A Survey of Job Satisfaction, Staff Morale and Qualifications in Residential Child Care in Scotland

Report

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Chapter 1
Introduction

The report of the National Children's Bureau study of staff morale, qualifications and retention in England (Mainey, 2003) rightly highlighted a number of crucial issues facing providers of residential child care. Entitled *Better Than You Think* the key finding was that the rates of morale and job satisfaction were not low despite the adverse environment in which residential care operates. Residential care in the modern world is intended to be mainly a temporary placement for some of the most demanding young people who require out-of-home care. However, as with foster care, significant numbers of young people are spending years in out-of-home care and many residential services have to accommodate a wide variety of needs within a single unit. This general remit is challenging enough but the sector also continues to struggle with the aftermath of a number of high profile public inquiries which have identified instances of abuse of children and young people in residential care (Kent, 1997; Utting, 1997; Waterhouse, 2000).

In order to protect service users and improve the quality of care for all client groups the government has instituted a number of major organisational changes. Independent agencies have been established to regulate care services (the Care Commission in Scotland) and to regulate the workforce (the Scottish Social Services Council). In Scotland, the Scottish Institute for Residential Child Care (SIRCC) was established to co-ordinate training for residential child care staff and to raise the profile of residential child care through research, publications, conferences and seminars.

However the best use of residential placements depends upon effective partnerships between residential staff and social workers and other professionals. There has been a severe shortage of field social workers in many local authorities in recent years and the residential sector itself has had problems of recruitment and retention, especially of qualified workers. It is well-known that many residential workers leave that sector

once they have gained a social work qualification and this trend has exacerbated the problem of building up a more highly qualified residential workforce.

Given this demanding and highly scrutinised environment the results of the English study of questioned the 'received wisdom' that morale among residential child care staff is low. The Social Education Trust (SET), which funded the English study, decided to extend the research and investigate the situation in the three other parts of the United Kingdom: Scotland, Wales and Northern Ireland.

A joint project between the Social Education Trust (SET) and SIRCC was established to replicate the English research in Scotland. This would provide important information for the development of residential care in Scotland and would also enable comparative analysis across the UK.

Aims

The aims of the project are to:

- Examine current levels of morale among staff working in residential child care in Scotland
- Explore what factors staff believe promote or undermine staff morale
- Explore how staff perceive the relationship between morale, training, achievement of qualifications and preparation for the task
- Examine the link between morale and the recruitment and retention of staff
- Identify models of good practice in promoting high staff morale
- Disseminate the findings to policy makers, managers and practitioners.

This report provides information on the experience of residential child care staff in Scotland. 402 care staff and managers in local authority, voluntary and private establishments across Scotland returned questionnaires in a national survey. Thirty-two staff who returned questionnaires also took part in a telephone interview to provide more in-depth responses to some of the issues addressed by the questionnaire. The study followed the model of the English study, indeed the same questionnaire was used (amended where necessary to take account of the Scottish context, for example, the Scottish qualifications framework). This will allow maximum comparability across the four studies.

The Report

Although preliminary discussions have taken place with colleagues undertaking the parallel studies in other parts of the UK, this report will focus on the findings of the Scottish survey. It would not make sense, however, to ignore the published report of the English study (Mainey, 2003) and comparison will be made to the main findings in the English study.

Chapter 2 provides an overview of the residential child care in Scotland, highlighting recent developments and placing it in the context of wider changes. Chapter 3 gives details of the research methodology and, in Chapter 4 we describe the respondents to the survey. Chapter 5 gives the core results to the questions measuring staff morale and job satisfaction while the following chapter on staff support provides some insight into how staff view supervision and other aspects of the job. In chapter 7 we look at the findings in relation to training and qualifications, and chapter 8 reports the views of residential workers on recruitment and retention issues. The last chapter summarises the key findings from the study and reflects on the impact of these in terms of the care experience of children and young people.

Chapter 2

The Changing World of Residential Child Care

While there are many similarities in the way that residential child care has developed in all the countries of the UK there have always been differences too, and the sectors in each country continue to evolve in relation to their particular conditions and legal and organisational contexts. This chapter explains the structure of the sector and draws attention to particular developments in Scotland.

The changing nature of residential care, the impact of scandals and public and professional scrutiny, all conspire to produce a very demanding working environment. Combine this with the fact that few residential workers are trained in advance of employment, and that this sector lacks a clear professional identity, and it is immediately apparent that building and maintaining morale is a major challenge.

The size and shape of the sector

Residential child care has undergone many structural changes in recent years. In the mid-1970s, over 6,300 children and young people were cared for in residential establishments at any one point in time, and many remained there for substantial portions of their childhood. By the end of the 1980s, places had fallen to a third of this figure and placements were in the main perceived as temporary; pending a return home, a move to foster care or onto 'independent living'. The latest national figures show that in March 2002, there were 1,962 children and young people in residential accommodation (Scottish Executive, 2003a). The balance between foster care and residential care has also changed significantly. In 1976, almost twice as many children and young people were in residential care compared to those in foster care. The reverse is true today (Scottish Executive, 2002a).

The number of residential establishments in Scotland shows a somewhat different pattern. In the mid-1970s, there were 288 establishments, and this fell to 158 at the end of the 1980s. However, this had increased to 207 in 2002. This can be explained by the long-term decrease in the size of residential establishments; falling from an average of 25 places in the 1970s to an average of 10 places today (Scottish Executive, 2003a). Residential establishments range in size; the schools naturally being larger and made up of several sub-units. The main types are children's homes, residential schools, homes for children with disabilities and secure accommodation establishments.

'Children's homes'

In England the Morale study was carried out among the staff of children's homes. The ownership and management of English homes has become much more diversified in recent years with a major expansion of the private sector. In Scotland the great majority of children's homes remain in local authority hands. In most parts of the country they are referred to as 'units' while in Edinburgh and some other East coast areas they are referred to as Young People's Centres (YPCs). This designation was adopted in the early 1980s in line with the policy – not always realised - in the then Lothian \region that no under 12's should be placed in residential care.

Residential schools

In England the former Community Homes with Education (CHEs), as their residential schools used to be known, have almost completely disappeared. There continue to be a number of special residential schools in England, notably 'therapeutic communities', and others which cater for children with disabilities. These schools are found almost exclusively in the voluntary and private sectors. The English study did not include this sector, although it did include some children's units for children with disabilities.

In Scotland the residential schools sector continues to play a significant role in the provision of residential placements; providing about half of the residential care places and employing about half of the staff. This sector is itself highly diversified including a number of schools which operate on a 'term-time' basis with children and young people returning to their home bases during the holiday periods. However most of the residential schools operate year round and offer an extensive 'care' as well as 'residential education' service. The latter group also include the secure units, currently undergoing a period of major re-structuring and expansion. There are also a few large schools which provide accommodation for children with physical disabilities; such as schools for deaf or blind children. These were all included in the sample for the Scottish study.

The statutory and independent sectors

It is noteworthy that nearly all the residential schools are in the voluntary or 'not-for-profit' sector, and in terms of ownership are a kind of mirror image of the children's homes sector. In the latter there are one or two voluntary and private providers, while in the former only 5 out of about 32 residential schools are run by local authorities (3 of which are secure units). Furthermore there is now only one authority which continues to operate a residential school for children with 'emotional and behavioural difficulties' managed by their Education Department rather than the Social Work Department. In total there are about 32 residential schools in Scotland – it is difficult to give an exact number because of the varying types of schools and how they may be categorised. Because of the size of the schools, usually taking between 18 – 40 or so children and young people, they employ many more staff than a typical residential unit.

In gathering information about the independent sector schools it was not always possible to be certain about categories such as private, 'not-for-profit' and 'for profit'. In Scotland there has been little development of the new private sector homes or schools as has been the case in England and Wales in recent years. In Scotland there are a number of large-scale providers which are clearly in the charitable and voluntary sectors such as the Church of Scotland, Aberlour Child Care, and the Catholic Church

to name a few. There are also a number of long-established residential schools managed on a family business model which are clearly 'not-for-profit'. Because the number of 'for profit' establishments is so small, and because it is not always clear if a residential school is a 'voluntary' provider or a 'private not-for–profit' provider all of them have been grouped together in the analysis of the findings of the study. In terms of this study about half of the responses received were from this 'independent' or 'non-statutory' sector.

Given the patterns of ownership noted above, when the study reports findings relating to the local authority sector this means that these are the views of staff mainly working mainly in children's units and YPCs. When findings are reported from the voluntary and private sectors they are the views of staff working mainly in residential schools of one kind or another. However while it is important for readers to be aware of the shape of the residential sector in Scotland, especially when making comparisons with other countries in the UK, it is quite striking that the responses to the questionnaire from the local authority (statutory) sector and the independent (voluntary and private) sectors are very similar. There are differences but they are usually only of one or two percentage points.

Patterns of care

Although the number of children and young people in residential care at any one time has fallen, recent statistics also show that the number of admissions to residential establishments has increased dramatically over the last fifteen years or so. There were 3,870 admissions to residential establishments in 1989 compared to 10,961 in 2002 (Scottish Executive, 2003a). The vast majority of children and young people stayed in residential care for short periods of time, three-quarters residing for less than a month. One of the reasons for the increase in admissions to residential accommodation is the development of respite care and shared care arrangements, particularly for disabled children and young people. It may also, however, reflect a more general trend for shorter stays in residential care. There are also a significant number of young people who do remain in residential care on a long-term basis, very many for one year or

more, and it is important that their existence is not ignored by policy makers or providers.

Size and shape of the residential sector – Conclusion

Those who have worked in residential care for many years have thus experienced profound changes in the size of units, the styles of work and modes of operation. Correspondingly staff who have been recruited in recent years have often found themselves working in units which have been re-structured in one way or another. One result is that new staff have often not been able to draw upon either long-established patterns of practice or sound cultures of care in which to develop their skills.

The 1990s saw a number of enquiries into abuse of children in care by staff (Edinburgh, Fife). Although Scotland has had nothing like the number of allegations and enquiries that have taken place in England or Wales nevertheless the sector has had to acknowledge historic and more recent examples of abuse of care. Another problem that has surfaced in various parts of the country has been local hostility to the opening of new units, sometimes fuelled by hysterical and antagonistic newspaper coverage.

All of these factors together have undoubtedly left the sector with a negative public image and under pressure to achieve better standards of care in a climate of suspicion in which mistakes command media attention and can quickly lead to investigation and disciplinary procedures. In a climate where staff may not feel confident that their practice will be valued or even understood it would not be surprising if morale was low. It was this confluence of factors that are apparently conspiring to devalue the residential care service that led the Social Education Trust to decide that it was important to check if the morale of the sector was as bad as was imagined and to try to identify those factors which would most contribute to improving morale and levels of job satisfaction and thus hopefully to improving recruitment and retention.

Improving the quality of care through inspection, training and inter-professional collaboration

The preceding section noted some of the structural factors and trends affecting the residential child care sector. However while the sector has been improved in terms of moving to smaller units with higher staff ratios the sector has also found itself questioned when the 'outcomes' of care are measured. Research has highlighted the poor outcomes for children leaving both residential and foster care. Most recently in Scotland, a survey of care leavers identified that the majority of care leavers had poor educational outcomes; over half were unemployed; and many of the young people had experienced mobility and homelessness (Dixon & Stein, 2002). One important aspect of these poor outcomes relates to instability whilst in care, multiple placements and educational disruption (Dixon & Stein, 2002; Kendrick, 1995; Triseliotis, Borland, Hill, & Lambert, 1995).

Inspection and National Care Standards

As has already been alluded to the agenda for improvement in all care services has been taken forward by establishing independent, national bodies to register and inspect care services. In Scotland, the Scottish Commission for the Regulation of Care (the *Care Commission)* was established on 1st April 2002. Parallel bodies were also established in England and in Wales.

The Care Commission has responsibility for the registration and inspection of care services. It will issue a certificate of registration to care services which meet the statutory requirements; taking into account the new National Care Standards which have been drawn up. The Care Commission will enforce the standards and when other routine actions have failed to improve the quality of services, it will be able to use legal sanctions to ensure improvement or, ultimately, to de-register a service.

