A E A S R

Action for the **E**ducation and
Advancement of **S**ocial
Responsibility

Morale In Care Organisations

Proposals on Staff Support and Participation

by Rogan Wolf

(in consultation with AEASR members and various groups of care workers)

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Introductory Remarks

Care organisations have people, not profit, as their *raison d' etre* and people's welfare as their "product." The quality of their work is an important measure of how civilised is our Society.

It is therefore strange and noteworthy that most care organisations are profoundly care-less of their own staff, their staffing policies and prevailing attitudes often lagging far behind those of organisations functioning in the commercial sector. This is surely contradictory as well as counter-productive and the recent Government paper "Working Together" is therefore a welcome trail-blazer.

However, if the paper is to lead to effective action, there will have to be improvements in quality at all levels of care organisations, in ways that are complex and closely inter-related.

Stray, isolated measures on behalf of ground level staff that can be proudly flagged up by certain prescribed dates - this won't answer. The measures will mean nothing unless they reflect, are part of, and help to create, the culture of a whole organisation.

Indeed, if just one or another of the elements listed below is initiated as the "solution" to the problem of staff retention and morale, leaving the others untouched and the general climate unaffected, this will not constitute an attempt at a solution, or even a step in the right direction. It will act as nothing more than as a cosmetic exercise and the creation of a fall-guy for when - as inevitably it will - the exercise fails to bring results.

Further, as there has to be an integrated strategy to create a new climate, so that strategy has to apply to all levels. It has become a truism that you can't expect staff to be effective in helping to empower service users, if the staff themselves feel disempowered. In just the same way, attempts to give more support and listen better to ground level staff won't work either, unless their managers are also better supported and better heard.

Further yet, as the solution to this problem has to be holistic and extend right across an organisation, so too it has to be addressed beyond organisational boundaries. For there are some components of low staff morale that have causes wider than any organisational measures can address, at whatever level. For instance, in major conferences, "the blame culture" is now singled out and deplored by the Health Minister. But it remains as potent as ever. Seemingly uncontrollable, it washes around and permeates the work of everyone involved in care work, at all levels, its effects insidious and devastating. It goes beyond appropriate expectations of standards and accountability and surely reflects a need across Society to deny distress and disturbance and to find scapegoats whenever distress and disturbance force themselves on the attention. Local or internal measures will therefore achieve little unless this issue is addressed in a pro-active and concerted fashion at a national level and across the board.

This paper will concentrate on the parts of the Government Paper "Working Together" that cover staff support on the one hand and staff involvement in policy-making and practice monitoring on the other. In doing so, we would not wish to imply that improvements in these areas would solve all the problems. For instance, better pay is no less crucial to staff morale and retention than the measures we set out here ; we are simply not able to discuss the issue of payment in this paper.

The paper will make proposals across various inter-related fronts. Several if not all of these proposals are probably already being followed by a number of organisations, most particularly - we believe - by organisations from the voluntary sector. We think the proposals should apply across all care organisations, whether statutory or voluntary, whether large or small. They should become standard policy across the NHS.

The thinking behind the proposals comes from discussion within AEASR, as well as from various staff support groups functioning in the Westminster area.

Element One - Staff supervision

All staff offering care directly to clients should be guaranteed regular and frequent supervision by people properly equipped to provide it. Frequency will vary according to area of specialisation and intensity of the work. For instance, in the case of staff functioning full-time in the mental health specialisation, we suggest that an hour's supervision once a fortnight should be the minimum requirement.

The time allocated should be given over entirely to the staff member concerned and should be interruption-free. Its venue should be conducive to good concentration.

We see supervision as having two essential components, both of which need to be available for adequate quality of work to be delivered. The two components are sometimes defined as "Supervision" on the one hand, "Consultation" on the other.

The "Supervision" component is essentially line-managerial, with the agenda set by the supervisor - staff-appraisal, the monitoring of training needs and career plans, case-load management, the monitoring and evaluating of the work being done.

The "Consultation" element is more to do with individual staff support and sustenance, and the opportunity to reflect on areas of difficulty, without fear of criticism. The agenda is set less by the manager than by the worker.

Some worker teams and managers combine both components in the regular line management supervision system. This is possible if the team culture allows it and the manager is equipped. Other teams keep the two components separate and employ an outside consultant for the second component.

Which model is adopted is for each team or locality to decide. But all organisations should have a protocol requiring managers to provide a supervision system in which both components are adequately covered.

In turn, all managers at every level should be given adequate training in how to supervise (even to give adequate supervision under Component One requires trained supervision skills) ; and they should receive regular and skilled supervision themselves.

Element Two - Caseload management

We propose that - where realistic - it should be a requirement for every team and every post to have an agreed maximum figure for the number of cases on each worker's case-load.

This figure is clearly not a simple one and should have variables built-in. In other words, cases vary greatly in how much time each requires, how much difficulty each brings with it, how much stress each carries, etc. There are researched and established methods and systems for addressing these issues, some of which are intricate. Perhaps the more trust there is in a team, and between team members and their manager, the less intricate and detailed the systems will need to be.

