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Who Cares About Skills? The Impact and Limits of Statutory Regulation on Qualifications and Skills in Social Care

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Abstract

This paper examines the impact of statutory regulation on qualification and skills in the social care sector in the UK. It draws on various sources and a set of case studies, first carried out in 2003 and replicated in 2008. The analysis shows that the advent of the statutory regime has had a positive effect on the volume of training and qualifications in the sector. However, few organisations have combined training with a broader set of human resource management practices. This constitutes one of the continuing limits to further skill development. Changes in the regulatory regime risk losing benefits which have been gained.

1 Introduction

Successive British governments have been committed to raising productivity and providing better value goods and services for customers and users. A skilled workforce is seen as essential for achieving these goals (Leitch 2006; Cabinet Office 2008). A variety of different strategies towards skills development are possible. One is to leave skill formation to voluntary action by firms and individuals, guided by market forces. Another relies on some type of voluntary collective self-regulation. A further approach, exemplified by the UK construction sector, is to encourage training via a system of compulsory levies. In the case of some, mostly professional occupations, qualifications are required in order to gain a 'licence to practice'.

This study focuses on a different approach to the regulation of workforce training and development. The UK government has stated that, where there are serious skills shortages and where there is some agreement on both sides of industry that a element of compulsion is required, it is prepared to support a statutory framework (Cabinet Office 2002: 67-68, 76-78; HM Treasury 2002: 19). A prominent example of such a framework can be found in the social care sector. In the late 1990s, widespread concern about deficiencies in the skills of the care workforce and in the quality of the service offered by providers led the government to introduce a statutory framework designed to regulate a variety of aspects of the provision of social care, including both the number and qualifications of workers. The regulatory framework consisted of a number of interlocking parts, including a set of standards and quality assurance procedures to which providers had to adhere, and an inspection regime to check compliance. This approach is in many ways unique in British industry.

This paper reports the results of an investigation into the impact of this framework on training and qualifications in the sector. The research took the form of a replication study, which examined – by means of case studies of providers, first undertaken in 2003 and repeated in 2008 – the framework's impact on workforce development. The evidence collected suggests that, while the framework has had a significant impact on training and the qualifications of the workforce, its impact on the broader set of human resource management (HRM) practices adopted by employers has been more limited.

Section 2 sketches the institutional context in which social care is provided in the UK, including the regulatory framework within which providers operate. Section

3 describes the methods employed in the research and outlines the main features of the case study organisations. The findings are outlined in Sections 4 and 5: the former assesses the impact of the regulatory framework on qualifications; the latter considers various impediments which have reduced the impact of the regulations. Section 6 considers the significance of the increased levels of qualifications, by considering whether the increase reflects no more than the certification of skills which workers already possess and whether the requirements have encouraged managers to examine not only how they train but also how they manage labour more generally. Section 7 draws conclusions.

2 The Nature of the Social Care Sector and its Workforce

2.1 The quasi-market in social care

The term 'social care' denotes a wide range of services which are designed to support people in their daily lives and to protect them in difficult situations. It encompasses a broad range of services, including domiciliary care, residential care (both with and without nursing support), and fostering of children (Department for Education and Skills (DfES) and Department of Health (DH) 2006: 3).

The 1990 Health Service and Community Care Act initiated a move towards a quasi-market approach to the delivery of care, whereby the state ceased to be both the funder and the producer of services and assumed instead an *enabling* role, continuing to fund services but not necessarily producing them (Le Grand and Bartlett 1993: 4-5; Deakin and Walsh 1996). The role of the state – in the guise of local authority social services departments – was to be primarily that of a commissioner or *purchaser* of care; while the services themselves were to be *produced* by a variety of different types of organisation, including private-sector and voluntary organisations, as well as local authorities, who competed for contracts on offer within this 'mixed economy of care' (Wistow *et al*. 1994). The aim of the reforms was to increase consumer choice and competition, with the ultimate objective of improving both the extent to which the users' needs were met and also the cost effectiveness with which services were delivered (Hoyes and Means 1993: 93-97; Lewis 2009). Consistent with the intent of the 1990 Act, local authorities now act primarily as commissioners of care from the independent (private and voluntary) sector. The latter now provides around 85 per cent of adult care, with local authority direct provision accounting for only 15 per cent

of services. There have been similar trends in the cases of care for the disabled and for children (CO / IPA 2008: 10; Eborall 2005: 6).

By the late 1990s, however, the prospect of vulnerable people being cared for by providers outside the direct control of the statutory authorities prompted concern about how to regulate the quality of services. Such considerations were reinforced by the widely perceived shortcomings of the prevailing system of regulation. At that time, the regulation of homes was fragmented, with local councils taking responsibility for registering and inspecting residential homes, while nursing homes fell under the purview of local health authorities. Such fragmentation was thought to produce an inconsistency in standards both geographically and between different types of provider (with local authority inspectors being accused of favouring council-run homes) (Burgner 1996). In 2000, the government responded to such concerns by introducing a new regulatory framework, based on *national* standards (DH 1998).

