The Role and Impact of the Statutory Framework for Training in the Social Care Sector

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Executive summary

Introduction
This study considers how the Care Standards Act 2000, the related Regulations, and the National Minimum Standards (NMS) are being used to tackle skill deficiencies in the social care sector via Work Force Development (WfD). The government is committed to WfD as a driver for raising productivity in the UK economy and to providing better value goods and services for customers and users. There are a number of different approaches to enhancing organisational capability. This sector provides an example of serious problems and an innovatory approach to WfD.

Research aims
The main focus of the research was to estimate the impact, both direct and indirect, of the new regulatory framework affecting training activity at National Vocational Qualification (NVQ) levels 2 and 3 within the social care sector in England. The aim was also to explore whether and how the NMSs have impacted differentially on different types of employer; difficulties and barriers encountered in meeting statutory requirements; and how changes were effected and any negative impacts of interventions. A subsidiary aim was to produce analysis and views on the potential for replication or application of this approach in other settings.

Methodology
The principal method was a series of qualitative, face-to-face interviews with individuals and organisations within the social care sector. Seven case studies of care providers were undertaken which included private, voluntary, and local authority (LA) provision, selected from a cross section of the sector to cover the following: the care of old people, younger adults, and children. The interviews and case studies are underpinned by consideration of the primary and secondary data and available literature.

Background to the social care sector
There are between 1 and 1.25 million workers in the social care sector. The category of social care worker constitutes more than half of this total. Statistics for training and qualifications for social care workers are poor, but it is estimated that only about 20 percent have some form of relevant qualification (this figure includes nurses and social workers). There are differences in
skill mixes between the sub-sectors. There are also skill shortages in some parts of the country coupled with skill deficiencies. For the most part, the sector has been dominated by low-skilled jobs. There are those within the sector and among policy makers who have adjudged that these gaps in skills affect the quality of service provision. Higher levels of training for lower-level staff could help reduce some of these problems.

The Care Standards Act 2000

The Act and related Regulations set out requirements for the staffing and fitness of social care workers. They place an obligation on the registered provider to ensure that all employees receive appropriate training, supervision, and appraisal and are enabled to obtain further qualifications appropriate to the work they perform. The NMS then set out in more detail the requirements for each group of service providers. Of particular significance are the requirements of each home to meet the following qualification ratios by April 2005. (1) Old people’s and young adult homes: a minimum of 50 per cent of all social care staff must be trained to NVQ2 or equivalent. (2) Children’s homes: a minimum of 80 per cent trained to NVQ3 or equivalent. The National Care Standards Commission carry out inspections of homes and failure to meet these standards may lead to the home being deregistered.

Findings

The main conclusions of the study may be summarised as follows. Given the skills problems and market failure characteristics of the sector, it can be argued that the sector was well suited to interventions of this kind. The new regulatory framework is changing employers’ attitudes and behaviour regarding training and skills both directly and indirectly. Directly, there is a positive effect on the training of managers to level 4 and also a significant and beneficial effect on the introduction of more formal induction training. On the basis of our analysis, we would suggest that the qualification targets for managers for 2005 are likely to be reached. Indirectly, there is also an effect via changes in management processes and agendas and the encouragement of employers to engage with outside bodies, such as groupings of employers in their localities. There is some evidence that the NMS are impacting differentially on different types of employer. In the eldercare sector, homes owned by large private operators and LAs are best placed to meet the new challenges. Smaller privately owned residential homes are less well placed, but there is some evidence that partnership schemes can be a considerable help. In the eldercare sector, many smaller, single-establishment homes will have difficulty meeting the 50 per cent target. In
the adult and childcare sectors, the NMS would seem to be having an effect on levels of training, though in the latter sector there is some scepticism as to the NVQ route. In the adult sector, given the nature of voluntary and LA homes and the supports which many of these have, we would estimate that more will reach the target. In the childcare sector, where the target is 80 per cent and the lead-time to obtain level 3 is longer, there are some problems. However, there is more of a background of training and there are also some good support systems. For some homes in this sector, accreditation of prior learning and recognition of alternative training is important.

There are a number of employer consortia throughout the country which have been brokered by Topss England, the Learning and Skills Council (LSC), Social Services departments, and the sector’s employers’ organisations. Some of these groups are rather ad hoc, but funding arrangements are playing an important role in extending partnership working.

In terms of costs, for the most part, the employer is paying for the time spent in training or being assessed. In all the case studies, the employer had some extra costs where trained staff take time to train others and where the employer provides the assessment. In some cases, the courses were paid for by the employer, but in most there was support from various government funds. It would seem that best practice, as it is developing, is for training to be on-site, with a good proportion off-the-job training for any underpinning knowledge.

There are multiple and complex funding streams to support training in the sector but these do not cover replacement wage costs. In this respect, it is interesting that approximately 45 per cent of all Employer Training Pilot starts are from the social care sector.

The main difficulties and barriers for employers are the tight time frames, financial pressures, and fears of poaching of trained staff. In general, there were a few difficulties encountered with training providers, but this does not seem to be a major constraint. A more important constraint is the absence of internal assessment capability. The main barriers for employees are time and other commitments, fears of ‘going back to school’, and deficiencies in basic skills. In terms of morale, there would seem to be a net positive effect. We saw some real desire for progression among staff and a belief that training will create more career prospects for some social care workers, leading to level 3 and beyond.
In terms of multi-tasking and multi-skilling, there would seem to be limited effect to-date. Here there are legal and organisational obstacles. However, in future, with the growth of domiciliary care and other changes in practices elsewhere in health care and social care, there will be a growing demand for more flexible workers.

From our evidence, we would suggest that any deadweight effect is small and restricted to larger homes and the childcare sector. Much of the training is new skilling, though there is undoubtedly some formal recording of skills already acquired.

There is a danger that the new minimum may become a maximum and employers may make little further effort to train beyond the required target levels. In the case of children’s homes, there is some danger that alternative (and some would argue superior) qualifications may be displaced. In this sector, there would seem to be a pressing need to establish equivalents and to give recognition to acceptable alternatives to NVQs.

**Possible extension to other sectors**

The potential for replication in other sectors might exist in settings with some of the following characteristics: industries or occupations where there were real concerns for public health, safety, and general welfare; where there are market failures; and where there is some desire on the part of a significant proportion of the sector for such arrangements. It might suit sectors where a central coordinating function has been lost and along with it traditions of training. Financial resources either from the industry or government, as well as managerial and training resources would need to be in place.
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1. Background to the study

The government is committed to raising productivity in the UK economy and to providing better value goods and services for customers and users. A skilled workforce is central to the achievement of this goal. One critical aspect of this is the enhancement of organisational capability and the tackling of skill deficiencies via Workforce Development (WfD).

There are a number of different approaches to WfD. One is to leave skill formation to competitive pressures in the market and to voluntary action by firms. A further step is a reliance in some industries on various types of collective self-regulation. An alternative approach has been to encourage training via a system of compulsory levies, and these still exist in a few sectors of British industry. Also, in a few industries and occupations, there are qualification prerequisites for entry and for operation, though these are mainly restricted to professional workers. This paper deals with an alternative and new approach which is to be found in the social care sector.

In its manifesto commitment from June 2001, the Government stated that it would be prepared to support a statutory framework where there are serious skills shortages and where there is some agreement on both sides of industry that statutory measures are necessary.\(^1\) An innovative statutory approach is to be found in the social care sector. However, to date, this is not particularly well known outside that sector and little information is available on the principles underlying it and on how it is operating. This study provides a preliminary overview of the training framework in the sector and an early evaluation of its operation.
2. Aims, scope, and outline

This section outlines the following: the aims and objectives of the study; the scope of the sector and occupations covered; and the structure of the study.

2.1 Project aims and objectives

There are two aims of the project, a primary aim relating to the social care sector per se and a secondary aim concerning broader implications.

1. The main aim of the research is to estimate the impact of new regulations on training activity within the social care sector. In particular, the aim is to analyse:

   - the extent to which the introduction and refocusing of regulations governing training have changed employers’ behaviour and attitudes towards training and skills: this can be analysed not only in terms of changes instituted to meet regulations, but also in more general terms e.g. deployment of training plans, budgets, structured WfD, involvement with government or other initiatives e.g. Modern Apprenticeships, Investors in People, which may go above and beyond regulations and employers’ general receptiveness to changes;
   - other positive impacts of the social care approach e.g. on staff recruitment and retention, morale;
   - whether and how regulations have impacted differentially on different types of employer, by type, size, region;
   - how any changes have been effected e.g. in terms of types of training and skills provided, the balance of formal and informal arrangements, training leading to qualifications;
   - the priority given to such changes vis-à-vis other statutory requirements and services;
   - difficulties and barriers encountered in meeting statutory requirements;
   - whether regulations have accelerated ongoing trends in training provision and skills acquisition or reinforced them or have had other impacts such as increased recruitment of already-qualified individuals;
any negative impacts e.g. displacement of other types of training or of other services, loss of staff due to imposition of qualification requirements, and barriers met when training undertaken;

the costs, both direct and indirect, to the employer of instituting any required changes and to other stakeholders, principally employees, financiers, other institutions; any costs passed onto customers in terms of direct charges and indirectly, in terms of changes to services.

2. A subsidiary aim is to provide analysis and views on the potential for replication or application of the principles underpinning the social care sector’s statutory arrangements in other sectors.

In order to achieve these aims, the following research methods have been used. The principal approach has been a series of qualitative, face-to-face interviews with individuals and organisations within the social care sector. This covers government officials, the statutory bodies in the industry, employers, sector representatives, and employees and their representatives. Seven case studies of social care providers have been concluded from a cross section of the sector so as to cover the following - the care of old people, young adult, and children; private, voluntary, and local authority (LA) provision; and small and large organisations. The interviews and case studies are underpinned by consideration of primary and secondary data and the available literature.

The research made use of the inspection reports produced by the National Care Standards Commission. These provided valuable information. The intention of the Commission is to use this information to construct a database of homes and their characteristics. Unfortunately, such data was not available at the time of producing this report. However, in future, it should be possible to obtain rich information on percentages of homes at different training levels and to correlate these with types of home and with care outcomes.

2.2 Definitions and scope of the study

Given that social care is a large sector and that the statutory framework is correspondingly complex, it is necessary to delimit the scope of the project.
The study does not cover health care, but rather the social care of various groups in homes and other settings. There are a wide range of related regulations and standards. We decided to concentrate on three main areas – the care of old people, young adults, and children. As will be seen, within these, there are sub-sectors, and these are referred to where necessary. Throughout, we are concerned with staff usually known as ‘care workers’ or ‘care assistants’ or ‘support staff.’

The report deals only with England, since there are different arrangements in place in the rest of the UK. It should be noted, however, that some statistics are only available for the UK.

For the purpose of this report, WfD is concerned primarily with training and development which occurs when an individual is in employment rather than pre-entry training. However, it does consider entry-level training of various kinds, such as induction training, as well as continuing training and development for those who have been in the industry for many years. The study concentrates on training at National Vocational Qualification (NVQ) levels 2 and 3. It touches on higher NVQ levels and other forms of qualification where this is necessary and where it has implications for the training of those who are the main focus of study.

2.3 Structure of the report

The next chapter provides a brief overview of the sector, covering the service / product market, the labour market context, and the skills background. Chapter 4 outlines the development and nature of regulation in the sector, in particular the interrelationship between law, statutory instruments, and new national minimum standards. Chapter 5 then presents an assessment drawn from a study of the primary and secondary sources and a series of consultations. It presents an overview of various organisations with statutory responsibilities and of other representative bodies. It also provides views from other organisations involved in WfD. Chapter 6 presents a series of case studies chosen to represent settings from across the social care sector. Chapter 7 deals directly with the question as to whether the statutory framework is influencing WfD and seeks to answer the questions posed in 2.1 above. Finally, chapter 8 summarises the study, suggests areas for further research, and considers the potential for replication or application of the principles underpinning the social care sector’s statutory arrangements in other sectors.
3 The social care sector

The social care sector is made up of a complex set of sub-sectors, with many similar, but also with some dissimilar, characteristics. Here we consider the product / service market, the labour market, and the skills context.

3.1 Product / service markets

The sector as we have defined it is made up of three separate markets – care for old people, younger adults, and children. The care of old people is by far the largest in terms of service users, employers, and employees; the next largest group are adults with learning disabilities; some way behind in terms of size are adults with physical disabilities; and the smallest group are children in care.

In 2002, the total value of the care home market for elderly and young adults was around £10 billion, of which private sector operators accounted for over £8 billion. In total, there were around 550,000 places in residential settings for elderly and young adults. During the 1980s and early 1990s, the size of the social care sector in terms of beds had risen, as a result of the rising number of old people requiring care. Since the late 1990s, however, the number of places has fallen by around 12,000 places per annum. In part, this reflects an increasing view that it is preferable that people are cared for in their own homes as long as possible rather than in residential homes.

Overall, there are said to be 25,000 employers and 30,000 homes in the social care sector. The vast majority of these are private and voluntary organisations in the independent sector. Private employers range in size from BUPA and Westminster Health Care, with hundreds of homes and thousands of employees, to small single-home operations, most of which are owner managed. Most of the private employers are ‘for profit’, though a few are mutuals of various kinds. Voluntary organisations, which are ‘not-for-profit’ and usually have access to charitable funds, include well known names such as Age Concern for old people, Mencap and Scope for learning disability, the Leonard Cheshire Homes and the Royal National Institute for the Blind for physical disability, and Barnado’s and the National Children’s Homes for children. Most are less well known, and there are a number of small charities and religious institutions in the voluntary
sector. Finally, there is the statutory or public sector, made up of Local Authorities (LAs) and their Social Services Departments. Homes in this category have been reducing their direct provision of services since the mid-1980s and they now represent less than 10 per cent of the total number of homes. Increasingly the role of LAs has come to be the commissioning of independent providers to provide services.

To concentrate first on the old people’s residential care sector. This is itself divided into two - residential homes and nursing homes. The former operate without a nurse in attendance; the latter provide for more fragile old people and must have a registered nurse in attendance. The residential sector is larger in terms of homes and places than the nursing sector, though the latter is growing as more people wait longer before moving into a home and as residents live longer.5

Most homes are small, the median size for elderly and young adults being about 25 beds. Over 90 per cent of homes are single-establishment institutions. However, multi-establishment for-profit providers have increased their share of the sector.6 Concentration is therefore growing, as a result of exits, mergers, and acquisitions. The ten largest operators now own or lease over 15 per cent of capacity. Their penetration is greatest in the nursing home sector, where homes tend to be larger, where they can obtain economies of scale, and where they have the potential to earn higher profits.

The majority of beds are LA funded, though some homes in both the statutory and independent sectors have all funded places and some in the independent sector have no funded places.7 Most of the sector has price regulation operating through the fees which are set by LAs. Homes are therefore constrained in their ability to pass on cost increases to service users in the form of higher prices. Therefore, any squeeze on local service budgets acts as a major constraint on care homes. Owners complain that, along with other costs (higher wages as a result of the National Minimum Wage (NMW) and higher standards as a result of the new regulatory framework which is the subject of this report), this means that many homes operate on the margin of financial viability.8 Thus, with this purchaser-provider split and in this market-type situation, homes have had to compete with one another for places, funded by budgets held by LA purchasers who look for a mix of best facilities and best value.9
The majority of places for adults with learning and physical disabilities are now also in the voluntary and private sectors. Again, most of the funding comes from LAs. Here also there has been a move towards care in the community, assisted living, and the growth of housing associations of various kinds.