Nineteen volumes of National Care Standards were issued by the Scottish Executive in the Spring of 2002 covering a wide range of social care services. The volumes on care homes for children and young people, and school care accommodation services are the most relevant and important for residential child care (Scottish Executive,

2002b; Scottish Executive, 2002c). The main principles upon which the National Standards are based relate to the needs of children and young people for: Dignity, Privacy, Choice, Safety, Realising Potential, and Equality and Diversity. Maclean (2002) considered that the decision to write the standards from the point of view of the children and young people who use the services was a brave and progressive one, and compared them favourably to the equivalent standards in England.

> The combination of Care Standards, national registration and inspection, and qualification and registration of staff provides a unique opportunity to ensure that children and young people in residential provision receive the services they need and deserve. (Maclean, 2002)

Ensuring the Quality of the Workforce

There has been a long-standing debate in the UK about the need to regulate the social care workforce (Bamford, 1990; Hugman, 1991). Alongside the establishment of the Care Commission, the *Scottish Social Services Council* was established to regulate the workforce. Again, parallel bodies were established in England and in Wales. The Councils have a number of responsibilities. They will set standards of conduct and practice for the workforce and publish codes of practice for social services workers and their employers. They will establish a register of individuals working in social work and social care and be able to discipline individuals and, ultimately, be able to remove individuals from the register. The Councils will also regulate education and training and approve courses. In Scotland, residential child care workers are included in the first phase of the registration process.

In the early 1990s, a government review of residential child care set national targets for the qualifications of residential child care staff in local authorities and independent organisations (Skinner, 1992). Unfortunately, little headway was made in subsequent years and a recent national audit of the training and qualifications of residential child care staff showed that a substantial number did not hold relevant qualifications (Frondigoun & Maclean, 2002). Over the summer of 2002, a consultation was held on the qualifications criteria for registration of the social services workforce. It was concerning that that the consultation set the required qualifications for residential

child care workers at a lower level than the Skinner targets. The qualifications criteria for residential child care staff have now been established, however, and it is encouraging that there has been significant movement from the initial proposal. There is now a balance between vocational, academic and professional qualifications. In addition, the range of professional qualifications recognised (occupational therapy, physiotherapy, speech and language therapy, community education and curative education, as well as social work) opens exciting possibilities for the development of the profession (Smith, 2003). It must still be said that the level of qualifications set for residential child care staff is still much lower than that set for social workers.

The process of registering residential child care staff is now under way and will be progressed over the coming years. There will be many challenges, for both individuals and organisations, that will need to be surmounted to achieve a fully qualified workforce.

Developing Quality Training for Residential Child Care

The Scottish Institute for Residential Child Care (SIRCC) was established on April 1st 2000. The aim of SIRCC is to ensure that residential child care staff throughout Scotland have access to the skills and knowledge they require to meet the needs of the children and young people in their care.

> Mission Statement
> Promoting learning and development, that respects and values children and young people, and the staff caring for them in residential establishments, through education, training, consultancy and research (Scottish Institute for Residential Child Care, 2002)

The partnership which is responsible for developing and managing the Institute consists of three academic institutions (Langside College, the Robert Gordon University, the University of Strathclyde); a major children's voluntary organisation (Save the Children) and an independent organisation for children and young people in care (Who Cares? Scotland).

SIRCC provides a range of education and training opportunities for residential child care workers in Scotland. In addition to its remit for training, it provides a consultancy and advice service for residential child care providers. Its library and information service provides an important resource for residential staff across Scotland. Regular seminars are held on topical issues and SIRCC's annual conference provides an important forum for residential child care staff to come together to learn of the latest research and developments in practice.

Improving health and education

Residential establishments in Scotland now tend to provide placements for adolescents who present a range of complex behavioural problems, although there are an increasing number of younger children being admitted to residential units because of very difficult to manage behaviours. It is unsurprising, then, that behavioural control is a major issue in children's homes and residential schools. A number of establishments are developing cognitive behavioural programmes to address offending and behavioural issues, for example, working with sexually aggressive young men (Kendrick & Mair, 2002). Children and young people in residential care also have a very high incidence of mental health difficulties. Often they have poor access to specialist mental health services, but initiatives are beginning to be developed to address this (van Beinum, Martin, & Bonnett, 2002). Similarly, general health issues of children and young people in residential care have been neglected although unacceptably high levels of long-term illness, alcohol and drug misuse, teenage pregnancy and sexually transmitted infections have been reported. Again, specific work is being developed in Scotland to improve the health outcomes of children and young people in residential care (Grant, Ennis, & Stuart, 2002; The Residential Care Health Project, 2004). The development of work to address these serious issues is patchy, however, and there are wide geographical variations.

The issue which has led to the most consistent development of work concerns the education of looked after and accommodated children and young people. The educational outcomes for this group of children has been very poor (e.g. Dixon and Stein, 2002; Francis *et al,* 1996; Francis, 2000). Following a report which highlighted

yet again these poor outcomes and the continuing gaps in services (Scottish Executive, 2001), the Scottish Executive stated that: all looked after children should receive full-time education; all looked after children should have a care plan which adequately addresses educational needs; and all schools should have a teacher designated to championing the interests of these children and set local authorities one year to achieve this (Scottish Executive, 2002). It also funded a development project to produce training and other materials to improve practice.

Summary

This chapter has sought to provide a 'pen picture' of the contemporary context in which residential practitioners work. As we have seen it is a type of work which has undergone considerable change and which is also under public, professional and political scrutiny. For people who enjoy young people and are skilled at relating to them it is very rewarding to provide care and guidance. However the young people in residential care are some of the most 'troubled and troublesome' and so the challenge of providing care in a considerable one. The residential sector has come through a period when its worst side has been exposed in the media and safeguards to protect children and promote their rights have been put in place. National Care Standards have been established accompanied by an independent inspection regime. Workers are expected not only to provide a good quality care environment but also to work closely with other professionals to ensure that young people's health and education is improved and that those who remain in care for longer periods are better prepared for 'leaving care' and living more independently. A demanding task indeed and it is little wonder that questions of morale and motivation arise in this context.

Yet in England, where the original research was conducted, the study found that levels of morale and job satisfaction were 'Better than you think', and, as the next chapters will show, in Scotland a similar picture was to emerge.

Chapter 3

Methodology

Research Design

The project employed both quantitative and qualitative research methods and followed closely the design of the English study. It comprised:

- A national survey of staff and managers* in a random sample of statutory, private and voluntary residential establishments in Scotland.
- Semi-structured telephone interviews with a sub-sample of questionnaire respondents.
- Interactive feedback seminars to staff, managers and policy makers, to report the findings, to receive suggestions for further analysis and to consider implications for policy and practice.

** Due to the large number of agencies (statutory and voluntary) which run residential services there are a variety of staffing structures and job titles in use in different parts of the country. The 'manager's questionnaire' was distributed to all promoted staff in a unit; who might be either deputes, assistants, or senior practitioners.*

The National Survey

A nationwide postal survey of staff in a large sample of residential child care establishments in Scotland was carried out between February – April 2004.

The Sample

In October 2003, the SIRCC Residential Unit Database (RUD) held records on a total of 232 residential establishments. A fifty per cent random sample was selected and this generated a sample of 116 residential establishments (65 local authority establishments (56 %) and 51 voluntary/private sector establishments (44 %)). The relatively small number of private establishments in Scotland meant that it was not feasible to distinguish these in the study. The sample included both children's homes and residential schools.

Identifying Staff in the Sample Establishments

Following the identification of the sample of establishments, local authorities and voluntary and private agencies were approached for consent to carry out the survey in their residential establishments. Consent was granted by all the local authorities and just under two-thirds of voluntary and private agencies. The researchers then contacted the managers of all the establishments for which we had agency consent and requested that they return a staff list for the establishment. After follow-up requests by post and/or telephone, staff lists were returned from 64 residential establishments, representing 55 per cent of the original random sample.

The staff lists identified 272 managers or deputy managers and 1,218 care staff, a total of 1,490 staff. Staff had a range of roles and could be employed part-time or full-time.

Questionnaire Development

The questionnaires used in the survey were based closely on the questionnaires of the English study in order to ensure the greatest degree of comparability between the studies. Two questionnaires were produced; one for managers etc. and another for care staff.

The questionnaires for the Scottish survey had to be amended, however, for a number of reasons. It was noted above that residential schools were included in the Scottish survey and the text of the questionnaire had to be changed to take this into account. The main change concerned the different qualifications recognized in Scotland for registration with the Scottish Social Services Council. The question on qualifications was therefore changed significantly.

In addition, five questions were added to the questionnaires which asked about the use and helpfulness of a range of services provided by the Scottish Institute for Residential Child Care: conferences and seminars; short courses; other courses; library and information services; and the Scottish Journal of Residential Child Care.

Given that the questionnaire had been piloted and used in the English study, it was not piloted again in Scotland. Discussions with the researchers in England did highlight a small number of changes which needed to be made to the questionnaires.

Individually addressed questionnaire packs were sent to the manager of each residential establishment for distribution to the named staff. Questionnaires were accompanied by information about the research and freepost reply envelopes, so that respondents could return their questionnaire to use directly. A series of postal and telephone follow-up contacts were made with managers of homes in order to increase response rates.

Respondents

In total, 402 staff from across Scotland returned questionnaires, consisting of 315 care staff and 87 managers and deputies etc. This was a response rate of 27.0 per cent. Table 3.1 shows that a slightly higher proportion of managers etc., returned questionnaires, just under one-third, compared to slightly over one-quarter of care staff.

Table 3.1: Questionnaire Response Rate

	Managers	**Care Staff**	**All**
Staff Lists Received	272	1218	1490
Questionnaires Returned	87 (32.0%)	315 (25.9%)	402 (27.0%)

Fifty-six separate residential establishments were represented in the survey; an average of seven from each establishment and a range of one to 23. Twelve questionnaires did not provide information on the establishment. 254 respondents (63.2%) worked in local authority establishments and 136 respondents (33.8%) worked in voluntary/private establishments. Local authority respondents worked in 38 separate establishments and voluntary/private respondents worked in 18 establishments.

Qualitative Interviews

Thirty-two semi-structured interviews were carried out by telephone in April and May of 2004. Respondents to the questionnaires had been asked whether they would be willing to take part in further interviews. The selection of those to be interviewed aimed to reflect the proportions of staff in the different sectors in the questionnaire survey, and the proportions who had indicated high, OK or low levels of morale in the survey responses.

The telephone interviews allowed residential staff to go into more details about aspects covered in the survey questionnaire. In particular, interview questions addressed: staff morale; teamwork; support systems; training; recruitment and retention; and residents' progress. Telephone interviews were not recorded but notes were taken during the interviews. Quotations in the text are not therefore verbatim but are based on the interview notes.

Interactive Seminars with Managers and Practitioners

In August 2004, interactive seminar workshops were held in Edinburgh and Glasgow with a total of 50 participants. Most participants were managers in residential establishments or external residential managers in local authority social work departments. The main findings from the research were presented and discussed in

small groups. Participants were invited to address the key themes arising from the research. The workshops aimed to involve practitioners in interpreting the results of the research. The participants were able to suggest further avenues for analysis of the data and the implications of the research findings for policy and practice.

Chapter 4

Respondents

Demographic Information

402 staff in 56 residential establishments from across Scotland returned questionnaires in the national survey; 315 care staff and 87 managers and deputies.

There has long been debate about the role of gender in caring professions and recently, in Scotland, there have been initiatives to recruit more men to residential child care. Although the workforce is predominantly female, a higher proportion of staff in Scotland were male, 39 per cent compared to 29 per cent in England. Table 4.1 also shows that, interestingly, a slightly higher proportion of managers were women (63 per cent) than care staff (61 per cent).

Table 4.1: Gender by Role

	Managers	**Care Staff**	**All**
Male	32 (37.2%)	122 (39.4%)	154 (38.9%)
Female	54 (62.8%)	188 (60.6%)	242 (61.1%)
Total	86 (100%)	310 (100%)	396 (100%)

The workforce is also predominantly non-disabled, with only 1 per cent of respondents reporting that they were disabled.

Table 4.2: Disability by Role

	Managers	**Care Staff**	**All**
Able	86 (100%)	304 (98.7%)	390 (99.0%)
Disabled	-	4 (1.3%)	4 (1.0%)
Total	86 (100%)	308 (100%)	394 (100%)

The vast majority of the workforce in the Scotland are white (99 per cent), even more so than the English study where 91 per cent were white.

