

Beyond Compliance

Confidence, Competence and Workforce Readiness in Care

Exploring confidence as an early workforce signal across adult social care and children's services

Your workforce is compliant. But are they ready?

This paper proposes that confidence, measured responsibly and interpreted alongside objective evidence, can add an important dynamic signal to workforce assurance. It does not propose confidence as a substitute for competence, nor as a regulatory requirement.

Executive summary

Care professionals make decisions every day that affect another person's safety, dignity, independence and wellbeing. They do so in residential care, domiciliary care, supported living, children's services and community settings, supporting people whose circumstances, health, behaviour and needs may change quickly. Training can prepare people for this complexity, but cannot predict every situation they will encounter.

Organisations routinely measure mandatory learning, knowledge, competency assessments, supervision, incidents and complaints. A less visible question is whether staff feel able to apply their knowledge and competence to the situations they are facing now, and whether managers would know if that confidence changed.

The 2025 DHSC Adult Social Care Workforce Skills Survey provides relevant national context. Among responding providers describing workforce skills gaps, the survey was voluntary and unweighted, so these figures are best interpreted as provider sentiment rather than prevalence estimates for the whole sector:¹

20.5% reduced confidence in the job role	28.2% increased need for supervision	33% increased stress and burnout risk	28.2% reduced quality of care	13.9% reduced ability to meet standards
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This paper advances a cautious proposition: confidence may operate as an early workforce signal when it is measured in context, tracked over time and triangulated with knowledge, observed competence, supervision, incidents and outcomes. A fall in confidence does not necessarily mean someone cannot do the job. It may reflect unfamiliarity, changed needs, an incident, lack of recent practice or appropriate professional awareness that additional support is needed.

Compliance › Knowledge › Competence › Confidence › Context & support = Workforce readiness

The central governance safeguard is that confidence must never be treated as competence. Research across health professions shows that self-assessment can be poorly calibrated. Some highly confident people may be less competent than they believe, while some competent people may underestimate themselves. Confidence is therefore most useful as an additional signal, not a pass/fail measure.^{2 3}

The cultural safeguard is equally important. If staff believe acknowledging uncertainty will be punished, they will report confidence rather than reality. Psychological safety and speaking-up research in healthcare supports creating environments where staff can raise concerns, errors and uncertainty, while the evidence for direct patient-safety outcomes remains mixed.^{7 8}

For regulators, confidence measurement is not required. Its value is evidential: it can help an organisation demonstrate how workforce needs are identified, supported, monitored and reviewed. This is aligned with CQC expectations around competence, training, supervision, changing needs and workforce wellbeing, and with Ofsted

expectations for effective supervision, tailored training, learning from practice and strong leadership in children's services.^{4 6}

1. The reality of care: uncertainty is part of the work

Care is not delivered in a controlled classroom. Staff make decisions in homes, care services and community environments where people's needs, relationships and circumstances change. The same worker may move from routine support to an unfamiliar or high-consequence situation within minutes.

- **Domiciliary care:** entering an unfamiliar home, working alone, discovering changed medication, illness, environmental risks, unexpected visitors or a person who no longer wants support.
- **Residential care:** responding to sudden deterioration, falls, distress, medication refusal, behaviour change, competing needs or an emergency when the usual experienced colleague is unavailable.
- **Supported living:** balancing independence, choice and positive risk-taking with safeguarding, capacity, consent and appropriate escalation.
- **Children and young people:** recognising disclosures, exploitation, online risk, changes in behaviour, trauma responses, boundaries and subtle safeguarding indicators.
- **Complex or specialist support:** adapting knowledge to the individual needs of people living with dementia, autism, learning disabilities, sensory impairment, epilepsy, diabetes, mental health needs or multiple conditions.

This uncertainty should not be framed as staff weakness. Professional practice includes recognising when a situation falls outside one's recent experience or when additional support is required.

2. The assurance gap

Traditional assurance measures remain essential, but each answers a different question. Completion records show whether an activity occurred; assessments show what a person knows; competency observations provide evidence of demonstrated performance at a point in time; supervision provides managerial oversight.

None alone describes how prepared the person feels to apply that capability **today**. The proposition is therefore additive, not substitutive: confidence adds a human, dynamic signal to the evidence already used for workforce assurance.