The smallest sector in terms of the number of service users and the size of homes is the childcare sector. There are estimated to be about 55,000 children in care of various kinds and about 1,000 homes in the UK, of which about 600 are deemed to be sizeable units, viz. with over 6 beds. This sector is now made up mainly of small units for very disturbed children, mainly in their mid-teens. It is the most expensive per service user and the most labour intensive. Again, there has been a move away from homes and towards fostering and other arrangements.

In all these situations, there has been a long-term trend from care in homes to care outside institutions, for the private and voluntary sectors to grow, and for LA funding to grow as a proportion of total funding. However, whereas the size of homes for old people is slowly rising, those for adults and children have been falling. There has also been a long-term trend from LA direct provision to LA indirect funding and many of these homes run on very tight budgets.

Finally, we will have more to say later on the management of homes. Here, we would point out that in the large private, large voluntary, and LA homes, management structures and capability are relatively well developed and local management can call on headquarters’ advice and assistance. By contrast, in small private homes for the elderly, management structures and capabilities have been under-developed. The owner and family members are often both managers and carers. Of necessity, they are largely self-reliant in management. In all homes, the tendency has always been to put professional qualifications and skills before management skills. However, there are increasing pressures for the up-grading of managerial skills and competency.

3.2 Labour markets

There are between 1 and 1.25 million workers in the social care sector, depending on how one draws its boundaries. Of these, over two-thirds and growing are in the independent private and voluntary sectors. The category of care worker constitutes more than half of this total. In all the
sub-sectors, wages are a high proportion of total costs. In old people’s homes, for example, the wages of staff are variously estimated to be about 60 per cent and rising of total income. 

Again taking the eldercare sector first, on average, social care workers work in homes employing about 20 staff. Around 95 per cent are female, on average aged around 40, and with most working around 25 hours per week. Labour turnover is high, with some homes estimating it to be as much as 30 per cent. Average job tenure in any particular home is about 3 years.

Wages for social care assistants are among the lowest in the country and in our case studies ranged from £4.20 to £6.00 per hour. Within homes, there is little of a wage hierarchy, but between homes there is rather more wage dispersion than might be expected in a competitive local labour market, with relatively homogeneous labour. Firms therefore seem to have a degree of discretion in setting wages. The advent of the NMW in 1999 raised the wages of a large number of care workers and caused a significant wage compression at the bottom end of the wage distribution. There is some evidence of hours and employment reductions after the NMW was introduced, though the estimated effects do not appear to be sizable. Union membership is very low in homes, with the exception of LA settings. Many staff work on temporary contracts and some have no contracts.

In some parts of the country, in particular London and the South East, there are labour and skill shortages. Competition for labour comes from other homes in often concentrated local labour markets, from the NHS, and from other industries such as retailing. To plug some of the gap in labour shortages and to deal with absences, agency staff are used. These may constitute up to 10 per cent of staff in some areas in the South East. It was suggested to us that their costs tend to be twice as high as those of direct labour and most of our interviewees saw their use as a necessity, but often a ‘false economy’.

The young adult and childcare sectors share some of these characteristics, but there are also some important differences. In homes for the learning disabled, there is a higher proportion of male staff, perhaps reflecting the tradition of careers as mental health nurses and auxiliaries. In homes for the physically disabled, there is more of a mix of staff, including nurses and specialists, such as physiotherapists and speech therapists. In this sector, there is also a higher proportion of volunteers. Also, in children’s homes, there have also been more male employees, but this may
now be on the decline. In children’s homes, as will be described below, there have always been a senior group of social workers. Wages are highest for care staff in the children’s sector. However, turnover and ‘burn-out’ are also said to be high in this sector. Agency staff are less used in children’s homes and are likely to be more qualified than similar staff in other settings.

3.3 Skills and work organisation

Skills are to be seen in the context of work organisation and staff deployment. In all parts of the social care sector, the work is labour intensive, with at least one care worker per service user, rising to two in the case of children’s homes. However, for the most part, the sector has been dominated by low-skilled jobs. The most skill intensive sectors have been nursing homes (with a minority of nurses on the staff), learning and physical disability settings (with a minority of nurses and other specialists), and children’s homes (with a minority of social workers usually in senior positions). Outside of these professional-type areas, the majority are care staff or care assistants. These are usually organised in a hierarchy of team leaders, senior assistants, and junior assistants, reflecting experience and skill. Movement beyond these levels is limited by two main factors: first, higher-level jobs have been blocked by nursing and other professional requirements; second, in small homes, there is limited scope for upward career movement.

Training leading to qualifications has historically been restricted to certain groups, such as nurses and social workers. Though various qualifications have existed (CSWQ, DipSW, C&G, BTEC) which care staff could take, these have not been required for jobs, and historically take-up has been low.

Statistics for training and qualifications for social care workers are poor. Various official statistics are not disaggregated according to occupational level or according to sector and usually include NHS and other health staff. Private surveys by employer groups and LAs provide more detailed information, but have tended to have poor response rates. However, limited data and interviews suggest that in the sector as a whole around 20 per cent of employees have a relevant qualification, and this percentage includes nurses and social workers.\textsuperscript{15}

There are differences in skill mixes between the sub-sectors. In the eldercare sector, traditionally the only group with extensive training and qualifications have been nurses in nursing homes.
Below that, there have been no formal qualification requirements or national frameworks. In this sector, there are also basic skills problems. The NVQ was developed in the early 1990s and since then there has been a steady increase in number obtaining the relevant levels 2 and sometimes 3 qualifications. However, the total numbers are small (See Table 1 below). In the adult sector, skills have been polarised, with nurse and other specialists on the one hand, and usually untrained labour on the other hand. We were not able to find any separate NVQ figures for the young adult sector but would estimate that they would be little higher than in the old people’s sector.

In the childcare sector, there was more of tradition of training and a growing belief that all staff should have qualifications. However, in practice, lower level staff were often only slightly more likely to have a relevant qualification than staff in the other two sub-sectors. Up until recently, it has been possible for the majority of staff to come into the childcare sector, as largely ‘green’ labour with no qualifications, and with no intention or likelihood of engaging in any formal training programme.

We have already suggested there are staff shortages in some parts of the country. There would also seem to be skill deficiencies. This takes the form of skill-shortage vacancies in that there are real problems obtaining nurses in nursing homes, nurses and specialists in adult homes, and social workers in children’s homes. In theory, higher levels of training for lower-level staff could help reduce some of these problems. There are also skill vacancies at the level of senior carers in some homes, and in smaller homes the owner and family members often have to step in to provide adequate and proficient staffing. In addition, there are also internal skills gaps in the sense that employers believe the complement of their staff not to be fully proficient. There are those in the sector and among policy makers who have also adjudged that there is gap in skills which affects the quality of service provision.
4. The development and nature of regulation in the social care sector

This section provides some brief historical background concerning regulation in the social care sector and then outlines the main features of the present regulatory system.

4.1 The situation before the 2000 Care Standards Act

This is not the place to enter in any detail into the complex nature of regulation prior to the Care Standards Act 2000 or to consider the long-term political and administrative search for solutions for regulating the social care sector. It is sufficient to say that prior to the Act, there had been a long-term tightening up of regulation of homes. However, this remained fragmented, with different legislation and regulations covering different settings and with LAs responsible for registering and inspecting some homes, health authorities responsible for others, and with some others falling through the gap in between. In turn, this led to charges that standards were inconsistent across the country and that LA inspectors were insufficiently independent in inspecting statutory sector homes. Moreover, legislation and regulation was deficient in some settings (e.g. domiciliary care) and for some areas of home management (e.g. staffing and training). Public disquiet, professional concerns, the interests of public and increasingly private providers, and political reactions drove a search for a new regulatory arrangements from the 1980s onwards. Increasingly it came to be realised that to achieve modernisation and better service delivery targets for qualifications for all staff had to be set.18

The new Labour government elected in 1997 decided on wide-ranging legislation which would cover the whole of the social care sector and establish related regulations and national minimum standards for particular sectors. It also came to favour two main regulatory bodies in the form of the National Care Standards Commission and the General Social Care Council.19 The Centre for Policy on Ageing was commissioned to draw up a set of national standards for older people in consultation with the sector. In turn, this became a framework for other settings.

4.2 The statutory framework under the 2000 Care Standards Act, with special reference to training
The present legal and regulatory framework is in three parts – the Act, the related Regulations, and the National Minimum Standards (NMSs).

The Care Standards Act 2000 covers homes for old people, young adults, children, and various other service users and institutions and agencies. The Act enables the Minister to make Regulations by means of statutory instruments (ss. 118). These cover such areas as the fitness of premises and standards of welfare. They also cover certain basic management functions: the fitness of the manager, requirements for finance and administration, and the establishment of systems of managerial control. More specifically, the Act allows for Regulations to be made on aspects of staffing and training. Thus Regulations can be made on the number and type of persons who can work in homes and their management and training (ss. 22). Further, the Act enables the Minister to set more detailed NMSs which are to be taken into account in decisions about registration and in any legal proceedings (s. 23). Failure to comply with the Act and its associated Regulations is an offence (s. 24).

The Act establishes a National Care Standards Commission (NCSC). All persons who carry on or manage homes have to be registered with the Commission which has the duty to conduct inspections and the power to cancel registration.

The Act also establishes a General Social Care Council (GSCC). A duty is imposed on the Council to promote ‘(a) high standards of conduct and practice among social care workers and (b) high standards in their training’ (s. 54). ‘Social care worker’ here means anyone who engages with relevant social care work or who manages or is employed in any relevant home or agency (s. 55). ‘Social workers’ constitute a separate category within the overall designation of social care worker. Both groups of workers are to be registered. To be registered, inter alia, the former must satisfy ‘any requirements as to training which the GSCC may impose’ and the latter must have successfully completed a course approved by the GSCC (ss. 56-58). In the case of social workers, only those registered will have the right to use the title in due course. The Council has the duty to maintain Codes of Practice for social care workers (s. 62) and to approve relevant courses for social workers (s. 63). The Minister has the function of ascertaining what training social care workers require, of seeing that occupational standards are established, and of ascertaining what financial and other assistance is needed to promote such training. Grants may also be made available for assisting training (s. 67).
The Care Homes Regulations 2001 for older people (SI 2001 3965) and for young adult (SI 2001 3965) and the Children’s Homes Regulations 2001 (SI 2001 3967) came into force in April 2002. Each of these provides more detail than is contained in the Act. Thus, they provide more detail on such matters as assessment of service users, service plans, premises and facilities, health and welfare, and the fitness of registered managers. They then proceed to outline requirements concerning the management of the home.

Most important for this study, the Regulations set out requirements for the staffing and fitness of workers. In the case of homes for old people and young adults, the registered provider must ensure that staff numbers are adequate for the size of the home and needs of the service users, that staff must be ‘suitably qualified, competent, and experienced’, and that that they receive ‘(i) training appropriate to the work they are to perform and (ii) suitable assistance, including time off, for the purposes of obtaining further qualifications appropriate to such work’ (s. 18). A fit social care worker is then defined *inter alia* as someone who has ‘the qualifications suitable to the work that he is to perform and the skills and experience necessary for such work’ (s. 19). The Regulations for children’s homes are on similar lines, but contain some variants. Thus, they place an obligation on the registered provider to ensure that all employees ‘(a) receive appropriate training, supervision, and appraisal and (b) are enabled from time to time to obtain further qualifications appropriate to the work they perform’ (s. 27).

The NMSs then set out in more detail the requirements for each group of service user.

Thus, the NMSs for Care Homes for Older People are contained in an 82-page document. The Standards focus on ‘achievable outcomes’ under a number of headings – choice of home, health and personal care, daily life and activities, physical environment of the home, protection and complaints, management and administration, and staffing. The Standards are stated to be ‘measurable’ and inspectors must look for various kinds of evidence on them (viii). The Standards ‘are considered when compliance with the Regulations is decided upon’ (viii). Behind all of them, the informing principles behind them are said to be that they focus on the provision of quality service for users and that they are comprehensive and take a total view of how the service is delivered. A further underlying principle is that they are posited on a quality workforce. ‘In applying the standards, NCSC regulators will look for evidence that registered
managers and staff comply with any Codes of Practice published by the GSCC and achieve Training Organisation for the Personal Social Services (TOPSS) requirements’ (x).

Specific to the management process, the Standards for old people’s homes lay down the following. (Here we have re-arranged the Standards in an order which suits the purpose of this report).

- **Standard 1** states that the registered person must produce and make available an up-to-date statement of purpose, outlining aims, objectives, and care philosophy.
- **Standard 31** outlines the requirements for a registered manager. Such a person may only manage one home at a time, must have an appropriate job description, and must have proper lines of accountability within the home and to any external management. In terms of experience and training, they must have at least two years’ experience in a senior management position in a relevant care setting and by 2005 they must have an NVQ 4 in Care and in Management or, in the case of a nursing home, they must be a registered nurse and have a relevant Management qualification.
- **Standard 32** states the home must have effective quality assurance and quality monitoring systems which are then spelled out in some detail.
- **Standard 34** requires certain accounting and financial procedures to demonstrate financial viability and ensure effective management. **Standard 37** states that records required by regulation for the protection of service users and the effective management of the home are maintained, up-to-date, and accurate.
- **Standard 36** requires that the registered person ensure proper staff supervision, including formal supervision at least 6 times a year, covering specified topics.
- **Standard 38** requires that the registered manager ensures health and safety of service users and staff.

More specifically in the area of staffing and training, a set of related Standards are laid down which are seen as central to the achievement of the other requirements.

- **Standard 27** states that the number and skill mix of qualified / unqualified staff are to be appropriate for the size and type of home and the assessed needs of service users. Reference is made to ratios. In addition, it is stated that staff providing personal care must be at least age 18.
• Standard 28 is the key to training and qualifications. The stated outcome is said to be that ‘service users are in safe hands at all times’. With a view to this, a minimum ratio of 50 per cent of care staff must be trained to NVQ 2 or equivalent by 2005. This ratio excludes the registered manager and any nurses in a nursing home setting (28.1). 28.2 states that agency staff working in the home are included in the 50 per cent ratio. 28.3 further states that trainees (including all staff under 18) are to be registered on a TOPSS-certified training programme.

• Standard 29 lays down that the registered person operates a thorough recruitment procedure based on service user protection and equal opportunities. This covers the provision to new employees of contracts of employment and copies of the GSCC Codes.

• Standard 30.1 reverts to training. The desired outcome is that ‘staff are trained and competent to do their job’. To this end, management must ensure that there is a staff training and development programme which meets TOPSS training targets.

• 30.2 states that staff must receive induction training to TOPSS specification within 6 weeks of appointment, including training on the principles of care, safe working practices, the role of the care worker, the needs of service users, and any particular requirements of the service setting. 30.3 requires that all staff must receive foundation training to TOPSS specification within the first 6 months of appointment, equipping them to meet service users’ assessed needs.

