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Securing Quality in the Mixed Economy of Care: Difficulties in Regulating Training

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This study explores issues about securing quality of provision in social care using evidence from research into training in the adult care sector in two English local authorities. It shows that progress towards securing a trained workforce is slow and explores reasons for this. It argues that since the government is making particular efforts to increase training in this sector, these data provide a good test case of the problems about using regulation to raise care standards. It concludes that significant progress is unlikely to be made in respect of training unless the impact of other factors, such as the occupational segregation of the workforce and contracting out, are also taken into account.

Introduction

Over the last two decades provision of adult care, including residential, day and domiciliary services, has changed drastically. Whereas in 1981 most provision came from local authorities, by 2000 local authorities were purchasing most of their care services from the private, and to a much lesser extent, voluntary sectors. Additionally, private purchasing of services has grown with the ageing, increased wealth and changing family structure of the population. Hence 82 per cent of all residential places were in private and voluntary sector homes (National Statistics, 2002: 140). Hence, the shift to private services has been justified in terms of the efficiency of the market in providing greater choice as well as higher standards.

As Walsh argues:

> There is much debate over the impact of market mechanisms on the quality of service, with proponents arguing that they are a means of ensuring better services, and opponents arguing that savings only result because services are worsened. A central purpose of the introduction of market mechanisms to the public service is to increase the level of choice that is available to the users of service and so to make services more accountable to those who use them. The requirement for clear standards is intended to ensure that the users of services are aware of the service that they are entitled to and can complain and obtain redress if they do not get what they are supposed to. (Walsh, 1995: 222–223)

Yet in social care there are severe problems about the extent to which these choices are in fact exercised. Services are purchased both by local authorities, often through block contracts, or by individuals and/or their relatives. In the first case, consumers are allocated what local authorities judge them to need according to stringent eligibility criteria and cost, and choice is mostly conducted at arm's length. In the second, individuals usually

have to take what is available in a shrinking residential and under-resourced market. In 2001 there was a fall of around 12,100 care places in the UK, 2000 of which were in the Southern counties (Laing and Buisson, 2002). Additionally, a lack of accurate information on services often makes them difficult to access. Thus consumer choice has scarcely been a main driver in improving the quality of care.

With the quality of care a continued focus of criticism, Government has resorted to various strategies beyond privatisation for improvement. One of these involves the extension of inspection through the recently constituted Commission for Care Standards Inspectorate (CSCI). A second has invoked extensive workforce planning in an attempt to improve services at their point of delivery (DoH, 2000a; DoH, 2000b) and it is with the training strategies involved in this that this paper is concerned.

In spite of, or maybe indeed because of, organisational change the care sector has remained one primarily staffed by low-paid women, often part time and usually working locally. This familiar pattern of occupational segregation carries with it a very low educational and qualification base. In workforce studies carried out in the mid 1990s most residential and home care workers were found to be unqualified, and of those unqualified only about 10 per cent were taking a relevant NVQ (Balloch, 1999). However, under the Care Standards Act, 2002, 50 per cent of all care workers must be qualified to NVQ2 and all managers of care homes must have achieved the Registered Managers Award (NVQ4) by 2005. There is a slight variation for those working in home care with a revised deadline of 2008.

Setting aside for the moment the debate about the extent to which training can improve the delivery of care, we turn to a recent study carried out in East Sussex and Brighton and Hove. The aim of this was to identify the training needs of the private and voluntary care sectors in the light of the new requirements and the gap between these and locally available training. In the course of this study a number of significant barriers to training emerged which raise serious questions about the potential effectiveness of central government strategy.

The first stage of this study involved a postal questionnaire to care providers in nursing and residential care homes, day centres and home care services in East Sussex and Brighton and Hove. Some telephone follow ups were used to increase the response rate. Of the 745 care providers identified, 310, 42 per cent, responded. The response rate was relatively similar from each of the key sectors (residential/nursing care, home care and day care) and from the different parts of the area.