We know of course that in some teams a fixed maximum case load figure is not possible. These would include Intake teams legally obliged to take on cases that apply to them. In such cases it is all the more important that there are adequate strategies worked out and agreed (and faithfully adhered to) for keeping the team's case allocation within manageable bounds.

Each staff-member's work-load should include time for supervision, time for planning, time for emotional de-briefing. For workers who are continually running to keep up cannot do their work properly and will soon burn out. Equally, workers continually functioning as if their work has no emotional impact on them cannot do their work properly and will soon burn out.

The ideal scenario is one in which the manager supports the worker in keeping the worker's case-load down to a level previously agreed, rather than seeks to load yet more onto workers already over-laden.

Element Three - Management Training and Support.

Many managers in Care Work were once ground level staff themselves and have since been promoted. There are real advantages to this. But the advantages are lost if the manager is not sufficiently equipped for the tasks and pressures peculiar to the management role.

All too easily the hierarchy of a large care organisation becomes a kind of staircase of anxiety, by which the impossible expectations visited by Society upon the Care Services in general are just shunted down from level to level until they reach the bottom. At the bottom is the ground level worker whose task is to meet with compassion the sometimes overwhelming distress of the service user. If the ground level position is thus everyone's dumping ground, the position is obviously impossible for those who occupy it.

This tendency was worsened in the Thatcherite era, during which being "tough" as a manager became an acceptable substitute for being skilful as a leader, with top-down rapid-fire directives the favoured tough form of communication.

A recent example of this followed rapidly the death of a service user closely supported by several care workers. A memo came down implying the possibility of staff neglect (actually there had been none) and requiring a report immediately. The denial in the memo of all consideration for the states of mind of the workers involved (the death had devastated them all) was a denial in itself of all the manager knew as a human being and as a trained care professional about the effects on people of bereavement.

Systematic and timely management training and appropriate ongoing support for managers at all levels might do something to equip them for their responsibilities as skilled leaders, able to act creatively and rationally and not just as conduits for anxiety. Managers properly managing provide the conditions necessary for ground level workers properly to concentrate on the service users' needs.

Incidentally, and in connection with the example used above, there might also be a purpose in working out and agreeing protocols for how an organisation deals with the death of clients or with serious incidents that involve its staff. We know of one organisation that has formed a team of trained personnel from within its own work-force that offers rapid support to workers who have been involved in serious incidents or whose clients have recently died. The support is offered in the form of counselling sessions and takes place within work time.

Element Four - Involving Staff in Policy Discussion and Practice Monitoring

The generic ground level care worker carries an ever greater responsibility on behalf of Society and to be adequate to the task has to use a high degrees of creativity, imagination, resilience, diplomatic and relationship skill, admin ability, knowledge of psychology, specific pathologies, the law, etc. This list is barely the beginning but should be enough to illustrate the absurdity of treating such a person as some functionary at the bottom of the heap who delivers "services" over a counter, in obedience to directives from far above, and who has to be "managed" as a difficult child across a divide. But too often this is the climate in which this person works.

Organisations will greatly benefit from treating their ground level workers not just as adults but as experts in what they do. Not to involve staff in decisions on policy, or the monitoring of practice already in operation, naturally alienates and demoralises them, the people most directly implicated, the closest witnesses ; but it also deprives the organisation of a wealth of talent, insight and experience which is at its disposal and which it cannot afford to ignore.

How best to obtain that involvement, the methods by which to do so, are difficult to get right and can afford to vary. Here are some possibilities :

* The encouragement, both in principle and through funding, of the notion of Practitioners Forums across all localities (see AEASR paper attached to its newsletter). These groups exist not just to offer support to participants but can be accepted by senior managers as opportunities for consultation on matters of policy and practice. In many cases, managers already consult with user groups in a similar fashion. (It is the case that managers wishing to hear what users feel should always also to talk to their workers - for many service users talk easily and openly only to familiar and trusted workers at certain optimal times - and then are reliant on their workers to pass on their thoughts at the meetings appointed).

* The encouragement, both in principle and through funding, of regular stocktaking days, perhaps on an annual basis, by which representatives of all stakeholders in the service being offered, are given the chance to come together to assess its effectiveness and identify the gaps that remain. Effective mechanisms should be put in place to ensure a real response to points raised on these days is offered, a genuine dialogue is encouraged, and contributors to the debate are given real evidence of their potential influence. A newsletter sent out between stocktaking days is one such mechanism.

* We have heard of instances in which care organisations involved the whole work-force in the making and monitoring of their locality plans (Riverside Community Healthcare NHS Trust is one example). We commend this approach and would be interested to hear more.

Element Five - A Counselling Service for all Staff

Most organisations have medical services and all have their Human Resources sections. But these are associated with organisational mechanisms, and transactions that take place between them and staff tend to end up on staff files.

We recommend a practice by which staff employed at all levels of a care organisation should have the opportunity to access an external and confidential counselling service free of charge at any time. The understanding would be that personal issues could be taken there, no less than professional ones, since - clearly - work that requires the use of self in a helping relationship is bound to be affected by personal issues and concerns that arise.

