signs of conditions such as urinary tract infections or sepsis in order to prevent their escalation. The UK Commission for Employment and Skills suggests that the imperative to deliver more services closer to service-users' homes means that, in the future, homecare workers and those working day centres, in particular, will be likely to work more closely with primary healthcare staff and will require increased knowledge of healthcare delivery. [71] With the expectation that both the age of the population and the number of people with moderate or severe

disabilities will continue to increase, it is also becoming more important to establish what conditions will be prevalent in the future in order to ensure that we will have the social care workforce required to deliver care to future service-users.[72]

Increasingly, across the UK, care workers can specialise in particular areas of care needs, such as dementia, learning disabilities, or rehabilitation,[73] but this often reflects the care worker's workplace setting or the nature of the wider team in which they work. Such specialisms however are routinely needed, for example 70% of care home residents have dementia or severe memory loss,[74] and 60% of older people in care homes have a mental health problem.[75]

In many cases, care workers are not receiving training that is specific to the needs of the individuals they support. In Scotland, for example, it has been identified that there is a considerable shortage of care workers with a relevant knowledge of complex conditions and illnesses.[76] In England, it is reported that 41% of care workers do not receive training specific to service-users' medical needs, such as stroke-related conditions, dementia or Parkinson's disease. [77] The Care

Lack of training can lead to disciplinary action

We were told of instances where care workers have been disciplined for unnecessarily restraining or shouting at a service-user in circumstances where they have not received adequate training in how to deal with escalating behaviour. Many care workers who work with people who have dementia or people with learning disabilities do not receive specialist training for their roles. They need to be trained in order to feel confident in how to identify and prevent behaviour escalation. This is an important part of ensuring service-users and staff feel safe.

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[66] Ibid.

[67] Ibid.

[68] Kingsmill (fn60), p23.

[69] Scottish Social Services Council (fn61); Centre for Workforce Intelligence (fn57); UK Commission for Employment and Skills (fn57); Workforce Policy Directorate (2018) Health and social care workforce strategy 2026: delivering for our people. [online] available at: https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-workforce-strategy-2016.pdf

[70] Scottish Social Services Council (fn61).

[71] UK Commission for Employment and Skills (fn57).

[72] Centre for Workforce Intelligence (fn57).

[73] Scottish Social Services Council (fn61); UK Commission for Employment and Skills (fn57).

[74] Alzheimer's Society. (2019b). Facts for the media, Alzheimer's Society, https://www.alzheimers.org.uk/about-us/news-and-media/facts-media accessed 8th July 2019

[75] Royal College of Psychiatrists. (2018). Suffering in silence: age inequality in older people's mental health care. Retrieved from https://www.rcpsych.ac.uk/docs/default-source/improvingcare/better-mh-policy/college-reports/college-report-cr221.pdf?sfvrsn=bef8f65d_2

[76] Scottish Social Services Council (fn63)).

[77] Kingsmill (fn60).

Quality Commission has found on inspection a particular lack of diabetes training in adult social care.[78] The deficit, or absence, of medical/health knowledge gives rise to health and safety concerns and also means that care workers may not be able to meet the needs of individuals for whom they are required to care.

It is also important to recognise that migrant workers comprise a significant proportion of the UK social care workforce, particularly in London.[79] A study by Cuban found that a large number of migrant social care workers in the UK were highly skilled and were often qualified as nurses in their countries of origin. Although these skills were put to use in their social care jobs, their formal qualifications and professional knowledge was not recognised in their pay and conditions of work.[80]

Values and Philosophies of Care (Personalisation and Enablement)

As well as developing knowledge of medical conditions and health care, care workers operate within a context in which there is an increased emphasis on 'values and softer competencies' in regulations, training, and commissioning by local authorities.[81] In Scotland, for example, the 'Common core of skills, knowledge and values' outlines that all social services workers must 'build trust', 'have self-awareness', 'promote dignity and fairness' and support everyone to be included.[82] Related to this, care workers are expected to become skilled at shaping services around the person receiving services,[83] (see earlier part of this report on personalisation). The concept of personalisation has guided approaches to recruiting and training workers. In Scotland, there is evidence of some employers tailoring job descriptions and specifications to the needs of individuals accessing

services.[84] Across the UK, mobile apps have also reportedly been developed which allow service-users to source and employ carers directly and to tailor advertisements to their needs; the popularity of such devices means the gig economy in care is expected to grow exponentially.[85]

In response to personalisation, care workers across the sector are now expected to be skilled at helping people to live independently and at 'helping people to help themselves', as opposed to carrying out tasks on their behalf.[86] The skills required to help individuals to live independently and to 'help themselves' have been described as 'higher level skills' than those previously required of care workers.[87] In Wales, in line with the principles of the Social Services and Wellbeing (Wales) Act 2014, care workers are required to understand 'enabling' and reablement approaches to the provision of services and to understand how these approaches are delivered in practice.[88] Social Care Wales has emphasised the need for care workers to be able to confidently deliver person-centred care which is also focused on outcomes.[89] More specifically, key competencies required to deliver a personalised service include communication skills, shaping services around the person receiving care, supporting service-users to make choices and maintain independence whilst regaining confidence, focusing upon a 'rights-based approach' (which places the service-user's rights at the centre of care provision, particularly in terms of end-of-life care), and demonstrating a capacity to work with staff from other sectors.[90]

Some reports have also noted a need for care workers, particularly those working in care homes, to be more

[78] Care Quality Commission, (fn63) p29.

[79] Barron, K. 2010. *House of Commons Health Committee, Social care: third report of session 2009–10, Vol. 2: Oral and written evidence*. Stationery Office.

[80] Migrant workers may have high level medical skills but lower level English language proficiency so they are unable to transfer their nursing qualification (or they may not have the time needed to attend language courses) see Johnson, E.K (2018) The Costs of Care: An Ethnography of Care Work in Two Residential Homes for Older People. Cardiff University: Unpublished PhD Thesis.

[81] UK Commission for Employment and Skills (fn57), p59.

[82] Scottish Social Services Council (no date) Common core of skills, knowledge and values. Available online at: http://ssscnews.uk.com/wp-content/uploads/Common-Core-Skills-Grid-2016.pdf

[83] Scottish social services council (fn61).

[84] Ibid.

[85] Care and Social Services Inspectorate Wales (fn6); see Ticona J and Mateescu A (2018) Trusted strangers: Carework platforms' cultural entrepreneurship in the on-demand economy, New Media & Society, 20(11), 4384–4404.

[86] UK Commission for Employment and Skills (fn57).

[87] Social Care Wales and Social Care Institute for Excellence (no date) Development of a strategic plan for care and support at home: literature review. Social Care Wales. Available online at: https://socialcare.wales/cms_assets/file-uploads/Care-and-support-at-home-in-Wales-Literature-review.pdf

[88] Social Care Wales (fn61).

[89] Ibid.

[90] Scottish Social Services Council (fn61).

skilled at enabling users of services to undertake physical activity and to keep active.[91] The personalisation agenda, according to the Centre for Workforce Intelligence,[92] may lead to both the creation of a new workforce and the expansion of the section of the workforce employed directly by individuals with a personal budget. This would require an expansion in care workers' skills and knowledge of how to inform people about the services they can access and how to support/enable them to make their own decisions. **There is a considerable gap between the promotion of personalisation and enablement in policy documents and standards, and care workers' knowledge, understanding and ability to put these concepts into practice in their work with service-users.[93]**

Literacy, numeracy, language, and communication

Together with care workers being encouraged to develop 'softer competencies', they are also urged to develop their literacy, numeracy, language, and communication skills. Indeed, many of the reports cited in this document show that much of care workers' labour involves writing reports and recording information. Moreover, greater regulation means that there are increased requirements for care workers to document the work that they

undertake (in writing) and, in turn, to have regard for how their documentation will be analysed and acted upon by others.[94] Evidently, workers now require a strong and sufficient level of literacy and numeracy competencies.[95] All forms of 'hands-on' care work also involve communicating with service-users, carers, and medical professionals; language proficiency, thus, is important for ensuring that staff are working safely and in a person-centred way.[96] Workers' ability to complete social care related qualifications can also be hindered by limited literacy or numeracy skills.[97] Employers have indicated that a growing reliance on migrant labour in the care sector (i.e. workers who may not necessarily speak English as a first language) has resulted in an increased need to develop and test literacy skills amongst the workforce.[98] Language barriers are also encountered in the workforce in Wales, where just 16% of staff working in regulated services and 10% of staff working for commissioned care providers can communicate effectively through the medium of Welsh.[99]

Technologies and Digital Capabilities

As identified above, the social care sector relies upon the literacy, numeracy, language, and communication skills of care workers. Moreover, a wide range of monitoring, assistive, and wearable technologies are now affecting how and where care is delivered.[100] Domiciliary care providers, in particular, have stressed the importance of technology in adding to the skills required of care workers.[101] **Homecare workers and staff in care homes are now regularly asked to support service-users with operating laptops or tablets, and digital learning resources – such as**

> ### Literacy and Numeracy are essential skills for care workers
>
> **Care workers require literacy and numeracy skills in order to ensure that they are delivering the appropriate care to a service-user. For example, homecare workers use a service-user's care plan to read about what the service-user's care needs are, to assess how these needs may have changed since a previous visit, and to write down what care they have delivered in a way that others can understand. Most care workers are also now required to administer medications to service-users and, therefore, require numeracy skills to read information on medicine charts, understand information from medical containers, and record what medication has been given.**

[91] Ibid.
[92] Centre for Workforce Intelligence (fn57).
[93] Scottish Social Services Council (fn61).
[94] UK Commission for Employment and Skills (fn57).
[95] Skills for Care (no date) What core skills do I need to work in social care? Available online at: https://www.skillsforcare.org.uk/Documents/Recruitment-and-retention/Careers-in-care/What-core-skills-do-I-need-to-work-in-social-care.pdf; Scottish social services council (fn61).
[96] UK Commission for Employment and Skills (fn57).
[97] Scottish Social Services Council (fn61).
[98] UK Commission for Employment and Skills (fn57).

[99] Data Cymru / Social Care Wales /Welsh Gov (2017a) Social care wales workforce development programme (SCWWDP) workforce data collection 2017: Commissioned care provider services. Available online at: https://socialcare.wales/cms_assets/file-uploads/Commissioned-services-final-report-2017-2018-Eng.pdf; Data Cymru / Social Care Wales /Welsh Gov (2017b) Social Care Wales Workforce Development Programme (SCWWDP) – Workforce Data Analysis 2017: Local Authority Regulated Services. Available online at: https://socialcare.wales/cms_assets/file-uploads/COM07006_SCWWDP_report_2017_internal_eng_Final-V2.pdf
[100] UK Commission for Employment and Skills (fn57); Workforce Policy Directorate (fn69).
[101] UK Commission for Employment and Skills (fn57).

apps covering adult support and protection, prompting/administering medication, and risk assessment – have been developed.[102] Computer tablets are also increasingly being used as a more efficient way to record work being undertaken.[103] Skills for Care (England) lists 'digital skills' as a core skill required in every role in social care, which includes being able to locate and manage digital information, share data, undertake e-Learning, and show proficiency in using digital technologies with service-users.[104] In Wales, the All Wales Induction Framework for Health and Social Care now also includes a section on social media in professional practice, which has been explicitly welcomed by the sector.[105] In order to realise the development of technological and digital capabilities, **the current social care workforce will require additional training in how to use new equipment and must also be skilled at adapting to technological change as,[106] at the current time, there is a large variation in digital / IT competencies.[107]** In addition, eLearning now comprises a key part of training for care workers and, in order to complete such training, care workers require a good knowledge of how to use, and to access, information technologies.

Employability Skills

As well as developing technological competencies, care workers are encouraged to extend a range of 'employability skills' as part of their role. Skills for Care (England) describes 'employability skills' as a set of core skills needed for every role in social care.[108] This skillset is broad-ranging and, according to a key report in Scotland, includes the ability to work in a team, to plan one's own development and learning, to manage one's own health and wellbeing, and the ability to problem-solve.[109] The Scottish Social Services Council also indicates that **there is a substantial need for care**

workers **to develop their management and leadership skills, such as 'dealing with conflict' and 'motivating and leading others'.[110]** These factors were also identified as areas of skills shortage, where vacancies in the care sector were hard to fill because of a deficit in these skills. The UK Commission for Employment and Skills has also reported that skills deficiencies in the social care sector are concentrated around planning and organisational skills and team working skills.[111]

One important aspect of these employability skills is the management of stress. **In order to work in the sector, and in order to effectively provide others with support, care workers need to be highly adept at withstanding the stress of working (often under time and staffing pressures) with people who are at crisis points in their lives or who are carrying heavy emotional and physical burdens.** In the care of older people for example, this stress is associated with working with people with mental health problems, people in emotional distress, people in poverty, people at end of life or in circumstances in which they are grieving the loss of life partners or friends.[112] Research about the labour of care includes an account by a homecare worker who explained that 'the job demanded total commitment and being prepared to 'take on what [service-users'] lives are, how emotional they are, and how they [struggle] dealing with their own life'.[113] The same research noted that homecare workers found it hard to use a language of 'skill' to discuss the abilities they put into practice in their work, preferring instead to talk about 'experience' and 'being up to date'.[114]

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[102] Scottish Social Services Council (fn61).
[103] Centre for Workforce Intelligence (fn57).
[104] Skills for Care (fn95).
[105] Social Care Wales (fn61).
[106] Centre for Workforce Intelligence (fn57).
[107] Scottish Social Services Council (fn61).
[108] Skills for Care (fn95).
[109] Scottish Social Services Council (fn61).
[110] Scottish Social Services Council (fn61) p7.

[111] UK Commission for Employment and Skills (fn57).
[112] Redfern, S., Hannan, S., Norman, I. and Martin, F. 2002. Work satisfaction, stress, quality of care and morale of older people in a nursing home. Health and Social Care in the Community. 10(6) pp512–517; Gillespie, J.Z., Barger, P.B., Yugo, J.E., Conley, C.J. and Ritter, L. 2011. The suppression of negative emotions in elder care. Journal of Managerial Psychology 26(7) pp566–583.
[113] 'Claire' as quoted in LJB Hayes (fn4) 122.
[114] Ibid, 50.

Body Work

Many skills identified so far in this report have **not recognised a core component of working in the health and social care sector: providing 'personal care' to service-users.** This centres on what might be referred to as 'body work' or 'body care', which has been described as the hands-on (and sometimes intimate)[115] activities of washing, bathing, and providing other forms of physical or bodily care (e.g. toileting; dressing; eating/drinking; helping a service-user in and out of bed).[116] These are the principal tasks carried out by care workers in their day-to-day work, in which they must negotiate and deal with 'aspects of bodily existence that modern society is reluctant to acknowledge openly'.[117] **Body work is a central component in the practice of many care workers. Nevertheless, it is overlooked in accounts of health and social care work which, instead, emphasise the social, emotional, and interpersonal elements of the job.**[118] Reports on social care rarely acknowledge this aspect of a care worker's role, which often has a distinctive gendered dimension and remains undervalued and considered broadly as 'dirty', low status, and poorly rewarded (although care workers may not necessarily recognise their labour in this way).[119] **This component of a care worker's role is rarely mentioned in the literature on care work, particularly where the knowledge and skills of care workers are discussed, and deserves far more analytical attention.**

Academic research has suggested that by overlooking the caring skills necessary in body work, wrongful social assumptions are made about the unskilled nature of hands-on care work.[120] It is significant that stigma about care work being 'dirty' appears to be reflected in the

The invisibility of body work

Much of the work undertaken by care workers involves caring for the bodies of service-users: assisting them with eating, washing, dressing, using the toilet, and/or changing incontinence pads. These bodily tasks are rarely spoken about in the context of professionalisation and are frequently unrecognised as tasks which require specialist knowledge and skill. Yet, assisting someone with using the toilet or changing an incontinence pad requires a high skill level to protect skin integrity, uphold the dignity of the service-user, and adhere to hygiene and infection control policies.

absence of body work in policy discussions about the skills needed to do care work well. **While body work remains relatively 'invisible' as a professional activity in which care workers are deeply engaged, a credible picture of the professionalism, dedication and skill of care workers cannot emerge.**

One example is end-of-life care and the care of service users immediately after they have died. There is a huge academic and policy literature on the importance of good quality end-of-life care, yet very little mention or recognition of the care workers who carry out this care and the skills that they require to do it.[121] In 2014, the UK government announced 'new priorities' for end-of-life care which called for the personalisation of caregiving to those at the end of life, and the promotion of a 'stronger culture of compassion' in health and social care institutions.[122] Little has been done, however, to establish how the accomplishment of such a culture might be made possible through particular forms of care work or to recognise the skills that are involved.[123]

End-of-life care combines physical and emotional tasks, the nature of which varies between settings and between individual cases, but which are usually focused on reducing the pain of the dying individual, maintaining their personal hygiene, making sure that they are safe and comfortable, and providing them with social and psychological support.[124] Much of this is 'body work' and

[115] England, K. and Dyck, I., 2011. Managing the body work of homecare. *Sociology of Health & Illness*, 33(2), pp.206-219.
[116] Twigg, J., Wolkowitz, C., Cohen, R.L. and Nettleton, S., 2011. Conceptualising body work in health and social care. *Sociology of Health & Illness*, 33(2), pp.171-188.
[117] Twigg, J., 2000. Carework as a form of bodywork. *Ageing & Society*, 20(4), pp.389-411.
[118] Twigg, J., Wolkowitz, C., Cohen, R.L. and Nettleton, S (fn116), Twigg (fn117).