The 310 care providers employed 5244 care staff (an average of just under 17 each). A crude estimate of the total size of the care workforce in East Sussex, Brighton and Hove can be derived by assuming that the non-responding employers employed a similar number of staff. That suggests a workforce of about 12,500. In addition, 121 respondents reported using 535 agency or relief staff during the previous week. Therefore the size of the staff group can be estimated to be at least 13,000. Of these 88 per cent were women and about 52 per cent worked part time.

Only 790 of the care staff employed by the respondents were stated to have care qualifications of NVQ2 or above. A further 802 staff were said to be working towards the qualification. Together these amounted to only 30 per cent of the total care staff included in the survey. While this shows an improvement on the national figures quoted earlier (Balloch, 1999), this estimate still requires a further 20 per cent to be trained by 2005 to reach the government's target. In addition, 30 per cent of the organizations surveyed

Table 1 Care staff in East Sussex and Brighton and Hove qualified to NVQ2 in Social Care, undergoing training or not trained in 2003

	Residential care for older people (inc. EMI) only		Residential care for people with learning disabilities only		Day care only		Home care only		Mixed services	
	No	%	No	%	No	%	No	%	No	%
Trained staff	504	17	127	19	32	19	45	5	82	15
Staff in training	456	16	122	18	17	10	68	7	139	25
Not trained	1920	67	433	63	121	71	841	88	337	60
TOTAL	2880	100	682	100	170	100	954	100	558	100

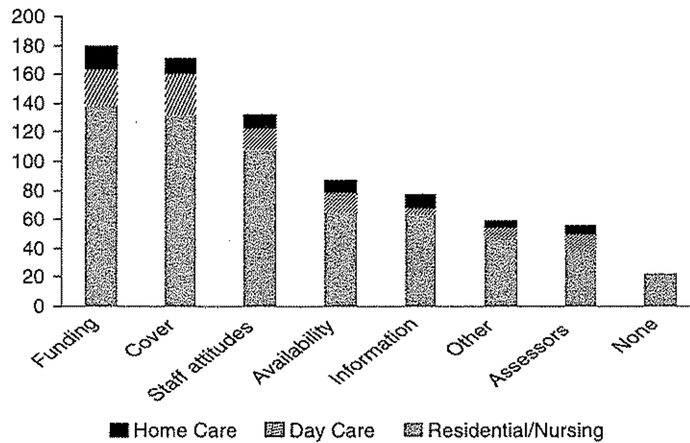

Figure 1. Bar chart of barriers to training experienced by the three types of care providers.

had no staff at all qualified to NVQ2 and half of these had no one working towards a qualification. Home care providers were particularly likely to lack qualified staff with only 6 per cent qualified to NVQ2. Table 1 sets out data on numbers trained or undergoing training from various sectors of the care system.

Employers' views on training

Although employers were not necessarily hostile to the new regulations, many were increasingly concerned about perceived barriers to training. Here we consider their views on costs, timing and staff attitudes.

Costs

Figure 1 demonstrates that the barrier to training most commonly identified by employers and managers (57 per cent) was difficulty with meeting costs and obtaining sufficient

funding. This was particularly the case amongst home care services (stated to be a main problem by 77 per cent). Finding cover (53 per cent) was also indicated by the majority as a main barrier for all types of services especially day care (66 per cent). These two barriers were very much connected, as obtaining cover was as much a financial problem as a recruitment one:

> The main barrier to accessing the training we require and accredited training (e.g. NVQs) in particular, is the cost, particularly the cost of replacing staff who are attending training. For example whilst the college costs of our NVQ 2/3 programme are £290 per candidate, the staff replacement costs are just under £2000 per candidate. To qualify 50 per cent of our staff by 2005 will cost us considerably more than £149,000 – and this figure assumes no staff turnover or drop out and no increase in the college fees between now and 2005! . . . The available funding is difficult to track, complex, not 'joined up' and unpredictable. Few funding sources provide funding for staff replacement costs . . . We also struggle to recruit sufficient relief staff to cover services when staff are attending training.