This recommendation for access to counselling is based on hard research findings that indicate the existence of such a service actually saves an organisation money, through improving staff retention rates. On the basis of such findings, the Metropolitan Police have introduced a counselling service for its staff and the facility is not uncommon in other organisations. Care organisations we know of who already run this or a similar service are both based in London and operate in the field of mental health. They are : Look Ahead Housing Trust ; and Umbrella (which functions in Islington). We suspect that, sadly, these two are relatively rare among care organisations in taking such care of their staff. We commend them.

A note of caution of course is that a counselling service is unlikely to flourish in an organisation whose overall climate remains macho and in denial of support needs. Some staff would be deterred from using it so long as doing so continued to be seen by others as a confession of weakness. This further emphasises the point made at the beginning of this paper that there are no instant or isolated solutions to the issue of staff support.

Element Six - Other Forms of Staff Support

Here are some other examples of staff support that we have heard of and would recommend :

* counselling and Shiatsu (a Complementary Therapy) were offered to staff of a large hospital due to close down, to help them adapt to this major change in their working lives.

* A large and well-known shopping chain encourages and assists its staff to go together to cultural events - concerts, exhibitions, etc.

* Many care teams regularly hold Away Days, not just to assess progress but as a team-building exercise. We recommend that these days should be facilitated externally.

Element Seven - Improving self-image - instituting a Praise Culture.

The Blame Culture has already been mentioned in this paper. But it has been described as a something that Society visits on care organisations and care professionals, not as something that care professionals do to each other.

However, an atmosphere of criticism and blame does permeate organisations in which morale is low. It becomes unusual and even unthinkable that colleagues should praise one another, or that managers should praise their staff. Instead, the prevailing form of communication becomes more and more restricted to the negative - have you done this, why did you fail to do that ? People work in the spirit of self-protection and denial and spend their working lives waiting for disaster.

On the other hand we all know that even the most sophisticated of us need and love to be praised, however awkward we are in acknowledging that praise.

This is a difficult subject and we are not advocating a move to some crude evangelist mode of corporate enthusiasm. What we are advocating is a carefully thought out strategy for acknowledging achievement at all times and at all levels. It should be included in management training, it should appear systematically in supervision throughout the organisation, it should be practised constantly in all the organisation's operations. And the habit and practice of praising should begin at the top, so that praising can become by example an activity that is both acceptable and safe.

Element Eight - Improving Public Image - A pro-active strategy.

Many Care Workers feel they stand on ground that is unsafe. They have to meet distress and dysfunction in their clients, which often they can do little to ameliorate to any real degree, while at the same time they continue to function on the basis of a professional identity and set of skills that is profoundly uncertain and even in dispute, with blame and criticism always on the horizon.

We have suggested above that a conscious policy of mutual praising where praise is due can do something to help build up and sustain professional self-esteem.

We suggest here that, in addition, a pro-active policy of media relations and an organisation-wide exercise in self-promotion would also help the care worker's sense of professional worth and self-definition. Some organisations make it a policy to feed local newspapers "good news" stories about their activities. Such a policy does not have to involve a surrender to slick "Spin" techniques, the hype of the ad-man. All it needs is a professional and consistent presentation of the genuinely high level of work going on all the time in so many sites in all areas of the country.

This policy is surely far better than to wait defensively for some public disaster to happen and then complain that reporters treat the organisation without respect or understanding of the issues.

Element Nine - Team Size

Both research and experience in practice suggest that teams where morale is high have a tendency to be relatively small. Of course the optimum number will vary according to task, but ranges from 8 to 12.

As more and more community care work teams become locality based and multi-disciplinary, so their size inevitably increases. This side-effect of an otherwise healthy development perhaps needs watching, as it can be destructive.

Once a team is over-large, it becomes less a source of support and renewal, than a threat ; there is a tendency for its individual workers to avoid exposing themselves to the judgement of the circle and retreat instead into self-protection. The prevailing team culture thus becomes defensive and tending to inertia. The creative workers keep their council. The more negative become the team voice.

We suggest an informed decision is reached at senior level on the optimum size for each team - and this decision is upheld across the organisation.

Element Ten - Staff Recruitment

Staff recruitment is perhaps the most crucial aspect of any manager's job. For, although great improvements would be achieved in organisations if all the elements listed above were adopted, their full success relies absolutely on the quality of the personnel who would be affected by them and would work with them.

In many care organisations, however, recruitment remains a crude process, its interviews hurried and scantily prepared for, training in interviewing a rare luxury among interviewers at all levels.

We recommend that all managers from first-line upwards receive training in staff recruitment - training not just in the procedures of Equal Opportunities, but in the skills of questioning and accurate assessment, etc, so that the interviews conducted by care organisations becomes a creative use of high skill, not just the clumsy mechanical exercise that many still are.

There have been some interesting examples recently of involving service users in staff interviewing. This approach properly applied, with training offered and appropriate support, offers a systematic way of directly assessing how the candidates actually are with service users, how genuine, how warm, how able to make real contact. We recommend this as a refinement of the traditional interview panel format, and would be interested to hear of other approaches that can make the instrument used for the crucial task of staff selection as fine and accurate as possible.

Rogan Wolf
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