Table 4.3: Ethnicity by Role			
	Managers	**Care Staff**	**All**
White British	77 (89.5%)	302 (97.4%)	379 (95.7%)
White Irish	3 (3.5%)	1 (0.3%)	4 (1.0%)
White Other	5 (5.8%)	6 (1.9%)	11 (2.8%)
Mixed White & Black Caribbean	1 (1.2%)	-	1 (0.3%)
Mixed White & Asian	-	1 (0.3%)	1 (0.3%)
Total	86 (100%)	310 (100%)	396 (100%)

Four-fifths of the respondents (81 per cent) were working full-time, with a higher proportion of care staff (19 per cent) working part-time than managers and deputy managers (6 per cent).

Table 4.4: Full-time / Part-time working by Role			
	Managers	**Care Staff**	**All**
Full-time	80 (94.1%)	239 (77.1%)	319 (80.8%)
Part-time	5 (5.9%)	71 (22.9%)	76 (19.2%)
Total	85 (100%)	310 (100%)	395 (100%)

Mainey (2003) commented on the vast amount of experience in the respondents to the English study. As in England, half of the workforce have been in residential child care for more than eight years and half have been in their current post for four years or more. However, she also makes the important point that 'the combination of an ageing workforce and current recruitment problems will have serious implications for the retention of a sufficient workforce in the future' (Mainey, 2003, p. 23). The workforce in Scotland is significantly older than in England with only 39 per cent being aged less than 40 compared to 46 per cent in England. While the proportion of staff aged fifty or over in the two countries was similar, 41 per cent of the workforce in Scotland were in their forties, compared to only 34 per cent in England.

Table 4.5: Age by Role			
	Managers	**Care Staff**	**All**
Less than 20	-	1 (0.3%)	1 (0.3%)
20-29	2 (2.4%)	42 (13.6%)	44 (11.2%)
30-39	25 (29.4%)	85 (27.6%)	110 (28.0%)
40-49	38 (44.7%)	123 (39.9%)	161 (41.0%)
50-59	17 (20.0%)	52 (16.9%)	69 (17.6%)
60 +	3 (3.5%)	5 (1.6%)	8 (2.0%)
Total	85 (100%)	308 (100%)	393 (100%)

As would be expected, managers and deputies were older than care staff and had also been working in residential care for longer.

Table 4.6: Years in Current Post by Role			
	Managers	**Care Staff**	**All**
1 year or less	18 (20.9%)	71 (23.3%)	89 (22.8%)
>1-3 years	22 (25.6%)	83 (27.2%)	105 (26.9%)
>3-6 years	14 (16.3%)	49 (16.1%)	63 (16.1%)
>6-9 years	12 (14.0%)	33 (10.8%)	45 (11.5%)
>9-12 years	8 (9.3%)	28 (9.2%)	36 (9.2%)
>12 years	12 (14.0%)	41 (13.4%)	53 (13.6%)
Total	86 (100%)	305 (100%)	391 (100%)

Table 4.7: Years in Residential Care (including Current Post) by Role			
	Managers	**Care Staff**	**All**
4 years or less	1 (1.2%)	112 (36.8%)	113 (29.0%)
>4-8 years	17 (19.8%)	64 (21.1%)	81 (20.8%)
>8-12 years	19 (22.1%)	53 (17.4%)	72 (18.5%)
>12-16 years	16 (18.6%)	35 (11.5%)	51 (13.1%)
>16-20 years	16 (18.6%)	24 (7.9%)	40 (10.3%)
>20 years	17 (19.8%)	16 (5.3%)	33 (8.5%)
Total	86 (100%)	304 (100%)	390 (100%)

Chapter 5
Job Satisfaction and Staff Morale

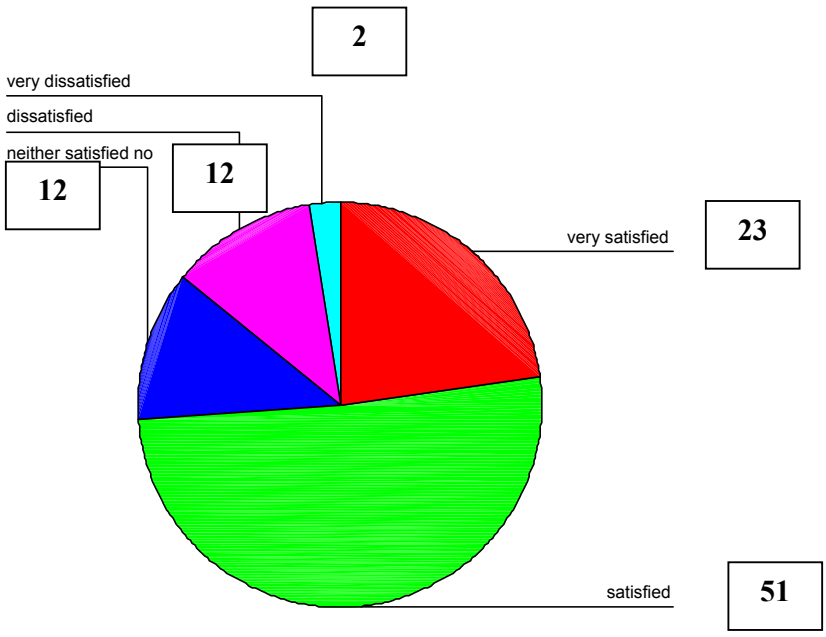
One of the primary aims of the research was to find out the level of staff morale and job satisfaction among residential child care staff in Scotland. Mainey (2003) acknowledges that morale is a complex concept and can be measured in a number of ways. Following the English study, respondents were asked whether morale was high, ok or low. Similarly, job satisfaction was measured by asking respondents to rate their satisfaction on a five-point scale ranging from very satisfied to very dissatisfied. An important point to be made here was that although job satisfaction is closely linked to morale, they are measuring different things. The question about staff morale focused on the workplace: *In my opinion, staff morale in my workplace is currently: High/OK/Low/Don't know,* while the question about job satisfaction focused on the individual: *Overall, how satisfied are you with your job?* Therefore, some respondents were very satisfied with their own jobs but felt that staff morale in the workplace was low; others were dissatisfied with their own job but considered staff morale to be okay (see Mainey, 2003).

As well as presenting the levels of job satisfaction and staff morale, this chapter also looks at motivation and at the factors contributing to high or low morale.

Job Satisfaction

When we asked residential staff how satisfied they are with their jobs, we found that almost three-quarters (74%) were either satisfied or very satisfied. This is very similar to the findings of the English study where exactly three-quarters were satisfied or very satisfied with their job (Mainey, 2003). A slightly higher percentage of staff in Scotland were dissatisfied or very dissatisfied (14%) compared to 9% in the English study.

Figure 5.1: Job Satisfaction of Residential Child Care Staff in Scotland.



When we compared job satisfaction by role (Table 5.1), we found that although a slightly higher proportion of care staff were *very satisfied*, significantly more managers were *satisfied* with their jobs. (Reminder: the 'Managers' group includes deputes, assistants and senior practitioners.)

Table 5.1: Job Satisfaction by Role			
	Managers	**Care Staff**	**All**
Very Satisfied	17 (19.8%)	74 (23.6%)	91 (22.8%)
Satisfied	52 (60.5%)	153 (48.7%)	205 (51.3%)
Neither	7 (8.1%)	40 (12.7%)	47 (11.8%)
Not Satisfied	8 (9.3%)	39 (12.4%)	47 (11.8%)
Very dissatisfied	2 (2.3%)	8 (2.5%%)	10 (2.5%)
Total	86 (100%)	314 (100%)	400 (100%)

There were slight differences in job satisfaction in relation to other factors: slightly more women were satisfied than men (75% compared to 71%); slightly more of those working in the voluntary sector as opposed to the local authority sector (76 %

compared to 72 %); slightly more part-time workers were satisfied compared to full-time workers (79 % compared to 73 %).

The Work

Respondents were asked to complete a question which related to a range of work-related tasks. They were asked to state whether they were involved in doing these tasks on a scale ranging from 'not at all' to 'very much'. They were also asked whether they ought to be involved in doing these tasks.

On the whole the findings paralleled the English study in that there was very little discrepancy between the tasks people were involved in and what they thought they ought to be doing. The findings did however reveal that participants felt they ought to be more involved in work training, family contact, therapeutic work and after care.

As part of their day to day work, three tasks that participants (like their English counterparts), were likely to be involved in on a more frequent basis (based on the number of responses to 'quite a lot' and 'very much') were:

1. Keeping order and supervision of young people/children (88%)
2. Social training (86%)
3. Care planning (77%)

> *I think what would help young people progress the most would be if staff could spend the time with them but we can't. We see the difference when there are less people around, we have the time and we are not dealing with crises and that is down to numbers. We also need more staff on the unit. We are more policing the unit rather than offering care*.
> (Residential care worker)

Table 5.2: Tasks – The Reality and the Ideal

			Not at all	A little	Quite a lot	Very much
	n		%	%	%	%
Domestic	391	Involved	24	39	26	12
	341	Ought to be	25	48	22	5
Admin	395	Involved	13	29	27	31
	342	Ought to be	10	30	32	29
Care planning	393	Involved	10	14	28	49
	339	Ought to be	4	11	32	53
Education	395	Involved	14	34	28	24
	336	Ought to be	10	27	35	27
Work Training	381	Involved	21	36	23	21
	328	Ought to be	13	23	35	29
Health	395	Involved	7	25	36	32
	338	Ought to be	4	20	40	37
Practical support	386	Involved	14	20	26	40
	329	Ought to be	12	19	29	41
Keeping order/ supervision	396	Involved	2	10	22	66
	339	Ought to be	2	9	25	65
Social training	396	Involved	1	13	27	59
	338	Ought to be	1	11	27	61
Key working	357	Involved	23	14	16	46
	303	Ought to be	19	14	22	45
After-care	386	Involved	46	33	12	9
	337	Ought to be	25	27	24	24
Therapeutic work	386	Involved	32	35	22	11
	332	Ought to be	15	27	33	26
Family contact	389	Involved	21	32	26	21
	335	Ought to be	15	21	33	31
Relationships outside	395	Involved	17	31	32	20
	336	Ought to be	8	24	43	25
Showing concern	396	Involved	1	5	21	74
	337	Ought to be	0	3	19	78
Staff supervision	386	Involved	27	27	20	26
	336	Ought to be	17	20	28	35

Education

One particular finding which stands out in the table above is that concerned with education. The table shows that only 52% considered that they were involved in the children's education 'quite a lot' or 'very much'. Given the great emphasis that the Executive has placed on the issue of the education of looked after children in the past 2 years this is a somewhat surprising finding. A year previous to the questionnaire being distributed the Executive had drawn a great deal of attention to the poor

educational attainments of looked after children. They had set up new systems of 'designated' senior teachers in every school whose job it was to champion and support the education of the looked after children in their school and had urged local authorities to make sure that education and social work staff at all levels are working together and implementing individual education plans for each child or young person. Further they also distributed a fund of £10 million so that some additional cash was made available to support the education for every looked after child.

The Executive also set minimum targets for all children doing Standard Grades and required all local authorities to report annually. Some authorities have reported improvements in these outcomes.

The wording of the question in the survey about residential workers involvement in education was drawn deliberately broadly and asked about level of involvement with education in terms of 'teaching constructive leisure use through sports and activities; helping with homework; assisting to go to school etc.' Yet even with this kind of definition the survey finds that only 62% considered that they 'ought to be involved' in children's education in these terms. This is a concerning finding which suggests that further work needs to be done among residential staff and managers to identify what the barriers are to them being more fully involved in promoting this vital aspect of children's care.

Health

Although there has been virtually no Executive guidance or national strategies or targets set out for the health of looked after children and young people, it has been increasingly recognised that this is another crucial aspect of looked after children's care which requires much more attention. Research in this area has demonstrated that this is another domain in which looked after children are doing very badly (ONS 2004, Grant et al., 2002). In the past 3 or 4 years, despite the lack of a national strategy a number of health boards have piloted looked after children's nursing and mental health projects of various kinds.