2.2 The regulatory framework

The 2000 Care Standards Act introduced regulation of various aspects of social care, including the fitness of the premises in which care is provided, the financing and administration of the home, and the standards of welfare achieved. For the purposes of the present paper, the most significant regulations concern the staffing of homes.

A well-trained workforce was thought to be central to the delivery of high-quality care. It was recognised that the care workforce was undertrained – 80 per cent had no recognised qualifications – and that the resultant skills shortages were a major obstacle to improved services (DH 1998, 2000; Training Organisation for the Personal Social Services (TOPSS) 1999). Accordingly, the regulations introduced by the 2000 Act stipulate that the registered owner of each home must ensure that both the number of staff employed, and also their skills, should be appropriate for the needs of the users for whom care is provided and that all employees should receive appropriate training and development.

The broad requirements set out in the regulations were elaborated in greater detail in an accompanying set of National Minimum Standards (NMSs). The latter are intended to be a genuine *minimum* in the sense that, rather than constituting a guide to best practice, they specify a floor beneath which no home should fall. In the case of training, the NMSs state that all homes must have a staff training and development programme designed to meet workforce training targets and satisfying

the requirements laid down by the Sector Skills Council for the sector, namely Skills for Care (SfC) (formerly TOPSS), along with a dedicated training manager and budget. All staff must: receive induction training to a set of common standards, within originally six, now 12 weeks, of being employed (SfC 2005); have an individual training and development assessment and profile; and receive a minimum number of paid days training each year (three, five or six days depending on whether the workers in question are caring for the elderly, for people with disabilities, or for children). All new staff must be registered on a training programme certified by SfC (DH 2002a-c).

The NMSs imposed two main obligations on providers, both of which had to be fulfilled by April 2005. First, all registered managers, directly responsible for the running of homes, should have both a National Vocational Qualification (NVQ) level 4 in Care (or a Diploma in Social Work (DipSW)) and also an NVQ4 in Management (or equivalent). Second, in the case of care workers who occupy the main direct roles in the sector, providers must ensure that their homes satisfy the following minimum qualification ratios: (i) in homes for old people and for the disabled, a minimum of 50 per cent of care staff must possess an NVQ2 in Care or Health and Social Care (or equivalent); (ii) in the case of children's homes, at least 80 per cent of staff should have an NVQ3 in Caring for Children and Young People (or equivalent).[1] Moreover, all staff working in homes for disabled people who did not hold an NVQ2 must be working to achieve one by an agreed date, unless it can be shown that they have already acquired, through past experience, an equivalent level of competence. Similarly, in the case of children's homes, all new staff must begin working for an NVQ3 within three months of joining the home, a requirement which implied that, ultimately, all staff should be qualified to that level (DH 2002a-c).

The NMSs were intended to provide a measurable and enforceable benchmark against which the quality of care in a particular home could be judged. Two regulatory bodies were established. The first was the General Social Care Council (GSCC), which is enjoined to promote high standards in the training and practice, of care workers. To that end, it has issued codes of conduct for both employers and employees, which require them to ensure that skills are adequate for the jobs they are doing, and has also begun registering the care workforce, starting with social workers

before moving on to those providing domiciliary care. The second regulatory body was the National Care Standards Commission (NCSC), subsequently renamed the Commission for Social Care Inspection (CSCI) and now again renamed the Care Quality Commission (CQC). Everyone who owns or manages a home has to be registered with the Commission. The Commission carries out inspections of homes and has the authority to cancel the registration of owners and managers whose homes are judged to be failing to provide a satisfactory quality of care.[2] A home's performance relative to the NMSs is one of the factors which inspectors take into account in reaching their verdict. It is not the only factor considered by inspectors, in that homes can be in breach of the regulations even if they satisfy the NMSs and they can be judged to be in compliance with the regulations even though some NMSs have not been satisfied. In the latter case, the failure to meet the standards is noted in the inspection report and a warning is issued to the provider, who must offer a plan for corrective action. In the event of continued failure, fines can be imposed, the home's registration cancelled, or, in the most serious cases, criminal proceedings taken. Training was viewed as an essential prerequisite for achieving other NMSs and was consequently an important focus in inspections. Indeed, inspection reports contained a box in which inspectors had to record the percentage of employees who had reached the relevant NVQ level.