• 30.4 states that all staff should receive a minimum of 3 paid days training per year and have an individual training and development assessment and profile.

The NMS for Young Adult Homes\textsuperscript{21} and for Children’s Homes\textsuperscript{22} are contained in equally lengthy documents and are set out in the same way.\textsuperscript{23} Adjusted for the different care settings, the Standards are in most respects the same as those outlined above for old people, with a few important differences. Here we refer only to these differences.

In homes for young adults, along with the 50 per cent NVQ 2 target requirement by 2005 (32.6), there are other training requirements which go beyond those in old people’s homes.

• Standard 32.4 states that trainees (including all staff under 18) must be registered on a Topss England standard training programme and work only under the direct supervision of qualified staff.
• Under Standard 32.5, social care staff are said to hold an NVQ 2 or 3 (or a nursing qualification if providing nursing care), be working to obtain one by an agreed date, or else the registered manager must be able to demonstrate that, through past work experience, staff meet this Standard. (The full intent of this Standard is somewhat unclear.)

• 33.7 states that trainees (including all staff under 18) should make up less than 20 per cent of total care hours and there should be no more than one trainee on duty at any one time.

• 35.2 lays down that a home must have a training and development plan, dedicated training budget, and a designated person with responsibility for the training and development programme.

• 35.5. Each staff member should have an individual training and development assessment and profile by 2004 and at least 5 paid training days per year.

• 35.6. A training needs assessment must be carried out for the staff team as a whole and an impact assessment must be made of all training and development to identify the benefits for service users and to inform future planning.

• 35.7. Training and development must be linked to the home’s service aims and to service users’ needs. There must be arrangements for managers to brief staff and for staff to give direct feedback (36.2).

• 36.4. The regular, recorded supervision meeting, which must take place at least six times a year, must cover training and development needs.

• 36.6. Staff must have an annual appraisal to review performance against job descriptions and to agree career development plans.

In children’s homes, again there is a baseline of staffing and training requirements similar to the above, but there are other requirements which are different to or go beyond those in the two previous settings.

• By 2005, the registered person must have either NVQ 4 in Care or the DipSW or an equivalent qualification and an NVQ 4 in Management or equivalent qualification (34.3). For a transitional period, new appointees to the post of registered manager who do not have the above must begin appropriate training within 3 months of employment (34.5).

• 28.2. Staff must receive at least 1 ½ hours of one-to-one supervision every month. New staff must receive such supervision fortnightly during their first 6 months. A written
record must be kept of the supervision (28.3). Supervision must cover certain issues, one of which is training and development (28.4).

- 28.7. There must be an annual performance appraisal, which among other matters will cover and record agreed training needs as part of a personal development plan.
- 29.4. By 2004, all care staff must be at least 18 years old and no person can work in a children’s home unless they are at least 4 years older than the oldest child in the home.
- 29.5. By 2005, a minimum ratio of 80 per cent of all care staff should have completed the relevant NVQ level 3. Staff may hold other qualifications which require similar competencies. New staff engaged from January 2004 need to hold the NVQ or another qualification or begin working towards them within 3 months of joining the home.
- 30.3. Every effort must be made to achieve continuity of staffing and no more than half of staff on duty at any one time are to be from an external agency.
- 31.2. Homes must have an induction training programme for new staff, which covers certain specified topics. An introduction to certain topics is required before staff commence work. Full induction must be completed within 6 weeks and foundation training within 6 months, both to Topss England specification (31.3).
- 31.4. All staff must have a personal development plan and receive at least 6 paid days of training per year. Where appropriate, they must also have access to continuing and post-qualifying training.

Some general points may be made about the Act, Regulations, and Standards which have special bearing on this report.

- The regulatory framework is derived from interlocking primary legislation (the Act), secondary legislation (the Regulations), and the NMSs.
- The Act is obviously as passed by Parliament; the Regulations are the responsibility of the Secretary of State for Health and are laid before Parliament in the form of Statutory Instruments; the NMSs are the responsibility of the Secretary of State, and these are issued by the DoH. It is the responsibility of the NCSC to apply these.
- Both the NCSC and the GSCC are concerned with employers and employees. However, the former focuses more on homes and the latter rather more on individual social care workers.
- The Act and Regulations are mandatory and homes must comply with them. The NMSs have a different status. When the Commission or Council make a decision about
institutional or individual registration or a regulatory breach, they may take the NMSs into account. They may also take into account any other factors they consider reasonable and relevant. Thus, the Commission could decide there has been a breach even though NMSs have been met. Conversely, the Commission could decide that the regulatory requirements have been complied with, even though in practice some NMSs were not being met. In this circumstance, the Commission would note this in its inspection report, issue a warning, and require corrective action plans. If Standards were not then met, the Commission could take enforcement action, either to cancel registration or to begin criminal prosecution. The Standards might be taken into account in any legal process.

- The Secretary of State for Health may amend the NMSs after due consultation. This has already occurred in the case of room size and room sharing.

- The NMSs lay down a comprehensive set of requirements concerning management processes. This is akin to a classic management model – aims and objectives, governance, product or service standards, financing, quality assurance, and human resource management.

- Within the management area, the NMSs cover finance and control, but focus in particular on human resource management and training and development.

- There are certain other statutory topics for training e.g. health & safety, manual handling, food hygiene, which have not been emphasised here.

- Different levels of training and development are set for homes in an ascending hierarchy of requirements, from old people’s, to young adults’, to children’s homes.

- The 50 per cent and 80 per cent ratios cover only care staff. They exclude auxiliary staff e.g. catering and cleaning. They also exclude the manager, but include any deputies. The ratios include all agency staff, and therefore a home could not increase its staffing with qualified agency personnel at the time of an inspection.

- New staff in children’s home are required to start on an NVQ3 and therefore, over time, all staff will be qualified to that level. As we said above, under Standard 32.5 in care homes for younger adults, care staff are said to hold an NVQ 2 or 3, are working to obtain one by an agreed date, or else the registered manager must be able to demonstrate that, through past work experience, staff meet this Standard. This would also seem to imply moving to 100 per cent.
There are other NMSs for other settings to which we have not referred here and new NMSs are still being produced. These follow the overall approach as described above, though again with differences to suit the different circumstances.
5. An assessment based on consultations with policy makers, statutory bodies, and representative organisations

This section contains a brief outline of the role and position of the main bodies and representative organisations in the sector. A list of the organisations and individuals who were interviewed is given in Appendix 1.

5.1 Department of Health (DoH)

The NMSs are the responsibility of the Secretary of State for Health and the Department of Health has been the driving force behind the new regulatory framework. This is seen as a substantial improvement on the patchwork approach of the past. It has the advantage that it starts with the service user and presents a comprehensive framework for care and management. In terms of training, the Department for some time believed that skills shortages were a major constraint on the modernisation of the sector and the improvement of service delivery. It was therefore deemed necessary to promote training by setting high, but achievable, targets. Benchmarks alone would always be aspirations. The competence-based assessment suits the sector’s employers and workforce, in that it can be achieved on the job and is cost effective. The targets will be reviewed in 2005. Though the Standards for accommodation have been revised, it has been specifically stated that the training-related Standards will not be changed. In the longer term, consideration will be given to enhancing the training Standards. The Department is the main source of funding for the support of training in the sector.

5.2 National Care Standards Commission (NCSC)

The Commission has primary responsibility for the application of the Standards to care homes. It is better able to take an integrated view of the sector, having assumed the regulatory responsibilities of LAs and local health authorities and having a wide remit in terms of services which had not been previously regulated. Training is seen as essential to achieving other Standards and is commented on fully in inspection reports.

The NMS are not an aspiration level or a benchmark to be emulated but a minimum below which Standards should not fall. In the area of training, there is a clear objective to make real
improvements and there is quantification of targets. This is a necessary approach and required to support other Standards. When the Commission inspects a home and takes a decision about registration or a breach of regulations, they take the NMSs into account. They may also take into account any other factors they consider reasonable and relevant. As stated above, the Commission could decide there has been a breach of regulations even though NMSs have been met. Equally, the Commission may decide that the Regulations have been complied with, even though in practice some NMSs have not been met. In this circumstance, the Commission notes this in its inspection report, issues a warning, and requires corrective action plans. If Standards still fail to be met, the Commission can take enforcement action, either to cancel registration or to begin criminal prosecution.

At the present time, in the training area, there are still some decisions to be made in recognising other training and qualifications which might be deemed to be equivalents of the NVQ. This is proving to be a problem in the case of qualifications in children’s home and discussion are continuing with various parties on this.

Over the next year, the NCSC will produce a report which will consider certain questions, such as whether the training requirements have been set at the right level, whether the level at which they were set historically remains relevant, and what supports might need to be given to ensure that the NMSs are met.

5.3 The General Social Care Council (GSCC)

The GSCC has the responsibility for issuing statutory codes of practice, establishing a register of social care workers, dealing with matters of conduct, and regulating and supporting training for social care workers.

Two Codes of Practice have been produced, one for employers and one for employees. The Codes are authorised by statute, and, if not obeyed, there could be a conduct hearing for breach and employers and employees could be removed from the register once it has been established. The NCSC may also take the Codes into account in their enforcement of the NMSs.
In the training area, the Code for employers enjoins them to ensure that staff are recruited with the appropriate skills; it then goes on to place an obligation on employers to ‘provide training and development opportunities to enable social care workers to strengthen and develop their skills and knowledge’. This covers induction, training, and continuing development (s. 3). The Code for employees states that they ‘must be accountable for the quality of their work and take responsibility for maintaining and improving their knowledge and skills’. This includes ‘undertaking relevant training’ (s. 6).

The GSCC is in the process of creating the first ever register of the social care workforce. In other words, it has the task of registering between 1 and 1.25 million workers. Registration will be based on fitness and competency which may include having successfully completed a period of approved training. In practice, the Council will move in stages towards registration. Social workers are the first group to be registered and they have to have the requisite qualifications; this will be followed by registered managers; and the third group will be child care staff.

The Council has not yet made a decision about the form of registration of the rest of the workforce – particularly whether and what evidence of skills and / or qualifications will be required. There would seem to be a number of possibilities. First, the attainment of NVQ 2 could be a prerequisite. However, only 50 per cent of employees in homes have to have this qualification by 2005 and it would be undesirable to force good carers out of the sector. Second, it might be possible to put those without level 2 on an interim register, with re-registration after they have received the qualification. A time period would have to be decided upon for this, and it would clearly be a more expensive and complicated process. Third, it might be possible in the case of other social care workers to have no qualifications as a prerequisite for registration and to rely on the Codes and NCSC to drive training. Some in the sector would support this latter approach as a pragmatic way forward; others would oppose it as contrary to the desire of raising skills in the sector and raising the esteem of social care workers.

5.4 Topss England – the prospective Sector Skills Council for Social Care

Unlike the two previous organisations, Topss England was not created by the Care Standards Act 2000, but has its origins going back to the former National Training Organisation for Social Care. It is an employer-led national training organisation which brings together in its
governance various parties from across the sector. The role of Topss England is to determine the training needs of the social care workforce, to develop national occupational standards for social care, to create and maintain the national occupational framework, to develop and implement a national training strategy, and to engage in workforce planning for the sector.

Thus, working within the Training Targets set within the National Training Strategy, Topss England has assessed the training needs of the social care workforce. It has developed a set of national occupational standards for the sector based on competencies. These it has used to create a set of national occupational frameworks which may be used for different levels and in different parts of the sector. Topss England believes the competence-based approach is well suited to sector employers and employee, in that it can be achieved on the job and in a cost effective manner. In 2000, Topss England produced a National Training Strategy for the Social Care Workforce which gives details of the qualifications which care workers in the sector should hold.26

Topss England is engaged in active planning and implementation of training in the sector. A set of standards for induction were developed to help employers and to provide a level of consistency. The completion of induction training gives care staff some background and competencies to commence level 2 training. Recognising problems of basic skills deficiencies in the industry, Topss is working to develop such skills and to integrate them into the NVQ process. Topss is a major conduit for the disbursement of funding to the sector in ways which will be described below. Finally, in our research we were struck by the role which Topss plays locally in bringing training providers together with homes and in creating groupings of employers to coordinate training.

5.5 The Learning and Skills Council (LSC)

The LSC brings together the former Training and Enterprise Councils and the Further Education Funding Council. It has the aim of increasing the quantity and quality of training for young people and adults in England.

The social care sector is now an LSC national priority area and a main concern for its local LSCs. To this end, the LSC disburses funding for training and both nationally and locally brings
together the various funding streams to focus on areas of greatest need. It provides information on training packages, supports in areas such as basic skills, Modern Apprenticeships, training providers, and alternative assessment methods. The LSC is working to develop sector networks and local Centres of Vocational Excellence (COVEs). At the present time, it is also running the Employer Training Pilots which re-imburse the wage costs of employers who allow workers to attend courses during working hours. The significant demand for training which the LSC notes suggests that it will be difficult for many homes to meet the 50 per cent target by 2005, though with the right supports now in place, this should be feasible in the longer term.

5.6 The funding of training

When the NMSs were introduced, it was realised that a significant amount of extra funding had to be put in place to support the training requirements. This has been flagged in the Topss England training strategy which provided a cost set of targets many of which were adopted by the NMSs. It is not the purpose of this paper to outline the complex funding arrangements for government support for training in the sector. It is sufficient to make the following points.

A number of income streams have been and are still being put into place. These include funding through the following bodies and under the following headings: the Training Support Programme (TSP) grant, the National Training Strategy (NTS) grant, and the Human Resource Development Strategy (HRDS) grants paid via LAs; LSC funds which includes significant support for Modern Apprenticeships; another DoH grant, the Training Strategy Implementation Fund (TSIF) via Topss and dispersed through its regional committees; ESF; and various pilots, such as the Employer Training Pilots. In practice, the main source of funding originates from the DoH. Some of this money has been earmarked for special purposes e.g. a £2m grant TSIF grant in 2001/2 was used for induction training based on Topss standards; a £15m TSIF grant for 2002/3 to support induction training and NVQ assessment, the training of registered managers of adult care homes, staff training for mentors, assessors, and verifiers. For 2003-4, monies are available under the following headings: National Training Strategy grant from DoH £25m – support mainly for employers to get their staff trained to qualification levels given in the NMSs; Training Support Programme grant £56.5m – general support for training of care staff, mainly for NVQs; Human Resource Development Strategy grant £9m – for management and social workers / to support new roles in social care. Earmarked funds are also available via the TSP,
NTS, and GCCC to support DipSW training. Much of this money is channelled through LAs, but is available for private and voluntary organisations with which they have contracts. In 2003/4, LAs have to use 50 per cent of both the NTS and the HRDS grants to develop private and voluntary contracted agencies. This percentage is likely to rise as better workforce data is produced.

It will be seen from the case studies presented below that funding for training is a constraint on the activities of these homes. The support for capability building and for courses and assessment is clearly extremely important and without it many homes would be further constrained. The use by the sector of the Employer Training Pilots suggests strong push pressures and a desire to cover wage costs.28

5.7 The employers’ organisations

We consulted two main employers’ organisations in the sector, the Registered Nursing Homes Association (RNHA), which covers nursing homes, and the National Care Homes Association (NCHA), which represents mainly residential care homes. Both organisations have in membership mainly smaller owners.

