

Your workforce is compliant. But are they ready?

Why confidence may be the missing workforce signal

“ The question is not whether confidence should replace competence. It should not. The question is whether organisations are missing useful information when they measure everything except how prepared people feel to apply what they know. ”

The reality of care

Care is delivered in changing, sometimes unpredictable circumstances. Staff work in residential care, domiciliary care, supported living, children's services and community settings. They support older people, children and young adults, people living with dementia, autistic people, people with learning disabilities, physical disabilities, mental health needs and people with complex or changing needs.

A domiciliary care worker may enter someone's home for the first time. A child may make an unexpected disclosure. A person may refuse medication. Someone's behaviour or health may change suddenly. Staff may recognise a safeguarding concern but be uncertain about what they are seeing. Training can prepare people for these situations; it cannot predict every situation they will encounter.

Their training record can remain unchanged while their confidence changes overnight.

The national picture

The 2025 DHSC Adult Social Care Workforce Skills Survey received responses from 3,058 CQC-registered residential and domiciliary providers in England. Among respondents describing workforce skills gaps, the survey reported:

20.5%

reduced confidence in performing the job role

28.2%

increased need for supervision and support

13.9%

reduced ability to meet regulatory standards

The same survey found 28.2% reporting reduced quality of care as an impact of skills gaps and 33% reporting increased stress or risk of burnout. These results are not weighted to represent the whole sector and DHSC describes them as a limited indication of provider sentiment, but they establish that confidence, supervision and regulatory impact are already recognised workforce issues.¹

The blind spot

Most organisations can tell a board or inspector whether learning is complete, whether knowledge has been assessed and whether competency observations are current.

Many cannot answer: **“Which people feel less prepared today to apply an important part of their role than they did three months ago?”**

A training record that says **“completed”** tells you what has been done. It does not tell you how ready someone feels to use it today.



Confidence is useful precisely because it is not competence

Research in health professions repeatedly warns that self-assessment does not reliably equal objective competence. A JAMA systematic review found that many comparisons between clinicians' self-ratings and external assessment showed little, no or inverse relationship, with particularly poor accuracy among some less-skilled and highly confident practitioners. A later review of health-professions education similarly concluded that self-reported confidence should be an adjunct to, not a substitute for, competency data.^{2 3}

That creates four useful states, and each requires a different response. Overconfidence may be as important to detect as low confidence.



Measure confidence in context

A single question such as “How confident are you at your job?” is too broad. Measurement should focus on the small number of role-relevant capabilities where uncertainty could materially affect care, for example safeguarding, medication, recognising deterioration, dementia, mental capacity, autism, learning disability, communication, positive behaviour support, moving and handling or emergency response.

“ A better question: “How confident are you that you could safely handle this situation, knowing when to act and when to seek additional support?”

Change matters more than a score

An employee who consistently rates medication confidence at 3.8 may not be the priority. An experienced employee whose pattern changes from 4.6 to 4.5 to 4.6 and then to 3.1 may be signalling that something has happened. The appropriate first response is normally not judgement; it is a conversation: **“What has changed, and what support would help?”**



Confidence can be captured lightly across induction, before and after relevant learning, alongside knowledge and competency assessment, during supervision, following significant events and through short periodic check-ins. It should not become another high-burden annual survey.

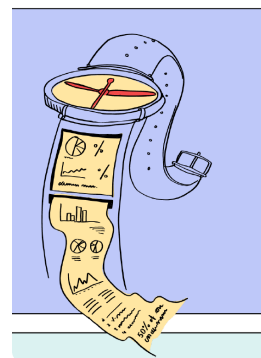
The response model



Support may involve guidance, targeted refresher learning, coaching, shadowing, supervised practice, reflective discussion or competency reassessment. If confidence concern is accompanied by failed competence, incidents or other risk indicators, managers may need to take more immediate action. The system should assist professional judgement, not replace it.

Why leaders should care

- **Earlier visibility:** identify changing support needs between formal assessments.
- **Better learning:** target development to actual need rather than repeat the same course for everyone.
- **Better supervision:** give managers evidence to focus conversations where they matter.
- **Better culture:** normalise asking for help as professional self-awareness.
- **Better organisational intelligence:** see trends by role, service and safety-critical capability.
- **Better assurance:** create an evidence trail from signal to action and review.
- **Potentially better care:** better-supported staff are better positioned to recognise uncertainty, seek help and make safe decisions.



CQC and Ofsted: why this strengthens assurance

Confidence measurement is not required by CQC or Ofsted and should never be presented as proof of competence. However, it can strengthen the evidence organisations use to demonstrate how they identify and respond to workforce needs.

CQC Regulation 18 requires sufficient suitably qualified, competent, skilled and experienced staff, appropriate support, training, professional development and supervision, and continuous review of staffing levels and skill mix as people's needs change. CQC's medicines guidance says learning and development needs may need review after a medicines safety incident.^{4 5}

Ofsted's 2026 children's-home framework expects a supportive environment through effective supervision and appraisal, high-quality induction and training tailored to children's specific needs, active monitoring of quality, learning from practice and feedback, and recognition of the emotional impact of the work on staff.⁶

The audit trail becomes:

Learning › Knowledge › Competence › Confidence signal › Action › Support › Review › Evidence

The cultural condition

If people believe a lower confidence score will damage their appraisal, role or employment, the data will become meaningless. Healthcare research on psychological safety consistently emphasises the importance of environments in which staff can speak up about errors and concerns. Evidence on direct patient-safety outcomes remains heterogeneous, so the strongest claim is that psychological safety supports speaking up, learning and improvement rather than guaranteeing better outcomes.^{7 8}

From compliance to readiness

1	Compliance	Have they completed it?
2	Knowledge	Do they understand it?
3	Competence	Can they demonstrate it?
4	Confidence	Do they feel able to apply it?
5	Context & support	Are they prepared and supported for what they are being asked to do today?
6	Workforce readiness	Is the person currently equipped and supported to perform the role safely?

Five questions for leaders

- 1 Do we know where our workforce feels least confident?
- 2 Would we know if confidence in a safety-critical area suddenly declined?
- 3 Can staff safely say “I need support”?
- 4 Do managers see learning, competence, confidence and supervision together?
- 5 Could we evidence to an inspector what we did when confidence changed?



“ The goal is not a workforce that claims to be confident about everything. It is a workforce competent and confident enough to act, and supported enough to say when they are not.

Sources

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4. Care Quality Commission, Regulation 18: Staffing, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
5. Care Quality Commission (updated 22 May 2025), Training and competence in medicines optimisation for adult social care staff.
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8. Montgomery A et al. (2025), Psychological safety and patient safety: a systematic and narrative review. PLoS ONE 20(4):e0322215.



See confidence alongside compliance, knowledge and competence.

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