Our survey shows that in relation to health, as with education only about two-thirds of workers consider that they are involved in health or should be. The question was again framed in very general terms. 'e.g. providing guidance on health issues, health promotion, administering medication etc.' 68% of respondents said they were involved 'quite a lot' or 'very much' and when they were asked to what extent they 'ought to be involved' in this aspect of care the numbers increased to a total of 77%. Thus leaving 20% who thought they should only be a 'a little' involved in this area and 4% who thought they should not be involved at all.

Desired changes to job

The questionnaires asked an open-ended question inviting respondents tom answer the question: *If you could change one thing about your job, which would make it more satisfying, what would it be*? All the answers were grouped and are presented in the table 5.3 below. Whilst as many as 47 per cent of the respondents felt their jobs would become more satisfying if changes could be made to residents' progress, that is in terms of choices, outcomes and conditions, practical issues such as shift work and shortage of staff were also deemed to be important. Interestingly though, respondents did not rate having more work hours or permanent job status highly. This reflects what was found in a study by Thorsteinson (2003) which examined the differences between job attitudes between part time and full time workers. He found that there was little difference between full time and part time workers on job satisfaction, organizational commitment and intentions to leave. The main difference found was that full time workers were more involved with their jobs than part time workers.

Table 5.3: Desired changes to the job	n	%
Choices, Outcomes And Conditions For Young People	47	14
Staffing Levels	33	10
Communication - within team or with management	30	9
Shift Work	30	9
Resources/Money	28	8
Recognition, Being Valued For The Work	22	7
Training	21	6
Increased Pay	21	6
Changes To Admissions Procedure	18	5
Leadership - Clear Direction & Policies	10	3
Contracts: More Hours Or Permanency	10	3
Career Prospects	9	3
Support/Recognition/Comm. with Other Agencies	9	3
More Time, Less Paperwork	8	2
Autonomy, Control Budget/Direction	7	2
Retention/Stability Of Staff Group	4	1
Less Reorganisations, Job Security	2	1
Less Violence/Abuse, YP Behaviour	2	1
Work Environment - Physical	1	0
Other	21	6
Total	**333**	**100**

Motivation

Occupational psychologists and other researchers have investigated many different kinds of employment however there are few studies of job satisfaction and related topics in social care settings generally or child care specifically. However given the concerns about the overall size of the national workforce within an ageing population and increasing requirements for social care staff increasing attention is now being paid to what are called 'workforce issues'. According to occupational theories of motivation etc. (e.g. Job Characteristics Theory) and empirical studies (e.g., Fried & Ferris, 1987; Tiegs, Tetrick and Fried, 1992), intrinsic work motivation is primarily predicted by task characteristics such as skill variety and autonomy. Therefore when employees have meaningful work that requires a variety of skills to be utilized, which includes a high level of autonomy, and when they receive positive and constructive feedback about their performance, they may experience a sense of well-being and hence intrinsic motivation to keep performing well. Our study illustrates that although residential staff do not experience high levels of autonomy they do appear to find the

work highly meaningful. In one of the few studies in this area Penna and colleagues (1995) also found high levels of job satisfaction. Residential workers with children formed a quarter of the population whose experiences were investigated. 91% of their overall sample reported satisfaction with their jobs, and three main reasons were given; contact with clients, responsibility and emotional satisfaction. (summarised in Moss and Cameron 2002).

This study attempted to explore motivation by asking respondents to list what to them are the three most important aspects of the work from a provided list. The results revealed that the three most important aspects of the job for residential workers are:

1. Residents' progress (69%)
2. Pride in their job (57%)
3. Teamwork (52%)

The interviews give a flavour of the importance that workers place on these issues.

Young people's progress:

> *It is about people always being there, having someone to go to.*
>
> *The key to a young person's progress is their engagement and relationships with staff as well as the quality of contact with staff and support. The initial admission process and match of the young person's needs to the facility is also important.*
>
> *Having a good understanding of young people and how they see themselves. It is about encouragement and not being judgmental. But we don't always see the good work we have done; it is rewarding to see the progress young people can make.*

Pride in the job:

> *As long as people get a clear message about what this work is. I have high morale and high standards. This isn't just a job. It has to be a commitment. It is not just any job. We need people with stability in this job because the young people have so many people coming in and out. People should know that it is not an easy job but there are rewards. The rewards are to see that the young people are happy and feel safe; it is making a difference.*

Teamwork:

> *If people have good leadership and clear roles and expectations then the team works well. We don't have a blame mentality, we focus on how to keep doing better through open honest dialogue.*
>
> *We wouldn't be able to function properly if the team wasn't working. Do this through communication and understanding the other person's roles and responsibilities. The completion of tasks no matter how trivial. Through*

teambuilding away days which, in the main, have been helpful. Through challenging colleagues rather than going to their supervisor.

Interestingly, the English study also identified the above three factors as the key ones, with the only difference being that teamwork (72%) was the most popular response, followed by residents' progress (62%) and pride in their job (41%).

In line with Hackman et al (1980), a sense of pride in their job and knowing that residents were making progress as a result of the workers' intervention made participants feel that what they did was meaningful, thus providing the motivation to keep performing well.

In this list *Level of pay* was not seen as one of the **most** important motivating factors for either English or Scottish participants, though this does not mean that it is not important at all. One explanation for this could be related to the notion of 'organization-based self esteem' (OBSE), a concept developed by Pierce, Gardner, Cummings and Dunham (1989). As the name implies OBSE is an indicator of the extent to which an individual assesses her/himself as a member of an organization - that is how worthy they are is strongly related to how worthy the aim or task of the organisation is. Individuals with a high OBSE therefore perceive themselves to be important, meaningful and worthwhile within their organization. As we note elsewhere the unit of organisation that seems to be the source of most satisfaction is the immediate residential team and not the whole agency it is part of. In this study OBSE is indicated by the fact that the research participants rated pride in their job as a significant motivating factor, thus the level of pay though important, was not the motivating factor.

Table 5.4: Motivating Factors for Work		
	Frequency (n=398)	**Respondents** %
Residents progress	273	68.6
Pride in the job I do	225	56.5
Teamwork	207	52.0
Good management	95	23.9
Interesting work	81	20.4
Career progression	79	19.8
Level of Pay	70	17.6
Job security	51	12.8
Training opportunities	48	12.1
Reasonable working hours	43	10.8
Opportunity to put ideas forward	17	4.3

As has been reported above *teamwork* has emerged as a major factor in this study. It is not just the fact that teams exist, and that residential practitioners spend a great deal of their time working directly alongside at least one colleague, but it is clear that a good team experience is what makes the job enjoyable and contributes significantly to the level of morale. Strong teams are also able to help members withstand challenging behaviour and other stresses, although it was also clear from many respondents that if the stresses were too great then teamwork suffered and consequently morale dropped. Many respondents felt this had a very direct impact on the children and young people.

It is clear that workers see the residential unit staff, and sometimes their shift group, as the team, they do not think of the team as including social workers or other professionals. One exception among the interviewees was one manager who did refer to the 'area team' and the need for the field social work team to work more closely with the residential unit. In general many of the interviewees linked the factor of feeling valued (or not) by managers as central to functioning better as a team, and when this happens then team members are better able to support each other. Some also spoke of teamwork as including the capacity for differences of opinion and view to be respected but also subordinated to the need to focus on the needs of the children and young people. The effect of aggression and violence on staff was felt to impact on teamwork.

Specific factors (either positive or negative) which were frequently identified in the interviews as having a significant impact on teamwork:

- Need for more time to debrief after a difficult shift and violent incidents
- Communication: quality of shift change-over and presence or absence of team meetings
- Degree of openness and honesty
- Long lasting temporary contracts

One residential worker defined good teamwork succinctly:

> *Wanting to do the best possible for kids – differences aside.*

While another emphasised the central importance of good communication and the importance to workers that they are being listened to. As so often in group care the qualities that we expect of workers in their relations with young people are mirrored by what they expect of managers.

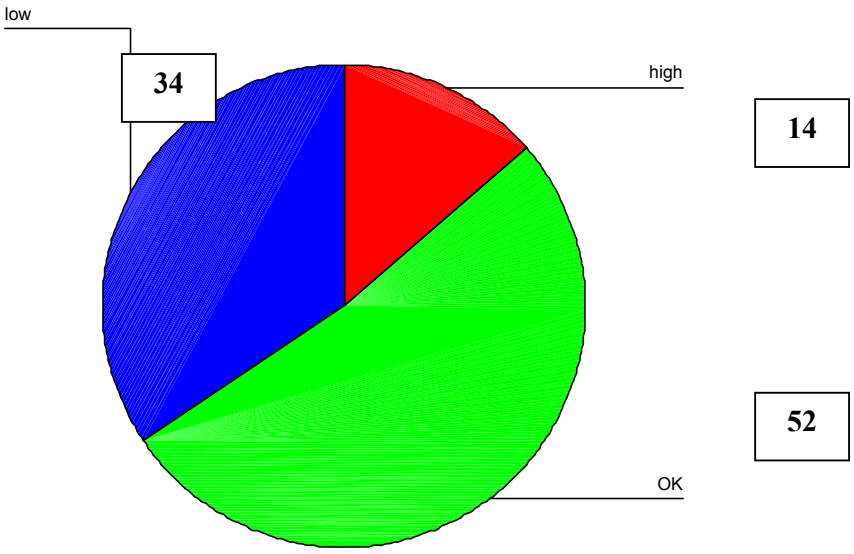
> *Communications are excellent because we have a good manager who listens and takes action.*

Staff Morale

> *Morale is still ok generally, the team is quite open and honest.*
> (Residential care worker)

Like the English study, this study did not give the research participants a definition of 'morale', thus allowing participants to apply their own interpretation. Assessing the morale of participants in their workplace therefore involved rating it as high, ok or low. Opportunities for participants to expand on how they thought morale affected the job they did were also provided as part of the questionnaire.

Figure 5.2 Staff morale in the workplace



The findings illustrated above may cause some surprise as many people expected that the morale in a sector would be low. However the findings of this survey show that two-thirds of Scottish residential workers, in all sectors, consider that the morale in their workplace is okay or high. It is important to recognise that morale has something of a cyclical character; that it can go up and down quite quickly, therefore this survey does represent a snapshot of a moving picture rather than a *fixed* one. The following quotes give a good picture of how workers perceive the key factors in changes of morale:

> *Morale is okay overall, for the general team, but it wasn't always that way. There are many anxieties about dealing with violence on my unit. Young people were persistently being violent and aggressive and many staff went on stress-related leave. It seemed like everyone was on stress leave. Then staff began to return to work. We became a full team again and tried not to bring in emergency admissions so that staff could build up trust and begin to work together again.*

> *We had a change of manager and a lot of changes were made. Morale was low for everyone at that time, Now we have got used to the changes, both myself and team. There were a lot of things like paperwork done differently,*

so there have been many changes and now that has been done, morale is quite high.

Morale is ok. There is a pleasant atmosphere now, before morale was low before and people were applying for other jobs. But now there is good team work, there is a positive feel and people are engaged in training.

Moral is low. The unit has been through a crisis period with a lot of assaults on staff and a difficulty keeping both kids and staff. We don't always get support when assaults and violence happen. Violence and vandalism and assaults at work. Resources are scarce but that doesn't justify a lack of safety for the other kids. It is really demoralizing. Staff need to be listened to by managers.

Table 5.5: Staff Morale by Role			
	Managers	**Care Staff**	**All**
High	13 (14.9%)	41 (13.3%)	54 (13.7%)
OK	51 (58.6%)	154 (50.0%)	205 (51.9%)
Low	23 (26.4%)	113 (36.7%)	136 (34.4%)
Total	87 (100%)	308 (100%)	395 (100%)

Almost the same percentage of managers and care staff had stated that morale amongst staff at their workplace was high. With regard to low morale, differences in perceptions between managers and care staff were found whereby only 26% of managers thought morale was low at their workplace compared to 37% of the care workers.

There did not appear to be a great deal of difference in how morale was rated between participants working in the voluntary/private sector and the statutory sector, except that those working within local authorities were a little more likely to state that morale was low. There was no difference in staff morale by gender discovered in the study. Morale among part-time staff was found to be not as high as for full-time staff.

Table 5.6: Staff Morale by Sector			
	Local Authority	**Voluntary/Private**	**All**
High	34 (13.8%)	19 (14.0%)	53 (13.8%)
OK	123 (49.8%)	73 (53.7%)	196 (51.2%)
Low	90 (36.4%)	44 (32.4%)	134 (35.0%)
Total	247 (100%)	136 (100%)	383 (100%)

Respondents were asked to rate a number of factors which they thought were either important or not important in contributing towards high morale in the workplace. All the factors were rated as important however the two least likely to be perceived as important were personal issues and status of job.