The RNHA is supportive of the new emphasis on training in the sector and sees this as an essential for improving care outcomes. It was suggested that nursing homes have a higher skills level than residential homes. There is a need for more pre-entry training for new entrants, but this would need to be state-funded. There is no alternative to the NVQ route, but there is a danger that the focus is on producing the portfolio not on the training. The Topss induction training will improve initial training in many homes, but it is also proving expensive. The targets themselves are probably unachievable, given the 2005 target and the need for the Standards to be met at all times of the day and night and over weekends. Another danger at the present time is loss of staff after training, both within the social care sector and to related sectors. There is a danger that the targets will introduce inflexibility into smaller homes and will lead to closure. There are more advantages for larger owners in terms of a levelling up and greater consistency throughout the country. Closures will accentuate the move towards more domiciliary care, and in the longer term could lead to some reversion to LA provision. All this is to be seen in the context of a funding regime for training which is too complex and insufficient.
The National Care Homes Association (NCHA) believes that training offers real benefits, in terms of greater self-efficacy for staff, better reputation for homes, and better care outcomes for service users. In the past, training was often poor. Training works best where it is workplace-based and mostly on-the-job. This is one of the main advantages of NVQs. On the other hand, NVQ 2 is rather too behavioural and general in nature. Owners therefore get discouraged, especially when they lose staff to the statutory sector and the NHS. Small owners are more likely to suffer in this respect. One way of tackling the poaching problem might be to make it contractual that if trained staff quit, they repay the costs of their training. However, this would be difficult to enforce. Staff should be paid for doing a bigger job, not for just getting the qualification, though it is not always possible to promote them. Homes have been closing, though mainly for funding reasons, and the new training requirements may accelerate this.

The NCHA believes the 50 per cent in the NMSs should be treated as a benchmark. Homes should not be closed for falling below, if they are actively trying to meet the Standards. By 2005, 50 per cent of homes will have got to 50 per cent; the other 50 per cent will be around 35-50 per cent. The NMSs as applied by the NCSC should not be ratcheted-up. As to registration of individual care workers by the GSCC, registration should be based on having a qualification: this could be in two stages – full and student or in training. In time, all staff will come to have NVQ 2.

The NCHA believes that the NMSs were not properly costed by government before their introduction. The Association was one of the organisations which offered us a rough costing exercise. According to them, the minimum costs of an NVQ 2 are about £1,000 (without wage costs) and grossed up over the sector, this could mean around £150 million for the independent sector, in course fees and assessment alone, if the 50 per cent target is to be achieved. Both employers’ organisations stressed shortcomings in funding support - it is insufficient, disjointed, favours younger people, and does not trickle down to small homes in the private sector.

5.8 Conclusions

Those we consulted felt that the new regulatory regime in general and the regulatory framework for training in particular are developments of considerable significance in the history of the
social care sector. More training is needed and is taking place. However, the following were more contested questions: whether targets can be met, whether they can be met without adverse consequences, and what supports might be necessary for an optimal outcome. These questions we consider in the next two chapters.
6. Case studies from the social care sector

The case studies were chosen to represent the relative size of the three main sectors (old people, young adults, and children) and the rough distribution within those of types of ownership (private, LA, and voluntary) by size. Table 2 below shows the case studies and their distribution. In all of these, interviews were carried out with a number of levels of management and employees.

6.1 Old People’s Home (1) Residential Home, South East

Old Peoples Home (1) is a 70 bed residential home in a suburb of a large town. In 2001, it was acquired by a new owner, who has two other homes in different parts of the South East. The registered manager is a nurse who is taking a degree in Care Management and the deputy is a nurse about to commence an NVQ4 in Management. There is a staff of 56 full-time permanent and 10 bank / part-time staff. Of the staff, 35 are care assistants and the others are support staff in administration, catering, and cleaning. With the exception of one full-time and one part-time male, the staff are all female.

Labour

Turnover among the staff was estimated to be around 15 per cent. Wages were said to be slightly above average for the area, though lower than for LA care workers. The home operates a bank of part-timers who can be called in as required. In part as a result, agency staff are not much used. The latter were said to be variable in quality, but on the whole less qualified, more expensive, and less effective.

Awareness of the new framework

The awareness of the Act, Regulations, and NMSs was good in the case of the two managers. For their part, care staff were not particularly aware of content and implications, though management said it had brought the Standards to their attention. A number of staff claimed that the NMSs require all staff to have an NVQ 2 or 3. In terms of training awareness, there was no knowledge among management or staff of the Modern Apprenticeship programme.

NVQ qualifications and training
In terms of qualifications, at the present time 22 per cent of the care workers have an NVQ at level 2 or 3. All of these were acquired before the staff joined the home, and they are all younger staff, having acquired their NVQs soon after school. At present, 10 are in training. Of these, 4 have been put on to level 3 courses and 6 on to level 2 courses. This selection process was made in collaboration with staff from a local FE college. It was stated that team leaders are the key workers and they need level 3. Two of the staff we interviewed who are not on courses at present would also seem to be at level 3 in terms of past experience and accreditation of prior learning.

NVQ training is provided on-site by trainers who come in from the local FE college for 3 hours on one afternoon a week. They also support and assess those in training. (Neither of the managers is trained as an assessor, though they said they would like to do more of the training and assessment themselves). Trainees do ‘homework’ which was said to range from 15 to 60 minutes per day. It was felt, both by management and employees, that FE staff had developed the right balance in terms of the content (- theory and practice) and level (- there had initially been some condescension). Management expects staff to have completed the NVQ 2 in a year, with about 3 hours per week of training and assessment.

Training

Induction training consists of a 1-2 day course for new staff. In the past, training beyond that was rather ad hoc and as needs required (e.g. training on the administration of medicines), but the new Standards have introduced a greater formalisation and extension of training. At induction level, the home has recently introduced a modified version of the Topss induction course. Management thought this to be rather time-consuming and bureaucratic.

The trainees to whom we spoke (4) thought the training was good. Not having to attend college and having training in the workplace was felt to be very important. Interviewees who were not on the course (3) said that they would be interested in starting the programme. The care workers felt the training was demanding, somewhat academic, and time constrained. Getting the portfolio together was a real challenge. Some wondered whether they were ‘a bit too old’.

All those interviewed said they expected that they should be paid more when they completed the training, certainly if this also led to them having to take on more responsibilities and bigger jobs.
They quoted a 10 per cent increase in pay. Staff also felt that the NVQ would give them a transparent and transferable skill. However, none of them said they would automatically look to move once completing the course, but they added that, if pay did not match enhanced skills and bigger jobs, they might do so.

**Costs**

On costs, the whole of the off-the-job training in terms of trainers’ costs are met by funds which the FE has made available. Management therefore costed the training in terms of lost work time, since staff on the course are paid for the hours in training. The cost is in the area of £5 x 2/3 hours per week x 10 staff or about £150 per week over a year. The owner and manager consider this to be high despite the positive advantages which they believe they obtain. As a result, in the future, they may discontinue payment for time spent training. The manager thought that staff would adjust to this and still come forward to do the training, especially younger staff. The deputy manager thought staff would not be prepared to pay for their own training in this way, given low pay and other jobs outside the sector with similar pay levels, but without the ‘hassle’ of NVQ training.

Staff calculated the cost to them in terms of study time and lost leisure time. Even if they had to pay for some of the training e.g. via a lower rate or no pay for the training hours, most said they would enter the programme. However, they suggested that they would then expect a higher return. Management conceded that turnover might increase, but felt that this could be contained by more sophisticated employment policies, with appraisals, selective promotion and pay increments, and the participative management style of the top team.

**Conclusions**

Both management and staff were positive about the effects of training. Management said that the training increased confidence, technical ability, flexibility, reliability, and team working. There was thought to be a real benefit for service users. It was also said to create the possibility of progression. Management think they will ‘just about’ be able to meet the 50 per cent target figure, barring any significant increase in turnover. We would concur in this assessment. However, management also suggested that even if they hit the target, they would continue because they have come to believe that training is a ‘good thing’.
6.2 Old People’s Home (2), Midlands

Old Peoples Home (2) is a single-establishment, residential home for 27 old people, situated on the outskirts of a large Midlands city. The home is owned and managed by a husband and wife team. There are two deputy managers, one of whom is another family member. The manager and one of the deputies are at present taking an NVQ 4 in Care Management and they are also in the process of qualifying as NVQ assessors. The home is under real financial and operational pressure. The last NCSC inspection report refers to a number of areas which require ‘prompt attention’. This includes basic induction and NVQ training.

Labour
There are 5 senior care workers and 15 care workers, 3 of whom are part-time. The care staff are all female. There was said to be a stable core, but the low rates of pay lead to a high quit rate among the others. Turnover is around 30 per cent. In terms of staffing, there is a gap between the number of staff hours required for the size of the home and the hours actually provided. Little or no use is made of agency staff, who were said to be twice as expensive and generally lower quality.

Awareness
Management had a good awareness of, and were generally positive about, the NMSs, including the 2005 training target. However, they were also aware that they did not meet many of the Standards. For their part, staff had limited awareness of the Act. For example, some expressed the view that all staff had to be trained to level 2 by 2005. Following the last inspection report the home has now introduced an induction programme, based on the Topss framework. This typically lasts 2-3 days, spread over several sessions, and has improved awareness among new staff. There was no awareness among management or staff of the Modern Apprenticeship. Investors in People was something beyond the homes capability given cost, time, and managerial constraints.

NVQ qualifications and training
At present, none of the staff have an NVQ. Last summer, the home had initiated a training programme for 6 staff at a local FE college. However, the programme collapsed after a few months – this was said to be due to failings on the part of the college rather than the home or
staff. This collapse was a real set back, in terms of cost and morale. Before the next programme (again with the same FE college) could re-start, 3 of the original 6 staff had left the home. NVQ training is now done on site, by staff from the same FE college, and consists of a 3 hour session once a week over a period of about a year. Management felt that induction training was having a positive effect on knowledge and skills.

Costs, benefits, and obstacles
Staff are paid while undertaking training, whether or not they are actually on shift. The costs of the course is met by FE funding. Training costs were not mentioned as a problem. However, this is in the context of the chequered history above, poor record keeping, and a real felt need to do something about training so as to stay in business.

There has been some partnership between the home and other local homes in sharing some of the costs of the mandatory training. Topss was instrumental in brokering this arrangement. However, management noted that some staff felt intimidated and would be inclined to quit rather than undergo training. Thus, absenteeism rose when training sessions were scheduled. It was stated that staff would not come in especially for training, even when paid. There was therefore a fear that some otherwise good carers will quit. Part of the problem was also said to be a lack of basic skills on the part of some staff. The majority just wanted a simple job, with no extra demands, though some younger staff do see care as a potential career.

For their part, the staff we interviewed said that the new induction training was good, making staff more ‘work-ready’ and more flexible. Those interviewed, stressed that training certainly needed to be done on-site and in paid time which would normally be working time. It was felt that there should be an increase in pay for obtaining qualifications, especially if there are increased responsibilities. On the negative side, staff said that many felt too old for training, though it might be appropriate for younger staff; they do not like written work and feared that overall the NVQ would be too time-constraining; it could cause anxiety and they would quit if training got too ‘stressful’; NVQs were said to be less important than ‘hands-on’ experience.

Conclusions
Management believe they can meet the 2005 target, despite the present low levels, high turnover, and other pressures. Crucial factors will be the nurturing of the core of long-service staff and the
support management might be able to look for from Topss. The home needs better quality staff to meet the NMSs. However, at the present levels of pay, the home will have difficulty attracting and retaining such staff.

6.3 Old People’s Home (3), Midlands
The third case study is a LA residential home, situated on the outskirts of a large Midlands city. The home cares for 18 residents. There are three other homes and 6 resource centres, e.g. day care centres, provided by the local Social Services. The future of the home is in some doubt and this was said to have a dampening effect on morale. There is one registered manager, who has a DMS and is working for NVQ 4 in Care and an assessor’s award. There are 3 team leaders and 19 care workers. Two of the team leaders are male, the rest of the staff are female. Most staff are designated part-time, though in fact they work quite high numbers of hours. Little use is made of agency staff who were thought on the whole to be less skilled.

Labour
Turnover is very low. Pay is better than in other local private and voluntary homes and there are enhancements for unsocial hours, sick pay, and pensions. Overall, therefore, the employment package is better than similar private and voluntary homes in the locality. In the past, the home has attracted staff away from private homes. Management is able to draw on its local Social Services department for back-up with human resource management and training support. The inspection report refers to ‘a dedicated group of staff’, with a ‘very good record regarding staff turnover’.

Awareness
The awareness of the Act was good in the case of the manager and team leader. In the case of care staff, however, awareness was again low – as in the other case studies, there was a mistaken belief that all staff will have to have NVQ 2. There was no knowledge of Modern Apprenticeships. Though their local social services had Investors in People status, this was not seen as having had any effect on practice, certainly relative to the impact of the NMSs.

NVQ qualifications
At present, 25 per cent have NVQ 2, three are presently training for NVQ 2, and one is doing NVQ3. One team leader has the assessor award and intends to do the verifier award. The manager and one other team leader are also doing the assessor award. This was said to be roughly similar in other Midlands LA homes. There is a formal written plan which aims to take 100 per cent of staff to level 2 by 2005. It further states: ‘ultimately it is aimed that we will maintain a continuous training programme, to ensure that a high proportion of staff are always trained’

The training process
In the past, there was less emphasis on training. This has now changed, in large part because of the NMSs and the ‘trickle down’ from the manager and team leaders themselves having received NVQ training.

The home has adopted the Topss induction package, as they were enjoined to do by their local Social Services department. The programme was said by both management and staff to be good – in breadth and depth, encouraging reflection by staff on their role, and requiring more interaction between staff and management. Beyond induction, there is foundation training which is also TOPSS-based and has to be completed within 6 months. This usually involves 1-2 hours per fortnight. The NVQ 2 process starts with a 3 day, off-site block and then about 1-2 hours per week over a year, though it can take up to 2 years. Most of the training for NVQ is done on site by local assessment, with a few days at the LA Training Centre. It is only possible do level 3 if staff are attached to a central pool for some time and can obtain more planning and supervisory experience than is possible in one small home.

Costs
The local Social Services pays for the training courses and assessment and they in turn are in receipt Topss money and TSP grant funds. Staff are paid for time spent training and the home has to reschedule staff as replacement. The cost of this is found from the homes training budget or other money and is a constraint which has to be taken into account. Management thought that staff would not do the NVQ in their own time or contribute to the cost of training. For their part, staff said that only the younger ones would be prepared to contribute to the cost of their own training. In contrast to the two previous homes, staff said they would not expect more money once they had received the NVQ.
The majority of the staff we interviewed were positive about training. On the other hand, there was some feeling among the older staff that they were too old – ‘wrong side of 50’; family commitments were a barrier; and there was fear of any writing involved. However, staff were now said to be less reluctant to train than in the past. In this respect, management felt it was important that the training was not done in college but on-site and that the home had its own NVQ assessor. Staff felt that they understood that the NVQ now involves less paperwork, there is the use of a room on site where they can go, and the presence of an internal assessor means the process is faster than in the past. Staff made the observation that some would like to progress to level 3, but the management seemed to want to put everyone through level 2, perhaps just to meet the targets and this might then be the end of the matter. This raises the prospect that the minimum might become the maximum.