Signal	Question answered	What it cannot prove alone
Compliance	Has required learning been completed?	Knowledge, competence or current readiness
Knowledge	Does the person understand the material?	Safe performance in practice
Competence	Can they demonstrate required performance?	How they feel in a new context tomorrow
Confidence	Do they feel able to apply it?	Objective competence
Context & support	What are they being asked to do, and what support is available?	Knowledge or competence

3. What the national evidence tells us

DHSC's 2025 survey offers an unusually direct connection between workforce skills, confidence, supervision and organisational impact. The voluntary survey received 3,058 responses from CQC-registered residential and domiciliary providers in England. Almost all respondents said all or most staff had the necessary skills, yet respondents also identified skills gaps and consequences from them.¹

These figures should not be extrapolated as national prevalence: DHSC explicitly states that responses were unweighted and constitute a limited indication of provider sentiment. Their value here is that providers themselves associate skills gaps with lower confidence, greater supervision needs, care quality and regulatory pressure.

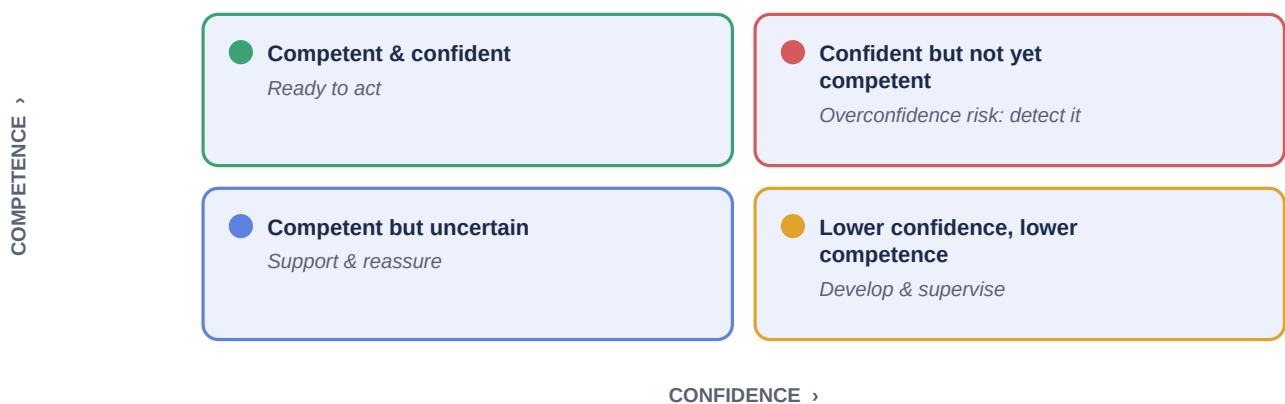
Skills for Care's 2025 workforce report provides a separate organisational context: average turnover among care workers who had received some form of training was 25.1%, compared with 30.4% among those who had not. This does not prove causation, but it reinforces the importance of learning and development as part of workforce sustainability.⁹

4. Confidence is not competence – and that is the point

One of the most important safeguards is conceptual clarity. Confidence is a subjective judgement. Competence requires objective or observed evidence. Conflating the two would create false assurance.

A systematic review of physician self-assessment found limited correspondence with externally observed competence in many studies and noted particularly poor accuracy among some of the least-skilled and most confident practitioners. A review across health-professions education similarly concluded that confidence perceptions may be useful as an adjunct but should not replace objective competence measures.^{2 3}

This makes overconfidence an important signal too. A high confidence score should never automatically reassure a manager where knowledge, observed practice or outcomes suggest otherwise.



5. What should be measured?

Confidence measurement should be role-specific, contextual and actionable. The objective is not hundreds of scores, but a small set of capabilities where uncertainty could materially affect safety, quality or a person's experience:

- Safeguarding and escalation
- Autism, learning disability and communication
- Medication and medicines support
- Moving and handling
- Recognising deterioration and emergency response
- Positive behaviour support
- Mental capacity, consent and positive risk-taking
- Infection prevention
- Dementia and distressed behaviour
- Role/service-specific specialist skills

“ Preferred construct: “How confident are you that you could safely handle this situation, including knowing when to stop and seek additional support?”

The word “safely” matters. The phrase “seek additional support” matters. The measure should reward appropriate professional judgement rather than imply that independence is always the desired outcome.

6. When should confidence be measured?

Confidence should be embedded into normal workforce development rather than introduced as a burdensome parallel process.