[119] Ibid.
[120] England, K. and Dyck, I (fn115); Twigg, J., Wolkowitz, C., Cohen, R.L. and Nettleton, S (fn116); Wolkowitz, C (2006) *Bodies at Work,* London, Sage.
[121] Johnson, E.K (fn80).
[122] Department of Health (fn28).
[123] Johnson, E.K (fn80).
[124] Ellershaw, J., Neuberger, R.J. and Ward, C. 2003. Care of the dying patient: the last hours or days of life. BMJ 326(7379) pp30–34.

its purpose should be to ensure that a service user 'dies with dignity'.[125]

After death, the care provided by workers immediately includes washing and dressing the deceased's body in preparation for their transfer to a mortuary or funeral home in order to prevent the leakage of fluids from the deceased in line with infection control procedures. **It is a task which involves both practical and emotional skills, skills which are rarely taught in formalised training and which are, instead, often passed on and taught by more experienced care workers who accompany newer care workers when a service user has died.[126] Providing a 'good death' for older people in institutional settings is a key aspect of quality care but the body work upon which it depends is rarely acknowledged in relation to 'skill'.**

Examples of care workers' skills:

➢ They need specialist skills and knowledge of a medical nature. They must understand Dementia, Parkinson's disease, Diabetes and know how the impacts of these conditions can be well managed.

➢ They administer medication, record medication and prompt / assist with medication.

➢ They must deal sensitively with end-of-life care and support needs.

➢ They perform nursing tasks including PEG feeding, taking temperature, blood pressure, measure respiration and pulse, stoma care, install catheters, give insulin, manage incontinence care, prevent pressure sores.

➢ They need stroke awareness, and to be aware of signs of urinary infection or sepsis.

➢ They deal with conflict and manage stressful situations.

➢ They need body work skills to support people with toileting, dressing eating/drinking, cooking, helping in and out of bed.

➢ They need to know how to rehabilitate people after accidents, operations or lengthy hospital stays.

➢ They must promote healthy living and help others to live independently. This includes enabling service-users to be physically active. They also need to know how to promote preventative care and public health and wellbeing.

➢ They need good IT skills for themselves and to assist others.

➢ They need good literacy and numeracy skills to write reports, record information and comprehend documentation, as well as to engage with training.

➢ They require knowledge of the services that others can access and the ability to help others make decisions about whether and how to use those services.

➢ They must be able to build trust, be self-aware, promote fairness and dignity, know how to make others feel included.

➢ They must deliver personalisation (see previous section).

➢ They need the ability to communicate with and to work with staff from other sectors. They need teamwork skills.

➢ They need to know about people's rights, understand how to keep others safe and know when to raise concerns about potential safeguarding problems.

➢ They need leadership skills to motivate others and excellent stress management skills.

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[125] https://www.nhs.uk/conditions/end-of-life-care/what-it-involves-and-when-it-starts/
[126] Johnson, E.K (fn80); LJB Hayes (fn4) p130.

Professionalisation in practice

So far in this document, we have identified a range of skills that – according to various reports and research – are expected of hands-on care workers. In the UK, £5.4 billion a year is reported to be spent by the health and social care sector (as a whole) on training, yet skills gaps continue to be identified. Hopes have been expressed that by recognising the professional skills of care workers, care quality will improve and employment conditions will reflect the professional status of the workforce.[127]

The data available on the existing qualifications and skills of social care workers is patchy and, at times, contradictory. In part, this is because collecting accurate data on the social care workforce is challenging due to its fragmentary nature, high turnover rates, the lack of regulation in some parts of the sector, and the difficulties of enforcing and verifying compliance (where services are regulated). For example, the Skills for Care Adult Social Care Workforce Data Set (ASC-WDS), formerly the National Minimum Data Set for Social Care (NMDS-SC), is the largest workforce survey of care workers in the UK, but is focused only on England, and includes just 48% of the total workforce and 23% of workers working for non-CQC regulated providers.

In this section we outline induction training and standards, registration, training, qualifications, and apprenticeships. These initiatives are currently being undertaken by regulators and workforce development actors with the stated intention of aiding the professionalisation of the workforce. They often form part of the process of 'becoming' a 'hands-on' care worker; that is, the process of undertaking induction programmes, registering as a care worker, gaining social care-related qualifications, and undertaking continued training. In addition, we also note some of the more informal and less measured ways that care workers develop their knowledge and skills. We then identify a wide range of difficulties associated with delivery in practice.

High quality learning experiences have the potential to transform caring relationships

Jenny used to be a hands-on care worker. She told us about training that she received that she felt had transformed the quality of care which she was able to provide to service-users. When she started in her role, a more experienced care worker led a training session on the importance of body language. This training was hands-on and involved new recruits sitting in a wheelchair whilst another member of staff simultaneously fed them a yoghurt and spoke to another care worker. Jenny told us about the insight she gained from this training. It had helped her see how service-users' felt when care workers did not focus on them or talk to them whilst undertaking care tasks and it resulted in her providing more dignified care to service-users throughout her career.

Registration

Many care workers in Scotland, Wales, and Northern Ireland are in the process of registering, or are already registered with the Scottish Social Services Council, Social Care Wales, and the Northern Ireland Social Care Council respectively.[128] In England, however, there are no current plans to register the social care workforce,[129] despite calls for all care workers to be licenced to practice.[130] In Scotland, the SSSC register was established to regulate and promote the training and skills development of workers across social services as well as boosting public confidence in the workforce (Kingsmill suggested England should follow Scotland's lead in this respect).[131] To register, care workers must hold, or be working towards, the relevant qualifications

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127 For example in Kingsmill (fn60).
128 British Association of Social Workers (no date) All Party Parliamentary Group on Social Care Professionalisation of the Social Care Workforce Inquiry. available online at:
https://www.basw.co.uk/system/files/resources/APPG%20on%20Social%20Care%20Submission%20%5B1%5D.pdf

129 Ibid.
130 For example Kingsmill (fn60).
131 Scottish social services council (fn61); Kingsmill (fn60).

for their role. The register is open to those working in adult day care, care at home, and adult care homes, and newly appointed workers must register within six months of starting in their role.[132] All registered workers in Scotland are obliged to fulfil certain post-registration training and learning requirements.

In Wales, a register for social care workers is used to provide registered workers with access to training and development resources as well as professional recognition.[133] To register, workers must be suitably qualified and must agree to meet certain professional standards. Workers can be removed from the register if they are deemed unfit to practice. Since 2018, the register has been extended to domiciliary care workers, who must register by 2020, and adult care home workers, who must register by 2022. Welsh Government describes registration as serving the dual purposes of professionalising and raising the status of the social care workforce, and reassuring service-users and their families that workers have the qualifications and skills required to perform their work professionally,

The viability and usefulness of care worker registration is contested

Some employers' and union representatives are concerned that the need to register as a care worker may act as a disincentive for potential recruits to the care sector, making it harder to recruit care workers. In Wales, a related concern was that, put off by the need to register and meet new training and skills requirements, some existing care workers may leave their jobs, opting to join the unregistered PA workforce.

compassionately and safely.[134] When applying to register, and in order to maintain their place on the register, care workers must declare any health conditions that may affect their ability to work and must also declare that they are of 'good character'.[135] The care worker's most recent social care employer must also provide them with an endorsement of 'good character'.[136]

In Northern Ireland, social care workers, including domiciliary care workers, care home workers, day care workers, and supported living workers have been required to join a register operated by the Northern Ireland Social Care Council since 1 April 2017.[137] As part of maintaining their registration, care workers are required to meet certain learning and development requirements, such as undertaking ninety hours of post-registration learning and training during their period of registration to ensure that their skills and knowledge remain up to date.[138]

Across the UK, and particularly in England, there is a significant reliance on induction training and vocational qualifications as a means to provide a skills and knowledge base for workers to be able to carry out their roles.[139] Below, we summarise the induction training and standards specific to England, Wales, Scotland, and Northern Ireland.

England: Induction and the Care Certificate

It has been reported that, of all workers in the adult social care sector in England, 90% have completed some form of induction training.[140] In England, care workers partake in the Care Certificate, a 12-week induction training course developed by Skills for Health, Skills for Care, and Health Education England with the intention of homogenising induction training across the sector.[141] The focus of the Care Certificate is on values, dignity, and hands-on care.[142] Developed as part of the response

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[132] Scottish social services council (fn61).

[133] Social Care Wales (2018a) Providing public confidence: A report on the professional regulatory work of Social Care Wales 2017 to 2018. Social care wales. Available online at: https://socialcare.wales/cms_assets/file-uploads/Regulation-Annual-Report-Final.pdf.

[134] Ibid.

[135] Ibid.

[136] Ibid.

[137] Northern Ireland Social Care Council (2017) The regulation and development of the social work and social care workforce, April 2016-March 2017. **https://niscc.info/storage/resources/20170901_ann-report_reg-and-dev-sw-and-sc-workforce-2016-17.pdf;** Workforce Policy Directorate (fn69).

[138] Northern Ireland Social Care Council (fn107).

[139] Social Care Wales (2018b) Impact report 2017-18 Making a positive difference to social care in Wales. Cardiff: social care wales. Available online at: **https://socialcare.wales/cms_assets/file-uploads/Impact-Report-2017-18_English.pdf;** Atkinson, C, Crozier, S and Lucas, R (fn52).

[140] Atkinson, C, Crozier, S and Lucas, R (fn52).

[141] UK Commission for Employment and Skills (fn57).

[142] Ibid.

to the Cavendish Review which highlighted a series of shortcomings in the provision of social care,[143] the Care Certificate has been mapped on to National Occupational Standards (NOS) for social care.

However, there is no legal requirement on employers to ensure their staff engage with the Care Certificate. Rather, they are required to follow the Care Certificate standards, meaning that the Care Certificate is a training benchmark, not a training requirement. It provides a recognised set of standards that care workers in England ought to abide by. It replaced Common Induction Standards for the sector in April 2015 and is used to promote certain skills, knowledge and behaviours that care workers ought to have and demonstrate.[144]

Though the certificate is available to all hands-on care workers, it is principally targeted at workers who have just started working in the sector.[145] The certificate is made up of fifteen standards that are expected to be covered in induction programmes across the care sector: understanding your role; your personal development; duty of care; equality and diversity; working in a person-centred way; communication; privacy and dignity; fluids and nutrition; awareness of mental health, dementia and learning disabilities; safeguarding adults; safeguarding children; basic life support; health and safety; handling information, and; infection prevention and control.

Importantly, the Care Certificate is not accredited as a *qualification* but, once completed, it might be used to count towards a qualification. However, there is criticism of the usefulness of the Care Certificate because of a lack of consistency in delivery across the sector.

> "there was no external validation of the [care] certificate. This meant that, while the participants' care homes used the

certificate to design its own induction programme, it could not be sure that care workers who had achieved the certificate elsewhere had been adequately trained. They would therefore make them repeat the induction programme, and some employees would note differences between the difficulty of achieving the certificate at their current care home compared to other homes outside of the organisation[146]

Alternatively, we were told by employers' representatives that low levels of completion of the Care Certificate may be because it was overly prescriptive. An example was that the required standards were not universally relevant to hands-on care roles and, as such, some care workers may find it difficult to meet all the training requirements for completion.

Skills for Care, using the Adult Social Care Workforce Data Set indicates that, in England, 68% of all hands-on care workers who have started working in adult social care since 2015 have either completed, partially completed, or are in the process of completing the Care Certificate (32% have completed the Care Certificate and 36% are in the process of completing it).[147] This figure indicates that 32% of those working in the sector since 2015 have not started the Care Certificate. Indeed, Care standards inspectors have reported that about a third of care workers do not get basic induction training when they start a new job and research has found instances where managers claim to provide training but workers say there is no training at all.[148]

Engagement with the Care Certificate varies widely across the care sector. For example, 40% of domiciliary care workers in the sector since January 2015 have completed the Care Certificate compared to only 21% of care workers in care homes.[149] Though PAs are not

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[143] Ibid.
[144] Skills for Care (2018) The state of the adult social care sector and workforce in England, September 2018, Skills for Care: Leeds. Available online at: https://www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2018.pdf accessed 21 May 2019.
[145] Ibid.
[146] Evidence presented by care workers at a private meeting with members of the Economic Affairs Committee, House of Lords (fn3) Appendix 4.

[147] Skills for Care (fn144).
[148] Atkinson C et al (2016) Factors that affect the recruitment and retention of domiciliary care workers and the extent to which these factors impact upon the quality of domiciliary care: Interim findings summary, Welsh Government; D Boffey (2015) Cash-starved, demoralised, and sometimes cruel: How England's social care system fails the most vulnerable. The Observer, 8 August.
[149] Skills for Care (fn144).

required to complete the Care Certificate, 27% have engaged with it.[150] **Evidently, there is a large discrepancy in England in the numbers of care workers in different types of services who have completed the recommended induction training.**

Wales: All Wales Induction Framework for Health and Social Care

In Wales, the All Wales Induction Framework for Health and Social Care was developed and launched in 2017.[151] This new framework was, in part, a response to recognition of a need to prepare health and social care workers for a more joined-up approach to service delivery.[152] Social Care Wales indicates that induction training can boost employee commitment by acting as a demonstration to new workers that they are valued by their employers, who are investing in their training and development.[153] Those working with adults are expected to complete five workbooks which include: principles and values, health and wellbeing, professional practice, safeguarding individuals, and health and safety.[154] For care workers required to register with Social Care Wales, this induction training is mandatory. In their impact report,[155] Social Care Wales reported that it invested £11.1 million in supporting the social care workforce 'so they have the right knowledge, skills, understanding and approach to provide good care and support'. They also report paying £7.15 million to local authorities which was match-funded (£3.06 million) through local authority funding (the local authorities also invested another £2.27 million into workforce development and training).[156]

Scotland: SSSC Induction Training

In Scotland, employers are expected to provide a good quality induction to new workers, but there is not a national induction programme, such as the Care Certificate in England. The Scottish Social Services Council (SSSC) has a Common core of skills, knowledge and values[157] – which includes skills in self-awareness, building trust, promoting dignity and fairness, and engaging people – to be used by anyone working with Scotland's people to provide social care / social services.[158] There is an intention to draw on this to design a multi-professional 'induction passport' all for public sector workers, but this has yet to be realised.

Northern Ireland: NISCC Induction Programme

In Northern Ireland, there are common induction standards.[159] The Northern Ireland Social Care Council (NISCC) launched a new induction programme in 2018 which is to be completed by all individuals entering the social care workforce within six months of starting in their role. The programme must also be completed by care workers who are changing employer or job role, regardless of their qualification level. The induction programme comprises seven modules which include: understanding duties and responsibilities; communicating effectively; delivering person-centred care; safeguarding individuals; maintaining health and safety at work; developing as a social care worker, and; standards of conduct (values, attitudes, and behaviours).[160] These modules are closely aligned to the NISCC Standards of Conduct and Practice. Applications for registration are part of a care workers' induction into their new role and completed training and learning is recorded as part of this registration.[161]

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[150] Skills for Care (fn144).

[151] Social Care Wales (fn139)

[152] Social Care Wales (fn61).

[153] Social Care Wales (fn139).

[154] Social Care Wales (2017) All Wales induction framework for health and social care: Introduction and guidance. Available online at: https://socialcare.wales/cms_assets/file-uploads/AWIFHSC-Intro-and-Guidance.pdf

[155] Social Care Wales (fn139).

[156] Ibid.

[157] Scottish Social Services Council (no date) Common Core of skills, knowledge and values. Available online at: http://ssscnews.uk.com/wp-content/uploads/Common-Core-Skills-Grid-2016.pdf.