Conclusions
It seems likely that this home will reach and exceed the 50 per cent target by 2005. This is for the following reasons: support from their local Social Services, lack of a strong financial constraint, a stable culture and low turnover, and the presence of internal assessors and a supportive management.

6.4 Old People’s Home (4), Home Counties

The fourth case study is a nursing home situated in the Home Counties. It provides a full range of nursing care for 40 residents, most of whom are medium to high needs. Its fees are high and residents are mainly fully self-funded. The home belongs to the largest independent care provider in the UK, with 250 homes, 17,000 service users, and 20,000 related staff. Most of the homes are for old people in nursing care. At corporate level, there is a central human resource function and a training department which provides support for training activity in the homes. All homes have a training plan and related budget. The organisation has Investors in People status, but there was no real evidence of how this feeds through locally.

At local level, there is a manager and deputy manager, both of whom are qualified nurses. Staffing is as follows: nurses - 7 full-time, 5 part-time, and 3 bank; care assistants - 13 full-time, 10 part-time, and 3 bank. As usual staff are overwhelmingly female. Turnover among assistants
is high, at about 50 per cent, which is twice this organisation’s national average. The home has 2 Modern Apprentices who are now working on level 3. Nationally, this organisation has around 50-100 Modern Apprentices. Agency workers are rarely used, in part because of the cost, but they are said to be well-trained and good quality. For the most part, both management and staff were positive about the NMSs.

**NVQ qualifications and training**

In terms of qualifications, 19 per cent have either NVQ level 2 or 3; in addition, 6 staff are training for level 2 and a further 3 for level 3. Induction training used to be based on the home’s own system, but this has now been replaced with the Topss package. The latter is thought to be good – somewhat broader and prompting more reflection on the job role. It consists of 2-3 days off-the-floor, some shadowing, and hands-on training. Beyond induction, a foundation stage was not in place. For those commencing NVQ, it takes about 9 / 10 months from start to finish to complete levels 2 or 3. Staff said it takes about 60 / 70 hours in total to achieve the NVQ.

The training is provided by a private provider who attends once a month at various homes, operated by the organisation, in the vicinity. In addition, 3 senior members of staff are NVQ assessors. The outsourcing of provision was said by central management to be a way of speeding up the process and maintaining control – ‘the providers have to perform’. There are no partnerships with other homes outside their group in the locality – it is not organisation policy to join such alliances because of dangers of loss of staff and confidentiality issues.

Overall, all staff are said to have 10 / 12 days devoted to training annually. Awareness of the NMS is high among management and staff generally

**Costs and benefits**

Old People’s Home (4) uses its own training budget to pay for replacement hours. Outside provision of NVQ is paid for from a central budget. The latter was estimated by central management to be around £750 per person for NVQ 2 and around £1000 for level 3. Local management did not seem to have a good idea of training costs. Staff do not have to contribute anything themselves, and it was suggested that only a minority of more ambitious, younger staff would be prepared to contribute to the cost of training.
Management felt that the NMSs, including the training targets, are useful and likely to have a small positive effect on outcomes. However, it should be stated that there has been a history of training in the home and in the organisation generally, and it is impossible to assess the extra which is being added by NVQ. The need to complete induction training within 6 weeks has led to operational shortages, because of the time spent off-the-job by both trainees and trainers. Management said that the NVQ process *per se* has not led to any significant change in the attitude of care assistants.

Staff felt that the NVQ training made them more confident and flexible and gave them more recognition within the home. For younger workers, it was said to raise aspirations and offer more prospects of a career. Major barriers were said to be lack of basic skills, age, family commitments, ‘going back to school’, and the intimidating nature of the portfolios which had to be assembled. Nevertheless, though there might be more prospects of a career, there is a ceiling at level 3 unless one goes on to become a nurse. Here as elsewhere, there was little or no awareness of progression to level 4. When questioned, staff said they might be prepared to contribute a small amount to the cost of training, especially at level 3, but this could only be small because the training would not lead to significantly higher pay.

**Conclusions**

Local management is confident that, despite labour turnover, it will meet the 50 per cent NVQ target. The circumstances of the home and the headquarter’s support available would suggest that this is possible. On the whole, staff felt that support for training from senior staff is good. National management feel the NMSs are an important driver. At present they have 1,000 on NVQ training programmes; but there is more demand than they can meet, especially among younger staff.

**6.5 Young Adults (1)**

This home is part of a long-established religious institution and is one of three establishments in the UK. The home cares for the young adults, both on a residential and day-care basis. The home has 60 on-site residents and 200 who live off-site in supported houses. The NCSC inspection report refers to the home being managed on a ‘high values’ basis. Because of its status, the home is able to supplement LA fees from charitable funds.
The management team is constituted as follows – one national director, 5 other directors, a number of assistant directors, and local unit managers who are responsible for independent houses. Director level is graduate entry; assistant directors have NVQ 4 or equivalent or are presently taking NVQ 4; local unit managers also have or are taking level 4. Of the circa 400 care workers (here referred to as ‘support staff’), 80 are on the main site. Three quarters are full-time. There are 6 Modern Apprentices all of whom are under 25. There is probably a higher proportion of male staff than in the old people’s homes we studied. Turnover is approximately 18 per cent at the present time. Exit interviews show that most staff leave for higher pay and better career opportunities. Agency staff are used, but are thought to be less attuned to the ethos of the home and less well-trained.

Awareness of the new framework
The awareness of the Act was high among both management and staff. For the most part, both were positive about the NMSs. In the area of training, the induction programme was seen to have had the greatest impact. It was said to have increased the work readiness and functional ability of staff. New staff are now more aware and better understand their duties and responsibilities. In the past, staff could just ‘walk in off the street’ and induction was very ‘hit and miss’ and not so closely monitored. However, it should be noted that other forces have been pushing for more training, both internal and external forces (e.g. Investors in People was achieved 5 years ago).

Training
In terms of qualifications, at present 20 per cent of the support staff on the main site and a similar proportion of the circa total 400 support staff have an NVQ 2 and a further 15 per cent are working towards level 2. The home has a well-developed training function which was commented on by the NCSC inspection report. In 2001, an NVQ co-ordinator was appointed. There are now 8 qualified assessors, 12 in training, and 10 more staff about to commence. Over 80 per cent of NVQ training is provided in-house and involves a significant amount of learning and assessment on the job. For any off-the-job training, the home is part of a partnership with 5 other local providers, under a scheme facilitated by Topss. This is based on some sharing of facilities and costs. Some use is also made of private trainers, the local FE, and other LA funded bodies. Management thought that these partnerships could be developed further – with assistance from Topss.
Costs
Management had recently costed an NVQ 2 in the range of £2,000 - £3,500, including replacement staff costs. On this basis, it was suggested that to get 50 per cent of staff to level 2 would cost as much as £400,000. The comment was made that, ‘This could buy a lot of other services’. The average time taken to completion of an NVQ2 is 10 to 12 months. According to staff, most of the time spent on training and assessment is in working hours, but some come along voluntarily outside their shifts and in this case are not paid. Induction training consists of approximately 32-42 hours of training spread over the first 6 weeks of employment.

Support for training costs come from a variety of sources e.g. Topss, Workforce Development Fund. In the future management might have to consider more cost sharing with employees. Staff thought they might contribute something to costs e.g. 20 per cent was mentioned by one member of staff.

Management are positive about the effects of the NVQ requirements. They said these had induced them to re-examine other practices, e.g. appraisal and training needs assessment, and had made them better manage their labour force. Management hoped that the possibility of careers would reduce turnover. On the other hand, the new training requirements were not thought to have made a difference in multi-skilling / multi-tasking, since the home already attempted this as much as possible. Above all, on the downside, there is the time spent by management, assessors, and trainees and the related costs. Nevertheless, in net terms, management felt there is a real positive effect of NVQ training.

Staff stressed the importance of the new induction training, with new entrants being able to contribute more quickly and effectively. They also thought the NVQ training was beneficial: it made them more aware of standards; it enabled them to question practices; and it offered the prospects of something more like a career, with progression. There had been some excitement, especially at first; but there was also some resistance on the part of staff - some did not have the basic skills, others thought they were too old, others feared it might be like ‘going back to school’. These fears were more present in the case of older staff. Some trainees found it very time consuming and felt they needed more assessor support. Finally, when asked, staff thought they should be paid extra on gaining the qualification.
Conclusions

Both management and staff do not think the 50 per cent target can be met by 2005. The target is seen as a benchmark, but its attainment is not realistic. The main constraints on achieving the target are the costs of training, turnover of staff, and logistical constraints given the size and distribution of the labour force. It was felt that in practice the NCSC will have to be realistic; it should be possible to show that procedures are being put in place and there is a genuine attempt to comply.

6.6 Children’s Home (1) and Children’s Home (2), Eastern region

For the childcare sector, we present two cases. The reasons for this are as follows: first, we decided that the initial case study might not be typical; second, we found we could make a useful comparison by taking two cases in one locality, one a LA home and one a voluntary sector home, one going down the NVQ route and one not. Both the homes are located on the outskirts of large town. Children’s Home (1) is owned by a charity and has 7 placements for children aged 7 - 12. Children’s home (2) is owned by a LA and has 6 placements for children aged 12-16. The LA Social Services fund both homes.

Labour

Neither home has much turnover - though turnover / ‘burn-out’ in other homes can be 25 per cent plus. In terms of labour supply, both homes look to mature entrants who are usually ‘green’ to the sector. Children’s home (1) says it has some difficulty in recruiting good quality staff, largely because of the high demands on carers. By contrast, the LA home (2) said it has no difficulty in attracting job applicants and can usually select from a range of good quality candidates. Neither home uses agency staff, because this would be contrary to the idea of the home as a community. At Children’s Home (1) and (2) both sets of staff have a better package than staff in old people’s or young adults’ homes. Both homes employ more male workers than in old people’s homes. Human resource management is supported in both cases from headquarters, including in each organisation a training manager.

Children’s Home (1) forms part of a charity which has 5 residential centres throughout the UK. It is committed to a therapeutic approach. At local level, there is a director (who has a DipSW
and an MA in Childcare), a deputy director (MA in Childcare), and a senior team manager (DipSW and an Advanced Diploma in Social Care). Under them there are 10 care staff, of whom, 8 are full-time and 2 part-time. The LA Children’s Home (2) has 6 homes throughout the county. This particular home has one manager, one assistant home manager, and one senior team manager. All of these have a DipSW. Under them are 11 care staff and 4 bank workers. The staff-child ratio in both homes is around 2:1.

Training and qualifications

Children’s Home (1) has chosen not to go down the NVQ route. It has a tradition of organising its own training, based on a psychoanalytic model and resulting in a Diploma. Training begins with an induction programme over a period of 6 months; this has been reorganised and formalised with the NMSs in mind. In this respect, the NMSs have had some effect. Beyond that, all new entrants are now put on the Diploma which takes around 2 years to complete. This is delivered on-site, largely by informal methods. On average, staff spend 36 days a year training. The headquarters’ training manager visits the home once a month for these sessions.

In Children’s Home (1)’s estimation, the NVQ would be a backward step in terms of training and care outcomes, though it might be a fall-back for less able staff. Some other homes which favour a therapeutic approach are also taking this position. It therefore hopes to show that their training / qualification is equivalent. If they cannot demonstrate this, then reluctantly they would have to disband their own training and accept NVQ. To date, there has been no deadweight effect and no acceptance of government funds, but, if they had to adopt the NVQ, there would be both a deadweight and a displacement effect.29 The desire to be recognised as equivalent has made management reflect more on what they do and how they should evidence equivalence. Assuming the equivalence of their Diploma, the percentage at the moment reaching the NMS target would be 55 per cent who have obtained their Diploma or who are on the course.

The LA Home (2) has adopted the NVQ route. The home had induction training prior to the Act and this has now been updated. Management cross-referenced the Topss package, but do not actually use it. Beyond induction, there was always training and the possibility of full secondment to do a DipSW, though Social Services has now suspended full secondment. All new members of staff in Home (2) without a social work qualification are now expected to commence NVQ training. This usually takes approximately 14 months from start to finish of an
NVQ 3, with one period a month off-site training (viz. 14 x 8 hours or a total of 114 hours). The training providers are a mixture of in-house staff, LA, and another LA Social Services consortium which sends an assessor to visit the tutees every six weeks. In terms of the NMS target, at the present time, 80 per cent of the staff have an NVQ 3.

Neither home has any experience of Modern Apprenticeship. The children’s home sector does have some examples of Modern Apprenticeship, but there are real constraints in terms of age in that no one can work in a children’s home who is not at least 4 years older than the oldest resident. Neither home placed any emphasis on Investors in People.

Cost and benefits

In both homes, local management had little knowledge of the cost of training and cost does not seem to have been a constraint on them. At Home (1), local management said training costs were met via money from the LA and from a central budget. They prefer on-site training, because this was said to be less disruptive and more can be covered at less cost. Reflecting on the earlier DipSW, Home (1) central management felt that it was expensive, had created a demand for agency staff, and had been used as a ‘ticket out’ of working in homes. As to the present training, staff do not contribute to the cost and were unlikely to do so.

Home (2) management commented that staff would not pay for their own NVQ training, though those in the past who have done a DipSW have had to pay £2,000 towards the cost. Local management at Home (2) made the following positive points about the new NVQ requirements. Staff have a better understanding of child psychology and of their own role. They are more reflective and prepared to question. The qualification provides recognition and the possibility of career progression. However, on the other hand, there has been no effect on absenteeism or turnover. Disquiet was also expressed that the LA may now be concentrating on NVQ 3 and 4 and that LA funding and secondment for the DipSW has ceased. This may put a cap on the career possibilities of some carers who will not be able to proceed to management. This may block progression for those who take the NVQ route. As a result, the NVQ may become a maximum for many care staff.

For their part, staff at Home (2) expressed the following views. After an initial anxiety, those who have done the NVQ have benefited. It has raised levels of skill and confidence and given
carers more recognition as professionals. Some may wish to go beyond level 3, so long as it does not become ‘too academic’. On the other hand, some negative views were expressed. Some of the content was said to be ‘obvious’ and the process was too complicated. The biggest obstacle was said to be time. Some staff felt they were too old to go ‘back to school’, and, if forced, this would lead to resignations.

**Conclusions**

Both homes believe they will reach and exceed the targets. However, in the case of Children’s Home (1), this will be dependent on recognition of equivalence.

**6.7 Summary**

Some summary data are to be found in Table 2. The analysis derived from the case studies is incorporated into the following chapter.