Moment	Purpose
Induction	Establish baseline and target early support.
Before learning	Understand starting confidence and tailor learning where possible.
After learning	Assess whether perceived preparedness changed; do not treat this as proof of learning.
Knowledge assessment	Compare confidence with knowledge to identify possible under- or overconfidence.
Competency assessment	Compare confidence with observed practice.
Supervision	Use trends to focus developmental discussion.
Significant event	Consider whether incidents, new needs or unfamiliar tasks have changed support needs.
Short pulse check	Identify meaningful change between formal reviews.

7. Change over time may be more useful than an absolute score

Confidence is dynamic. A single rating has limited meaning without context. Trend and change can be more actionable. Consider medication confidence recorded across four quarters:



A sudden reduction can justify a supportive check-in: Has an incident occurred? Has medication changed? Has the person been away from the task? Has a new clinical or behavioural complexity appeared? Is workload or wellbeing affecting confidence? The change should trigger curiosity, not an automatic conclusion of incompetence.

8. Responding to the signal



Responses should be proportionate. Guidance or microlearning may be sufficient for a minor gap; coaching, shadowing or supervised practice may be appropriate where confidence has fallen following a difficult experience; reassessment may be required where there is evidence of competence concerns. Where confidence concern coincides with failed competence, incidents or safeguarding risk, the manager should apply established risk and capability procedures.

The system must not make clinical, safeguarding or employment decisions solely from a confidence score. It should highlight signals for professional review.

9. Psychological safety: the condition that makes the data usable

Confidence data becomes unreliable if lower scores carry stigma or punitive consequences. Staff need to believe that appropriately acknowledging uncertainty is professional behaviour. This is closely related to psychological safety and speaking up.

A 2020 systematic review noted that psychologically safe healthcare teams can support learning, creativity and performance, including speaking up about errors. A 2025 systematic review found heterogeneous evidence: five of nine included studies showed significant associations between psychological safety and objective patient-safety outcomes, but the authors concluded that no clear overall causal conclusion could yet be drawn.^{7 8}

The practical implication is straightforward: build a culture that encourages speaking up, but do not overclaim that confidence measurement itself improves safety. The appropriate hypothesis is that earlier visibility plus a reliable organisational response may improve support and assurance, and should be evaluated.

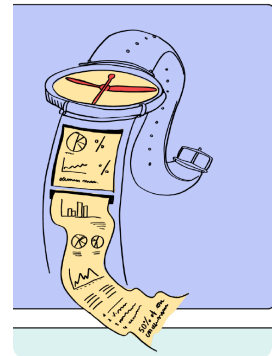
10. The organisational value

- **For the worker:** permission to identify uncertainty, receive targeted support and see development over time.
- **For the manager:** earlier visibility between formal supervisions; more focused conversations; evidence to target coaching and practice.
- **For the organisation:** trends by role, location and capability; potential early indication of changing support needs; stronger evidence of responsive workforce governance.
- **For people receiving care:** staff who are more likely to recognise uncertainty and seek appropriate help rather than bluff through unfamiliar situations.
- **For families:** a richer assurance story: the provider monitors not only training completion but how staff are supported to remain ready.
- **For commissioners and regulators:** an auditable trail showing how workforce needs were identified, actioned and reviewed.

11. From individual signals to organisational intelligence

Aggregated appropriately, confidence can become a service-level signal. The objective is not to rank individuals or create league tables, but to identify meaningful patterns:

- Safeguarding confidence falls across several services after a policy change.
- Medication confidence falls after introduction of a new medicines system.
- Dementia confidence declines in a service receiving residents with more complex needs.
- New starters show high confidence but lower observed competence in one capability, suggesting onboarding needs recalibration.
- A team's confidence falls alongside increased incidents or complaints, prompting review.



Triangulation is essential. Confidence trends should be interpreted alongside learning, knowledge, competency, supervision, incidents, complaints, safeguarding, medication errors, service-user feedback and changing needs.