[158] Scottish Social Services Council (2016) New Common Core of Skills, Knowledge and Values. Available online at: http://ssscnews.uk.com/2016/03/15/new-common-core-of-skills-knowledge-and-values/.

[159] Workforce Policy Directorate (fn69).

[160] Northern Ireland Social Care Council (no date) Induction Workbook. Available Online at: https://learningzone.niscc.info/storage/uploads/Induction-Booklet-Guidance-for-Social-Care-Workers%20(WEB).pdf.

[161] Northern Ireland Social Care Council (no date) Registration Standards. Available Online at: https://niscc.info/registration-standards.

The extent of training

Compared to other sectors, a great deal of training is reported to take place in the adult social care sector. The UK Commission for Employment and Skills (UKCES) reports that, in 2013, 90% of health and social care establishments in the UK provided training, which compared to 66% of employers in the economy as a whole.[162] This figure was highest in Scotland, where 95% of establishments were reported to provide training. In England, 81% of the hands-on care workers who were included in the Adult Social Care Workforce Dataset (ASC-WDS) are said to have completed some form of training relevant to their role.[163] Other reports of skills development in the social care sector, however, indicate much lower levels of training for care workers. For example in England, the Kingsmill Review reported that one third of care workers do not receive any regular ongoing training and one fifth of health and social care apprentices receive no training at all.[164] Of UK social care employers who were reported by the UK Commission for Employment and Skills to provide training, 70% offered both 'on-the-job' and 'off-the-job' training'.[165] **While we know some information about the formal training courses frequently undertaken by care workers, we know much less about the on-the-job, informal training that they might receive**. In what follows, we outline two forms of training for care workers, distinguished as on-the-job training and off-the-job training.

On-the-Job Training

Many care workers undertake 'shadow shifts' as part of their induction training. These are initial shifts where new care workers observe another care worker (or care workers) in order to learn, for instance, the practicalities of delivering hand-on care, the names and preferences of individual service-users, and organisational routines. **Shadow shifts are rarely discussed in the literature on the care workforce, despite forming a core part of the induction training of most care workers and representing a vital way for experienced care workers to pass on their knowledge and skills.** Shadow shifts are often reported to be unpaid or underpaid and they also involve the transfer of skills and knowledge from more experienced care workers, often without these care workers being paid for their training skills or being acknowledged for having skills as trainers.[166] Skills for Care encourages social care employers to use shadow shifts as a means to attract and select the right people to join their workforce, that is, it suggests that shadow shifts are a way to see if individuals are right for the care work role.[167] It appears that, though a standard part of a new employee's induction, shadow shifts may be being recorded by employers as unpaid work trials. This requires further attention in the literature.

Academic studies have highlighted the importance of 'learning on the job' in occupations such as care work. This form of training is highly valuable because it enables workers to gain new knowledge from handling objects or using equipment in occupational settings and to acquire skills by handling real people in authentic situations.[168] In addition, learning on the job allows care workers to gain practical skills and knowledge from more experienced care workers. **However, there is an absence of research about workplace learning in social care and consequently very little has been written about the way in which care workers, and especially homecare workers, know about and learn about caring in practical ways.** The example of end-of-life care provides a good illustration of the central importance of on-the-job training, of the passing down of ways of knowing and doing from one care worker to another, but it also indicates its virtual invisibility in formal discussions of care workers' skills.

[162] UK Commission for Employment and Skills (fn57).
[163] Skills for Care (fn144).
[164] Kingsmill (fn60).
[165] UK Commission for Employment and Skills (fn57).
[166] Johnson, E.K. (2018); LJB Hayes (fn4); Interview data gathered for this report.
[167] Skills for Care (2018b) Guide to safe staffing [online] Available at: https://www.skillsforcare.org.uk/Documents/Standards-legislation/CQC/Safe-staffing/Safe-staffing-guide.pdf

[168] Gherardi S (2006) *Organizational knowledge: The Texture of Workplace Learning*, Blackwell Publishing; Hopwood N (2014) Four essential dimensions of workplace learning, *Journal of Workplace Learning,* 26 (6/7), pp349-363; Harman K (forthcoming) Taking care – possibilities for reconfiguring 'the distribution of the sensible' in paid homecare work, available from k.harman@bbk.ac.uk

Off-the-Job Training

In contrast to on-the-job training, such as shadow shifts, off-the-job training (i.e. workers do not perform their regular labour and are requested to attend training instead) is more often recorded by employers in official reports and records. It appears that the most popular areas of formal training received by care workers mirror areas of regulatory priority, such as areas covered in national induction standards. In a study of care homes carried out by Gospel and Lewis,[169] it was found that training in mandatory topics such as health and safety, moving and handling, the protection of vulnerable adults, and infection control appeared to be built into the routines of care homes. The areas of training that were most frequently recorded by care workers, as included in the ASC-WDS in England, were moving and handling (75%), safeguarding adults (71%), and health and safety (63%).[170] Other popular training categories were fire safety (60%), food hygiene (57%), prevention and control of infection (55%), first aid (55%), medication safe handling and awareness (53%), the Mental Capacity Act and deprivation of liberty safeguards (49%), and dementia care (41%). These areas of training priority suggest that employers are motivated to reduce their liabilities in the event of accidents or errors and to reduce the risk of safeguarding concerns arising.

Within the adult social care sector in England, there is variation in the type of training undertaken in different parts of the care workforce. For example, the training undertaken by PAs appears to reflect the likelihood that they are engaged in lone working; prioritising first aid training (75%) and health and safety training (73%). They appear less likely than other care workers to have completed training in safeguarding adults (60%). The amount and type of training most likely to have been undertaken by PAs was, in part, related to whether they were a friend or family member of the individual receiving care.[171] PAs who were not family members or friends reported more training in almost all categories than those who were family members or friends of the person receiving services.[172] However, the work of PAs across the UK is unregulated and there are no formal expectations of undertaking training or meeting induction standards.

In summary, and as may be expected in a market-based system, the type and degree of training undertaken by care workers varies by employer and by care setting. All training in England, including induction training, is employer-led. Across the UK, training is characterised by localised, as opposed to centralised, delivery. This leads to much variation in who provides training to care workers, when and where such training takes place, how it is delivered (online, using DVDs, face-to-face), the quality of learning experiences, how learning is assessed, and whether training achievements are certified.

Qualifications

As well as undertaking induction training, being registered, and having both on-the-job and off-the-job training, care workers are often expected to have the necessary qualifications to perform their roles. The Care Standards Act 2002 required that half of the workforce of a registered provider were qualified to at least NVQ level 2, the equivalent of a school-leaving age qualification at age 16.[173] However, there were many difficulties with reaching the NVQ 2 benchmark across the sector and the benchmark was replaced by the Qualifications and Credit Framework, and most recently, by the Regulated Qualifications Framework.[174] Evidence suggests that the introduction of qualification targets back in 2002 had a positive impact on the uptake of qualifications in care homes.[175] Indeed, Skills for Care indicates that around 50% of the total adult social care workforce in England have a relevant adult social care qualification, albeit that it maybe not be an NVQ, and may not be at a level 2 standard.[176] That percentage is higher for senior care

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[169] Gospel, H. and Lewis, P.A., 2011. Who cares about skills? The impact and limits of statutory regulation on qualifications and skills in social care. *British Journal of Industrial Relations*, 49(4), pp.601-622

[170] Skills for Care (fn144).

[171] Ibid.

[172] Ibid. 20% more of PAs who were not family members or friends had received safeguarding training and 19% more had received training in

dignity, respect and person-centred care, as well as mental capacity and deprivation of liberty.

[173] Atkinson, C, Crozier, S and Lucas, R (fn52).

[174] Unison, Introducing the Care Certificate, A Unison branch guide, https://www.unison.org.uk/content/uploads/2015/04/On-line-Catalogue23121.pdf accessed 9th July 2019.

[175] Gospel, H. and Lewis, P.A. (fn169).

[176] Skills for Care (fn144).

workers, of whom 84% hold a relevant adult social care qualification. However, reports have provided different figures and reveal a discrepancy in figures, with some suggesting that the acquisition of vocational qualifications in England is as low as 30%.[177] **Hence we can estimate that between 50% and 70% of social care workers in England do not have an occupationally relevant qualification.** With respect to PAs, it is reported that 45% of PAs in England hold a relevant adult social care qualification. PAs are more likely than other care workers (19%) to be qualified to level 3 and above (25%), though fewer hold a qualification at level 2 or above (39% compared to 49% of other care workers).[178] **This points towards a split in the PA workforce where there may be many highly qualified PAs but, also, a large number of PAs who are entirely without formal qualifications.**

In Wales, a new package of health and social care related qualifications, the core content of which will mirror the all Wales Induction Framework for Health and Social Care, is expected to be delivered in late 2019.[179] Data collected on 130 regulated services and 83% of commissioned social care services in Wales indicates that there is some variation in the uptake of required qualifications between care workers working in different local authority areas, in differently managed services (e.g. private/local authority managed), and in different roles and levels of seniority.[180] **Amongst those working for commissioned care providers, 58% of care workers and 80% of senior care workers had the required qualifications for their role,[181] whereas amongst those working in services managed by Welsh local authorities, these figures were 68% and 88% respectively,[182] with 100% of senior care workers in 9 local authorities having the required qualification for their role.** The percentage of care

workers with the required qualifications for their role was lowest amongst PAs in Wales, at just 15%.[183] In Scotland, by comparison, the SSSC's consultation of care workers and employers identified that there was a shortage of potential employees who held the appropriate qualifications to work in the sector.[184]

It is worth noting here that low qualification rates are seen to reinforce the perception that the social care sector in low-skilled.[185] It has been argued, however, that the social care workforce is labelled in this way because it is predominantly made up of women and the work itself is considered 'women's work'.[186] The issue of low qualification rates is very complex and the argument that this is evidence of care work being 'low-skilled' is flawed.

As well as qualifications, apprenticeships are being used to develop the sectors' skills and knowledge base. For instance, the Scottish Social Services Council has developed foundation apprenticeships in social services and health care.[187] In England, Skills for Care recently introduced a Higher Apprenticeship (HA) in Social Care that relates to the QCF Level 5 Diploma in Leadership for Health and Social Care.[188] The introduction of the Higher Apprenticeship is identified by Kingsmill as a 'big development' which will enable care workers with little or no formal qualifications to gain university degrees.[189] The Kingsmill review suggests that, with the development of a new nursing apprenticeship announced by the Department of Health in March 2014, experienced care workers will, in the future, be able to pursue a nursing degree on the job.[190] One potential challenge of this, however, is that the social care sector will lose its newly skilled apprentices to healthcare organisations.[191] There has also been concern expressed amongst nurses that such apprenticeships will deskill the nursing role.[192] As we report in the next

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[177] Atkinson, C, Crozier, S and Lucas, R (fn52).
[178] Skills for Care (fn144).
[179] Social Care Wales (fn61).
[180] Data Cymru / Social Care Wales /Welsh Gov (fn76, 2017a); Data Cymru / Social Care Wales /welsh gov (fn99, 2017b).
[181] Data Cymru / Social Care Wales /Welsh Gov (fn99, 2017a).
[182] Data Cymru / Social Care Wales /welsh gov (fn99, 2017b).
[183] Data Cymru / Social Care Wales /Welsh Gov (fn99, 2017a).
[184] Scottish Social Services Council (fn61).
[185] Atkinson, C, Sarwar, A, and Crozier, S (fn61).
[186] Ibid.
[187] Scottish Social Services Council (fn61).

[188] Kingsmill (fn60).
[189] Ibid.
[190] Ibid.
[191] Skills for Care (2017) Scoping Integrated Apprenticeships in Health and Social Care [Online]. Available at:
https://learning.wm.hee.nhs.uk/sites/default/files/ICT_Integrated%20Apprenticeships%20Final%20Report%2012%20June%202017.pdf
[192] Davies, J (2017) We must approach the introduction of new nursing roles with caution. Nursing Times. [Online] available at:
https://www.nursingtimes.net/opinion/we-must-approach-the-introduction-of-new-nursing-roles-with-caution/7015767.article

section, there are a number of difficulties and challenges associated with schemes designed to help care workers develop their knowledge and skills.

Challenges for Delivery

As outlined above, a series of publications/reports suggest that attempts to professionalise the workforce are a means to boost both the quality of care and employment conditions in the sector. In what follows, we outline the difficulties of delivering the professionalisation of the social care workforce and attempts develop the knowledge and skills of workers. Problems have historically included a **lack of regulatory clarity, lack of funding and a lack of enforcement in relation to training standards**, especially in England where there continue to be few formal mechanisms in place to professionalise the workforce through upskilling or registration (see the following section).[193] **Staff have expressed concerns about requirements that they become formally qualified** in order to establish themselves as professionals.[194] For example, Social Care Wales indicate that **managers have shared their apprehensions about the new Induction Framework in Wales and, in particular, about whether they possess the relevant knowledge and expertise required to support their staff and the time to assess them.**[195] Moreover, in their consultation on the same framework prior to its launch, some stakeholders were concerned that the completion of the framework would amount to a 'tick-box' exercise.[196]

Relatedly, there have been concerns raised that NVQs in health and social care – which are available in England, Wales and Northern Ireland – function as assessments and certification of *existing* competencies rather than training programs designed to enhance workers' skillset for the future and provide new information and instruction.[197] This, in turn, leads to **concerns that such qualifications do not improve**

existing skills levels. Nonetheless, evidence suggests that NVQs can bring benefits to both care workers and their employers.[198] In Scotland, training courses may be available, but the quality is reported by staff as being limited and they say only minimal time is available to attend the courses, reflect on one's learning and put it into practice.[199] Moreover, **training may be provided but it is not certified. Workers can find it virtually impossible to attend training if they work part-time, as night-shifts workers, as lone workers, in very small or rural service settings, and/or have other care responsibilities (e.g. childcare).**[200] It has been reported, too, that domiciliary care workers are often isolated from other staff and do not receive the necessary support to determine whether they are delivering care at an appropriate level.[201]

Kingsmill identified that (in England) only 72% of UK workers are reported to have completed any induction and how, when completed, this induction is of a short duration and offers a low-level of learning.[202] A minority of care workers (41%) are reported to have access to specialised training to help manage their client's specific medical needs, such as stroke-related conditions and dementia, despite being identified as a key component of a care worker's role (as discussed earlier).[203] Kingsmill also identified that a third of care workers were reported to not receive regular ongoing training.[204]

A further difficulty in the delivery of training concerns **costs and funding.** The UK Commission for Employment and Skills, indicates that the two principal reasons that health and social care employers give for not offering additional training are costs (69%) and being unable to spare the staff time (48%).[205] The UK Commission for Employment and Skills suggested that this was a consequence of cost pressures in the social care market which reduced the amount of money available for employers to invest in training and

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[193] Ibid.
[194] Based on some interviews we conducted for this report, see also UKHCA (2019) A Survey of Homecare Providers in Wales, Version 1, March 2019.
[195] Social Care Wales (fn139).
[196] Social Care Wales (fn61), see also UKHCA (2019) A Survey of Homecare Providers In Wales, Version 1, March 2019.
[197] Gospel, H. and Lewis, P.A., (fn169), also interviews conducted for this report.