**Table 2. Summary of case studies**

<table>
<thead>
<tr>
<th>Name</th>
<th>Sector</th>
<th>Size</th>
<th>Ownership</th>
<th>No. of staff</th>
<th>Turnover %</th>
<th>Pay range</th>
<th>% NVQ at Present</th>
<th>% NVQ In-training</th>
<th>Likelihood of achieving target</th>
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</thead>
<tbody>
<tr>
<td>OPH (1)</td>
<td>Old People</td>
<td>Medium</td>
<td>Private</td>
<td>35</td>
<td>10 to 15</td>
<td>£4.94 - £6</td>
<td>22</td>
<td>28</td>
<td>Good</td>
</tr>
<tr>
<td>OPH (2)</td>
<td>Old People</td>
<td>Small</td>
<td>Private</td>
<td>23</td>
<td>30</td>
<td>£4.20 - £5.50</td>
<td>0</td>
<td>22</td>
<td>Poor</td>
</tr>
<tr>
<td>OPH (3)</td>
<td>Old People</td>
<td>Small</td>
<td>LA</td>
<td>24</td>
<td>0</td>
<td>£5.52</td>
<td>25</td>
<td>17</td>
<td>Good</td>
</tr>
<tr>
<td>OPH (4)</td>
<td>Nursing Home</td>
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<td>Private</td>
<td>26</td>
<td>50</td>
<td>£5.15 - £6</td>
<td>19</td>
<td>27</td>
<td>Good</td>
</tr>
<tr>
<td>YAH (1)</td>
<td>Adult Learning</td>
<td>Large</td>
<td>Voluntary</td>
<td>80 mainsite</td>
<td>18</td>
<td>£5 - £5.75</td>
<td>20</td>
<td>15</td>
<td>Medium</td>
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<tr>
<td>CH (1)</td>
<td>Children</td>
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<td>Voluntary</td>
<td>15</td>
<td>7</td>
<td>£5.44 - £6.19</td>
<td>None</td>
<td>None</td>
<td>Seeking equivalence from NCSC</td>
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<tr>
<td>CH (2)</td>
<td>Children</td>
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<td>LA</td>
<td>18</td>
<td>0</td>
<td>£7.42 - £8.29</td>
<td>80</td>
<td>11</td>
<td>Good</td>
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7. Is the statutory framework influencing WfD?

This section uses the materials presented above and other data to draw general conclusions as to the effect of the statutory framework.

7.1 Is the new regulatory framework changing employers’ attitudes and behaviour regarding training and skills?

From our interviews, it would seem that some employers might be putting off the day when they have seriously to engage with training. Others may be playing a game of ‘wait and see’ and holding off till nearer 2005. Their hope then would be that they would be able to poach from others who have trained. Some employers point to the fact that environmental standards have already been reduced and are hoping that the Commission will interpret training requirements sufficiently flexibly for them to be deemed to have met the NMSs even though not having attained the specified targets. This dilemma was referred to by several employers and their representatives.

However, our interviews and the case studies suggest that many employers are engaging in training in a new way. This can be discerned at a number of levels.

First, there are direct and specific effects. Employers are concerned about the training requirements and are taking seriously the new obligations which are placed on them as managers. Firms are undoubtedly introducing Topss induction standard based training. They would appear to be providing trainees with days off for training as specified in the different Standards. They are also making significant efforts to obtain the requisite ratios of staff with NVQ 2 and 3. Here, though, there is an element of ‘jumping through hoops’ in order to meet targets. This might be described as the target-driven effect.

Second, it might be argued that there are more general and indirect changes which are being brought about by the NMSs. These are changes which are being brought about in the management of homes in general and in human resource management in particular. Under the Standards, homes have to think through a whole set of decisions, including a statement of purpose, outlining aims and care philosophy, their business and financial plan, and their own
competence to run a home. They then have to think through and put into place a set of human resource management practices, including staffing plans, recruitment policies, supervision and appraisal, the development of training plans, and the implementation of such plans. In other words, the NMSs are encouraging firms to think not just about meeting targets, but also to think more strategically about training as part of broader management. This might be described as the agenda- or process-driven effect.

Third, the requirements are encouraging homes to engage with various bodies and initiatives which expose them to outside influences. Some of this is exposure to governmental bodies and initiatives e.g. the NCSC, the GSCC, Topss, Employer Training Pilots; some of it relates to non-governmental bodies e.g. their employers’ associations, training providers, and local networks of other firms.

Thus, on the basis of our evidence, we would conclude that the new regime is having an impact on training and skills development in the sector. The consultations suggest that the impact is both direct and indirect and probably greater than that found in an earlier DfES study on regulation and Codes and Practice.30

Table 1. Total number of level 2 registrations and certificates for care sector NVQs from December 1999 to December 2002, UK

<table>
<thead>
<tr>
<th>Time</th>
<th>Registrations</th>
<th>Full awards</th>
<th>Time</th>
<th>Cumulative registrations</th>
<th>Cumulative awards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2000</td>
<td>8786</td>
<td>4105</td>
<td>Dec 99</td>
<td>51968</td>
<td>11759</td>
</tr>
<tr>
<td>Q2 2000</td>
<td>7410</td>
<td>3757</td>
<td>Mar 00</td>
<td>60754</td>
<td>15864</td>
</tr>
<tr>
<td>Q3 2000</td>
<td>10286</td>
<td>5541</td>
<td>June 00</td>
<td>68164</td>
<td>19621</td>
</tr>
<tr>
<td>Q4 2000</td>
<td>10816</td>
<td>4707</td>
<td>Sept 00</td>
<td>78450</td>
<td>25162</td>
</tr>
<tr>
<td>Q1 2001</td>
<td>10130</td>
<td>5153</td>
<td>Dec 00</td>
<td>89266</td>
<td>29869</td>
</tr>
<tr>
<td>Q2 2001</td>
<td>10190</td>
<td>4448</td>
<td>Mar 01</td>
<td>99396</td>
<td>35022</td>
</tr>
<tr>
<td>Q3 2001</td>
<td>9544</td>
<td>5428</td>
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<td>39470</td>
</tr>
<tr>
<td>Q4 2001</td>
<td>13866</td>
<td>4661</td>
<td>Sept 01</td>
<td>119130</td>
<td>44898</td>
</tr>
<tr>
<td>Q1 2002</td>
<td>12272</td>
<td>4758</td>
<td>Dec 01</td>
<td>132996</td>
<td>49559</td>
</tr>
<tr>
<td>Q2 2002</td>
<td>12302</td>
<td>5523</td>
<td>Mar 02</td>
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<tr>
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<td>10727</td>
<td>7114</td>
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<td>157570</td>
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</tr>
<tr>
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<td>15575</td>
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<td>Sept 02</td>
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<td></td>
<td></td>
<td>Dec 02</td>
<td>183872</td>
<td>73020</td>
</tr>
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</table>

Unfortunately, as yet, it is difficult to document this in any detail from statistical data. As has already been suggested, there are deficiencies in both public and private statistics. It is also of course still early days to discern an effect on trends, given that the NMSs have only recently been introduced and that official and other statistics lag a year. Data on NVQ starts and awards is presented in Table 1. This suggests a recent upturn in new registrations, despite some fluctuations and despite overall low numbers. More detailed NCSC data on the percentage of homes with levels of qualifications is awaited.

7.2 Have the NMSs impacted differentially on different types of employer?

In the eldercare sector, there is some evidence that the NMSs may have had a larger effect on residential homes compared to nursing homes. This may be because nursing homes have historically tended to have more of a training culture, in part perhaps because of the presence of nurses and because nursing homes are on the whole larger. In terms of ownership type, LA homes have been able to take advantage of their central capability and in-house assessors. At the prompting of the NMSs, they may have moved faster down the training route. However, it should be remembered that LA homes are a declining part of the sector. We do not have a strong feel for voluntary sector homes, but a casual examination of inspection reports suggest that some of the larger of these have been able to use central resources and extra funds to move more quickly towards a greater engagement with training.

In the private, ‘for profit’ sector, there is a spread. Some private employers have always been very good trainers and were early users of NVQs. These have tended to be bigger, multi-home companies. By contrast, some small homes are clearly struggling, and the training NMSs are compounding pressures on them. However, as will be referred to below, some small homes have been able to develop their training, in particular through working in groups and consortia with other homes. Size is therefore important, but (1) it is not just the size of the individual unit, but also the size of the owning organisation (e.g. Old People’s Home 1 and Old People’s Home 3) and (2) the size constraint can in part be lifted via collaborative working.

A view was expressed that where there is more self-funding and higher fees, there is more training, because service users demand it. However, we were not able to verify this. Moreover, if indeed training in LA homes has advanced, this would suggest that fee levels alone are not the
only factor driving training, since LA homes tend not to charge higher fees. When the NCSC database becomes available it should be possible to investigate this further.

It is difficult with the data available to draw any conclusions about the younger adult sector. From our case study, it would appear that larger organisations are engaging actively with training. This was certainly the case with our case study.

In the childcare sector, due to training targets and initiatives which were in operation prior to the NMSs, training levels were probably higher from the start. In LA and voluntary homes, the NMSs would seem to be having an effect on the level of training. However, as the Children’s Home 1 case study suggests and as will be discussed below, there is more incentive to poach.

It is difficult to say whether there are any regional differences. There are clearly skills shortages and skills gaps in London and the South East. Here there is therefore more of an incentive to train. On the other hand, there may be funding constraints where LSC budgets cannot meet local demand and there may be more opportunity for poaching.

There is the interesting question of the effect on staffing agencies which operate in the sector. As stated, agency work can be as high as 10 per cent in some parts of the country in the eldercare sector and it is likely to grow in the future. There was some disagreement as to whether agency staff are more or less well trained. On the one hand, there is some anecdotal evidence that more qualified care workers and social workers tend to move into agency work. A further argument might be that both agencies and their staff have a big incentive (- agencies in order to sell their services and staff in order to obtain work in agencies) to train and be trained to NVQ 2 level and above. On the other hand, many in the sector doubted this and contended that agencies are likely to poach staff from others who have trained. In addition, in the case of agency workers, there is also a problem of receiving NVQ training at work in that employers are unlikely to train and assess those who do not have a permanent contract with them. Topss is working with a group of agencies on training in this part of the sector.

7.3 What effect are the requirements having on training for different types of skills and at different levels?
Our case studies and other evidence suggest that the NMSs are having an effect on the training of managers. The new regime is driving the take-up of NVQ 4 in Care and even more so of NVQ 4 in Management. Of course, this is essential for homes to operate and for managers to continue as managers. However, it is also arguably an important prerequisite for the training of others. In addition, it should be added that a number of managers and team leaders are being trained as NVQ assessors.

At the other end of the skills spectrum, there is a real and long-standing problem with basic skills in the sector, especially in old people’s homes. The new emphasis on training has drawn further attention to deficiencies in basic skills. Some local managements were very aware and good at working around this e.g. in one instance by the use of a tape recorder. Topss England is making efforts to integrate basic skills training into induction and foundation stages as a basis for progress to NVQ2.

The NMSs and the work of Topss would seem to be having an effect on induction training. In the past, this was often ad hoc and training lasted for little more than a day. It often included a cursory introduction to the home and mandatory topics such as fire precautions and basic health and safety. It is now carried out over 6 weeks, is more formal, and provides a fuller appreciation of care work. Most people to whom we spoke were positive about the new induction training. The only criticism was that there was a danger that it could be presented in such a way as to suggest that work in the sector was too demanding for the pay and one might as well go off and ‘work for TESCO’.

We saw little evidence of the formal use of ‘foundation’ training which is supposed to take place over the next 6 months of employment. Our feeling was that this does not seem to have developed as a formal stage or practice.

The major desired effect on training is at NVQ level 2 in homes for old people and younger adults and NVQ 3 in children’s homes. Some (familiar) criticisms were expressed of the NVQ – that it is assessment rather than training, that it offers little understanding of underlying principles, that constructing the portfolio is bureaucratic and cumbersome, and that assessment can vary within and between institutions. On the other hand, most interviewees felt that NVQ
training and assessment are better than what had gone before which in many cases was very little.

Both interviewees and the researchers found it difficult to distinguish between technical and general training. But, when it was suggested that the former might cover such topics as lifting, bathing, medication, dealing with people with various disabilities and problems, and child development, and the latter related more to such matters as communications, report writing, and team working, most interviewees put the split at about 60 v. 40 per cent. This is in keeping with an earlier DfES report which found that regulations are more likely than voluntary codes to impact on technical skills.31

The training on which we have focussed is mainly training leading to qualifications, at NVQ levels 2 and 3. We have also commented on other training in the case of induction training. In addition, there is also training which is statutorily required e.g. fire, health and safety, food hygiene, which was frequently commented on by interviewees. There is also training as mandated under the NMSs for all staff whether or not they are doing NVQ, viz. 3 paid days per year for staff in homes for old people, 5 in homes for young adults, and 6 in children’s homes. We were not able to ascertain how extensive this was: in some case studies, it was clearly being done; in others it was not yet in place.

7.4 How are changes being effected?

Training is being provided by a mixture of private providers and FE colleges, split roughly on a 60 per cent private, 40 per cent FE basis. These bodies are also often providing assessment and verification. There were cases where assessment was being provided internally and this seemed to work well. In total, it was suggested that there might be around 1,000 training providers in the social care sector. However, in the time available, we were not able to interview any training providers. From secondary reports and evidence we can say that some were clearly good. Others were less good, delivering ‘off-the-shelf’ packages, lacking in flexibility, failing to consider prior knowledge, and with little feel for the workplace. In one of our case studies, a provider disintegrated half-way through the course, and this clearly had a deleterious effect on the employer and employees.
Most training and assessment seems to have been provided on-site, either by local staff or with outside trainers visiting. This was valued by staff, and there was a desire not to have to ‘go back to school’. Rather more training than might have been expected was provided off-the-job. It would seem that best practice, as it is developing, is for training to be on-site, with a good proportion off-the-job, with off-site training being for underpinning knowledge. In practice, therefore much of the training is informal in nature. Though there is talk of distance learning and e-learning, we encountered none in our case studies. Moreover, this might be rather difficult with some employees in this sector who lack the basic facilities and skills to benefit from such arrangements.

There are a number of employer groups or consortia, some of which cover similar employers in the social care sector and some of which also extend to NHS, Primary Care Trusts etc. In our case studies, we came across three – in Liverpool, Birmingham, and Norwich. Others which were cited to us are to be found in Northamptonshire, Shropshire, Cambridgeshire, Herefordshire, Sussex, Somerset, Humberside, South London, Greater Manchester, Bolton, and Brighton. These have been brokered by various organisations. Topss England has played a very significant role in creating such groups, partnerships, and regional forums, in part by channelling money through them. Other such activity has been led by the LSC, Social Services, and independent employers’ organisations. Some aspects of this would seem to be rather ad hoc, but funding through LAs, TOPPS, and the LSC are clearly playing an important role in extending coverage.

There are a number of Centres of Vocational Excellence (COVEs) in this area, some created by LSCs, others put together by local bodies. The LSC has identified care and health as priority areas for the COVE programme and more are expected to come on stream in future rounds. By contrast, we came across little evidence of ‘lead employer’ situations, where a large employer coordinates or sells its services to other homes. The nearest to this was in the children’s homes sector. More important is LA leadership where the LA Social Services can play a significant role as the purchaser of services. Significantly, increasing numbers of DoH grants are paid through LAs to private and voluntary organisations, and this is making some LAs de facto lead employer.