The extra cost of training as a result of high staff turnover was also commented on by a number of employers:

> Funding is always an issue. One particular difficulty is, once a person has qualified, retaining them as they are keen to move onwards and upwards.

> There is an issue that once they have gained the qualification they leave for better pay in the NHS. This has happened to me over and over again. Consequently I haven't any qualified staff and I cannot afford this ongoing process.

While our research does not throw more explicit light upon the problem of movement to employers outside the care sector, it does offer a little evidence on movement of trained people within the care sector. While most of the already trained staff had had quite substantial periods of service with their present employer, it was noted that there were 80 people who were both trained to NVQ2/3 level and had been with their current employer less than a year. This is a not insignificant number who might, in some sense or other, be described as having been 'poached' after someone else had borne their training costs (though we do not know who their employer was during their training). One residential home had six qualified staff (out of 15) and all six had joined the organisation in the last year. Another, with nine care staff in all had taken on five out of its seven qualified staff in the last year.

Timing

There were also comments about the logistical/time difficulties with arranging training around shifts and other commitments held by staff. This was in part about cover but involved other issues such as the extra workload the NVQ required for staff to meet in their own time as well as arranging training for night staff and so on. Some managers expressed difficulties they had with organizing in-house training due to workload pressures and problems of releasing several members of staff to attend at one time. Others preferred in-house training, seeing it as more flexible and convenient than college courses:

> In-house is difficult due to a lack of room for long periods and as a small team unable to release all staff at once.

> Due to the increased workloads for management teams within [name of organization] it is increasingly difficult to arrange in-house training and to provide quality.

> In regards to NVQ2 in-house training is preferred to save time travelling and cover at work.

> In-house training works well, but it's difficult to get staff to go out to college because fitting it in around work and other commitments is difficult especially for night staff.

> It is difficult to allow staff to attend college especially in the light of financial constraints (replacing staff) due to under-funding in residential care. Hopefully within the next month we will be starting NVQ Level 2 Care in-house through . . . College.

Yet another issue arises because of the extent to which a practical training system like that used for the NVQ course needs to make use of existing care practitioners as 'assessors'. While quite a lot of senior care staff had been trained as assessors, many were not being used because of time and workload pressures.

It needs then to be borne in mind that the pressures described here are particularly likely to fall upon small homes. In market terms these can be described as amongst the 'weakest parties', particularly vulnerable to the undermining of their economic viability by relative small cost increases. There was a statistically significant relationship between the size of organisation and the percentage qualified or working towards the qualification (in the residential/nursing care sector $x^2 = 113.78$; $df = 35$; $p = 0.0001$ and in the day care sector $x^2 = 45.09$; $df = 20$; $p = 0.001$). Very small homes (with one to five staff) were less likely to have or to be working towards the qualification (44 per cent) than larger organisations. This was even more apparent in day care, where 88 per cent of services with one to five staff had no one who held or were working towards the qualification.

Attitudes of older staff

Another reason, as indicated by a significant proportion of employers (42 per cent) was the negative attitude of staff towards training which was noted by many to be shared mainly by older workers, whereas younger carers tended to be more enthusiastic:

> Care staff do not wish to work to NVQ2/3. They see it as hard work and not worthwhile. Only those in their 20s are interested.

Some employers expressed their accordance with the outlook of their older care staff and emphasised the value they placed on 'experience' over qualifications:

> We are fortunate to have a good core group of 'mature' carers who neither wish to nor indeed need to undertake an NVQ . . . our new or younger carers are mostly interested in training.

Similarly a manager from one of the recruitment agencies described why she felt further training for her staff was unnecessary:

> They are all mature women who could train the trainers, it's like teaching grannies to suck eggs!