[198] Ibid
[199] Scottish Social Services Council (fn61).
[200] Ibid.
[201] Kingsmill (fn60).
[202] Kingsmill (fn60).
[203] Ibid.
[204] Ibid.
[205] UK Commission for Employment and Skills (fn57).

development. In England, for example, **local authority funding for care does not incorporate a payment to care providers for time spent in training.**[206] Other studies have noted the implicit training costs which are largely borne by employers.[207] This includes the costs of replacing staff who take time out of work to train or be assessed, or to train or assess their junior colleagues. **High levels of labour turnover in the sector means that time spent training risks time being wasted on workers who leave soon after joining the workforce.**[208] When workers remain within the workforce, a further concern of employers and managers is **the need to fund cover** – that is, the practical problem of altering work rotas to ensure care workers can take time out for training and assessment.[209]

For workers, concerns have been raised about accessibility. For example, the Social Care Wales' consultation indicated **a need to develop more accessible training, particularly for domiciliary care workers who are unlikely to have a shared fixed workspace.**[210] Another issue was a lack of time to be able to sufficiently engage in training programmes. In Gospel and Lewis' study of NVQ qualifications, many care workers reported that they had **insufficient time to carry out the homework required for NVQs, often because of other caring responsibilities.**[211] Interviewees suggested that an NVQ2 required care workers to study for 1-2 hours per week in their own (unpaid) time, and this was a significant barrier to overcome.[212] Similarly, Social Care Wales suggests that care workers have expressed concerns about the amount of time it will take for them to gain the necessary qualifications for registration and about the cost of registration fees.[213]

Prior to the launch of the All Wales Induction Framework for Health and Social Care, care workers conveyed their **anxieties about the wide scope of competences that**

they were required to establish and, as such, whether they would have enough time to undertake the framework within the proposed six months.[214] Lack of confidence with basic literacy and numeracy skills may be an important factor underpinning some care workers' fears about training. **However, there has been very little research undertaken about the functional and day-to-day literacy and numeracy skills and practices of care workers.** There may also be issues with language competencies for care workers who do not speak English (or Welsh) as a first language. Some of these workers may find it harder to adequately complete the required tasks. This relates to the **concern raised that literacy and numeracy are not always tested,** as there are often no minimal requirements to begin working in the sector.[215]

A further challenge of attempting to develop care workers' knowledge and skills is **the notion of progression for workers.** As identified by the UK Commission for Employment and Skills, progression is an ongoing skill challenge across the social care sector.[216] There are frequently **limited career choices** and, although, some employers offer progression to 'senior care worker', the proportion of these roles is relatively small. In addition, in England, Skills for Care reports that the median difference in pay between care workers and senior care workers is a mere £0.50 per hour.[217] Advancement to higher level jobs can also be 'blocked' by nursing or other professional requirements needed for progression.[218] Nonetheless, it is possible that retention levels have been improved by training requirements, particularly where qualifications boost a care worker's chances of progression.[219]

Yet concerns remain about the financial viability of undertaking training and further qualifications. One barrier to the uptake of NVQs and other training, for example, is care workers' awareness that, although

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[206] Atkinson, C, Crozier, S and Lucas, R (fn52).
[207] Gospel, H. and Lewis, P.A. (fn169).
[208] Kingsmill (fn60).
[209] Gospel, H. and Lewis, P.A. (fn169).
[210] Social Care Wales (fn64).
[211] Gospel, H. and Lewis, P.A. (fn169).
[212] Ibid.
[213] Social Care Wales (fn139).

[214] Social Care Wales (fn61).
[215] Kingsmill (fn60). Although see regulatory requirements for evidence of linguistic skills in Wales and Northern Ireland discussed later in this report.
[216] UK Commission for Employment and Skills (fn57).
[217] Skills for Care (fn95).
[218] Gospel, H. and Lewis, P.A. (fn169).
[219] Gospel, H. and Lewis, P.A. (fn169).

there is some evidence of links between pay and skills,[220] **the financial rewards for completing training and vocational qualifications, in general, remains relatively small.[221]** It is ostensibly difficult for care workers to understand how qualifications relate to opportunities for progression, job titles, and pay rates,[222] and it has been reported that, in England, high levels of staff turnover mean that, despite many care workers beginning on vocational qualifications, **few complete them.[223]** Similarly, Kingsmill reports that qualifications in social care are 'patchy';[224] the Care Quality Commission's oversight of workforce issues, according to Kingsmill, is 'weak and **the provision of training and education relies on a fragmented independent sector'.** Training is described as varying considerably with no enforcement of a common framework for workers – and with a 'poor regulation of training providers and no enforcement of a standardized system for qualifications' - which, in turn, produces questions about qualification quality. Kingsmill adds that the workforce typically employs older women or migrant workers, who have few other employment options (younger people are perceived as reluctant to join given that there is no career progression).[225]

Another challenge identified in terms of delivering appropriate training and induction are shortcomings in the allocation of funding. The UK Commission for Employment and Skills, for instance, notes that, **care work tasks can mimic those undertaken in nursing roles, but that care workers' specialist training is less formalised, less well-funded, and does not precede entry into the workforce. [226]** In Northern Ireland, it is claimed that, in the independent sector, investment in learning and improvement for social care workers, including through funded training, is typically more limited compared than other areas of the UK.[227] In Scotland, private sector employees report fewer funding

sources for workforce developments compared to employees in the public sector,[228] though the latter similarly identifies an inability to access 'modern apprenticeships'.[229]

Finally, and within the research literature more broadly, emphasis has been placed on the need for adult social care organisations to match their commitment to training with a similar commitment to good employment practices, such as pay, career development, and working conditions, including employment security.[230] This is vital if they are to recruit and effectively retain trained staff and, in turn, increase care quality.[231] For Kingsmill, a poor investment in training and progression for employees is a **'false economy'**; [232] 'where extensive training is invested in and career pathways are open to all workers, employers benefit from improved quality of service, improved worker satisfaction and performance, and reduced costs due to lower turnover rates'.[233]

Some reports have made recommendations for addressing learning and development challenges. In Scotland, this includes organisations developing their own qualifications, working alongside providers and local authorities (particularly in rural areas), helping workers to identify a link between their training and practice, and identifying a career structure and progression opportunities for workers.[234] Kingsmill's recommendations include (but are not limited to) professionalising services (this is related specifically to England), providing high-quality training, introducing a 'two-week shadowing period' for new employees before working unsupervised, and working with Higher Education bodies to bridge vocational and academic qualifications.[235] However, reports documenting extensive formal recommendations remain in their infancy and require further attention.

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[220] Atkinson, C, Crozier, S and Lucas, R (fn52).
[221] Gospel, H. and Lewis, P.A. (fn169).
[222] Kingsmill (fn60).
[223] Atkinson, C, Crozier, S and Lucas, R (fn52).
[224] Kingsmill (fn60).
[225] Ibid.
[226] UK Commission for Employment and Skills (fn57).
[227] Workforce Policy Directorate (fn69).
[228] Scottish Social Services Council (fn61).

[229] Ibid.
[230] Gospel, H. and Lewis, P.A. (fn169); Atkinson, C, Crozier, S and Lucas, R (fn52).
[231] UK Commission for Employment and Skills (fn57).
[232] Kingsmill (fn60).
[233] Ibid.
[234] Scottish Social Services Council (fn61).
[235] Kingsmill (fn60).

Summary of Professionalisation in practice

➢ In England, there is a reliance on induction rather than occupational registration. However, there is no legal requirement on employers to ensure engagement with the Care Certificate. The Care Certificate is not a qualification.

➢ Only 1/3 of care workers in England have completed the Care Certificate, a further 1/3 have begun it but not completed it and the remaining 1/3 have not started.

➢ There is a large discrepancy in the number of care workers in different type of services who have completed induction training.

➢ In Wales, the emphasis is on training as a mechanism through which care workers can learn that they are valued by employers. The purpose of sector-wide training is to provide good care and it is mandatory for workers who must register.

➢ In Scotland there is no national induction programme as yet, but it is forthcoming.

➢ In Northern Ireland common induction standards and a training programme must be completed by all workers within 6 months of starting a new role. Applying for registration is part of the induction and completed training and learning is recorded through registration.

➢ Many workers in Wales, Scotland and Northern Ireland are already registered or in the process of registering as social care workers. Registration is linked to training in all these nations.

➢ 'On-the-job' shadow-shift training is a very important practice within the sector, but it is under-recognized and under-researched. Workers' abilities to train up their peers and new starters are not formally acknowledged or valued.

➢ 'Off-the-job' formal training is predominantly concerned with health & safety and safeguarding issues, suggesting employers are motivated by reducing potential liabilities in the event of errors or accidents.

➢ The type and extent of training varies by employer and by care-setting. All training in England is employer-led, including inductions.

➢ Across the UK, training is characteristically localised, there is much variation in who provides it, where it happens, how it is delivered and assessed, and the quality of learning, including certification.

➢ Levels of relevant qualifications across the care workforce are unclear. Between 50%-70% of care workers in England do not have an occupationally relevant qualification. Levels of qualification are much higher in Wales, particularly in the Welsh public sector where 68% have a relevant qualification. In England, 39% of PAs have at least an NVQ level 2 qualification compared with only 15% in Wales.

➢ Care workers have expressed concern about gaining formal qualifications and anxieties about the range of competencies required. Fears about literacy and numeracy abilities may be an important factor. There is a view that qualification may accredit existing practices but does not improve skill levels. If training is not certified is may be regarded as worthless.

➢ Care workers can find it hard to access training outside of working hours and they often have no time for 'homework'. There is little financial reward for becoming better trained and little opportunity for career progression. Homecare workers, in particular, can find training difficult because they have no fixed place of work and insecure and zero-hour contracts are especially common in homecare jobs.

➢ Managers have expressed concerns about whether they have the knowledge to support staff and assess their learning. They can have difficulty in finding cover for staff in training and risk wasting resources on training staff who often leave their jobs within the first few weeks.

➢ Employers have expressed concerns about a lack of funding for training and about the low rates of local authority funding for social care services, which does not include the costs of training.

Regulation of staffing and standards: Overview

This section sets out the staffing standards that are required in social care provision and the legal obligations on both providers and workers to meet those standards. The section is split into four parts according to each country within the UK. **Each part begins with an overview of the regulatory framework within the relevant country before examining a number of core matters in relation to staffing, including the 'fitness' of workers, qualifications and training, and obligations on workers themselves.**

Across the UK, regulation is the key means of maintaining standards in social care provision in general, including the standards of the care provided by the workforce. **There are distinctions and differences of emphasis in regulation in each of the countries of the UK, the most significant of which is the ongoing decision in England not to register the social care workforce.** In all the other UK countries, registration of the workforce is in place or ongoing. The regulation of providers of care services is carried out in each of the UK countries, with the registration of providers and the workforce separated and under the control of different agencies.

Summary of regulation in England

➢ Care workers are not regulated as an occupational group and are not required to register with a professional body.

➢ Employing a PA to undertake personal or nursing care is not a regulated activity.

➢ The decision to reject registration in 2011 was based on concern for cost.

➢ Providers must be registered and meet fundamental standards of care.

➢ Three regulatory standards relate to workers: on staffing levels, on ensuring workers are fit and proper persons, and in respect of safeguarding.

➢ It is the responsibility of employers to ensure workers are fit and proper persons.

➢ There is no offence committed if a provider breaches standards relating to workers (unless avoidable harm or exposure to a significant risk of harm results from a breach of the safeguarding regulation).

➢ There is no minimum qualification level for care workers in England and no minimum qualification standard.

➢ It is an employers' responsibility to ensure employees receive adequate training, support, professional development, supervision and appraisal.

➢ The employer determines what is appropriate and adequate.

➢ The key regulatory training requirement in is an adequate induction and the definition of adequacy is at the discretion of the employer.

➢ Ensuring workers' fitness to practice is achieved by CQC inspections and checks by the Disclosure and Barring Service (DBS).

England: Regulation of staffing and standards

Introduction and regulatory framework

In England, the organisation and delivery of social care is provided within a legal framework established by the Health and Social Care Act 2008 (as amended) (the 2008 Act) and attendant Regulations. This Act established the Care Quality Commission (CQC) to regulate and inspect care provided in a variety of contexts, including social care provided by local authorities and care provided by the NHS. Distinctively in the countries of the UK, social care workers in England are not regulated as an occupational group and are not required to register with a regulatory agency.

Registration has been previously considered in the English context. In 2007, the Department of Health announced that within three years every social care worker in England would be required to formally register with a professional body.[236] Registration based on training and professional ethics was to be underpinned by the potential to refer complaints to fitness to practice panels. The declared purpose was to 'improve safety, assure protection and improve the quality of services'.[237] Further embedding the connection between registration and needs to safeguard service-users, the national workforce strategy for England detailed: 'the conduct and practice of some [care workers] falls below what society would expect'. Its proposed workforce registration scheme would be 'holding [workers] to account against codes of practice for social care workers'.[238] The registration scheme failed to materialise by 2010, a stumbling block had been cost. In 2011, Secretary of State for Health Andrew Lansley MP scrapped the proposed registration scheme:

The risk to service-users and the general public posed by groups of unregulated health and social care workers is not considered to be such that regulation of individual workers is necessary ... the Government does not believe that the extension of statutory regulation to all workers in the health sector across the UK and the social care sector in England would be a proportionate response. The emphasis should be on employers of unregulated workers to take responsibility for the quality of services provided.'[239]

Accordingly, the government in Westminster had downgraded the risk of safeguarding problems in England and argued care worker registration would be disproportionate. Responsibility for professional conduct was purported to lie with providers. In England, ensuring the fitness of care workers is achieved through a combination of inspections at establishments by the CQC and the provision of pre-recruitment checks on workers by the Disclosure and Barring Service (DBS).

Under section 3 of the 2008 Act, the main objective of the CQC is to encourage the improvement of health and social care services, the development of health and social care services that focus on the needs and experiences of those using care, and the efficient use of resources in care provision. Under the Act, various activities are designated 'regulated activities.[240] Any organisation carrying out any of these activities is required to register with the CQC,[241] and to have a registered manager for each regulated activity it

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[236] Kirsty McGregor, 'Government rules out registration for social care staff' *Community Care* (16th February) <http://www.communitycare.co.uk/2011/02/16/government-rules-out-registration-for-social-care-staff/>

[237] Department of Health, *Working to Put People First: The Strategy for the Adult Social Care Workforce in England* (2009) p47.

[238] Ibid, p48

[239] Secretary of State for Health, *Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers* (Cm 8008, presented to Parliament, February 2011), Para 4.2

[240] Section 8. Regulated activities are set out under Schedule 1 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

[241] Sections 10-12, Health and Social Care Act 2008. Under s10 of the 2008 Act it is an offence to carry out a registered activity without being registered. For information on which organisations are required to register with the CQC, see: Care Quality Commission, 'The Scope of Registration' (March 2015) https://www.cqc.org.uk/sites/default/files/20151230_100001_Scope_of_registration_guidance_updated_March_2015_01.pdf accessed 20 May 2019.

undertakes.[242] Regulated activities include the provision of personal care and the provision of residential accommodation together with nursing or personal care.[243] **Employing a PA to undertake personal or nursing care is not a regulated activity.**

Regulations under the 2008 Act create a wide range of legal duties on those carrying out 'regulated activities'. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended) ('the 2014 Regulations') are pivotal, and contain, in Section 2, a series of 'fundamental standards' for care. The CQC describes these as standards below which care cannot fall.[244] These include, for example, a duty on providers to provide person-centered care, requirements to provide care in a way that treats those using support with respect and ensures their dignity, the obligation to safeguard anybody using a service from abuse or improper treatment, and a duty to ensure the good governance of care providers. **The fundamental standards include three which relate specifically to workers – Regulation 18, which relates to staffing, Regulation 19, which imposes an obligation to ensure that 'fit and proper' persons are employed to provide care, and Regulation 12(2)(c), which is about safeguarding.** The CQC monitors and inspects services according to every aspect of the legal duties imposed by these Regulations. It has developed guidance on the Regulations[245] to which providers of regulated activities must have regard,[246] and is legally required to take this guidance into account when making regulatory decisions.[247] Since April 2015, the CQC has also been required to monitor the financial sustainability of care providers that would be difficult for local authorities to replace in the event of the provider becoming unable to continue to deliver services.[248]

The CQC may carry out routine 'comprehensive' inspections of adult social care services or 'focused' inspections in response to a particular concern being raised. Inspections are based on five 'key questions': is the service safe, effective, caring, responsive and well-led?[249] A number of further questions have been established under each of these aspects. Following an inspection, the CQC will rate the service 'outstanding', 'good', 'requires improvement' or 'inadequate'.

Staffing requirements and the 'fitness' of workers

In England, any service provider carrying out a regulated activity is under a legal obligation to **ensure that there are adequate staff numbers, and that staff are 'suitably qualified, competent, skilled and experienced'**. Regulation 18(1) of the 2014 Regulations states:

> **18.— Staffing**
>
> (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

In addition, Regulation 12(2)(c) imposes a requirement on a service provider to ensure that **'persons providing care or treatment to service-users have the qualifications, competence, skills and experience to do so safely'.** It is therefore a regulation concerned solely with safeguarding matters.

Unlike Regulations in other parts of the UK (see below), there is no indication of how the 'sufficient number' of staff is to be calculated, or what matters must be taken into account, and no requirement to be able to demonstrate how such a calculation has been made. However, the guidance under the

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[242] Sections 13-15 of the 2008 Act.
[243] Schedule 1, Health and Social Care Act 2008. Regulated activities extend well beyond this, for example, to medical and dental services.
[244] Care Quality Commission, 'Guidance for providers on meeting the regulations' (March 2015) p5. https://www.cqc.org.uk/sites/default/files/20150324_guidance_providers _meeting_regulations_01.pdf accessed 22 May 2019.
[245] Care Quality Commission, 'Guidance for providers on meeting the regulations' (March 2015) https://www.cqc.org.uk/sites/default/files/20150324_guidance_providers _meeting_regulations_01.pdf accessed 22 May 2019. The guidance is created under Section 23 of the Health and Social Care Act 2008.