Two of our case studies had Modern Apprentices (Young Adults and Old People’s Home (4)).
However, it should be noted that these were two which had real corporate capability and an ability to research and institute such training. It might be thought that more use would be made of Modern Apprenticeship, in particular since, as one of the employer representatives commented, the training is ‘free’. However, overall there is little knowledge of Modern Apprenticeship in the sector. In part, this might be because of age issues. Service users are said to be unhappy with young people undertaking personal care. Moreover, the NMSs state that, in old people’s and younger adults’ homes, under 18s should not undertake certain kinds of care; in children’s homes staff have to be at least 18 years old and 4 years older than the oldest child in the home; and from January 2004 all care staff have to be at least 18 years old. In practice, an NVQ could be taken without the personal care element, but this might not be acceptable to employers. Also, in practice, there is space to do a MA, with funding support up to 25, and, without support, from above 25 – though this would be a less acceptable option for an employer. There is clearly a case for publicity to attract employers and younger people into Modern Apprenticeship. There may also be a case for raising the 25-year upper support limit on funding, in a sector where the bulk of the labour force is above that age.

We did not talk to any of the Modern Apprentices, but, in the two cases, their employers seemed positive about the programmes. Those who have researched in this area are generally supportive of Modern Apprenticeship in the sector. However, along with aforementioned sector-specific problems, they point to the often-cited problems with key skills and their testing. There is also some suggestion that employers do not favour technical certificates.

We did not find accreditation of prior learning to be as extensive as might have been expected. Most training providers prefer to start an NVQ from the beginning, regardless of previous training. However, as the case studies suggest, in a number of instances some staff were put straight on to level 3. In the childcare sector, there is more debate about accreditation and equivalence, to which we will return later.

On the basis of our case studies, there would seem to be little impact of Investors in People in the sector, though at least two of the case studies had achieved it at organisational level.

7.5 Costs of training
We have already referred above to the complexity of multiple funding streams or what was described by one interviewee as ‘cocktail’ funding.

It proved difficult to ascertain the cost of training and who paid. However, we make the following observations.

1. In most of our cases and most of the cases of which we heard, the employer is paying for the time spent in training or being assessed, though, in one case, the employer was said to be considering shifting this cost to the trainees. The number of hours / days taken to obtain an NVQ varied considerably between settings, between homes, and between individuals, though 1 year was about average for completion of an NVQ 2.

2. In some cases, the courses were paid for by the employer, but in others there was some sort of subsidy or they were receiving such courses ‘free of charge’ from local FEs or other providers. In these instances the homes seemed to have no idea from whence financial support ultimately came.

3. In all cases, the employer had some extra costs where trained staff took time to train others and where the employer provided the assessment.

4. Some organisations costed in an increment, though an automatic award would seem rare and an increase was only forthcoming if it resulted in a bigger job. Some staff expected to be paid for completion of an NVQ, but this was not common and the anticipated amounts were small.

In summary, we would estimate the total replacement wage cost for an NVQ 2 would be between £750 and £1,000 per person. The cost of the course might range from about £500 to £1,000. With other miscellaneous costs, the commentators put the total cost of an NVQ 2 at between £2,000 and £3,500, with the cost of an NVQ 3 being as much again.

Some of the case studies and organisations to which we talked were then able to do rough calculations on this basis for their home, company, membership, or LSC area. These calculations (basically multiplying e.g. £2500 by numbers employed) produced high total figures. One manager commented that the total would ‘buy an awful lot of care’. In respect to the wage of trainees, it is interesting that approximately 45 per cent of all Employer Training Pilot starts are from the social care sector.
We were not able to ascertain whether any of these costs had been passed onto service users in terms of charges or in terms of changes to services. However, we do revert below to the general question of costs and benefits and possible effects on the viability of homes.

7.6 Are the employers likely to hit the targets imposed by the NMSs?

On the basis of our case studies, interviews with various parties, and an examination of inspection reports, we would make the following points. We came across no managers who are not engaging in training for themselves and, indeed, to remain in operation, this is essential. On the basis of our case studies, we would conclude that the targets for managers are likely to be reached.

In the case of care staff, in old people’s homes, there is a problem. We collected 24 NCSC inspection reports, at random from throughout the country and from different types of homes. Of these only 2 had 50 per cent or more of their staff trained to level 2 when they were last inspected viz. on average the middle of 2002. Only one home (part of a large voluntary sector organisation) had a high score viz 75 per cent. On the other hand, 6 scored zero and a further 9 had less than 20 per cent. It is mainly smaller single-establishment homes which are towards the lower end. However, it should be noted that Old People’s Home (4) (part of a very large group) has only 20 per cent, and we were told that for the whole of this organisation the average is 30 per cent. Homes with zero clearly have a massive job to hit the 50 per cent target. For homes, over 20 per cent and with a training and assessment programme in place, which most of them now seem to have, it is likely that they will hit the target, barring more intense poaching and higher turnover.

In homes for younger adults, there are probably fewer at zero, though our impression is that there is a sizable number at or below 25 per cent. However, given the nature of the voluntary and LA homes in the sector and the supports which many of these have, we would estimate that more will reach the 50 per cent target. In the childcare sector, the target is of course 80 per cent and the lead-time to reach level 3 is longer. We know of one home which has already reached that target and others which we would guess are highly likely to meet the target by 2005. Turnover could be a problem. For some homes, such as Children’s Home (1), it is obviously essential that alternative training is recognised by the NCSC. In both young adults’ and children’s homes
accreditation of prior learning would be an important supporting factor.

7.7 Difficulties and barriers encountered in meeting statutory requirements?

A real difficulty in the case of many employers is finance, especially for those smaller homes who have no reserves set aside for training and who have difficulty accessing the complex income streams. They complain in particular about the replacement staff costs and the rescheduling of work. According to some, a more important difficulty will be completing the training in time: as one manager said, ‘it has just come on us so quickly, along with all the other requirements’. At the back of the mind of some homeowners are fears of poaching, especially when it gets nearer to the 2005 target date. It was suggested to us that some owners will make a token effort, but either hope that the Standards will be changed or that they will be applied generously.

In the case of employees, the main barriers seem to be a mixture of time and other commitments and fear of ‘returning to school’. Older staff commented particularly on the construction of the portfolio. Staff of all ages may be constrained by deficiencies in basic skills. Shift systems can also be a constraint. It is interesting that few said to us that they could be part of the 50 per cent in homes which is not required to have level 2. This reflects a basic misunderstanding with many staff that everyone has to have level 2. Some, under this misapprehension, suggested that they would just work their time and then leave or retire. On the other hand, these comments should be put in the context of staff who were extremely enthusiastic about the NVQ process and who intended to embark on further training.

We have commented on some difficulties with training providers, but this may be a declining constraint. An equally important constraint is the absence of internal assessment capability. Homes which had this could clearly move more quickly and efficiently towards completion of the NVQ process.

Supports are mainly the obverse side of some of these problems. Hence having access to extra funds, the provisions of on-site training, and on-site assessors are important facilitators. For staff also having managers who are themselves trained and who are familiar with the NVQ approach is clearly also important. Finally, again, we stress the support which is being provided by Topss
which was widely commented upon, the support for some homes from LA leadership, and the support which comes from working collectively with other employers in consortia.

7.8 Are there any other positive impacts?

In terms of recruitment, it is difficult to form any firm conclusions. It was suggested to us by some interviewees that staff might be put off and look for comparable jobs in the NHS where there is no training requirement for comparable jobs or look for employment elsewhere outside the sector. Thus, some said that potential recruits might think of a less complicated job in retailing; in one of the children’s homes a new staff member who had come from the merchant navy expressed some unease about what he had got himself into and the amount of training involved. On the other hand, the prospect of higher status, progression, and something more like a career was said to be likely to attract some, especially younger, staff. In terms of retention, we have already rehearsed some of the arguments, especially that older staff and those deficient in basic skills might be forced out of the industry, but that others might be more likely to stay as they come to appreciate and understand the work, feel more valued, and see more prospects for progression.

Arguments similar to the above and supported by our case study can be put about staff morale. On interviewing staff, we felt that those who had done an NVQ or were in the process of doing one felt more positive about their job and working in the sector. Some staff, in particular younger ones, were very enthusiastic. Of those who had not and did not intend to begin an NVQ, there was some feeling of exclusion and a greater likelihood that they might leave the sector or retire. Firm conclusions on morale would clearly require further research.

In all the homes, one effect was said to be that training related to the NVQ gave staff greater confidence and helped them question practices which might be undesirable and taken-for-granted aspects of the regimes in their workplaces.

In terms of multi-tasking and multi-skilling, there would seem to-date to be limited effect. In part there are legal obstacles e.g. aspects of medication and some interventions can only be done by nurses. However, in future, there may be more need for both multi-tasking and multi-skilling. So, for example, as domiciliary care expands, the visiting care assistant will need to
carry out more tasks. Primary Care Groups will also require more team working. There is a possibility that if nurses are up-skilled to take on some work previously performed by doctors, this may leave areas where better-trained care assistants can enter. It was pointed out to us that a lot of agency nurses and district nurses who come into old people’s homes have little geriatric experience and that it might be better to up-skill care staff further rather than rely on such nurses. These factors could lead to flatter structures and more flexible working in the future.

We saw a real desire for progression among some staff and a belief that training will create more of a career for care workers, leading to level 3 qualifications and beyond. Again, we add though that there are legal checks on what care staff are allowed to do (e.g. nursing interventions) and also organisational checks on what they can do (e.g. the small size of homes means that team leader, senior carer, and deputy jobs are limited). In children’s’ home, there may be a continuing ceiling and divide, between those who have the DipSW and its successor and those who go through the NVQ route.

7.9 What are any other negative impacts?

Some negative effects have already been mentioned. These include the possibility that potential entrants may switch elsewhere, some staff may be intimidated and quit, and poaching may increase, especially closer to 2005. On the other hand, counter-suggestions have been put. Over time poaching pressures may reduce as more staff are trained.

One further possible danger is that the new minimum may become a maximum. Employers may make no further effort to train beyond the required target level and give little encouragement to those who might have gone on to further training. This was suggested by some staff and seen as a dilemma by some employers and their representatives. One way to deal with this possibility might of course be to ratchet up the NMSs over time and change them so that in homes for old people and young adults a certain proportion are required to have level 3 qualifications.

This leads on to the question as to whether there is any sort of displacement effect. There is some suggestion of outward-displacement out of the sector, with some talk of staff leaving for other parts of the NHS or other jobs. We found no evidence of any inward-displacement into the sector, in the sense that more qualified staff are being sucked in from other parts of the NHS or
other caring services.

In one part of the sector, there is the possibility that a different kind of displacement may be taking place. In children’s homes, the argument was put to us by various commentators and was highlighted in the Children’s Home (1) case that there are alternative and perhaps better ways of training in the sector. Reference was made to the DipSW. This has taken two years to completion, involved an outside placement, and required outside assessment. It was suggested that this is better than on-the-job training in one’s own workplace to NVQ 3 standards. On the other hand, it should be added that the DipSW was only undertaken by a small number of staff, who were usually heading for management positions or who were looking for a way out of front-line care. Moreover, in some areas, such as London and the South East, the uptake was patchy and placements were variable. By contrast, the new system will cover 80 per cent of staff by 2005 and in time 100 per cent of staff. Moreover, staff can and may be motivated to proceed to the new degree which will replace the DipSW in 2003. The cost of doing an NVQ 3 is lower than the DipSW or the new social work degree will be.

Two final points may be noted. First, there is a need to establish equivalents in the childcare sector and to give recognition to acceptable alternatives. The NCSC is working on this. Second, there is a need to ensure that the successor to DipSW is a success and provides progression for some from NVQ 3. The DoH are investing in this.

7.10 Are the regulations accelerating or reinforcing ongoing trends in training provision and skills acquisition? Are they leading to expenditures to accredit already existing skills? 

From our evidence, it would not appear that money is not being spent by government to support training which would have been carried out anyway. In the absence of the NMSs, there would of course have been training. In particular, this would have occurred in children’s homes and homes for younger adults. It would also have been done in old people’s homes, especially by larger employers as the market environment has become more competitive and so as to attract service users and secure LA contracts. However, the Regulations would seem to have accelerated the amount of training and any deadweight effect is probably small.

There is the question as to whether the training is new skilling or the accreditation / confirmation
of existing skills. Of course, this is a key question with NVQs. We have already said that we found little accreditation of prior learning, in the sense of accrediting existing formal qualifications. Beyond that, it is difficult to ascertain within a particular NVQ process the relative extent of new training and assessment of skills which employees had previously acquired informally on the job. In some instances, there was clearly formal and informal training going on; in others, when we examined portfolios, there seemed to be a lot of formal recording of skills already acquired.

7.11 Has there been and will there be an effect on service provision?

We were not able to talk to service users. Therefore, we can rely solely on the assessment of managers, staff, and others. Most of our interviewees said that going through the new induction training and the NVQ process had an effect on outcomes. It more thoroughly imparted technical knowledge, awareness of service user needs, self-confidence, and the ability to reflect on the job. Only a few said such things as ‘carers are born and not made’ and that ‘caring comes from the heart and can’t be taught’.

In the future, it should be possible to use the NCSC database to explore the effect of training levels on outcomes. It would also be possible to conduct studies of training and outcomes using both self-efficacy scores and service user assessment. Studies to date within the sector, suggest that there is a positive relationship between levels of training and outcomes as adjudged by service users. There is clearly work here for the SCIE.

One of the ultimate deleterious effects on service users would be if the cost of training led to a reduction of supply. This might happen in various ways. It might lead to exits from the industry, and care home representatives referred to this as a real possibility. However, any such effect would be the accumulated consequences of an increasing number of pressures – restraint on fees, wage increases, other regulations, other requirements in the NMSs, and other opportunities which home owners might see to use their assets. A reduction of supply might also be caused by reducing new entry into the industry. Potential new entrants might be deterred by the perceived inability or cost of attracting and training staff. Of course, a reduction of supply could mean that service users and government might have to pay more for care. On the other hand, if only better providers survive and the government policy is to encourage domiciliary
care, a new higher-level equilibrium might be established in the market.
8. Conclusions and implications

In this section, broad conclusions are drawn, some possibilities for further research are outlined, and implications for other sectors are considered.

8.1 The statutory framework and its effects on WfD

This study provides information through which to gain an understanding of the extent to which the Care Standards Act 2002, the related Regulations, and the NMSs are currently being used to tackle skill deficiencies via WfD in the social care sector. However, it must be borne in mind that it is still early days, for the new framework and broader statistical evidence is not yet available.

The main conclusions of the study may be summarised as follows.