Furthermore, the findings indicated that relationships with others in the form of a team and levels of support through a manager for example, are key elements to high morale. The values and norms of the main groups that people belong to, serve to act as an important benchmark for a person in evaluating his/her own behaviour or quality of work.

The interviews revealed some detail behind the factors listed in table 5.7 below (Causes of High or Low morale). Most of these were to do with organisational factors to do with staffing and rotas but the behaviour of residents also emerged.

Among the most frequently mentioned factors that shape morale were:

- Rotas for basic grade staff: how well are the needs of staff taken into account?
- Quality of communication: open and honest?
- Anxieties and stress due to persistent violence (e.g., verbal abuse, threats and physical assault) in the work place
- Feeling valued, supported and safe.
- Having a 'full team environment' or adequate and effective complement of staff.
- Unpredictability due to emergency admission

Table 5.7: Causes of high or low morale			
	very important	quite important	not important
	%	%	%
Level of support available (395)	94	6	1
How the team works together (400)	91	9	0
Knowing good quality work is valued (398)	85	15	0
Guidance given to staff (398)	81	18	1
Knowing high standard of care expected (397)	80	19	1
Staff feeling informed about local decisions (397)	78	21	1
Relations between staff and management (395)	76	24	1
Ratio of staff to children (396)	75	24	1
Residents' behaviour (397)	75	23	3
Training (395)	72	27	1
Whether home has a clear remit or purpose (392)	72	26	2
Suitability of admissions for the remit (395)	68	30	2
Inspection regime (396)	66	31	3
Supervision sessions (396)	65	33	2
Conditions of work (397)	64	36	1
Job security (398)	61	37	3
Residents' participation in school (394)	59	36	5
Level of staff participation in policies/practices (398)	57	38	4
External relationships (397)	55	40	4
Rewards (396)	54	44	3
Whether people are friendly (399)	53	45	3
Whether staff consulted about new admissions (397)	50	41	9
Proportion of emergency admissions (389)	45	44	11
The tasks staff carry out in job(397)	44	48	7
Level of autonomy (392)	39	58	3
Whether staff key work (396)	38	48	14
Status of job (396)	33	52	15
Qualifications (397)	31	57	12
Personal issues (394)	30	54	16
Staff feeling informed about national initiatives (395)	29	61	9

The effect of morale (low or high) on work

The questionnaire posed an open question which asked respondents to describe the effect of morale on the job they did. The answers provided have been analysed and group under the headings in Table 5.8 below.

Table 5.8: How does morale affect the job	n	%
Enthusiasm and motivation	95	44
Quality of care/work for young people	91	38
Rubs off on young people & affects their behaviour	71	37
Teamwork	61	30
Contagious level of morale picked up by other staff	38	16
Stress levels & ability to cope with job	34	18
Efficiency and running of unit	34	10
Other	26	22
Staff culture & conflict	16	11
Sickness levels	12	5
No effect	9	3
Increased workload for some	7	5
Completion of tasks, administration etc	5	1
Retention of staff	3	3

The great majority of responses indicated that it affected enthusiasm and motivation within the team and the quality of care and work undertaken with young people. Interestingly very few respondents mentioned any impact on retention of staff. In the subsequent interviews interviewees were unanimous in their view that levels of morale had a direct impact on the quality of care and that young people could tell when morale was bad and that they tended to react to it. However it is not always the case that challenging behaviour by residents reduces morale. As one care worker put it:

> *If people have good leadership and clear roles and expectations then the team works well. We don't have a blame mentality; we focus on how to keep doing better through open and honest dialogue.*

Chapter 6

Information, Support and Management

Communication within residential units is a continuous and complex issue and one that features regularly in team meetings and plans. This is because of the '24/7' nature of the task and the effect of shift-work. Put simply, when workers come on duty a great deal is likely to have happened since they were last at work, even if they had been at work the previous day. Issues of change-over, recording and passing on information, and the requirements of working in a consistent manner across shift teams is thus an enduring feature of modern residential work. The survey sought respondents' views about the flow of information within units and the extent to which staff at least felt informed about what was expected of them and what was happening to their young people. These and wider questions about how well staff feel managed and supported are reported in this chapter.

Information

Given the importance which has been placed on congruence of goals (Anglin, 2002), it is good to see that the overwhelming majority of care staff (92%) felt there was clarity about their role and how this contributed to the overall aims of the organization. Most respondents also agreed that the level of information such as staff guidance (76%) and changes to care plans (74%) was provided, and 75% believed they had all the information needed to carry out the duties associated with their jobs.

> *The fact that we have formal meetings on a weekly basis is pivotal and you need good shift changeovers and good communication between all aspects of the team and each person's care plan*.
> (Residential care worker)

Another respondent, however, acknowledged that although it was central to the task, lack of time could be an issue.

> *These are taken for granted as part of the job; they are needed. Communication is important. Sometimes, though, it is rushed.*
> (Residential care worker)

Table 6.1: Communication within the establishment

	Strongly agree	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
	%	%	%	%	%
There is clear guidance for staff (e.g. on touching) (305)	35	41	12	7	4
I know how my role contributes to the objectives of the establishment (311)	37	55	5	2	1
I receive all the information I need to do the job (312)	21	54	19	4	2
I am kept informed about changes to care plans (313)	17	57	16	8	2
I know all about what happens when I am not here (313)	10	42	29	15	4
I can approach my manager with problems about my work (313)	48	37	10	4	1
I feel my manager listens to my ideas (313)	33	40	17	8	3
My manager recognises my contribution to this establishment (313)	30	43	16	8	3
My manager supports me to improve my performance (314)	32	44	15	6	3
My manager is in touch with what goes on in this establishment (314)	40	38	11	7	4
Staff have a common approach (314)	20	47	21	9	3
I can talk to my colleagues about work-related problems (314	41	48	7	3	1
Staff in my establishment work well as a team	31	44	16	7	2

Research has also highlighted the crucial role of the manager in relation to quality residential child care (Brown et al, 1998; Whitaker, Archer and Hicks, 1998) and

approximately three-quarters of the care staff felt that their manager listened to them, recognised their contribution, supported them in improving performance and was in touch with what goes on in the establishment. Over four-fifths felt that their manager was approachable with work-related problems. One respondent stated that:

> *The unit manager is very helpful, supportive and encourages us just to keep doing better. And the manager empowers staff, we are not just told what to do... We feel we are working together and the manager is reliable and takes our concerns seriously. Everyone, including the manager, works well together; it is really democratic. The manager can be firm but fair.*
> (Residential care worker)

Not all staff had such a positive view, however:

> *Basically, managers need to know how to manage people first. We need to know when we do a good job as well. In 20 years of this work, I have never been told I do a good job—once in a while you need to hear when you are doing it right.*
> (Residential care worker)

Support in daily work

The study tried to group together various aspects of residential practice under the heading of 'support systems' to elicit views on how effective these were in actually giving staff the feeling that they were being 'supported'. On the whole most participants thought that support systems and practices at their workplaces did help. Informal systems of support were identified as being more helpful, for example 97% of the participants felt that informal discussions with colleagues were helpful and 91% felt informal supervision sessions were. Staff meetings (91%) and more formal individual supervision sessions (87%) were also viewed as helpful.

It is clear that 'change-overs' and other informal discussions between colleagues are highly valued by staff, and in fact are to some extent taken for granted, and certainly seen as an important part of the job.

A good changeover is the most important part of the shift.
(Residential care worker)

I think staff need more time to off-load on colleagues when it has been a difficult shift. There is not enough time to do that. A big part of this job is support, supervision, and being available to support each other and that means other tasks have to go to the side.
(Residential care worker)

Table 6.2: Usefulness of various support systems

	Very helpful	**Helpful**	**Neither**	**Unhelpful**	**Very unhelpful**
	%	%	%	%	%
Informal discussions with colleagues (311)	71	26	2	0	1
Staff meetings (289)	41	50	6	1	1
Field social workers (255)	12	59	25	4	1
Other professionals (264)	22	64	13	0	0
Parents/ relatives (283)	24	52	22	2	0
Individual supervision (287)	43	44	11	1	1
Group supervision (195)	21	57	19	3	1
Informal supervision (285)	40	51	8	0	0
Performance appraisals (197)	35	50	15	1	1

Meetings!

A great deal of residential staff time is spent in meetings of various kinds. These demand a wide range of professional skills and inter-personal communication gifts if they are to be effective. This question sought to capture information about the amount of participation by residential workers in different kinds of professional 'talk'; some of it happens in formally organised 'meetings' but much also happens in one-to-one conversations between residential workers and young people, family members and social workers etc. On a day to day basis, the most frequent form of purposeful 'talk' or meeting was between the participants and the residents (65%), followed by meetings with the residents' families (35%). On the other hand, some respondents had apparently never met with social workers (15%) nor with other professionals (16%) to

discuss residents' progress. A third of the participants also stated that they had never attended joint meetings with staff and residents. This latter finding raises some questions that would benefit from further examination. Is it the case that in some units 'residents meetings' rarely or never happen, or is it the case that meetings do happen regularly but only involve some of the staff and not others?

Table 6.3: Levels of participation in various support meetings

	Most days	About once a week	About once a fortnight	About once a month	Six monthly/ annually	Never/ almost never
Formal staff meetings (309)	8%	46%	12%	15%	10%	10%
Supervision sessions (306)	0%	1%	4%	43%	37%	14%
Performance appraisals (301)	1%	3%	3%	13%	31%	50%
Talks about residents progress/problems with social workers (301)	34%	27%	9%	9%	6%	15%
Talk about residents with other professionals (304)	34%	25%	7%	9%	9%	16%
Talk about residents with families (305)	35%	30%	9%	10%	5%	11%
Talk about residents with residents (309)	65%	19%	2%	5%	2%	7%
Joint meetings with staff and residents (301)	9%	18%	13%	19%	8%	33%

Supervision has long been established in residential work and as we have noted already is welcomed by residential staff. However the survey confirms anecdotal evidence that supervision is one of those aspects of the job which seems to be frequently cancelled under the pressures of work.

> *I am supposed to have supervision regularly but it doesn't happen. When people are tired and stressed they are less likely to get supervision and too tired to push to get it.*
> (Residential care worker)

The Edinburgh Enquiry report (Marshall et al.,1999) into abuse by 2 care workers in the Edinburgh had found weaknesses in supervision and made strong recommendations on the subject. While that report was confined to an examination of the situation in Edinburgh all councils would say that supervision was part of their

standard practice therefore it is very disappointing that our survey found that less than half (48%) of the respondents had had supervision in the last month. While staff meetings were clearly much more well-established with 80% reporting that they attended formal staff meetings (80%) at least once a month. The finding on appraisal is also interesting as increasing numbers of employers introduce forms of job appraisal and review. While it is not surprising to finds that a large number of respondents had not had an 'appraisal' 85% of the respondents stated these appraisals were or would be helpful in performing their job.

Management approaches and communication

Table 6.4: Table Management approaches

	Strongly agree	**agree**	**neither agree nor disagree**	**disagree**	**strongly disagree**
	%	%	%	%	%
Manager listens to staff (313)	33	40	17	8	3
Recognises staff contribution to home (313)	30	43	16	8	3
Supports staff to improve (314)	32	44	15	6	4
Is in touch with what happens (314)	40	38	11	7	4
Is approachable with problems (314)	48	37	10	4	1

Managers were also generally seen to be approachable (85%) and supportive of staff with regard to improving their work (76%). The predominant view was that managers were aware of what goes on in the establishment (78%) and staff members' contributions were recognized (73%). Amongst colleagues, the general feelings were that they could approach each other with work related problems (89%) and worked as a team (75%). These are generally very encouraging findings given the challenging nature of the job and the finding that teamwork was one of the three main motivating factors.