[246] Regulation 21 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 (as amended).
[247] Section 25(1) Health and Social Care Act 2008.
[248] Care Quality Commission, 'Market oversight of adult social care' (last updated 8 June 2018) https://www.cqc.org.uk/guidance-providers/market-oversight-corporate-providers/market-oversight-adult-social-care accessed 20 May 2018.
[249] Care Quality Commission, 'Key lines of enquiry for adult social care services' (last updated 13 June 2018) https://www.cqc.org.uk/guidance-providers/adult-social-care/key-lines-enquiry-adult-social-care-services accessed 20 May 2019.

Regulations states that 'providers must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs' under the fundamental standards. Providers are required to have a 'systematic approach' in establishing the number of staff and skills required, considering 'the different levels of skills and competence required' to meet service-user needs, as well as 'the registered professional and support workers needed' and the requirements for supervision and leadership.

Regulation 19 of the 2014 Regulations requires a service provider to ensure that anyone employed to carry out a regulated activity is **a 'fit and proper person'.[250] This means that the person must be of 'good character', have the qualifications, competence, skills and experience necessary for them to perform their role, and be physically and mentally capable of carrying out tasks intrinsic to the role (after reasonable adjustments are made if relevant).** In other parts of the UK, the matter of who is considered 'fit and proper' to carry out social care work is largely governed by the requirement of individual care workers to be registered with the relevant regulatory agency. In England, the onus for ensuring that an individual is suitable to be a social care worker falls essentially on the employer. The employer is required to have in place, and to operate, recruitment procedures to ensure that it is employing fit and proper persons,[251] and to have available certain information on each employed person.[252]

No sanction is prescribed under the Regulations, should a care provider fail to meet these requirements, and the breach of the Regulations cited above is not a prosecutable offence in law.[253] However, breach of Regulation 12(2)(c) *is* an offence

if avoidable harm results, or if a service-user is exposed to a significant risk of harm. This reflects a narrowed focus onto safeguarding matters in an English regulatory context. The main form of enforcement of care standards is enforcement action by the CQC. As part of an inspection of a care provider, the CQC is required to ensure that the provider is employing staff who are able to provide the care, treatment and support that is appropriate to their job role.[254] To meet this requirement, providers must undertake the relevant checks on any employee, including a DBS check if relevant, and have a procedure for the ongoing monitoring of staff. The CQC will also request information on employees' work history and evidence of their conduct in any previous roles in relation to the provision of social care (including information on why any previous such roles have ended), documentary evidence of relevant qualifications, and information about any physical or mental health conditions relevant to the person's ability to undertake their role in a regulated activity.[255] If a provider is not employing 'fit and proper' people in any regulated activity, the CQC will take this into account in any investigation report.

The CQC has the power to take enforcement action against service providers if it considers that individuals are being harmed or are at risk of harm. Examples of enforcement action available include the power to withhold, cancel or suspend registration, or to impose or vary conditions on a registration.[256] It also has the power to undertake criminal enforcement action if it considers that a prosecutable offence has been committed.[257] **The CQC guidance states that it is required to refuse registration if it is not satisfied that employers can or will continue to comply with either Regulation 18 or 19.[258]**

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[250] Regulation 19(1)
[251] Regulation 19)2)
[252] Regulation 19(3).
[253] Except where a breach of Regulation 19 (the requirement to employ 'fit and proper' persons) is also a breach of a Regulation that amounts to an offence.
[254] Care Quality Commission, 'Regulation 19: Fit and proper persons employed' (undated) https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-19-fit-proper-persons-employed#full-regulation accessed 20 May 2019.
[255] These requirements are set out under Schedule 3 of the 2014 Regulations.

[256] It should be noted that these powers relate to the 2014 Regulations in general, not just to Regulations 18 and 19. The CQC's Enforcement Policy is available at https://www.cqc.org.uk/sites/default/files/20150209_enforcement_policy_v1-1.pdf accessed 22 May 2019.
[257] Care Quality Commission, 'Enforcement: adult social care services' (last updated 29 June 2018) https://www.cqc.org.uk/guidance-providers/adult-social-care/enforcement-adult-social-care-services accessed 20 May 2019.
[258] Care Quality Commission, 'Guidance for providers on meeting the regulations' (March 2015), pp70 and 74. https://www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf accessed 22 May 2019.

Training, staff development and qualifications

Care workers in England are not required to have any minimum qualification. **There are, however, obligations on employers to ensure that employees receive adequate training, support, professional development, supervision and appraisal to carry out their role.** Regulation 18(2) of the 2014 Regulations states:

> Persons employed by the service provider in the provision of a regulated activity must—
>
> (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,
>
> (b) be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and
>
> (c) where such persons are health care professionals, social workers or other professionals registered with a health care or social care regulator, be enabled to provide evidence to the regulator in question demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practice or a requirement of their role.

The guidance under the 2014 Regulations requires employers to assess the training, learning and development needs of individual staff members at the beginning of their employment, and to keep this under review 'at appropriate intervals'. Where appropriate, employers must also supervise staff until they are able to demonstrate adequate competence to carry out their caring role. Ongoing or periodic supervision should also be undertaken to ensure that a person's competence to carry out their role is maintained, and staff should receive

regular performance appraisals 'from an appropriately skilled and experienced person'. The guidance also states that 'staff must be supported to undertake training, learning and development to enable them to fulfil the requirements of their role' and should be 'supported to make sure they are can participate' in statutory, mandatory or other training. 'Appropriate action' should be 'taken quickly when training requirements are not being met'.[259]

As with the matter of suitability to be a care worker, there is therefore a heavy reliance on the care provider to establish what constitutes 'appropriate' training, support, and supervision, or what qualifications are relevant to the worker's work and 'professional development'. As a result, there may be significant differences on what is considered necessary across the workforce and in different work settings. Guidance under these Regulations states that providers must have an induction programme that adequately prepares staff for their roles, with those employing care workers or healthcare assistants expected to follow the standards of the Care Certificate. **The key training requirement for social care workers in England is an adequate induction, although the definition of adequacy is largely at the discretion of the provider. This minimum level of induction, which may or may not involve formal training or the award of the Care Certificate, contrasts with requirements for qualifications and post-registration training and learning (PRTL) that exist in the other countries of the UK.**

As with matters of staffing levels and fitness to work in social care, there are no specific sanctions on providers for breaches of the duties imposed by Regulation 18(2) and breach of the Regulations is not a prosecutable offence in law. Enforcement is the remit of the CQC.

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[259] Care Quality Commission, 'Guidance for providers on meeting the Regulations' (March 2012) 70-72.

Wales: Regulation of staffing and standards

Introduction and regulatory framework

In Wales, providers of social care and the social care workforce are both regulated. The legal framework is provided by the Regulation and Inspection of Social Care (Wales) Act 2016 (the '2016 Act'). Under section 4 of this Act, the 'general objectives' are to 'protect, promote and maintain the safety and wellbeing of people who use regulated services' and to 'promote and maintain high standards in the provision of regulated services'. Under the 2016 Act, organisations carrying out 'regulated' services are required to register with the Care Inspectorate Wales.[260] Regulated services include care homes (including nursing homes)[261] and domiciliary support services.[262]

Once registered, providers must meet registration standards, comply with inspections and maintain care standards in order to maintain registration status. The Care Inspectorate Wales (CIW) has powers of inspection and procedures for cancelling registration and obligations on providers are underpinned by criminal and civil offences for non-compliance with key requirements of the 2016 Act and its regulations. **The enforcement powers of the Inspectorate include imposing or varying conditions on registration, issuing compliance or improvement notices, undertaking extra inspections, and suspending or cancelling registration, certain of which actions can be taken as emergency measures.[263] Where an offence has occurred, or is suspected, the Inspectorate can instigate a criminal investigation, recommend prosecution or issue a penalty notice.[264]** The CIW published a Code of Practice for Inspection of Regulated

Summary of regulation in Wales

➢ **(Most) care workers and providers (employers) are required to register with a professional body.**

➢ **It is a criminal offence for any unregistered person in Wales to take or use the title 'social care worker'.**

➢ **Improving training and qualifications of social care workers is a priority for Welsh Government. Social Care Wales has a duty to consider how the social care profession can be developed.**

➢ **PAs are not required to register in Wales.**

➢ **A registered person must demonstrate appropriate knowledge and skill, be physically and mentally fit, have the character and competence for the role and abide by a Code of Professional Practice as well as undertake post-registration training and learning.**

➢ **Six regulations are about workers: on staffing levels, ensuring workers are fit and proper persons, supporting and developing staff, complying with an Employers' Code of Practice, providing information to staff and having disciplinary procedures.**

➢ **Regulatory standards require providers to consider the type of staff they employ, the contracts of employment they use, qualification levels, and whether the number of temporary workers employed might disrupt continuity of care.**

➢ **It is a prosecutable offence if providers breach regulations because workers or volunteers are not fit persons or because providers do not ensure sufficient numbers of suitably qualified staff and as a result there is an avoidable harm or risk of harm.**

➢ **There appears to be a lack of clarity about whether time off for training must be paid time.**

➢ **Workers are personally accountable for the quality of their work, are responsible for maintaining and developing knowledge and skills, they have a responsibility to the social care profession.**

➢ **Employers are not obliged to arrange training or to ensure staff development takes place in working, paid, hours. They must support learning and provide supervision and appraisal.**

➢ **Employees must provide evidence of their linguistic ability to support service-users.**

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[260] Section 5.
[261] Under Schedule 1, paragraph 1(1) of the 2016 Act, a 'care home service' is 'the provision of accommodation, together with nursing or care at a place in Wales, to persons because of their vulnerability or need'.
[262] Section 2.

[263] The Care Inspectorate Wales, 'Securing Improvement and Enforcement Policy' (May 2018) https://careinspectorate.wales/sites/default/files/2018-06/180601-securing-improvement-enforcement-policy-en.pdf accessed 26 June 2019.
[264] Ibid, 1.11.

Services in January 2019.[265] This states that inspections focus on the four themes of: the wellbeing of individuals receiving care and support, the quality of care and support provided, the physical setting in which care and support is provided and leadership and management.[266]

Social care workers in Wales are required to be registered with Social Care Wales, the body responsible for maintaining the register, developing the workforce and overseeing fitness to practice procedures, including disciplinary hearings. Social Care Wales opened their professional registration scheme to domiciliary care workers in April 2018 and this voluntary register becomes mandatory from April 2020. An annual registration fee is to be paid by individual workers, beginning at £15 a year in 2018 and increasing each year thereafter.[267] Care workers working in care or nursing homes are not currently required to register, unless they are managers of a service, although there are plans to register adult care home workers from 2022.[268]

Section 111(2) of the 2016 Act makes it an criminal offence for any person in Wales who is not a registered social care worker to take or use the title 'social care worker', or to imply they are registered, or to pretend to be a social care worker with intent to deceive another. Under section 68 of the 2016 Act, Social Care Wales has the objective of protecting, promoting and maintaining the safety and wellbeing of the public in Wales, as well as promoting and maintaining high standards in the provision of care and support services as well as in the conduct and practice of social care workers.

Development of the social care workforce, including the improvement of the training and qualification of social care workers, the enhancement of the status of roles in social care work, and securing stronger opportunities for career progression is a current priority for the Welsh

Government.[269] **Social Care Wales has a remit not simply to ensure that social care workers are registered, but also to consider how the social care profession can be developed and to conduct research into social care to establish, for example, what forms good practice, and how this may be achieved.[270]**

Workers who are currently required to register include:

- qualified social workers using the title social worker;

- students studying approved social work degrees in Wales;

- residential childcare managers and workers;

- adult care home managers (see plans for workers in adult care homes to also be registered, noted above)

- domiciliary care managers;

- domiciliary care workers (ie: people who are employed by a domiciliary support service registered with the Care Inspectorate Wales to provide care and support to people in their own homes). Registration will be mandatory for domiciliary care workers in Wales from April 2020, although individuals can register as a domiciliary care worker prior to this if they choose).

PAs are not required to register with Social Care Wales.

To register with Social Care Wales, a person must demonstrate that they have the right knowledge and skills, are physically and mentally fit to practice, have the character and competence to perform the relevant role, and that they agree to follow the Code

[265] Care Inspectorate Wales, 'Regulation and Inspection of Social Care (Wales) Act 2016 Code of Practice for Inspection of Regulated Services' (January 2019) https://careinspectorate.wales/sites/default/files/2019-03/190313-code-of-practice-en.pdf accessed 26 June 2019.
[266] Para 4.13.
[267] Social Care Wales, 'Domiciliary Care Worker Registration' (last updated 18 June 2019) https://socialcare.wales/registration/domiciliary-care-workers-registration#section-29877-anchor accessed 26 June 2019.

[268] Mark Drakeford, 'Written Statement - Registration of Social Care Workers' (12 November 2015) https://gov.wales/written-statement-registration-social-care-workers accessed 17 June 2019.
[269] Social Care Wales: Making a Positive Difference to Social Care in Wales. Our Strategic Plan (2017-2022) https://socialcare.wales/cms_assets/file-uploads/Strategic-plan-final.pdf accessed 7 July 2019.
[270] Social Care Wales: 'What we do' (undated) https://socialcare.wales/about/what-we-do accessed 17 June 2019.

of **Professional Practice for Social Care.**[271] Registration is for up to 3 years.[272] Social Care Wales places a strong focus on the professionalisation of social care workers, as the Code of Practice demonstrates (see further below).

Regulations also cover matters such as definitions of a 'social care worker', proceedings before fitness to practice panels, the information to be contained in an application for registration as a provider of a regulated service, and so on.

Staffing requirements and the 'fitness' of workers

In relation to staffing, the relevant regulations in Wales are The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017 (as amended). They set out requirements for service providers and the duties of a 'responsible individual', who is to be the person in charge at each site of registered provision. Part 10 of the Regulations concerns staffing matters which are principally designed to ensure adequate care standards. **It comprises six regulations relating to overarching staffing requirements to ensure sufficient numbers of suitably qualified staff (Reg 34), the requirement to ensure that staff are 'fit and proper' persons to work in the care sector (Reg 35), the support and development of staff (Reg 36), compliance with the employer Code of Practice (Reg 37), information for staff (Reg 38) and disciplinary procedures (Reg 39).** The Welsh Government has also issued guidance on the 2017 Regulations.[273]

Regulation 34(1) requires a provider to ensure that a service has a sufficient number of suitably qualified, trained, skilled, competent and experienced staff. This 'sufficient number' must be calculated with regard to the purpose of the care service, the needs of the persons to whom care is provided, the need to support individuals to achieve personal outcomes and the meeting of

regulatory requirements. **The service provider is also required to be able to demonstrate that the way they have determined sufficient numbers is based on the type of staff deployed and the numbers of each type (Regulation 34(3)).** What is meant by staff type is not explained, and is not clarified in the guidance, but presumably skills, qualification, pay grade and responsibility could be factors**. Regulation 34(5) requires that the employment of staff on temporary and zero-hours (non-guaranteed hours) contracts does not prevent the continuity of care that is reasonable to meet service-users needs.**

Regulation 35 states that service providers must not employ a person, or permit volunteers, or allow any other person to work in regular contact with individuals receiving care and support if they are not fit to do so. The test of fitness explained at Regulation 35(2) includes matters of integrity and good character, personal health, and the requirement to provide certain documentation (including a DBS certificate).[274]

A breach of certain of these regulations is a prosecutable offence in law. Specifically, if a breach of Regulations 34(1), 34(2) or 34(3) results in avoidable harm – or the risk of harm – to an individual (including the theft, misuse or appropriation of money or property) an offence has been committed.[275] **Breach of Regulation 35(1) is also a prosecutable offence regardless of whether avoidable harm may result.** Establishing the fitness of social care workers is a core purpose of the regulation of the workforce.

Training, staff development and qualifications

A registered provider must also ensure arrangements are made for the support and development of staff (Regulation 34(4)). Whether such arrangements include arrangements within paid

[271] Social Care Wales 'What is Registration?' (last updated 24 June 2019) https://socialcare.wales/registration/what-is-registration accessed 26 June 2019. The Codes of Practice for both workers and employers are available at Social Care Wales, 'Codes of Practice and Guidance' https://socialcare.wales/fitness-to- practice/codes-of-practice-and-guidance accessed 20 May 2019.
[272] Social Care Wales 'Renewing your registration' (last updated 5 April 2019) https://socialcare.wales/registration/renewing-your-registration accessed 17 June 2019

[273] Welsh Government, 'Statutory Guidance for service providers and responsible individuals on meeting service standard regulations for: Care home services, Domiciliary support services, Secure accommodation services; and Residential family centre services' (Version 2) (April 2019) https://gov.wales/sites/default/files/publications/2019-04/guidance-for-providers-and-responsible-individuals.pdf accessed 17 June 2019.
[274] The required documentation is set out in Schedule 1, Part 1 of the 2017 Regulations.
[275] Regulation 85.

time during normal working hours is not stated, and the guidance on Regulation 34 is silent on all aspects other than staff numbers. It would be concerning if providers interpreted this requirement such that staff were expected to make arrangements as a matter of personal development outside of contracted working time in order to demonstrate an individual commitment to professionalisation.