- There have long been skills problems and market failures in this sector. Given this and some of the characteristics of the sector (a large number of small firms, high labour turnover, administered pricing by government), it is can be argued that the sector was well suited to interventions of this kind.
- The new regulatory framework is changing employers’ attitudes and behaviour regarding training and skills. The targets themselves are having a direct effect; but there is also an indirect effect on management processes and agendas. In addition, the requirements are encouraging employers to engage with outside bodies, such as groupings of employers in their localities.
- There is some evidence that the NMSs are impacting differentially on different types of employer. In the eldercare sector, homes owned by large private operators and LAs are best placed to meet the new challenges. Smaller residential homes are less well placed, but there is evidence that working together can be a considerable help. In the young adult and childcare sectors, the NMSs would seem to be having an effect on levels of training, though in the latter sector there is some scepticism as to the NVQ route.
- The requirements are having effects on different types of training and levels of skills. They are having a positive effect on the training of managers to level 4. They are also having a significant and beneficial effect on the introduction of more formal induction
training. There is some debate in the sector about NVQ 2 and 3 training, its content, and assessment. Overall, most of our evidence would suggest that the NMSs are having a positive effect on NVQ-based training and assessment. However, there are basic skills problems in the sector which need more attention.

- Training is being provided by a mixture of private providers and FE colleges, split roughly on a 60 per cent private, 40 per cent FE basis. These bodies are also often providing assessment and verification. Internal assessment has some advantages, but also some potential problems. It would seem that best practice, as it is developing, is for training to be on-site, with a good proportion off-the-job, with off-site training being for underpinning knowledge.

- There are a number of employer groups and consortia throughout the country. These have been brokered by Topss, the LSC, Social Services, and the employers’ organisations. Some aspects of this would seem to be rather ad hoc, but funding arrangements are clearly playing an important role in extending partnership working. In some instances, LAs are acting as lead employers.

- There are a number of Centres of Vocational Excellence (COVEs) in this area, some created by LSCs, others put together by local bodies. The LSC has identified care and health as priority areas for the COVE programme.

- Not much use is being made of Modern Apprenticeship, in part because there are a number of specific constraints in this sector. However, in our case studies, the employers who had Modern Apprentices were positive about their programmes.

- Formal accreditation of prior learning is not very extensive, though informally it may be being done within the NVQ process.

- In terms of costs, for the most part, employers are paying for the time spent in training or being assessed. In all case studies, the employer had some extra costs where trained staff took time to train others and where the employer provided the assessment. In some cases, the courses were paid for by the employer, but in most there was support from various government funds.

- There are multiple and complex funding streams to support training in the sector. However, these do not cover replacement wage costs. In this respect, it is interesting that approximately 45 per cent of all Employer Training Pilot starts are from the social care sector.

- On the basis of our analysis, we would suggest that the qualification targets for managers
for 2005 are likely to be reached.

- In the eldercare sector, many smaller single-establishment homes will have difficulty meeting the 50 per cent target by 2005. In the young adult sector, given the nature of voluntary and LA homes and the supports which many of these have, we would estimate that more will reach the target. In the childcare sector, where the target is 80 per cent and the lead-time to obtain level 3 is longer, there are some problems. However, there is more of a background of training and there are also some good support systems. For some homes in this sector, accreditation of prior learning and recognition of alternative training is important.

- The main difficulties and barriers for employers are tight time frames, financial pressures, especially for replacement staff costs, and fears of poaching of trained staff. The main barriers for employees are time and other commitments, fears of ‘returning to school’, and deficiencies in basic skills.

- We have commented on some difficulties with training providers e.g. the provision of off-the-shelf courses and a failure to consider prior knowledge. On the whole, this may be declining as a constraint. An equally important constraint may be the absence of internal assessment capability.

- We found it difficult to come to any firm conclusions about the net effects on recruitment and retention. In terms of morale, however, there would seem to be a net positive effect, though clearly it would be necessary to conduct further research to confirm this. We saw some real desire for progression among staff and a belief that training will create more career prospects for some care workers, leading to level 3 and beyond.

- In terms of multi-tasking and multi-skilling, there would seem to be limited effect to-date. Here there are legal and organisational obstacles. However, in future, with the growth of domiciliary care and other changes in practices elsewhere in health and care, there will be a growing demand for more flexible workers.

- In the case of children’s homes, there is some danger that alternative (and some would argue superior) qualifications may be displaced. In this sector, there would seem to be a pressing need to establish equivalents, to recognise acceptable alternatives to NVQs, and possibly to integrate them with NVQs.

- From our evidence, we would suggest that any deadweight effect is small and restricted to larger homes and the childcare sector. Much of the training is new skilling, though there is undoubtedly some formal recording of skills already acquired.
• The research did not talk to service users. Overall, however, interviewees suggested that the new training regimes are having a positive effect on care outcomes. It should be possible to investigate this in the future.

• Whether the new requirements will increase exits from the industry by service providers or act as a barrier to new entrants was briefly considered. An argument is put that this may be an opportunity to establish a higher skills equilibrium in the market.

8.2 Possibilities for further investigation

There are a number of possibilities for further investigation in connection with the social care sector approach to regulation and WfD.

First, in time, it will be possible to do a more statistically based study. We have mentioned that official statistics have shortcomings (e.g. care and health are combined together) and that employer statistics also have problems (e.g. low response rates). To date, it is too early to identify any trend lines before and after the new regulations have taken place. However, in time, it should be possible to see whether there has been any upward trend over time in NVQs and Modern Apprenticeships in the sector.35

Second, in the future, it will be possible to use the NCSC database of inspection reports for further research. This will provide data on training levels, other aspects of human resource management, and outcomes, by type of home, size, ownership etc. This will allow for a more thorough assessment of causes and consequences of WfD.

Third, another approach would be to conduct more detailed studies of training and outcomes at the level of organisations and individuals. There already exist some such studies of nursing and one study of care workers. These take levels of training and service user scores of satisfaction and / or employee self-efficacy scores. Studies to date, suggest that there is a positive relationship between levels of training and outcomes as adjudged by service users.36

Fourth, it would be useful to draw on the international comparative literature in the area. Work has been done on training in care homes in the US, suggesting a spread of care providers with different types of human resource regimes and different outcomes.37 There is also work on
Germany and France, where there would seem to be less diversity in the quality of provision and where more use is made of pre-entry training and of specialist geriatric nurse training. However, in the actual training of care workers, the UK would seem to have developed a more formal and extensive system of training, though with the possible objection that the UK has fewer nurses and their equivalents working in old people’s homes.

Finally, a related piece of research which might be conducted would be a study of the operations of similar regulations in other sectors. Early years and childcare might be one such sector. This has in place a regime somewhat similar to the one we have described here. Another might be financial services. This is an industry with certain similarities to the social care sector – it is a service industry, large parts of which are in the non-traded goods sector, and there are public concern with some selling of financial products. It is a sector which is subject to a myriad of regulations and codes of practice and where the regulator is actively seeking to encourage WfD.

8.3 The potential for replication in other sectors.

This last point leads to the final area the report was asked to consider, viz. what is the potential for replication or application of the principles underpinning the social care sector’s statutory arrangements in other industries.

The essence of the care model would seem to be as follows: a set of service standards are mandated; to help achieve these a related set of management standards are established; in the training area, standards and targets are established, which are more than aspirations, but are requirements to operate. The system regulates both employers and employees, though with more requirements on employers. Though it is conceivable that such a system might be voluntarily based, it is more likely that it will need to be legally based, as in the social care sector, where it rests on interlocking Act, Regulations, and NMSs.

Such an approach might be well suited to certain areas, with some of the following characteristics.

- These might include industries and occupations where there were real concerns for public health, safety, and general welfare.
• Put differently, they might also be sectors where there is an element of risk which is
deemed to be too high to be left to market forces and voluntary action.

• These might include situations where there had been a significant market failure, in that
an inadequate product or service has been provided. The market failure would then have
to extend to a failure in the labour market to produce sufficient workers with the requisite
level of skills.

• They might be industries or occupations where there are real informational asymmetries:
in such situations, customers / service users may purchase ‘lemons’ or may hold off
purchasing. Ultimately this could lead to a collapse of the market.39

• They would probably be situations where there is a general good, rather than a firm-
specific or private good. In the latter circumstances, the market or voluntary action
would be more likely to be used.

• Such arrangements might be well suited to industries in the non-traded goods sector of
the economy. In other words, they might suit situations where international competition
could not produce the good or service.

• In the non-traded goods, this approach might also be well suited to sectors where there
might be potential for collusion by the producers or service-providers. In other words,
situations where market forces cannot operate effectively.

• It might also be well suited to sectors which had previously been in the public sector and
where, as a result of privatisation or marketisation, a central coordinating function has
been lost and a related tradition of training.

• If it included sectors where there are may have been or could potentially be threats to
public health and safety or to public well-being, these arrangements may be triggered by
an incident or a set of incidents.

In terms of design features, a few general points may be made.

• There may be regulation of inputs (labour), or processes (management), or outputs (the
product or service) or any combination of these. The social care sector regulates all
three.

• Regulation may cover the employer, employees, or functions or any combination of
these. The social care sector focuses on employers and employees.
• It may be either based on voluntary codes and private regulation or on the law and public regulation. Most likely, we are talking about the latter or at least some combination of the two. However, it is not inconceivable that some aspects of the architecture and regulation of the care sector might be attempted on a voluntary basis.

• Of course, as with any interventions, voluntary or statutory, benefits would have to exceed costs. It would be no good increasing levels of training and perhaps the efficiency of the sector, if this did not lead to a good flow of trainees. It would also serve no purpose, if it led to a reduction in supply, an increase in price, and inequalities in who could afford to purchase the good or service.

• Equally, it only makes sense to have interventions if they can be enforced.

As illustration, we mention a few areas where to the best of our knowledge this form of regulation does not exist and where some of these conditions might be met.

It might seem odd that assistants and similar staff in the NHS are not subject to the same requirements as those in the social care sector. Aspects of the jobs are similar and the two areas draw from the same labour market. Indeed, it was suggested to us that discouraged staff might leave the social care sector and move to the NHS and that trained social care staff are leaving in pursuit of higher wages. Of course, it could be objected that the NHS has a high ratio of doctors, nurses, and other specialists. Moreover, there is at the present time a significant push, involving significant amounts of money, to get NHS support staff to level 3 and above.

An approach similar to that in the care sector already exists in the case of pre-school / early years / childcare and is covered by OFSTED. In this sector, 50 per cent of assistants will have to have NVQ 2 and supervisors NVQ 3. However, in schools, teaching assistants are not covered. This might be because most of the staff in schools are qualified teachers and it is sufficient to have unqualified assistants to complement them. However, this is to be a growing area of employment and some concerns have already been expressed, not least by some of the teacher unions as to the skills of these assistants.

Railway maintenance might be mentioned as an example of a sector which has been privatised and is now subject to extensive market contracting. Here there is also considerable public concern, following on a number of major accidents. Arguably traditions of training have either
been lost in the sector or have not been further developed to meet the needs of a changing railway system.

In the Communications Bill 2003, there is an obligation on employers to train. This includes sectors such as TV and radio, but also parts of the industry involved in film and allied production. It will be interesting to see how the obligation to train may be operationalised, but there may be lessons to be learnt from some aspects of the social care sector.

Outside of areas which lie in the public sector or recently privatised sectors or increasingly marketised sectors, there are some areas of construction where it could be argued there are market failures. This would include areas such as general building and maintenance and specialist areas such as plumbing. There are voluntary arrangements of various kinds in the sector already and in the case of gas fitting an example of statutory arrangements.

In areas of food preparation, there are various health and safety, food hygiene, and more specific regulations e.g. for meat handling. Recent concerns in the sector connected to foot and mouth, BSE, and E.coli might suggest that there are areas here which could be considered.

When we enquired of individuals and organisations in the social care sector as to whether these arrangements could be replicated elsewhere, they tended to reply in terms of prerequisites which would be needed to make such arrangements work. Above all, they stressed that this form of regulation could only work if resources were available, in good time, either by the industry or by government. This included financial resources, but also managerial and training resources. Some also suggested that such a framework could only be made to work if a similar total package was mandated, viz. service / product standards, management standards, systems of human resource management, and related systems of training. However, such an extensive framework might be less essential for other sectors where, for example, management structures are stronger.

In conclusion, one of the organisations in the social care sector has referred to the new arrangements as ‘a new and exciting form of regulation’ Undoubtedly, there are some problems and challenges in making the system work, but there are some indications that it may provide an effective vehicle for service provision and workforce development.
Appendix 1. Interviewees and those consulted

**DfES**
John Doherty, Pauline Esposito, Ian Kay, Judith Roe, Peter Smalley, Paula Townsend,

**DoH**
Sue Brennan

**National Care Standards Commission**
Sharon Atkinson, Trish Davies, Chris Johns, Mike Lindsay, Roger Morgan, Anthony Prudhoe, Heather Wing

**General Social Care Council**
Rodney Brooke

**Topss England**
Richard Banks

**LSC**
Gail Bailey, Christopher Cherry

**Centre for Policy on Ageing**
Gillian Dalley

**Employers organisations**
Sheila Scott, National Care Homes Association
Frank Ursell, Registered Nursing Homes Association

**Case study organisations**
Old People’s Home (1)
2 managers, 6 staff.
Old People’s Home (2)
1 manager, 2 deputy managers, 3 staff

Old People’s Home (3)
1 manager, 1 team leader, 3 staff

Old People’s Home (4)
3 managers, 6 staff

Young Adults’ Home
5 managers, 5 staff

Children’s Home (1)
3 managers, 3 staff

Children’s Home (2)
2 managers, 4 staff

Others
Tony Archer, Eaton Hill, Children’s Home, Derby
Alex Bryson, PSI
Cheryle Bashforth, Northern Edge Training
Owen Davies, UNISON
Peter Finn, Peper Harow Foundation
Mustafa Hussain, Frontier Economics
Julie Lockwood, Pre-School Learning Alliance, Northamptonshire
Tom Savory, Norfolk Social Services
David Schooling, Ambition Agency
Billy Pughe, Cotswold Community
Sarah Tebbutt, Frontier Economics
Alan Worthington, Peper Harow Foundation
**Academic researchers**

Stephen Bach, KCL
Ingrid Eyers, Surrey
Jim Foreman, LSE
Stephen Machin, UCL
Alan Manning, LSE
Helen Rainbird, Northampton
Paul Ryan, Cambridge
A. V. Sargeant, MMU
Hilaray Steedman, LSE
Notes


2 However, the National Care Standards Commission reports have some shortcomings at the present time. For example, overall numbers employed are not provided and there is some inconsistency in the data, with homes for younger adults not containing a percentage trained.


5 One estimate puts the number of beds as approximately 280,000 in residential homes and 220,000 in nursing homes. Interview with Frank Ursell, RNHA.


10 Interview with Frank Ursell, RNHA, and Sheila Scott, NCHA.


17 S. Bernard, ‘The Social Care Workforce Today: Current Information and Some Key Issues’,
LSC, January 2003.


23 They also became effective on 1 April 2002.


28 Approximately 45 per cent of starts under the Pilot are for care workers. Information supplied by Gail Bayley, LSC.

29 A deadweight effect is defined in terms of government funding going to finance training which would have been carried out anyway. A displacement effect occurs when one form of training replaces another.


32 Based in part on interview with Cheryle Bashforth, Northern Edge Training.

33 Information supplied by Gail Bayley, LSC.


35 Over time, it might also be possible to look at trends in wages as a proxy for movements in skill levels.


40 [www.gscc.org.uk/about.html](http://www.gscc.org.uk/about.html)