Table 6.5: Managerial concerns and difficulties					
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Staff have a common approach (83)	16%	61%	13%	10%	0%
Staff work well as a team (85)	21%	55%	12%	11%	1%
Happy to tell others I work in residential care (85)	58%	33%	8%	0%	1%
Sufficient resources to meet objectives of this establishment (85)	8%	24%	22%	35%	11%
Staff actively involved in decisions in about how establishment operates (85)	13%	58%	15%	12%	2%
External management supportive of work (84)	15%	57%	20%	7%	0%
Establishment's remit is feasible (85)	21%	47%	20%	9%	2%

Most of the managers agreed that staff had a common approach to work (77%), were actively involved in decisions about how the establishment operated (71%) and worked well as a team (76%). In addition to team structures within the establishments, external management was reported by managers to be supportive of the work (72%). In terms of their own level of pride in their jobs, 91% said they would be happy to tell others they worked in residential care. 46% of the managers felt there were not enough resources to meet the organizational objectives compared to 32% that thought there were. Their establishments' remit was viewed as feasible by 68% of the managers.

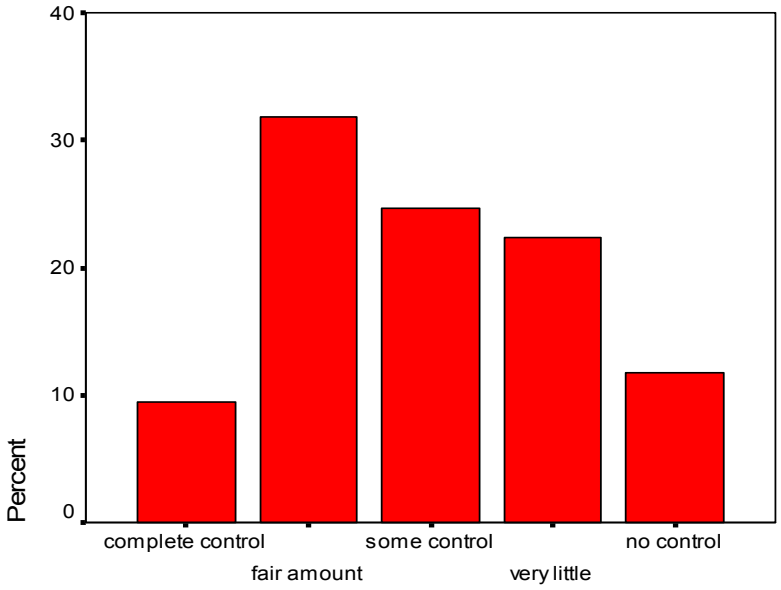
Levels of control over admissions reported by managers

As has already been noted there were numerous comments about the high volume of emergency or unplanned placements and the fact that, due to a general shortage of placements, both residential and foster, that children and young people had to go where there was a bed. This obviously undermines the concept of units having a degree of specialization of function, which is in turn an expectation of the statutory requirement for a statement of Function and Aims to be reviewed annually. Apart from the question of what this does to the quality of care, it also undermines the sense of control and authority that unit managers have. This issue of the decline in the degree of autonomy or power of managers has emerged in recent years; local authority 'headquarters' appear to have become more directive in areas that unit

Managers used to be responsible for. In the past perhaps Managers might have been expected to have a significant influence on the admissions to their units. There is still some distinction here between the experience of managers in the statutory sector for who this seems a most pronounced problem compared to those in the voluntary or not-for-profit sectors who appear to retain a much greater degree of control over admissions.

The table below shows the overall responses to the question asked of managers however it disguises significant differences between the local authority and independent sectors. In the latter 7% report very little or no control while for the local authority almost half (46%) say they have either little or no control.

Figure 6.1. Overall figures for 'Level of control over admissions'



The impact of residents' behaviour on morale

Table 6.5: Residents' behaviour			
	True	Sometimes true	Not true
Young people believe staff have little influence over them (310)	23%	58%	19%
Residents have a say in running the home (311)	36%	55%	9%
Home is a friendly place (314)	73%	23%	4%
Families feel uneasy when they visit (308)	3%	37%	59%
Residents abuse staff (314)	59%	39%	2%
Some young people force others to give them things (315)	38%	46%	16%
Residents' needs taken into account when making new admissions (310)	38%	33%	29%
The work we do makes a positive difference to residents' lives (313)	42%	55%	3%
Residents actively involved in decisions about them (311)	64%	32%	4%

Most participants felt their homes were friendly places (73%) and families were at ease when visiting. It was stated by just over a third of the participants that residents had a say in how the home was run, and a further 55% said it was sometimes the case. Almost all the participants believed that their work was making a positive difference to the lives of the young people (97%) and they were also empowered to make decisions about themselves (96%).

Aggression

Despite all the positive aspects however, most of the participants also felt that they were abused by the residents (98%) and there was some level of bullying going on within the home whereby some young people were forced to give things to others (84%). The effect of aggressive and violent behaviour by young people towards staff was raised by a number of interviewees, as something that negatively impacted on morale. One interviewee when asked about issues to do with staff retention said: 'Debriefing has to be a priority especially debriefing immediately after the crisis.' In this aspect of practice the issue of support from colleagues, and especially managers is important. Others offered the following contributions:

I don't think there is enough time for staff to recover from dealing with aggression in the work place: verbal, threats and assault. These forms of aggression happen a lot. ... We must put the needs of the child first in this work but what we don't do enough of is take care of the emotional well being of residential child care workers.
(Residential care worker)

I am not stressed. It is the working conditions that are stressed. I do not want to come into violent working conditions. When the levels of violence are persistent then I don't feel it safe to work here—it is about poor working conditions. We need to protect and support staff.
(Manager/ senior practitioner).

Chapter 7
Training and Qualifications

Training and qualifications

Over many years, there has been a recognition of the need to improve the training and qualifications of residential child care staff. Inquiry after inquiry has stressed the central importance of the education and training of staff to ensure good child care practice and the safe care of children and young people (Utting, 1991, 1997; Waterhouse, 2000). However, the Skinner Review of Residential Child Care in Scotland highlighted the low levels of staff qualifications: 28 per cent of officers in charge; 52 per cent of assistant officers in charge; 88 per cent of houseparents; and 83 per cent of other residential child care staff had no relevant qualifications (Skinner, 1992). The Skinner Review set national targets for local authorities and independent organisations and recommended that 30 per cent of all residential child care staff and 90 per cent of all senior residential child care staff should hold a Diploma in Social Work or equivalent, and 60 per cent of residential child care staff should be assessed as competent at HNC/SVQ level 3 (Skinner, 1992, p. 73). Unfortunately, little headway has been made in subsequent years. Kent (1997) wrote that there has been 'unfortunately less progress towards these targets than might have been wished' (Kent, 1997, p. 59).

In 2003, the Scottish Social Services Council announced the qualifications criteria for registration of residential child care staff. There was a balance between vocational, academic and professional qualifications staff. Basically, residential child care workers will need an HNC or equivalent qualification and an SVQ in Caring for Children and Young People, Promoting Independence, or Care at level 3 or one of a range or other qualifications such as: Diploma in Social Work, SVQ in Care level 4, Degree or Diploma in Curative Education, Degree or Diploma in Community Education, or a qualification which meets the registration requirements of the General Teaching Council, Nursing and Midwifery Council, General Medical Council, etc.

Residential child care staff with supervisory responsibilities must hold one of the following: Diploma in Social Work, SVQ in Care level 4, Degree in Curative Education, Degree or Diploma in Community Education, or a qualification which meets the registration requirements of the General Teaching Council, Nursing and Midwifery Council, General Medical Council, etc. Head of residential child care must hold one of these qualifications plus a management qualification.

In 2003, the Scottish Institute for Residential Child Care carried out a second audit of the qualifications of residential child care staff in Scotland. Questionnaires on 3,070 staff were returned, 70 per cent of the workforce. The audit found that just over half of staff (51.2%) had at least one care qualification. When the figures were analysed against the qualifications criteria, it was found that only 7.4 per cent of managers were qualified because although the majority (73.5%) had a relevant care qualification, few had the necessary management award. Thirty per cent of supervisors were qualified. Only 16.4 per cent of care workers were qualified although 27 per cent were partly qualified by having either an HNC or an SVQ level 3.

> These findings raise some key concerns. Although there is an increased number of staff undertaking qualifications, the numbers of qualified staff remain low. Comparing what we can of this data to that of the 2001 audit the shift in the number of currently qualified staff is minimal. This cannot be attributed to significant increases in staffing levels and raises critical questions regarding residential child care workforce recruitment and retention. (SIRCC, 2004, p. 3)

Qualifications and roles

Just under 75% of the respondents had some form of relevant qualification. This is significantly higher than the figure in the SIRCC qualifications audit. There are two possible explanations for this. The first is that a significant number of residential care staff have achieved qualifications in the nine months between the two studies. The second is that, given the different methodologies of the two studies, the respondents to the current study tended to be more highly qualified. It is probable that the higher figures are due to a combination of these two factors. In the feedback seminars, it was

suggested that because the respondents were more highly qualified, this would mean that the job satisfaction and staff morale figures would be inflated. Previous research, however, has shown that more qualified staff tend to report lower morale and this is confirmed by this survey.

Table 7.1 details the figures for the different qualifications and it can be seen that most care staff hold the HNC in Social Care (37.5%), followed by the SVQ level 3 (28.3%). Managers were more likely to hold a professional social work qualification (43.7%).

Table 7.1: Qualifications by Role			
	Managers	**Care Staff**	**All**
SVQ3	33 (37.9%)	89 (28.3%)	122 (30.3%)
SVQ4	-	3 (0.9%)	3 (0.7%)
HNC in Social Care	29 (33.3%)	118 (37.5%)	147 (36.6%)
Other accepted qualification	6 (6.9%)	44 (14.0%)	50 (12.4%)
Professional SW	38 (43.7%)	16 (5.1%)	54 (13.4%)
Dip/Deg Curative Education	-	1 (0.3%)	1 (0.2%)
Dip/Degree Community Ed	2 (2.3%)	10 (3.2%)	12 (3.0%)
Nursing Qualification	13 (14.9%)	9 (2.8%)	22 (5.5%)
Other Health Qualification	-	15 (4.8%)	15 (3.7%)
Teaching Qualification	4 (4.6%)	5 (1.6%)	9 (2.2%)
Management Qualification	4 (4.6%)	6 (1.9%)	10 (2.5%)
No Qualification	6 (6.9%)	105 (33.3%)	111 (27.6%)
Total	87 (100%)	315 (100%)	402 (100%)

Registration status

When we looked at qualifications on the basis of whether the respondents would meet the criteria for registration with Scottish Social Services Council, we found that there were marked differences depending upon the different roles. This is similar to the

Table 7.2: Qualifications by Role			
	Registerable	**Not Registerable**	**All**
Manager	3 (8.1%)	34 (91.9%)	37 (100%)
Supervisor	30 (46.2%)	35 (53.8%)	65 (100%)
Care Staff	81 (27.0%)	219 (73.0%)	300 (100%)
Total	114 (28.3%)	288 (71.6%)	402 (100%)

SIRCC qualifications audit. Overall, more than a quarter of care staff have the qualifications necessary to register, much higher than the 16.4% in the SIRCC qualification audit. Almost a half of the supervisors were registerable compared to less than a third in the SIRCC audit. The figures for managers were very low in the two studies because they did not hold the necessary management qualification.

Staff views about training

Table 7.3: Training Issues

	Strongly agree	**Agree**	**Neither**	**Disagree**	**Strongly disagree**
	%	%	%	%	%
Staff are keen to update skills (399)	35	48	14	2	1
Manager committed to training and development (397)	34	43	16	5	2
Personal development plan integral to job (394)	34	40	20	5	2
Qualifications and training prepared me for job (398)	32	46	19	2	1
Training relevant to needs of children (400)	28	55	13	4	1
Can ask manager for training when needed (398)	28	45	18	7	3
Aware how to handle most situations (399)	27	57	12	4	0
Colleagues supportive of training (399)	27	54	17	2	1
Training relevant to work (399)	25	62	10	2	1
Kept informed of training opportunities (398)	24	41	19	11	4
Training received of good quality (399)	21	62	13	3	1
Have received sufficient training (397)	14	43	23	17	4

Given that the registration of workers is about to take place and following controversies about what the training requirements for registration would be, this survey should be an important source of information about how workers perceive the qualifications on offer, and the relationship of these top their work experience. The SSSC in Scotland has adopted a position that all workers will have to have both a minimum academic component (at Higher National Certificate level) and a Scottish Vocational Qualification level three (in Care of Children and Young People), unless

they have a professional level social work, community education or teaching qualification. This means that many workers are currently undergoing either HNC in Social Care training (in a variety of modes: distance-leaning, day release and so on) or demonstrating their competence within the SVQ framework. While various forms of training have been around for many years the recent changes means that all staff will have to get qualified and thus would be expected to raise some anxieties, perhaps particularly among older workers who have been told they have been doing a good job but now need to gain qualifications to remain in it.