Regulations 36 to 38 essentially require a service provider to **ensure that, in relation to their role, staff members receive adequate induction, adequate core and adequate specialist training, that they are made aware of their responsibilities, that they receive support to undertake further appropriate training,[276] and that they have information as to how the service is run.[277]** While a policy must be in place for the support and development of staff, the obligation does not require the policy to be written or available for all workers to view. **Providers must also ensure appropriate supervision and appraisal.** Notably, these support and development obligations apply in respect of all persons working, including volunteers. As in the English context, the word 'appropriate' is doing a lot of heavy lifting in this regulation and no indication is given as to how a determination of what is appropriate should be made but seems to point to an important role for Social Care Wales. The guidance on this Regulation is relatively detailed. It stipulates, among other things, that social care workers should complete 'the relevant induction programme required by Social Care Wales within the defined timescale alongside any service-specific induction programmes',[278] that staff should receive feedback on their performance including feedback from service-users, there should be one-to-one supervision from a line manager or similar no less than quarterly and there should be an annual appraisal. Care workers will also be required to adhere to statutory training

requirements in accordance with employer obligations under safeguarding and health and safety legislation.

Regulation 37 is significant in respect of the professionalisation agenda. Providers must adhere to a Code of Practice for Social Care Employers. This code of conduct is published by Social Care Wales under section 112(1)(b) of the 2016 Act. The employer is also required to provide support in relation to registration with the appropriate regulatory body, and must make employees aware of the standards of conduct expected under relevant Codes of Practice.[279] The broad requirements of the Codes of Practice for both workers and employers are set out in the subsequent section of this report.

As noted above, registration with Social Care Wales is now open to domiciliary care workers and will become mandatory for these worers in 2020. Voluntary registration is open to workers with a basic qualification and workers without qualifications if they have at least three years' experience and the signature of their manager to confirm their competence.[280] From April 2020 under the compulsory system all new registrants will require certain qualifications.

The qualifications required to register as a social care worker vary depending on the role that the individual is registered for. Information on the various roles in social care and the qualification requirements for registration for each role is available from Social Care Wales.[281]

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[276] These fall under Regulation 36.
[277] Regulation 38.
[278] P58.
[279] Regulation 37.
[280] Social Care Wales, 'Domiciliary care worker registration'
https://socialcare.wales/registration/domiciliary-care-workers-registration#section-29852-anchor

accessed 17 June 2019.
[281] Social Care Wales, 'Qualifications you need to register'
https://socialcare.wales/registration/qualifications-you-need-to-register-1 accessed 20 May 2019.

Sanctions

Where breaches by service providers of the Regulations cited above do not amount to an offence, they will be dealt with through the regulation and inspection process. The CIW states that:

> we inspect against the requirements of the legislation and take action against service providers where these requirements are not being met.[282]

The duties on workers

Under Regulation 39 of the 2017 Regulations, **employers must have a disciplinary procedure which must make it a disciplinary matter if employees fail to report abuse or suspected abuse.** Further, a disciplinary procedure established and operated by a service provider must contain a provision that:

> 'a failure on the part of an employee to report an incident of abuse, or suspected abuse, to an appropriate person, is grounds on which disciplinary proceedings may be instituted'.

An appropriate person is defined as the service provider or a responsible individual within it, the regulatory body, the local authority for the area in which the service is provided, the NSPCC (if relevant) or the police. In addition, a service provider is required to have and operate a whistleblowing procedure.[283]

It is noted above that, under Regulation 35(2)(d), an employee is required to produce certain documentation in order to be employed,[284] although the legal obligation to ensure that these are produced is on the employer. **The required information includes evidence of 'satisfactory linguistic ability for the purposes of providing care and support to those individuals for whom the worker is to provide care and support'.[285]**

This focus may arise from the requirement in Wales to be able to provide services in Welsh where this is the chosen language of the person receiving support, although it is likely also to disproportionately impact on both workers and 'service-users' whose first language is otherwise not English or Welsh.[286]

Most notably in Wales, there are duties upon social care workers which stem from the requirement to register. **In particular, there are requirements to follow the Code of Professional Practice for Social Care, and to undertake post-registration training and learning (PRTL).** Social care workers are legally obliged to adhere to the Code and are responsible for ensuring that they do so. **It is stated in the Code that it sets 'clear standards of the conduct and practice expected of the social care profession in Wales'** *including* **those who are not obliged to be registered and are therefore not legally bound by it**. The whole of the Code is relevant to the provision of adequate, safe and high-quality support, but **section 6 is particularly pertinent. This requires the registrant to be accountable for the quality of their work and to take responsibility for maintaining and developing their knowledge and skills.** Employers are required to promote and take account of the Code. There are seven sections of the Code which comprise:

> ➢ Respect the views and wishes, and promote the rights and interests, of individuals and carers;
> ➢ Strive to establish and maintain the trust and confidence of individuals and carers.
> ➢ Promote the wellbeing, voice and control of individuals and carers while supporting them to stay safe.
> ➢ Respect the rights of individuals while seeking to ensure that their behaviour does not harm themselves or other people.

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[282] Care Inspectorate Wales, 'Securing improvement and enforcement policy' (May 2018) https://careinspectorate.wales/sites/default/files/2018-06/180601-securing-improvement-enforcement-policy-en.pdf accessed 22 May 2019, para 1.1.
[283] Regulation 65.
[284] The required information is set out in Schedule 1 of the Regulations.
[285] Schedule 1, part 1, paragraph 9.
[286] A recent fitness to practice hearing of a care home manager found breaches of a large number of legal duties by the manager concerned,

including failure to ensure that 'at all times suitably qualified, competent, skilled and experienced persons were working at the Home….. resulting in:… (d) staff members being unable to communicate with service-users due to staff members having an insufficient command of English. This hearing was conducted under the Regulations prior to those now in force. See, Social Care Wales, 'Rosemin Mawji' https://socialcare.wales/hearings-content/rosemin-mawji accessed 26 June 2019.

➢ Act with integrity and uphold public trust and confidence in the social care profession.

➢ Be accountable for the quality of your work and take responsibility for maintaining and developing knowledge and skills.

➢ In addition to sections 1 – 6, if you are responsible for managing or leading staff, you must embed the Code in their work.

In terms of professionalisation, there are therefore strong requirements on workers under the Code of Practice by which they are bound to take responsibility for their work and their professional development, and to hold a responsibility towards the social care 'profession' in general. This demonstrates a significant shift from the former status of and expectations on care workers.

Following registration, **all registered social care workers are required to complete 15 days or 90 hours of training and learning during each three-year period of registration.** Training and learning comprises activities such as study, training, courses, seminars, reading and teaching.[287] Professionalisation is again referenced here, with the term **'continuing professional development'** used in connection to PRTL.[288]

Employers are required to support post-registration training and learning by **supporting a learning culture in the workplace, ensuring training and learning opportunities, providing supervision and appraisal and giving constructive feedback on performance and development.[289]** However, it is noted above that while employers are required to ensure that arrangements are made for the support and development of staff, **they are not obliged to make these arrangements themselves, or even to ensure that support and staff development takes place in**

working, paid, hours. Given the requirements of PRTL, the onus of which falls on the worker, rather than the employer, it is possible – and even likely – that workers may indeed be expected to undertake such activities in their own time and unpaid.

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[287] Social Care Wales (no date) How to meet your post-registration training and learning requirements (PRTL): A guide for social care professionals registered with Social Care Wales' https://socialcare.wales/cms_assets/file-uploads/PRTL-Requirements_ENG.pdf accessed 17 June 2019.

[288] See Social Care Wales, 'Continuing professional development toolkit for social care, early years and childcare' October 2018

https://socialcare.wales/cms_assets/file-uploads/CCPD-toolkit-for-social-care-ENGv01.pdf accessed 17 June 2019.

[289] Social Care Wales, How to meet your post-registration training and learning requirements (PRTL): A guide for social care professionals registered with Social Care Wales' https://socialcare.wales/cms_assets/file-uploads/PRTL-Requirements_ENG.pdf accessed 17 June 2019.

Scotland: Regulation of staffing and standards

Introduction and regulatory framework

In Scotland, there are two core statutes that regulate social care – the Regulation of Care (Scotland) Act 2001 (as amended) and the Public Service Reform (Scotland) Act 2010 (as amended). The 2001 Act established the Scottish Social Services Council, which is responsible for regulating the social care workforce – typically known as the social *services* workforce in Scotland. The 2010 Act established the Care Inspectorate (legally known as the Social Care and Social Work Improvement Scotland).[290]

Service providers in Scotland are required to register with the Care Inspectorate, which has responsibility for inspecting all registered services, including those working in health and social care and social work. Services subject to registration and inspection by the Care Inspectorate include care homes for adults, services providing domiciliary support and care, other support services, such as day centres, and secure accommodation.[291] In addition to registration and inspection, the stated aim of the Care Inspectorate is to secure improvements in the quality of care and support provided.[292] In addition, the Care Inspectorate is legally required to follow the principles of protecting and enhancing the safety and wellbeing of service-users, promoting their independence, and promoting diversity in the provision of social services, in order to enable choice.[293]

The Care Inspectorate has various powers of enforcement including changing the conditions of registration of a service, serving an improvement notice, and cancelling a service.[294] In regulating services, the Care Inspectorate is required to follow the Scottish Regulators' Strategic Code of Practice, issued by the

Summary of regulation in Scotland

➢ **(Most) care workers and providers (employers) are required to register with a professional body. All workers in new roles must register within 6 months of starting work.**

➢ **Employers commit a prosecutable offence if they employ an unregistered person.**

➢ **The Scottish Social Services Commission places a strong focus on professionalisation and equates care workers with teachers and nurses in its documents.**

➢ **PAs are not required to register.**

➢ **The new Health & Care (Staffing) Scotland Act 2019 deals with staffing requirements and transparency in staffing and employment practices.**

➢ **The requirement for providers to have enough staff working at all times includes consideration of the wellbeing of staff in respect of service-user interests. This is distinctive in the UK. Staffing arrangement decisions should also take account of the views of staff and their wellbeing. A breach of staffing level requirements is not an offence.**

➢ **It is a prosecutable offence if providers breach regulations requiring workers or volunteers to be fit persons to be employed.**

➢ **Registered workers must follow the SSSC Code of Practice and breach of the code by workers may result in fitness to practice proceedings.**

➢ **For registration, a person must hold required qualifications and must meet standards of character and competence. They must behave suitably when outside their workplace as well as when working. They must also undertake post-registration training and learning of 60 hours over 5-years.**

➢ **Registered providers must ensure that care workers receive appropriate training and suitable assistance, including time off work to obtain further qualifications appropriate to work, (it is unclear whether time off must be paid).**

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[290] The Care Inspectorate is created under section 44 of the 2010 Act.
[291] Care Inspectorate, 'Services we regulate, check and inspect' (undated) http://www.careinspectorate.com/index.php/type-of-care accessed 21 May 2019. These services are prescribed in s47 of the Public Services Reform Act (Scotland) 2010 and defined in Sch 12 of that Act.
[292] Care Inspectorate, 'About Us' (undated) http://www.careinspectorate.com/index.php/about-us accessed 21 May

2019. Section 44 of the 2010 Act states that the Care Inspectorate 'has the general duty of furthering improvement in the quality of social services'.
[293] Section 45 of the 2010 Act.
[294] The Care Inspectorate 'Enforcements' (undated) http://www.careinspectorate.com/index.php/enforcements accessed 26 June 2019. The Care Inspectorate enforcement policy is available at http://www.careinspectorate.com/images/documents/4474/Enforcement%20Policy_v3.pdf accessed 26 June 2019.

Scottish Government, which covers all regulatory bodies in Scotland. It is also required to consider guidance under the 2010 Act. Recent guidance includes the *Health and Social Care Standards: My Support, My Life*.[295] The stated aim of these standards is to improve outcomes of these services, to ensure that people's basic human rights are upheld, and that people are treated with respect and dignity. Other stated objectives are improving services, promoting flexibility and encouraging innovation.[296] **These standards are underpinned by five principles: dignity and respect, compassion, being included, responsive care, and support and wellbeing.**[297] Inspections centre around five key questions relating to service-users' wellbeing, leadership, staffing, care environment and care and support planning.

The majority of social services workers are required to register with the SSSC and to re-register every five years.[298] The introduction of registration has been phased and registration for some of these roles is not yet fully in place, although **workers coming into new roles are required to register within six months of starting in post.** Once compulsory registration is in place, employers commit a prosecutable offence if they employ an unregistered person (see further information on this below). Registration fees vary according to the role to be undertaken. Workers in a care at home service currently have a registration fee of £25.00. **The SSSC places a strong focus on the professionalisation of the workforce, equating social service workers with, for example, teachers and nurses.**[299]

Staffing requirements and the 'fitness' of workers

Requirements on social care providers in relation to staffing are currently in a state of flux in Scotland, with **new obligations shortly to be introduced by the Health and Care (Staffing) (Scotland) Act 2019**, which

received royal assent on 6 June 2019. This Act essentially writes into statute a number of provisions that already exist under Regulations. The stated policy purpose of the Act is **to enable 'safe and high quality care and improved outcomes for service-users, to enable a 'rigorous, evidence-based approach' staffing requirements, to support transparency in staffing and employment practice** and to facilitate multi-disciplinary and multi-agency working as the integration of health and social care progresses.[300]

Under section 6 of the new Act both the quality of care and safety matters are referenced, echoing similar requirements in the Regulations currently in force. Distinctively in the countries of the UK, the Act also refers to the wellbeing of workers. Section 7(1) states, in full:

> **7 Duty on care service providers to ensure appropriate staffing**
>
> (1) Any person who provides a care service must ensure that at all times suitably qualified and competent individuals are working in the care service in such numbers as are appropriate for—
>
> (a) the health, wellbeing and safety of service-users,
>
> (b) the provision of safe and high-quality care, and
>
> (c) in so far as it affects either of those matters, **the wellbeing of staff.**

In addition, sections 1 and 3 of the 2019 Act set out a series of 'guiding principles' for health and care staffing which care providers are required to take into account.[301] In relation to care services, section 1 stipulates that the main purpose of staffing is to provide **'safe and high-quality services'** and **'ensure the best … care outcomes**

[295] Scottish Government, 'Health and Social Care Standards: My Support, My Life' (June 2017) https://www.gov.scot/publications/health-social-care-standards-support-life/ accessed 26 June 2019.
[296] Scottish Government, 'Health and Social Care Standards: My support, my life' (June 2017), Introduction.
[297] Ibid, Introduction.
[298] The Registration of Social Workers and Social Service Workers in Care Services (Scotland) Regulations 2013.

[299] Scottish Social Services Council, 'There are benefits to being a registered social service worker' (undated) https://www.sssc.uk.com/registration/what-are-the-benefits-of-registration/ accessed 21 May 2019.
[300] Scottish Government, 'Health and Care (Staffing) (Scotland) Bill: Policy Memorandum' (May 2018) https://www.parliament.scot/S5_Bills/Health%20and%20Care%20(Staffing)%20(Scotland)%20Bill/SPBill31PMS052018.pdf accessed 24 June 2019
[301] Section 3(1).

for service-users'. **Guiding principles for staffing arrangements include – among other things – taking account of the views of staff and service-users, ensuring the wellbeing of staff and 'being open with staff and service-users about decisions on staffing'** – insofar as these are compatible with principles in section 1. These guiding principles reflect a new legal focus on both service-users and staff in relation to staffing arrangements suggesting that workforce regulation is taking on greater importance in Scotland.