Others noted that older staff were particularly likely to face further barriers such as inadequate basic skills or a lack of confidence in their ability, as well as time restrictions

due to family commitments:

> Older staff feel that they are unable to do the paperwork but are excellent carers and I do not want to lose them. NVQ 2 does not come anywhere near the standard of life learning experiences . . . The type of person who becomes a carer are not academic. If they were they would not be in the care industry as they would get better pay for less audacious tasks.

Fifty-five respondents (19 per cent) mentioned other barriers. Many of these were around a sense of lack of faith in the relevance or training requirements as a whole, particularly in terms of the credibility of the NVQ as a reliable indicator of ability or achievement:

> NVQ does not have the underpinning validity which give confidence to employers – and indeed colleagues.

> Staff perceive training provided as lengthy, bureaucratic, mainly for training providers to charge exorbitant prices and little to do with proof of competence.

Owner/'managers' of 'adult placement' type small care units on the whole were particularly disdainful of training requirements, which they saw as unnecessary and irrelevant:

> My husband and myself look after the clients as part of our family, but all this bureaucracy is ruining a happy family life for our boys. We have no training and have done this work for 10 years without any problems. We are not prepared to change things now and would rather close the home down.

The views of training providers

The second stage of our research involved in-depth interviews with training providers. Their main concerns were with lack of support and drop-out rates. There was a general consensus amongst them that one year was the optimum time it should take to complete a NVQ2 in care. Some candidates could complete sooner but where candidates were taking longer than this there were several common reasons noted. Personal problems, lack of work place support or learning support needs were all issues and the modern apprenticeships group seemed to have the most difficulty completing in the time funded.[1]

Drop out rates varied but were significantly higher amongst the private providers. It is worth noting by way of explanation that drop out was highest amongst the younger age group and particularly amongst the Modern Apprenticeships. Given that the private providers have much higher numbers of Modern Apprenticeships this would account in some way for their higher rates of drop out.

Providers had found that improving levels of support and consistency of contact with candidates had helped improve the drop out rates. Initiatives like study centres, increased use of handouts/reminder sheets, counselling support and pro-active tutor and assessor support were cited.

Perceived drop out reasons were consistent throughout the providers and included:

- Lack of motivation, particularly where candidates were not paying for the course and felt they had to take it.
- Poor workplace support.
- Pressure of work, long working hours.
- Change of career away from care.

- Key skills requirements are a real issue particularly for those who have had a poor schooling experience. This will probably be made worse by the introduction of technical certificates.
- Family and childcare responsibilities.

The training providers were very clear that their clientele were very much local. Trainees who were low paid and working long hours were unlikely to travel far for courses, and trainers found it difficult to provide in-house courses for small employers.

It seems appropriate to hypothesise that there will be problems about getting staff to undertake training or employers to support them if:

- They are part-time: 1,822 staff in our study were and 90 per cent of them were without NVQ2 or above.
- They are near the end of their working life: 831 staff were over 50 and 85 per cent of them were without NVQ2 or above; the training providers reported that their trainees were predominantly in the 25–40 age group.
- They are unlikely to stay with the employer or in the sector: while this is hard to estimate from the data it may be noted that 776 people had been with their employer less than a year and 90 per cent of these were without NVQ2 or above; another way of looking at this issue is in terms of the age distribution (unfortunately it was not possible to cross reference age with length of employment) – 648 were under 25 and 81 per cent were without NVQ2 or above.

Conclusions

This paper has explored some of the issues about securing a substantially trained workforce in social care. Similar conclusions to ours were provided by an earlier national study by Kell:

> The National Minimum Standards specify a range of issues that care homes need to address in relation to staff supervision and training. At the moment, though, few homes have reached the target of 50 per cent of care workers having achieved at least a level NVQ2 in Care.
>
> Many care home owners felt that they have neither the time nor the resources to properly meet these standards. In this study, in some homes, staff had all course fees and expenses paid and were allowed to undertake the course during work time. But other homes paid nothing towards course fees or expenses and expected staff to do the courses in their own time, even the statutory study days. (Joseph Rowntree Foundation, 2002a)

Training is but one of several strategies that can be used to address the overall problem of securing high standards in social care. Our evidence shows that there are serious difficulties in achieving the targets set and that there is a widespread lack of enthusiasm among staff for the way in which training is being delivered. These problems are directly related to the structure of the workforce being targeted and the market in social care.