However there was very little questioning of the value of training (in general terms) recorded in the survey. Rather a number of respondents questioned the sufficiency of the training on offer and the fact that many people entered the workforce without any prior training. As one basic-grade worker put it:

> *You are dealing with people's lives and it is scary to think of the lack of training and standards.*

Overall, respondents perceived training in a positive way, with many feeling that their managers were committed to their training and development (77%). The respondents were also keen to update their skills (83%) and viewed training as relevant (87%) and integral to their jobs (74%). 21% of the respondents felt they had not received sufficient training and 23% were not sure.

> *I got a lot out of HNC. SVQ I am not sure about it being that useful – it's hard to see the point of it much of the time.*
> (Residential care worker)

> *I think the HNC gave me a better understanding of this work. I have more in-depth knowledge of what I do and why. SVQ wasn't so much about learning it was about documenting what I already knew.*
> (Residential care worker)

> *The SVQ is good – I must admit it made me think about the job, although the jargon is unbelievable. You need experience before you do it. It really is time consuming. The knowledge evidence points kill it.*
> (Residential care worker)

Table 7.4: Further comments on training and qualifications	Frequency	%
	n = 333	
Training overall needed	36	10.8
Good quality training received	32	9.6
Relevant/certain training not available	29	8.7
Lack of training available	25	7.5
Good access & training available	24	7.2
Shift work issues/timing	19	5.7
Management restrict training	18	5.4
SVQ insufficient alone & too much emphasis on it	16	4.8
Other barriers	15	4.5
Want training (personal level)	13	3.9
Staff shortages	13	3.9
Workload/time	12	3.6
Lack of places for training	12	3.6
Lack of money	11	3.3
Poor quality training received	10	3
Priorities in a team	6	1.8
Recognise previous qualifications	5	1.5
SVQIII requirement is positive	4	1.2
Value experience/personal attributes	2	0.6
Lack of interest so none available	2	0.6
Other	29	8.7

When respondents were given the opportunity to write down additional comments relating to qualifications and training, their comments were categorised according to the headings in the table above. The most common response was that training was needed (11%) and training received tended to be of good quality (10%). Interestingly, out of 333 comments received, only four respondents rated the SVQ3 positively. Sixteen participants felt that SVQs on their own were not sufficient and there was undue focus on them. This is an interesting finding, given that the qualification being pursued by the respondents the most was an SVQ, and it perhaps reflects the continuing struggle about qualifications which are seen by residential staff to be both relevant and of equal status to social work and other professions involved in the education and care of children.

Managers were also asked to identify any barriers they perceived to impact on training. The most common response (72%) was the difficulty in releasing staff for training, the implication here being that there is a shortage of staff to cover for those who attend training courses. Funding difficulties (32.6%) and staff motivational levels (25.6%) were also highlighted by managers as barriers to training.

Access to training

In the seminar groups the issue of the numbers of staff needing training in order to meet registration requirements, how it would be possible to release staff to attend training courses, and the lack of budget to provide shift cover was a major concern. However the increased amount of training that was available (albeit with some of the access problems just mentioned) was also raining a number of questions about what use training gets put to. A number of managers expressed the frustration that there seemed little transfer of knowledge when staff returned from training course. It seems that some agencies are beginning to introduce 'personal development plans' for their staff groups and others are trying explicitly to generate an organisational 'learning culture' and the seminar participants were agreed that the existence of a learning culture in a unit helped make much more sense of individual training experiences. They suggested that promoted staff at all levels in units needed to become much more explicit about getting staff to 'report back' on training they have received but also on helping staff to influence the practice of the unit based on their learning.

Training and retention

The thorny issue of the relationship between training and retention of staff that has bedevilled residential care for many years seemed once again to be a high profile issue in the current labour marker where there are major shortages of qualified social workers in child and family (child protection) fieldwork posts. For long enough this has meant that in many parts of the country workers who gained a DipSW while doing residential work (perhaps through employer secondment schemes) left for a fieldwork posts as soon as they were qualified. Now it appears that even with lower level qualifications such as the HNC in Social care that workers with these qualifications and with residential experience are being 'creamed off' into local authority trainee schemes or other forms of 'fast-track' training that have been set up to address the shortfall in qualified field workers

Table 7.5: Further comments on training and qualifications	N = 86	%
Releasing staff	62	72.1
Difficulty in accessing funding	28	32.6
Staff motivation/confidence	22	25.6
Mobility and flexibility	20	23.2
Information	15	17.4
Too many initiatives	13	15.1
Lack of learning culture	12	13.9
Other	12	13.9
Assessment costs	6	7

The Scottish Institute for Residential Child Care

We have noted that a significant development in Scotland has been the setting up of the Scottish Institute for Residential Child Care. The national survey provided an ideal opportunity to gauge to what extent the services provided by SIRCC were being used by residential child care staff. We therefore included a number of questions relating to the use of SIRCC.

Each respondent was asked if they had participated in SIRCC conferences or seminars; short courses; or other courses. They were also asked if they had used SIRCC library or information services, or read the Scottish Journal of Residential Child Care. The results are presented in Table 1.

Table 7.6: Use of SIRCC Services			
	Managers	**Care staff**	**Total**
Conferences/Seminars	59 (69%)	108 (37%)	167 (44%)
Short Courses	60 (70%)	149 (51%)	209 (55%)
Other Courses	8 (9%)	54 (19%)	62 (17%)
Library/Information	39 (45%)	63 (22%)	102 (27%)
Journal	66 (76%)	141 (47%)	207 (54%)

It can be seen that managers/depute managers, in particular, have made a high usage of SIRCC services. Over two-thirds have participated in conferences or seminars or

attended short courses. Three quarters have read the journal and just under a half have accessed the library or information services. A lower proportion of care staff have accessed services. Short courses have been accessed most with a half of the care staff having participated. Just under a half have read the journal, and just under two-fifths have attended conferences or seminars. One fifth of care staff have accessed library and information services, or participated in short courses.

The questionnaires also asked respondents to rate the helpfulness of the SIRCC services on a scale of very helpful to very unhelpful. The results are presented in Table 2.

Table 7.7: Helpfulness of SIRCC Services

	Very Helpful	**Helpful**	**Neither / Nor**	**Unhelpful**	**Very Unhelpful**
Conferences/Seminars	68 (41%)	86 (52%)	7 (4%)	2 (1%)	1 (1%)
Short Courses	96 (46%)	100 (47%)	11 (5%)	3 (1%)	1 (1%)
Other Courses	39 (67%)	15 (26%)	2 (3%)	2 (3%)	0 (0%)
Library/Information	39 (39%)	55 (56%)	4 (4%)	1 (1%)	0 (0%)
Journal	63 (30%)	135 (65%)	9 (4%)	1 (1%)	1 (1%)

The respondents who had used SIRCC services rated them positively. The percentage of respondents who considered them helpful or very helpful was as follows: Conferences/seminars (93%); Short courses (93%); Other courses (93%); Library and information services (95%); Journal (95%).

Chapter 8

Recruitment and retention

In this chapter we will look at the staff experiences and opinions around the issues of recruitment and retention. While these topics can be examined separately they are obviously closely connected; where there is a high level of retention than the difficulties of recruitment are usually lessened. However in this area of work with considerable numbers of temporary staff employed in some units and to cover for a variety of situations including sickness or training then the question of the *quality* of recruitment is perhaps still significant even where retention is not such a problem when considered in general terms.

The figures show that recruitment is a significant problem. Almost a third of the managers stated they had serious difficulties in recruiting staff and a further 43.5% said they experienced some difficulties. Once in employment, staff were somewhat easier to retain – less than 10% stated they had serious difficulties in this area and others (55%) reported some difficulties in retention.

Table 8.1: Difficulties in recruitment and retention (managers)			
	Serious	**Some**	**None**
Recruitment (85)	28 (32.9%)	37 (43.5%)	20 (23.6%)
Retention (82)	7 (8.5%)	45 (54.9%)	30 (36.6%)

Recruitment

Managers provided a number of reasons for difficulties in recruitment and retention, the main one was perceived to be that the package was not attractive to potential employees (31%). Lack of qualifications and training (21%) were also identified as barriers to recruitment and retention. Other reasons given included the perceived (low) status of residential work and the lack of experienced staff.

You need better wages and to deal with the stigma of this work.
(Residential care worker)

I think it is good that we have to be qualified. This work is so often still seen as nannying, and that needs to change before we get people interested in the work.
(Residential care worker)

When this question was explored in the interviews many of the responses included improving the pay and having better training, and the possibility of progressing – having residential have more of a career structure within social work. The way that many local authorities recruited was also raised; the tendency to recruit from the 'temporary register' meant that permanent jobs are rarely advertised. People considering a move into this field may have to give up permanent jobs to take on a temporary job if they want to start in this field, which is clearly a major dis-incentive.

However lack of knowledge of residential care was also considered to be a factor. A number of interviewees identified the need to provide more information about residential in a careers context to school leavers and people thinking about College. Some people thought that information was needed simply because many people didn't know about residential care at all, while others thought that work needed to be done to tackle *mis*-information and stigma surrounding the service. Some also mentioned the need to highlight residential care within social work, offering placements to students would it was felt promote better understanding of the role.

If you can attract people that have creativity…there are units that function well... Make job more creative rather than oppressive—it is so often about containing young people and that is oppressive for workers and young people.
(Residential care worker)

Tours of units and schools – you can write it down but sometimes you actually need to see it. If people have an interest they need information and they need to know you can gain qualifications and progress.
(Residential care worker)

Retention

Most care staff felt a sense of pride about their work and this was reflected in the fact that 88% stated they were happy to tell others where they worked. 53% said they were reluctant to leave residential care work and over three quarters of the respondents (77%) said they had no intentions of leaving their work in the next 12 months. Only 7% said they would leave and the remainder (16%) were unsure. These statistics are interesting when set beside the large number of respondents (70%) who agreed that shortage of staff affected their ability to do the job. It may be that staff have simply got used to working with a certain level of shortages and believe that it affects the quality of the job they can do rather than making them feel that they want to leave the job altogether. These figures do tend to support the findings of about residential child care found in a study of recruitment and retention in social care and social work (Eborall and Garmeson, 2001) reported in the Moss and Cameron study (2004). They found that there was an 11 percent turnover among local authority residential child care staff which was similar to the figures for other forms of residential work, while the turnover rate for field social work was 15%.

Just under a third of the respondents (31%) reported a high turnover of staff, however an equal number of respondents thought that vacancies were filled reasonably quickly. In relation to what would improve recruitment and retention there were many comments made about the importance of feeling valued; listened to and supported in what is often a stressful and demanding job. Salary level was also mentioned in the sense that it should reflect the difficulties of the job. Training was given as a factor that could help retention, both in the sense of induction training to help new workers understand their role, and training to meet the particular difficulties associated with the job. Two respondents specifically mentioned the mental health problems of the young people and the need for training to work with this.

> *I think retaining staff in RCC is all about staff being valued and supported and good communication*.
> (Residential care worker)

> *We have an incredibly stable environment even though the work is intense. Good leadership and good managers and working teams. We don't have a problem with retention*.
> (Residential care worker)

In some units it was clear that there had been recent changes to the structure of the rota and a number of respondents were clearly unhappy. But the subject of the rota also came up frequently when respondents were asked what single change would make the job more satisfying (Q.9 Care Workers questionnaire). While working evenings and week-ends are clearly an integral part of residential work it was considered important that managers should take a flexible approach and that it should reflect staff needs as well as children's needs.