The core Regulations that are currently in force, and which the Act will replace, are The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (as amended) ('the 2011 Regulations'). Regulation 15 states that providers must ensure that 'at all times suitably qualified and competent persons are working in the care service in such numbers as are appropriate for the health, welfare and safety of service-users…'. As in both England and Wales, therefore, the decision as to what constitutes a suitable number and level of workers, and suitable competence, is decided by the service provider, although both the current Regulations and the 2019 Act require certain factors to be taken into account, namely the nature, size and objectives of the service and the number of, and needs of the service-users. In relation to workers' competence, matters such as qualifications and experience are presumably also taken into account in practice. **The Care Inspectorate previously provided 'staffing schedules' which set out standards in relation to staffing that specific services might be required to follow. These included ratios of staff to service-users, but they are now being withdrawn on the basis that they were overly prescriptive and did not enable providers to exercise judgement and flexibility.** The Care Inspectorate emphasises that the responsibility for assessing appropriate staffing needs lies with service providers.[302] Under Regulation 19 of the

2011 Regulations, breach of Regulation 15 is not an offence.

The 2011 Regulations also **create obligations on providers in relation to the fitness of employees. Regulation 9(1) states that a provider must not employ any worker in the provision of care unless that person is 'fit to be so employed'. According to Regulation 9(2) 'unfit' persons include people with certain criminal convictions and people who do not have the relevant qualifications, skills and experience necessary for their work. These provisions apply to volunteers as well as employees.**[303] In addition, Regulation 13 stipulates that people who are listed on the adults' list of the Protection of Vulnerable Groups (Scotland) Act 2007 may not be employed in (or provide or manage) a care service for adults. Fitness is taken especially seriously in Scotland - **a breach of Regulation 9(1) constitutes a prosecutable offence.**[304] Other breaches are sanctioned via the regulation and inspection process and the enforcement options available to the Inspectorate set out above.[305]

In Scotland the fitness of workers is also governed by the requirement for social care workers to register with the SSSC. **Registrants are required to follow the SSSC Code of Practice. Alleged breaches of the Code may be subject to a fitness to practice investigation, governed by The Fitness to Practice Rules 2016.**[306] These state that to be fit to practice, a worker must meet 'the standards of character, conduct and competence necessary for them to do their job safely and effectively' and that fitness to practice may be impaired by misconduct, deficient professional practice, health, previous decisions by a regulatory body and *any* criminal conviction.[307] If an investigation finds that fitness to practice is impaired, the registrant may be liable to a fitness to practice hearing and to sanction.

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[302] Care Inspectorate, 'Staffing Schedules' (undated) http://www.careinspectorate.com/index.php/changes-to-registration/staffing-schedules accessed 26 June 2019.
[303] Regulation 2(2).
[304] Regulation 19.
[305] The Care Inspectorate states: We give care services grades when we inspect them, and look at key areas like care and support, physical environment, quality of staffing, and quality of management and

leadership. Care Inspectorate, 'About Us' (undated) http://www.careinspectorate.com/index.php/about-us accessed 23 May 2019.
[306] Scottish Social Services Council, 'Fitness to practice Rules 2016' https://www.sssc.uk.com/knowledgebase/article/KA-02133/en-us accessed 23 May 2019.
[307] Ibid, Paragraph 2.

The registration of workers also places duties on employers. Under The Registration of Social Workers and Social Service Workers in Care Services (Scotland) Regulations 2013, **once compulsory registration is in place an employer is committing a prosecutable offence if they employ a non-registered worker.**[308] Responsibility for enforcement lies with the Care Inspectorate, which has the power to make requirements on providers relating to registration, to take note of non-registration in inspection results and to take enforcement action, including reporting the matter to the Procurator Fiscal.[309]

Employers of registered social services workers are also bound by the Employers Code of Practice (see further below.)

Training, staff development and qualifications

Under Regulation 15 of the 2011 Regulations, service providers are required to ensure that people they employ in relation to the provision of care receive **'training appropriate to the work they are to perform' and 'suitable assistance, including time off work, for the purpose of obtaining further qualifications appropriate to such work'.** This requirement is effectively reproduced in section 8 of the 2019 Act. This raises again the question of whether or not workers are expected to undertake training and obtain qualifications outside their contractual hours of work and while unpaid. The implication here, of the phrase 'time off work' is likely to imply that paid time off should, indeed, be the case. It is notable that there is not deployment of a term such as 'paid time away from caring duties'. Given the onus on individuals registered with the SSSC to undertake PRTL (see below), expectations of training in unpaid personal time would be a heavy burden on low paid workers who who are not legally required to reach new standards of training and professionalisation. **Breach of any part of Regulation 15 is not an offence under Regulation 19 of the 2011 Regs.**

As in Wales, specific requirements relating to qualifications emanate from the process of registration with the SSSC. **In order to register, individuals are required to hold certain qualifications which, as in Wales, vary according to the role being undertaken.**

The duties on workers

In Scotland, the main obligations on workers to ensure that care is appropriately delivered stems from the new and developing obligations to register with the SSSC. **Registrants are also required to meet certain standards of character and competence, and to behave in a way does not call into question their suitability to work in social services *outside* their workplace as well as when working. This is a high level of professional conduct, comparable with that of nurses, teachers and solicitors.** Registrants are also required to abide by the SSSC Code of Practice.

Registrants are also required to undertake post-registration teaching and learning (PRTL). The type and amount of training required varies with the role undertaken. For example, **support workers in care at home services are required to undertake 10 days or 60 hours over a 5 year registration period.** Training can comprise activities such as: formal training (for example, undertaking relevant SVQ units), reading relevant publications, job shadowing, independent research, or mentoring. [310]

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[308] Regulations 3 and 5.
[309] Care Inspectorate 'Workforce registration with the SSSC' (undated) http://www.careinspectorate.com/index.php/guidance/workforce-registration-with-sssc accessed 24 June 2019.

[310] Scottish Social Services Council, 'Post registration training and learning (PRTL)' https://www.sssc.uk.com/knowledgebase/article/KA-01044/en-us accessed 21 May 2019.

Northern Ireland: Regulation of staffing and standards

Introduction and regulatory framework

As in Wales and Scotland, **in Northern Ireland service providers and social care workers are both required to be registered.** The regulation of service providers is undertaken by the Regulation and Quality Improvement Authority (RQIA), established in 2005 under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. The Order states that the general duties of RQIA in relation to the provision of services are to keep the relevant Department informed about the provision of services (particularly on matters of availability and quality) and 'encouraging improvement in the quality of services'.[311] The Northern Ireland Assembly Research and Information Service states that the main purpose of regulating the quality of health and social care services and the workforce within these services is stated to be 'to limit the risk of harm to patients and maintain public confidence in services and health care professionals'.[312]

Summary of regulation in N. Ireland

➤ All care workers and providers (employers) are required to register with a professional body.

➤ Different types of care-setting are governed by separate sets of regulation but each makes requirements in relation to staffing.

➤ There must be appropriate numbers of suitable workers at all times and the employment of temporary workers must not interrupt the continuity of care.

➤ Care homes must not employ workers who are unfit to practice or allow unfit third-party employees with regular contact with residents. Similarly, domiciliary care agencies must not supply workers who are not fit persons.

➤ Failure to comply with any of the fitness to practice requirements is a prosecutable offence.

➤ There are no qualification requirements for becoming a care worker but once in post, employers must provide training to workers, as well as appraisal and supervision. All newly appointed staff must complete induction training within 2 days of starting employment.

➤ Care workers must be registered (unless a volunteer) and of integrity, good character, have appropriate qualifications and training and have sufficient mental and physical fitness to undertake the role. Registration requires 90 hours of post-registration training and learning over 5-years.

➤ Managers must support and encourage care workers to obtain qualifications and must ensure staff attend training and maintain competency. There must be training to prevent residents suffering abuse or harm. Standards prescribe training topic requirements.

➤ Domiciliary care agency regulations are most explicit on training; including safeguarding and moving & handling and require induction training of a minimum of three full days duration. There must always be available a suitably qualified person for domiciliary care workers to consult.

➤ While providers must provide time off for training it is unclear if time must be paid, working time.

➤ On recruitment there must be evidence of English linguistic ability to support service-users.

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[311] Article 4(2).
[312] Northern Ireland Assembly Research and Information Service, 'Who regulates health and social care services in Northern Ireland?' (29 March 2019) https://www.assemblyresearchmatters.org/2019/03/29/who-regulates-health-and-social-care-services-in-northern-ireland/ accessed 21 May 2019.

Services that are required to register with RQIA[313] include nursing and care homes and domiciliary care agencies, and it is a prosecutable offence to conduct or manage such a service without registration. Following registration, agencies delivering health and social care services are subject to RQIA inspection. Residential care homes and nursing homes are subject to inspection at least twice a year, with other services inspected a minimum of once a year.[314] If RQIA has concerns about a service, it may carry out additional inspections. During an inspection, inspectors visit and examine the premises, conduct interviews and may request particular information. **RQIA reports do not grade or rate services, but do contain recommendations for improvement, if relevant.[315] An independent review of RQIA, carried out in 2014, found that the inspection of services was a central aspect of driving improvement in the sector.[316]**

During an inspection, inspectors consider four core areas: whether care is safe, effective, and compassionate, and whether services are well-led.[317] Inspections are also guided by the Quality Standards for Health and Social Care, published by the Northern Ireland Department of Health, Social Services and Public Safety in March 2006.[318] These are based around five core themes: leadership and accountability, safe and effective care, accessible, flexible and responsive services, promoting, protecting and improving health and social wellbeing, effective communication and information. Sets of national care standards are currently being developed by the NI administration, under the 'HPSS (Quality, Improvement and Regulation) (NI) Order 2003' ('Care Standards'). **These are intended to 'focus on the safety, dignity, wellbeing and quality of life of service-users' and 'address unacceptable variations in the standards of treatment, care and services and to raise the quality of services'.[319]** These Standards are detailed and are used by RQIA in assessing the quality of individual services**. Such standards are already in force for residential and nursing homes and domiciliary care agencies.**

The work of RQIA is governed by multiple legal and policy documents. **Different care settings, such as nursing homes, residential care homes and domiciliary care agencies are governed by separate sets of Regulations, and inspections take account of both the Quality Standards for Health and Social Care and the Care Standards for the relevant setting.** If RQIA finds a breach of regulations or the Standards by a service provider, it has the power to take enforcement action.[320] Such action can range from issuing a formal notice for compliance with the regulations within a stated timeframe[321] to placing conditions on registration of service or the provider.[322] RQIA also has the power to cancel or alter registration or to prosecute.[323]

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[313] These are set out in Article 8 of the 2003 Order. The Requirement to register is under Article 12. Services that are subject to registration include residential care and nursing homes, day care settings, domiciliary care agencies, mental health and learning disability services, and independent hospitals and clinics. Regulation and Quality Improvement Authority, 'How to register with RQIA' (undated) https://www.rqia.org.uk/what-we-do/register/how-to-register-with-rqia/ accessed 21 May 2019.

[314] Regulation and Improvement Authority (Fees and Frequency of Inspections) Regulations (Northern Ireland) 2005/182, Regulation 6. The 2014 independent review of RQIA recommended that this frequency should move to a 'risk-based approach to inspection' (section 11.14), but the original Regulation governing frequency of inspection is still in force.

[315] British Medical Association, 'Regulation of healthcare quality in Northern Ireland' (last updated 7 December 2018) https://www.bma.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/monitoring-quality-in-the-nhs/regulatory-systems-for-healthcare-quality/northern-ireland accessed 21 May 2019.

[316] RSM McClure Watters, 'Review of the Regulation and Quality Improvement Authority: Final Report (October 2014), para 1.4.3.

[317] British Medical Association, 'Regulation of healthcare quality in Northern Ireland' (last updated 7 December 2018) https://www.bma.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/monitoring-quality-in-the-nhs/regulatory-systems-for-healthcare-quality/northern-ireland accessed 21 May 2019.

[318] Northern Ireland Department of Health, Social Services and Public Safety, 'The Quality Standards for Health and Social Care' (March 2006) https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/the-quality-standards-for-health-and-social-care.pdf accessed 21 May 2019.

[319] Department of Health (NI) 'Care Standards' https://www.health-ni.gov.uk/articles/care-standards accessed 27 June 2019.

[320] RQIA policies on enforcement and inspection are available from: https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

[321] RQIA 'Enforcement Activity Definitions' (undated) https://www.rqia.org.uk/inspections/enforcement-activity/enforcement-activity-definitions-(1)/ accessed 26 June 2019.

[322] British Medical Association, 'Regulation of healthcare quality in Northern Ireland' (last updated 7 December 2018) https://www.bma.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/monitoring-quality-in-the-nhs/regulatory-systems-for-healthcare-quality/northern-ireland accessed 21 May 2019.

[323] British Medical Association, 'Regulation of healthcare quality in Northern Ireland' (last updated 7 December 2018) https://www.bma.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/monitoring-quality-in-the-nhs/regulatory-systems-for-healthcare-quality/northern-ireland accessed 21 May 2019.

In terms of the workforce, all people designated as 'social care workers' in Northern Ireland are now required to register with the Northern Ireland Social Care Council (NISCC),[324] established under the Health and Personal Social Services Act (Northern Ireland) 2001. Workers required to register include social care workers in adult residential homes and nursing homes, and domiciliary care workers.[325] The stated aim of the NISCC is to improve standards in the social care workforce by setting standards for conduct and practice and supporting professional development.[326]

Staffing requirements and the 'fitness' of workers

Separate regulations cover domiciliary care agencies,[327] day care settings,[328] nursing homes[329] and residential care homes.[330] Each of these sets of Regulations has specific requirements in relation to staffing. **The Regulations for care and nursing homes are largely identical, but there are distinctions between these and the Regulations for domiciliary care agencies.[331]**

Various terms are used in the regulations to define the relationship between worker and care provider. This is most pronounced in The Domiciliary Care Agencies Regulations (Northern Ireland) 2007 (the Domiciliary Care Agencies Regulations), in which terms including 'domiciliary care agency', 'direct service provider', 'employed/employment', 'domiciliary care worker', and 'supply of a domiciliary care worker', and 'staff' are all used, not all of which are defined. In the discussion below, the terms used are those used in the Regulations. Where more than one working relationship is not clear, the term 'worker' is used.

In relation to registered nursing or residential care homes, broad staffing responsibilities are found in regulation 20 of each of the relevant sets of Regulations. **Care and nursing homes are required to ensure that there are appropriate numbers of 'suitably qualified,**

competent and experienced persons' working at all times. The number of staff required should take account of the health and welfare of residents and residents' needs, and the size and the statement of purpose of the hom. **The home is also required to ensure that the employment of any temporary workers does not interrupt the 'reasonable' continuity of nursing or care provided.** Domiciliary care agencies are under similar requirements.[332] As in nursing and residential homes, the agency is required to ensure that, at all times, an 'appropriate number of suitably skilled and experienced persons' are employed, with reference to the size and purpose of the agency and the number and needs of the service-users it supports. Again, the employment of temporary workers must not prevent reasonable continuity of care for service-users.

The Care Standards for nursing and care homes, and domiciliary care agencies add more detail to these requirements. In addition to statements that broadly echo those in the Regulations, **the Care Standards for Nursing Homes stipulate that a registered manager must ensure that during any 24 hour period there is 'a minimum skill mix of at least 35% registered nurses and up to 65% care assistants'[333] and that a registered manager 'ensures arrangements are in place to support staff in day to day decision making'.[334] The home is expected to keep a record of how staffing requirements have been determined.[335]** Care homes are not subject to such specific requirements, but are expected to calculate the number and ratio of staff to residents according to a method determined by RQIA.[336]

Both nursing and care homes and domiciliary care agencies are under obligations that relate to the fitness of the workers they employ. Regulation 21 in each set of Regulations relating to nursing and care homes states that **a home must not employ people - or allow people**

[324] The Northern Ireland Social Care Council (Social Care Workers Prohibition) and Fitness of Workers Regulations (Northern Ireland) 2013
[325] Northern Ireland Social Care Council, 'Registration & Standards' (undated) https://niscc.info/registration-standards accessed 21 May 2019.
[326] NISCC, 'About' (undated) https://niscc.info/about accessed 26 June 2019.
[327] The Domiciliary Care Agencies Regulations (Northern Ireland) 2007.
[328] The Day Care Setting Regulations (Northern Ireland) 2007.
[329] The Nursing Homes Regulations (Northern Ireland) 2005.