12. CQC: from compliance evidence to continuous assurance

CQC Regulation 18 requires providers to deploy enough suitably qualified, competent, skilled and experienced staff. Staff must receive the support, training, professional development, supervision and appraisal necessary for their duties. CQC guidance states that staffing levels and skill mix must be reviewed continuously and adapted to changing needs and circumstances, and that learning and development needs should be reviewed at appropriate intervals.⁴

CQC's medicines guidance adds a practical example: following a medicines-related safety incident, providers may need to review learning and development needs to prevent recurrence.⁵ Its workforce wellbeing and enablement quality statement emphasises recognising and meeting staff wellbeing needs so they can deliver safe, effective, person-centred care.¹⁰

Confidence measurement is not a CQC requirement. Its potential value is that it can add evidence to the provider's own assurance process:

Learning › Knowledge › Competence › Confidence signal › Manager response › Support › Review › Evidence

This creates a richer answer to inspection questions about how the provider knows staff remain appropriately skilled, supported and able to meet changing needs.

13. Ofsted and children's services

Ofsted's 2026 Social Care Common Inspection Framework for children's homes places strong emphasis on the effectiveness of leaders and managers. It expects the right supportive environment through effective supervision and appraisal and high-quality induction and training programmes tailored to the specific needs of children. It also expects leaders to monitor quality, use learning from practice and feedback, provide effective support and challenge, and recognise the emotional impact of the work on staff.⁶

The framework states that training and development should enable staff to meet the specific needs of the children for whom they are responsible and that activities should be evaluated for their effect on practice. It also considers staff confidence in managers when reporting and addressing safeguarding matters.⁶

A confidence-readiness model could therefore support an Ofsted-regulated provider's own evidence of responsive supervision and development, particularly around safeguarding, trauma, complex needs, behaviour, medication, communication and emotional impact, without claiming that Ofsted requires confidence scoring.

14. Risks, ethics and safeguards

Risk	Safeguard
Do not use confidence as proof of competence	Maintain objective knowledge and competency assessment.
Do not make confidence a performance KPI	Targets will encourage score inflation and destroy the signal.
Do not punish ordinary low confidence	Treat it as a support signal unless other evidence indicates performance or safety concerns.
Protect privacy and proportionality	Collect only role-relevant data, define access, retention and escalation rules.
Avoid false precision	A 4.2 is not meaningfully "better" than 4.1 without context. Focus on patterns and significant change.
Use human review	Algorithms may flag patterns; managers remain responsible for interpretation and action.
Measure the intervention	Evaluate whether the process improves support, competence maintenance, staff experience and organisational assurance.

15. A practical implementation framework

1	Define	Select 5–10 role-critical capabilities by role/service; involve staff and people with lived experience.
2	Baseline	Capture confidence alongside existing knowledge and competence evidence.
3	Embed	Add short confidence prompts at relevant learning, competency and supervision moments.
4	Detect change	Set cautious, transparent rules for significant change rather than chasing arbitrary "high scores".
5	Respond	Use a support pathway: conversation, guidance, learning, coaching, practice or reassessment.
6	Triangulate	Compare with competence, incidents, complaints, supervision and changing service-user needs.
7	Review	Measure whether interventions restore preparedness and whether objective competence remains sound.
8	Learn	Use anonymised/aggregated patterns to improve training, staffing, supervision and service design.

16. What should be tested next?

The case for measuring confidence is plausible and supported by workforce evidence, regulatory expectations and wider research on self-assessment and psychological safety. It is not yet evidence that continuous confidence measurement improves care outcomes. That should be tested:

- Which questions produce reliable and useful role-specific confidence signals?
- What size or duration of confidence change predicts a genuine support need?
- How does calibration between confidence and competence vary by experience and capability?
- Does targeted response to confidence changes improve objective competence, staff experience, retention, incident rates or quality outcomes?
- What governance model best preserves psychological safety and prevents misuse?
- Can aggregated confidence trends anticipate service-level development needs before retrospective indicators worsen?

This research agenda is important because it keeps the proposition evidence-led rather than turning a promising signal into an unsupported assurance claim.



Conclusion

The future of workforce assurance in care should not stop at asking whether training has been completed. Organisations need to know whether people have the knowledge, demonstrated competence, confidence, context and support required for the responsibilities they face now.

Confidence is neither competence nor a regulatory rating. Its value is as a dynamic human signal: “I am less sure about this than I was,” “I have not done this recently,” or “I would like support before I do this alone.” When that signal is captured safely, triangulated with objective evidence and followed by a proportionate response, it can help managers understand where support may be needed earlier.

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

That is the difference between recording compliance and continuously understanding workforce readiness.

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See confidence alongside compliance, knowledge and competence.

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