Most working in social care feel deeply about their work and are keen to provide a good service, with strong evidence to suggest that even low-paid, older, part-time women workers are interested in training and qualifications (Balloch, 1999). To be accessible, however training must be delivered in an affordable and manageable way. At the moment the system has entrenched inequalities relating to age, poor education and gender. It is, for

example, discriminatory to provide free training for those under 25 while expecting others, or their employees, to bear the cost, to expect those lacking basic literacy and numeracy skills to undergo training without proper support and to require women with other caring responsibilities to fit in training around shift work. For a local, low-paid workforce, also, training must be delivered locally or transport provided – the latter particularly important in rural areas where the daily bus is unlikely to be of much use. Finally, it is unreasonable to expect people to willingly undertake training if there are no financial rewards at the end. But to appreciate the relevance of this to social care we must turn to the market.

Previously there has been little evidence to suggest that, in the area we studied, privatisation and the contracting process have been used to raise standards. The regulatory process faces, and will be likely to continue to face, difficulties in putting on pressure for the raising of standards in a sector severely constrained by market forces. This evidence might even be used to argue against privatisation of this sector. However, there are some paradoxes to be resolved here. Ironically the main source of so-called 'market-pressure' comes from public sector purchasers. It was argued, before the enactment of the Care Standards Act 2002, that it was undesirable that local authorities should be both purchasers and regulators. However, the separation of those roles still leaves an unresolved contradiction between the two functions. If the regulator forces raised standards what impact does that have on the local authority's willingness to pay the costs of those? On the other hand if the local authority uses its contracting power to raise standards where the regulator is unwilling to act the providers will have a legitimate complaint that they are being put under unfair pressure. Overall, bearing in mind that little progress was made towards the provision of a trained workforce when the local authority were direct providers, to what extent is the real source of the problem the intense pressure from the government to minimise costs in this area of social policy?

Taking the issue of training on its own it is perhaps easier to see scope for an alternative approach. Training costs fall inequitably upon care providers, provoking the greatest difficulties for the smallest and weakest elements in the system. To let market forces sort out this problem would lead to a decline in the availability of small, often owner-operated, homes. These may well offer a high quality of personalised care, and it may well be desirable to protect them. But viewing the issue overall there is also clearly a problem that training is in a sense an 'externality': a collective benefit emerges from it, yet its costs fall upon individual entrepreneurs who may then lose the staff they train. There is thus a clear public policy solution, the socialisation of training costs.

In fact our study showed that there is some socialisation of costs here. Some colleges offer cheaper course than others (and indeed one in the area provided free courses). There is also general subsidy of courses for young people, though the objection to these voiced by employers was that in a situation in which there is a large stable middle-aged (largely female) workforce there is a distortion of effort towards the training of young people (often male) who are particularly likely to move on, and even out of the sector.

There is clearly then an issue here about the more effective socialisation, that is shifting of training costs on to the public purse, focussing upon the staff most in need of training. Then in addition there are, as the discussion above suggests, issues to be considered about the extent to which that process needs to have regard both to the fact that releasing staff for training imposes a cost and to the fact that much training needs to be organised at least partially in-house, which means that another cost that must be given

attention is that entailed in the provision of 'assessors' from amongst the ranks of already trained staff.

Ironically attention to these issues is made rather more complicated by another purchaser/provider split in the training sector, with publicly owner colleges and private providers competing to provide training of this kind. But this is a topic for a separate article.

Note

1 Modern apprenticeships are fully funded and awarded only to those under 25.

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