[330] The Residential Care Homes Regulations (Northern Ireland) 2005.
[331] The Domiciliary Care Agencies Regulations (Northern Ireland) 2007.)
[332] Regulation 16 of the Domiciliary Care Agencies Regulations (Northern Ireland) 2007
[333] Standard 41(4).
[334] Standard 41(8).
[335] Standard 41 – evidence.
[336] Standard 25(2).

employed by others to work in regular contact with residents - if they are not fit to do so. To ensure fitness, the provider is required to obtain certain information and documents in relation to each employee.[337] These are similar to documentation that is required to be produced in England and Wales, and include items such as photographic identity, criminal record certificates, written references, verification of why previous similar employment finished, and evidence of qualifications. Those required to register with NISCC are also required to produce evidence of registration. **A person is deemed to be unfit to work at a nursing or care home if they are not 'of integrity and good character', or do not have appropriate qualifications and training and the relevant skills and experience. They must also be physically and mentally fit to undertake the work, and appropriately registered (unless the person is a volunteer).[338]**

Under the Domiciliary Care Agencies Regulations **domiciliary care agencies are required to ensure that 'no domiciliary care worker is supplied' unless they are a fit person** (although this term is not explicitly used in the text of Regulation 13, which covers this matter). Fitness of domiciliary care workers is identified similarly to those working in nursing and care homes, with the agency required to demonstrate that domiciliary care workers are 'of integrity and good character', have the necessary experience and skills, are physically and mentally fit for the role, and that 'full and satisfactory information is available in relation to him [/her]'. They are also required to be registered with the relevant regulatory body (other than volunteers).

Failure to comply with *any* of the above requirements is a prosecutable offence.[339] The scope of available sanction creates a significant criminal liability. If a breach is found RQIA has the power to serve on the provider a notice, which identifies the breach, states what action is necessary to ensure compliance with the

regulations and gives a timescale (with a maximum of three months) for that compliance. If the employer does not comply, RQIA has the power to issue proceedings against them.[340]

Training, staff development and qualifications

No specific qualifications are required for people to become social care workers in Northern Ireland, although NI Direct states that 'some employers require applicants to have formal qualifications (usually QCF level 2 or 3).[341] **Once in post, however, both nursing and care homes and domiciliary care agencies are under obligations to provide certain levels of training to workers.** Care and nursing homes are **required to provide employees with appropriate appraisal and mandatory and other training appropriate to their role;** [342] and appropriate supervision to all those working at the home.[343] Again, there is a heavy focus here on the word 'appropriate' and decisions as to what is appropriate are essentially left to the managers or owners of the home in question. However, certain training requirements are also placed into the relevant Regulations, and the Care Standards provide significant further detail. The discussion below sets out first the requirements relating to nursing and care homes, followed by those relating to domiciliary care agencies.

Nursing and care homes must ensure that employees are 'enabled from time to time to obtain training and / or further qualifications appropriate to the work they perform'.[344] The Regulations relating to both nursing and care homes indicate that certain training – for example, relating to safeguarding and fire safety – is explicitly required. In addition, the Care Standards for Nursing Homes stipulate that all newly appointed and agency staff must complete 'a structured orientation and induction', including an initial induction within two days of starting

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[337] Regulation 21(1)(b) and 21(4)(b) in both sets of Regulations. If the home is not the employer, the person's employer is required to obtain this information and documentation. The information and documentation is set out in full in paragraphs 1 to 7 of Schedule 2 of each set of Regulations.
[338] Regulation 21(5) in both sets of Regulations.
[339] Regulation 36 of the Regulations in relation to both nursing and care homes and Regulation 32 in the Domiciliary Care Agencies Regulations.

[340] Regulation 36, in both sets of Regulations.
[341] NI Direct, 'Careers in social care' (undated) https://www.nidirect.gov.uk/articles/careers-social-care accessed 21 May 2019.
[342] Reg 20(1)(c) in both sets of Regs.
[343] Reg 20(2) in both sets of Regs.
[344] 20(1)(c)(iii)

employment.[345] Training needs must be identified, and arrangements put in place to meet them,[346] and managers **must encourage and support care assistants to obtain the relevant vocational qualifications suitable to their role and function.[347]** In addition, mangers are responsible for **'ensuring that staff attend training and achieve and maintain competency as well as meeting requirements for ongoing professional development.[348]** There are therefore clear responsibilities and expectations placed on service providers and managers, as well as on workers to ensure that training is undertaken. Similar requirements are found in the Care Standards for Care Homes, although these are less detailed.[349]

The clearest requirements on training relate to safeguarding. Regulation 14(4) in the Regulations governing both care and nursing homes requires the service provider to make arrangements, 'by training … or by other measures' to prevent residents suffering abuse or harm, or being at risk of harm'. Further requirements are provided in the Care Standards, and the Care Standards for nursing homes stipulate that **workers must have refresher training every three years.** On other matters, the Care Standards for nursing or care homes or both also **stipulate that care workers should, presumably only where appropriate, undertake training in matters such as dementia care and communication, falls, palliative care and records and medicine management.**

The Domiciliary Care Agency Regulations are more explicit than the Regulations relating to nursing and care homes. **In addition to safeguarding training,[350] and training on moving and handling,[351] an agency is required to ensure that employees receive appropriate training, supervision and appraisal, and**

that domiciliary care workers are provided with 'an appropriately structured induction training lasting a minimum of three full working days.[352] During this induction, new workers are not permitted to work with a service-user alone, but must be accompanied by another suitably qualified and experienced worker, *and* are required to be supervised by a suitably qualified 'member of staff'. **The Domiciliary Care Agency Regulations provide no content for the three-day induction, although the Minimum Standards for Domiciliary Care Agencies state that induction for newly appointed staff should have regard to the NISCC Induction Standards.[353]** As with care and nursing homes, the Minimum Standards set out a number of training requirements, on matters such as infection control, management of records, food hygiene, etc.

Agencies must ensure that employees receive 'suitable assistance, including time off,' to obtain appropriate qualifications.[354] As in Wales and Scotland, there is no indication in the Regulations as to the meaning of 'time off' or whether such 'time off' should be paid time away from caring duties, or unpaid time away from work. The Minimum Standards for Domiciliary Care Agencies does not clarify this.[355] If unpaid, the requirement on social care workers registered with the NISCC (see below) to undertake 90 hours of Post-Registration Training and Learning (PRLT) over a five-year period would become an onerous time and financial commitment on workers who more likely than other workers to have a low income and informal caring responsibilities. **Under the Regulations, agencies are also required to provide a staff handbook setting out 'staff' members' roles and responsibilities, expected conduct – and disciplinary action that may be taken – and training and development 'requirements and opportunities.[356]**

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345 Standard 39(1). The full induction is required to be completed within three months. In nursing homes, induction must include initial information on behaviour that challenges.
346 Standard 39(4)
347 Standard 39(5).
348 Standard 39(9).
349 For example, there is no timescale for induction. The relevant Standard is Standard 23.
350 Regulation 15(9), like Regulation 14(4) in the Regulations governing care and nursing homes, Regulation 15(9) of the Domiciliary Care Agencies Regulations requires providers to make arrangements 'by training or by

other measures' to prevent service-users being harmed or suffering abuse or neglect (or being placed at risk of harm, abuse or neglect).
351 Regulation 15(8)
352 Regulation 16(5)(a).
353 Standard 12(1).
354 Regulation 16(2)(b).
355 Department of Health, Social Services and Public Safety, 'Minimum Standards for Domiciliary Care Agencies' (August 2011) https://www.rqia.org.uk/RQIA/media/RQIA/Resources/Standards/domiciliary_care_standards-Aug-11.pdf accessed 24 May 2011.
356 Regulation 17.

The reference to requirements for training – which may or may not be the same as PRTL – reinforces the potential existence of requirements to undertake training that may not be paid.

As with staffing levels and fitness of staff, breaches of the Regulations outlined above – other than regulation 25 of the sets of Regulations governing care and nursing homes – amount to a prosecutable offence and are subject to the same enforcement action by RQIA as is described above.

The duties on workers

As in Wales and Scotland, the bulk of the duties on workers arise from the registration process. There are, however, some implied expectations on workers, particularly those employed by agencies. The regulations in relation to agencies contain various statements that reflect the more fragmented quality of work carried out by domiciliary care workers, which suggest that certain responsibilities are shared between the worker and the agency. **Both 'appropriate information and advice' (including as to service-users and their needs, and the provision of services) and 'suitable assistance and … equipment' are to be provided to workers and made available to them *at their request*.**[357]

It appears that a greater level of responsibility may be placed on someone working in connection with a domiciliary care agency than might occur in a nursing or care home, although this provision may reflect the requirement of domiciliary care workers to work alone and without immediate supervision. **This is emphasised by the requirements on domiciliary care agencies to have available, at all times that work is being undertaken, a suitably qualified and competent person for workers to consult if required;**[358] and to provide the staff handbook referred to above. On recruitment, evidence of a satisfactory knowledge of English is one of the pieces of documentation that workers are required to provide, which does not pertain to recruitment in nursing or care homes. The greater

general onus on workers in domiciliary settings is, perhaps, a simple outcome of the often significant requirements of that role. It is notable, however, that a distinction is made between 'information and advice', which is to be provided to 'persons *employed* for the purposes of the agency' and assistance and equipment, which are to be provided to 'persons *working for* the purposes of the agency'. The distinction would appear to account for information to be provided to workers who maybe operating on a self-employed basis or employed by a third-party.

Certain duties, or expectations, are also seen in the Regulations applying to care and nursing homes, which are required to have arrangements in place to enable staff to inform the home, **RQIA or the local health and social care trust in confidence of 'their views about any matter' to which the relevant regulations apply – that is, matters such as the fitness of the provider or the manager, the requirements to ensure good quality care and to promote and make provision for the health and welfare of residents.**[359] **However, there is no legal *obligation* under the regulations on employees or other workers to make such disclosures.**

The registration process will be a key driver of the development of the social care workforce in Northern Ireland, and the NISCC places significant focus on this role. The code of practice is known as 'standards' and contains two elements: the Standards of Conduct and the Standards of Practice. The Standards of Conduct relate to the 'values, attitudes and behaviours expected of social care workers in their day to day work' and the Standards of Practice set out the 'knowledge and skills required for competent practice'.

Of equal interest in Northern Ireland is the focus placed by the NISCC on PRTL. Registered social care workers are required to undertake 90 hours of PRTL in five years. Social care workers are required to base their PRTL around five learning and development standards: Principles of Care, Health and Safety, Social Care Skills, Communication and Safeguarding.[360]

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[357] Regulation 16(1)(b). The distinction between 'providing' one of these items and 'making it available at their request' is not clear.
[358] Regulation 16(1)(d).

[359] Regulation 23 in both sets of Regulations.
[360] There are further standards in supervision and appraisal for senior social care workers and social care managers, and standards in leadership

Codes of Practice / Conduct for social care workers and for employers

This section sets out core principles and requirements from the Codes of Practice for social care workers in Wales, Scotland and Northern Ireland. **These are set out together in this section so that comparisons between the Codes in the different countries of the UK can be more easily observed.** Certain distinctions between the Codes are immediately obvious from their formats. In Wales, the Codes of *Professional* Practice (emphasis added) for social care workers and employers are presented in two separate documents. In Scotland, the Codes of Practice for social service workers and employers are combined into one document (with the Code for employers set out first), emphasising the complementary nature of these Codes. In Northern Ireland, the relevant documents are the Standards of Conduct and Practice for Social Care Workers and the Standards for Employers of Social Workers and Social Care Workers. For social care workers, the Standards of Conduct and Practice form two separate (but combined) documents, with the first setting out requirements for conduct in and outside the workplace, and the second setting out requirements that pertain to the means of providing care.

In their overall principles and main content, the Codes relating to Wales and Scotland and the Standards of Conduct relating to Northern Ireland are broadly similar, although the Northern Ireland Code is more detailed and, arguably, more onerous. In addition, **in Northern Ireland, the Standards of Conduct and Practice are stated to be 'binding on all social care workers registered with the Council,** *irrespective of employment status or work setting***' (emphasis added). If social care workers wish to avoid allegations of unfitness, they are therefore obliged to**

follow the standards in *any* **work setting, beyond those relating to social care.**

All of the Codes for social care workers have a **focus on fitness to practice and the binding nature of the codes, and all emphasise the worker's accountability for their own work and the responsibility of the care worker to meet the standards set out in the relevant Code.** Under each Code, registrants are accountable for the quality of their work and have responsibility for maintaining and improving their own knowledge and skills. As discussed above, this may have an onerous impact on the worker if that obligation is expected to be met outside working hours. The overarching standards of conduct are very similar across all the Codes. For brevity, those relating to Scotland only are set out here, as an indicator of expectations. These standards state:

1. As a social service worker, I must protect and promote the rights and interests of people who use services and carers.

2. As a social service worker, I must create and maintain the trust and confidence of people who use services and carers.

3. As a social service worker, I must promote the independence of people who use services while protecting them, as far as possible, from danger and harm.

4. As a social service worker, I must respect the rights of people who use services, while striving to make sure that their behaviour does not harm themselves or other people.

5. As a social service worker, I must uphold public trust and confidence in social services.

6. As a social service worker, I am accountable for the quality of my work and will take responsibility for maintaining and improving my knowledge and skills.

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and management for social care managers. Post Registration Training and Learning (PRTL): Continuous Learning & Development Standards Guidance for Social Care Registrants' (April 2018)

https://niscc.info/storage/resources/20180423_scwaudit-2018-final-guidance-for-registrants-_jh-final.pdf accessed 21 May 2019.

Overall, the Codes create strong expectations on social care workers. Among other things, all the Codes impose requirements on workers to advise their employers if they are experiencing 'personal difficulties' that might affect their ability to carry out their work, to raise concerns with their employer or regulatory body where the practice of *others* may be unsafe or adversely affecting standards, and to challenge abuse. Registered workers are therefore required to be responsible not only for their *own* standards, but also to take a certain responsibility in relation to matters that impact on the securing of an adequate and competent workforce overall, including, potentially, the work of those in positions of greater responsibility than themselves. Additionally, workers are required to bring their employers' attention to resource or operational difficulties which may get in the way of the delivery of social care support (or 'safe social care support' in Northern Ireland and Wales) – a requirement that places strong expectations on the ability of care workers to challenge their employers or managers on matters that are likely to be well beyond the worker's – and potentially even the service providers' – control.

The Standards of Practice, which are unique to Northern Ireland, create a further set of standards relating to work practice, many of which impose significant expectations on social care workers. The six overarching standards of practice are that a social care worker must:

1. Understand the main duties and responsibilities of your own role within the context of the organisation in which you work.

2. Be able to communicate effectively.

3. Deliver person-centred care and support which is safe and effective.

4. Support the safeguarding of individuals.

5. Maintain health and safety at work.

6. Develop yourself as a social care worker.

These include requirements, for example, to keep 'records that are up to date, complete, accurate and legible', to 'contribut[e] to the planning process with service-users and carers', to access 'full and up-to-date details of policies, procedures and agreed ways of working from your employer' and adhere to them, and to know 'the regional policies and procedures relating to safeguarding'. There are therefore significant practical requirements on social care workers at all levels.

In Wales, Scotland and Northern Ireland there are also Codes of Practice for Employers, which complement and augment the Codes for social care workers in these countries. As for the Codes relating to social care workers, those in Wales and Scotland are similar, with those in Northern Ireland covering similar ground, but also having significant distinctions. For reference, the six overarching principles in the Code in Scotland are set out here, to indicate the general aims of the Codes in Scotland and Wales. These state:

1. As a social service employer, you must make sure people are suitable to be social service workers and that they understand their roles and responsibilities.

2. As a social service employer, you must have the culture and systems in place to support social service workers to meet their Code of Practice.

3. As a social service employer, you must provide learning and development opportunities to enable social service workers to strengthen and develop their skills and knowledge.

4. As a social service employer, you must have written policies and procedures in place to protect people who use services and carers, and to support social service workers.[361]

5. As a social service employer, you must publicise and promote the Code of Practice for Social Service Workers to people who use services

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[361] In Wales, this overarching principle does not state that policies must be written and makes no reference to supporting workers. In full, the equivalent principle reads: 'Have policies and systems to protect people from damaging or dangerous situations, behaviour and practice'.

and carers and cooperate with us in our proceedings.

In contrast, the overarching principles of the Code in Northern Ireland state that employers must:

1. Provide vision and leadership to registrants in line with organisational expectations and governance requirements, to ensure they are enabled to deliver safe, effective and values-led care focused on the needs and experiences of service-users;

2. Make sure people are suitable to enter the workforce;

3. Have written policies and processes in place to enable registrants to meet the NISCC Standards of Conduct and Practice;

4. Provide learning and development opportunities to enable registrants to strengthen and develop their skills and knowledge;

5. Promote the NISCC Standards of Conduct and Practice to registrants, service-users and carers and co-operate with NISCC's proceedings.

In all the countries, the Codes reinforce the requirements set out in Regulations, guidance and other standards to ensure that those they employ are fit to carry out their work and have opportunities for development and learning, that adequate employment policies are in place, and that registrants and other workers are aware of and are able to abide by their own Codes.

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