> *We need better rotas and we need more leave if we have to deal with a rota where we work on weekends, evenings and nights--more flexibility with the rota.*
> (Manager)

In terms of why they stay a number of interviewees talked about the variety in the job and the rewarding character of making a difference for young people. However the survey reveals that these are not enough in themselves to make people stay. As noted above the feeling of being *supported* by colleagues and managers is important whether in terms of how children are managed or how the rota is designed. But beyond this there is the even less tangible question of feeling *valued*; this interviewee had an interesting suggestion:

> *If management talked to people that were leaving RCC and said "what can we do to have you stay"-it might make me think about staying. I would feel valued. This work has so much potential.*
> (Residential care worker)

Table 8.2: Care staff experience of recruitment issues					
	Strongly agree	**Agree**	**Neither**	**Disagree**	**Strongly disagree**
	%	%	%	%	%
Manager consults about recruitment needs (306)	5	34	32	21	8
Always someone to cover annual leave (311)	13	40	17	25	5
Happy to work with agency staff (298)	11	36	32	15	6
Staff shortages reduce my ability to do my job (312)	29	41	15	11	4
Always enough staff in emergencies (311)	6	18	23	39	14
High turnover of staff here (311)	10	21	26	31	11
Vacancies are filled reasonably quickly (310)	5	26	29	27	13
Agency staff are used too often (296)	6	11	28	34	21
Reluctant to leave residential work (311)	21	32	19	18	11
Happy to tell others I work in residential care (312)	45	43	8	3	2

Chapter 9

Summary and Conclusions

Summary

This survey of over 400 residential staff in children's units and residential schools across Scotland has provided a wealth of information about job satisfaction, morale, qualifications and many of the factors associated related to current problems of recruitment and retention.

Perhaps surprisingly the survey reveals that two-thirds of the respondents consider that morale is either high or okay. While this is an encouraging finding it also reveals that a third (34%) of staff consider that morale in their units is low. This figure must be of concern to all, especially the external managers and Heads of Service in both statutory and independent sectors. Many of our respondents acknowledged that the level of staff morale had a direct and significant impact on the quality of care provided to the children and young people.

Despite the mixed picture on morale the figures for personal job satisfaction are high with three-quarters (74%) either satisfied or very satisfied. It is clear that staff find their work meaningful and they derive satisfaction from that despite the frequently challenging behaviour of the young residents. When asked to identify the three most important aspects of the job from a list of eleven, 69% selected 'Residents progress' as the most important. This was the highest rated item, followed by 'Pride in the job' and 'Teamwork'. As well as these core findings a number of cross-cutting themes have emerged and these are described below, and a number of implications for policy and practice are noted.

3 Key Themes

The study has identified three cross-cutting themes which arise throughout the study. They are of course inter-related and together they form the matrix against which the components of good or poor morale can be plotted. The report concludes with a review of the themes and the implications for policy and practice which arise from them. The three themes are:

- Qualifications, training and retention
- Meeting the needs of children and young people
- Working in teams

Qualifications, training and retention

The thorny issue of the relationship between training and retention of staff that has bedevilled residential care for many years seemed once again to be a high profile issue. A significant related factor is the high rate of vacancies for qualified social workers in child and family (child protection) fieldwork posts in most parts of the country. Retaining qualified workers in residential care has been a problem for many years, and a large percentage of workers who gain a DipSW while doing residential work (perhaps through employer secondment schemes) move onto fieldwork posts soon they qualify. Evidence from the seminars indicates that even residential workers with qualifications such as the HNC in Social Care are being 'creamed off' into local authority trainee schemes or other forms of 'fast-track' training that have been set up to address the shortfall in qualified field workers.

Implications for policy and practice

It appears from the study there continue to be major issues about training in connection with the registration process and at the level of improving practice. The study found that a number of managers are by no means confident that there is enough funding to release all the staff who require to undertake training in order to meet registration requirements. Furthermore there are worries that there will continue to be

a drain of the best qualified workers into other areas of social work. Meanwhile there are many voices questioning how well learning can be put into practice and whether even the current focus on training is really equipping staff with the level of skill needed to deal with some extremely 'needy' children and young people.

> *The skill base of the team doesn't match the level of need and challenges of the young people. The team doesn't have the chance to get the training they need, although it has got a little better in terms of access to training*. (Manager)

Meeting the needs of children and young people

As has been seen 'the residents progress' was the item that was most frequently cited as a source of job satisfaction, yet the research also elicited many comments which indicated that workers were frustrated at what they saw as the lack of resources, or the lack of *appropriate* resources to meet children and young people's needs. When asked what contributed most to young people's progress interviewees overwhelmingly emphasised the importance of the quality of relationships with the care staff.

> *Always being there for the young people is what really helps them progress*.
> (Residential care worker)
>
> *Building up relationships with young people is first and foremost, then creating a good care plan after that*.
> (Residential care worker)
>
> *We are first of all role models. If we are seen as stable and share our life experiences it helps motivate the young people. Encouraging them to stay on at school, setting small goals, treating them as individuals*.
> (Residential care worker)

However the time and money available to staff, and sometimes the skills of staff members, were seen as insufficient to meet needs. Some interviewees reported a lack of cash to provide the kinds of activities and experiences they felt young people should have. There were also a number who felt that the staffing ratios did not allow

for the amount of 'one-to-one' time that they felt would enable a better quality of service to be provided.

However there were also many comments about the vulnerability of young people when they returned home or left care for some kind of 'aftercare' accommodation. Several interviewees said that the age of 16 was too young to be leaving care and that improvements in aftercare were vital. It is worth noting here that leaving care at 16 is not suggested or endorsed in any legislation or policy guidance but nevertheless it is well-recognised within the sector that that there is an expectation, shared by staff and children alike, that young people will be in the process of leaving when they turn 16. For those working in residential schools this is also very much a fact of life which seems closely connected to the funding of placements, rather than proper care-planning, and the apparent refusal of Education Departments in local authorities (who share the costs of most residential school placements) to fund such education after the young person reaches the school leaving age. Such an approach to care-planning flies in the face of the recent policy developments requiring education and social work officials to work more collaboratively and the specific emphasis on improving the educational attainments of looked after and accommodated young people.

In this context it is important to acknowledge the hoped-for effect of the recently implemented Leaving Care regulations. Scottish Executive Guidance which has recently been issued to accompany the Pathway Planning process for care leavers does in fact indicate that young people should not normally be seen as care leavers until they have turned 18.

However the concerns about the adequacy of resources available to looked after young people was not related only to the needs of those 'care leavers'. There were also many comments in interview and seminar about the inadequacy of resources to meet the needs of young people during their time in care. Managers and other staff commented on the use of units for emergency placements on an indiscriminate basis and the impossibility of meeting the needs of a diverse group of residents in a generic unit that was expected to accommodate all kinds of children, short and long-term and so on. The use of residential as a 'fall-back' option and the relationships to fostering was also raised. It seemed to some respondents that young people were sometimes

'designated' for a fostering place but in the face of foster care shortages they tended to remain in residential care on a 'temporary' basis but for an extended period.

Disempowerment and meeting needs

One theme that emerged form the research may be summed up by the word 'disempowerment' in relation to the organizational environment in which units, and especially unit managers, have to operate.

In Chapter 6 we noted that many managers, especially those in the statutory sector felt they had little involvement in and consequently little control over admissions. However it is not just in relation to admissions that managers have become to some extent dis-empowered. In one seminar voluntary sector managers expressed amazement when they discovered that some unit mangers in the larger local authorities were not even involved in selecting the staff who are given jobs in their units. This discussion arose in the context of the theme of 'teamwork' and the responsibility of managers to build up their teams and get them to work to a shared ethos and so on. All those present agreed that if managers were not even involved in selecting staff then it weakened their position to build and develop teams, as well as reducing their professional status and influence. Research has confirmed the crucial role of unit managers in setting standards and providing the leadership that is necessary to sustain good quality care practice.

Implications for policy and practice

When addressing issues of resources it is tempting but generally fruitless simply to make a request or demand for more. Residential places are currently seen as relatively expensive and it is important that staff teams and agencies become clearer about what sort of care they are being paid to provide, and thus to be able to be specific about what the gaps are. If a demand is made for more resources then residential units should expect to have to demonstrate that they provide 'value for money'. Residential units may well need more resources of various kinds, be it in cash or skills, but it is important that they are willing to measure what they do, and how it improves young people's lives, and what difference the extra resource would make.

The survey shows that staff recognise the needs of the young people and want to do better. Attention does need to be paid to what particular forms of care are needed, how units can work more therapeutically, and what degree of control they can be expected to have over placements must form part of that. If local authorities' only response to rising levels of need is to force units to take children willy-nilly then they cannot expect them to provide a professional type of service. Furthermore, increasing expectations about standards in the public sector more generally, and also in terms of government pressure to demonstrate clarity of purpose and value for money, mean that the needs of young people and the resources to meet them must be more transparently represented. Simply using residential as a kind of 'last resort' to soak up need in an undifferentiated way will tend to undermine professional practice or indeed aspiration. Failure to address the question of what needs a residential unit is there to meet and the methods by which it does so will only lead to more subversive strategies such as the one adopted by a unit manager reported at one of the seminars. She explained that when she recently opened a new unit she had deliberately decided to buy 2-seater settees only rather than any with three seats because; 'if you have only got 2-seat settees then 'they' cannot force you to take a teenager and put them up on the settee.' She was speaking from experience.

Working in teams

As reported in chapter 5 *teamwork* has emerged as a major factor in this study. Respondents identified 'good team working, work environment' as one of the most important aspects of the job. Residential practitioners spend a great deal of their time working directly alongside at least one colleague, and it is clear that a good team experience is what makes the job enjoyable and contributes significantly to the level of morale. Strong teams are also able to help members withstand challenging behaviour and other stresses. Many respondents felt the quality of the teamwork had a very direct impact on the children and young people. This aspect of the job was also explored in questions about communication and management which many respondents identified as crucial to the sense of being supported and valued.

Implications for policy and practice

Seminar participants highlighted a number of factors which make teamwork very challenging. They agreed that it was very important to try to articulate a philosophy or at least some kind of shared language about the ethos or purpose of the unit and to get teams to 'buy into' an agreed approach to the task. The challenge to managers is to get the balance right between *imposing* a framework or philosophy for the unit which all staff are expected to follow and allowing some degree of *autonomy* for individual members of staff or shift teams. This is important because we are not dealing with a single team even in a small residential unit, there are shift teams and workers are expected to take responsibility for what happens while they are on shift. The challenge to unit managers is therefore to keep everyone working to agreed principles and practices while at the same time empowering the shift and expecting them to make decisions when the manager is not on duty.

The prominence of this issue in the research suggests that those responsible for teams, both unit managers and external managers, should make specific plans to promote and enhance good team working. Clearly in a shift-working context this is a demanding requirement. Every unit needs some sort of systematic approach to shift 'changeovers' and a regular timetable of team meetings. However even when these basics are in place we know that team members need to be able to draw on one another's support at times of strain or crisis, for example, when managing a particularly difficult young person. SIRCC is often been asked to provide team-building and to facilitate team development days of one kind or another. However frequently such requests are related to periods of crisis, instability or re-structuring. While these are valid occasions for taking time out as a whole team it seems clear from this study that if managers were more proactive in setting aside time for team building and team development on a regular and planned basis then there may be less requirement for strategies or activities that are essentially reactions to crisis or difficulties of one sort or another.

Building up and maintaining good quality teamwork is a demanding task, made the more difficult in situations where there might be a high degree of staff turnover or where there is extensive use of temporary staff. This study suggests that managers

need perhaps to give more attention, time and resources to supporting team working and team development.

In conclusion

During the interviews people were asked if they had a general comment to make about the sector. As might be expected there were a wide range of responses. One theme that emerged was the idea that the sector needs a greater sense of clarity about what it was doing; a greater sense of direction and of being valued. There was something of a feeling that in some units staff were embattled but there was also a strong desire to see things improve and suggestions about how this could be done. There were repeated calls for more resources of various kinds to be put into the system; for some it seemed to be about money for activities or equipment and in others it was about resources in terms of staffing, or training but there were also several messages about units having some control over their admissions in order for them to be able to work to their remits.

Last words

> *We need support and the kids need more support too*.
> (Residential care worker)

> *All the councils need to take residential child care seriously. Unless there are changes in staffing levels ands training the care that young people experience will continue to be impacted.*
> (Residential care worker)

> *We don't have a voice as residential child care workers… I wish the public could have a better perception. The changes have to come from the very top. It is easy to blame the system but many children come in from extremely dysfunctional experiences and this is their first experience of care and the best care they have ever had.*
> (Manager)

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