The regulatory regime for social care took the form of a classic quality assurance model: service standards are mandated; to help achieve these, managers are required to install a set of internal, quality control procedures which will enable them to identify shortcomings and to ensure that, where necessary, corrective action is taken; and an external inspection regime is established to monitor compliance with the standards and procedures. As the NMSs for homes for older people put it, there should be 'continuous self-monitoring, using an objective, consistently obtained and reviewed and verifiable method (preferably a professionally recognised quality assurance system)' (DH 2002a: 37, standard 33; also see DH 2000: 9-11, 37; DH 2002a: 35, 37-38; DfES and DH 2006: 7). Regulatory frameworks of this kind have been central to New Labour's attempt to promote the public interest in circumstances

[1] These ratios exclude the registered manager, along with any nursing and agency staff, but include any deputy managers.

[2] In early 2007, the responsibility for inspecting children's homes was transferred from CSCI to OfSTED.

where the delivery of services is undertaken, via quasi-markets, by providers from outside the public sector (Newman *et al*. 2008: 536-40; Lewis and Ryan forthcoming).

2.3 The social care workforce

There are around 1.6 million workers in the care sector, constituting about five per cent of the total UK workforce. The category of care worker accounts for about two thirds of that total. Around 60 per cent are employed by private and voluntary organisations. Over 85 per cent of the workforce is female, 50 per cent work part-time, and only around 30 per cent have relevant qualifications. Over 65 per cent of all care workers are estimated to be 35 years of age or older. Thus, the social care workforce is dominated by relatively mature women, many of whom are part-timers and few of whom possess educational or professional qualifications (Eborall 2005: 7, 26-31; Moriarty 2008: 3, 13). Both turnover and vacancy rates are high: estimates of turnover vary from about 13 per cent in the case of local authority workers (in 2004) to 19 per cent for those employed in adult social care (in 2007); while in 2003 the proportion of all care establishments with vacancies (32 per cent), and the vacancy rates themselves (six per cent), were about twice the corresponding national averages for all employers. Around half of the vacancies in question were termed 'hard to fill', while about one quarter were attributed to a lack of workers with the relevant skills (Eborall 2005: 41-48; CO / IPA 2008: 17). More and more employers have attempted to deal with such shortages by relying on international recruitment, with estimates indicating that 11 per cent of the workforce was born outside the UK (DfES and Department of Health 2006: 18; Moriarty 2008: 17-18). In all the sub-sectors, labour costs account for a high proportion of total costs: 80 per cent of all spending in social care is on the workforce (DfES and DH 2006: 13).

3 Research Methods

The research took the form of a replication study, involving semi-structured interviews with managers and staff both in the run-up to (2003), and after the introduction of, the NMSs (2008). The aim was to compare five-year before-and-after snapshots, so as to ascertain magnitudes of change over time and to examine the dynamics of the adjustment process.

Table 1a. Summary of case studies, 2003

Name	Sector	Ownership	No. of staff	Turnover %	Pay range	Registered manager has NVQ4?	% NVQ2 (or 3) / above at present	% NVQ2 in-training	Comments
OPH (1)	Old People	Private	35	10 to 15	£4.94 - £6	No (in training)	22	28	
OPH (2)	Old People	Private	23	30	£4.20 - £5.50	No (in training)	0	22	
OPH (3)	Old People	LA	24	0	£5.52	No (in training)	25	17	
OPH (4)	Nursing Home	Private	26 + 13 nurses	50	£5.15 - £6	No (in training)	19	27	NVQ figure for care staff and not including nurses
PLDH	Disabled	Voluntary	80 main site	18	£5 - £5.75	Yes	20	15	
CH (1)	Children	Voluntary	18	10	£5.44 - £6.19	Yes	None 55	None 45	Seeking equivalence
CH (2)	Children	LA	18	0	£7.42 -£8.29	Yes	80	11	

Table 1b. Summary of case studies, 2008

Name	Sector	Ownership	No. of staff	Turnover %	Pay range	NVQ4	% NVQ2 (or 3) / above at present	% NVQ in-training	Comments
OPH (1)	Old People	Private	30	15	£5.72 - £6.18	Yes	57	Nearly all the rest	
OPH (2)	Old People	Private	13	20	£5.52	Yes	70	15	Former home closed and substituted
OPH (3)	Old People	LA	11	0	£6.30	Yes	80	0	Home being moved to new provider
OPH (4)	Nursing Home	Private	30 + 15 nurses	50	£5.80 - £6.70	Yes	70	5	NVQ figure for care staff and not including nurses
PLDH	Disabled	Voluntary	120 main site	12	£6.80 – £7.80	Yes	50	10	
CH (1)	Children	Voluntary	18	10	up to £9.60	Yes	None 70	None 30	Equivalence recognised de facto
CH (2)	Children	LA	15	0	£8.17 - £10.80	Yes	80	20	

Note: Some of the above figures, especially on turnover, are estimates by informants. Full pay ranges were not always given. The NVQ figures were taken from NCSC or CSCI reports, estimated by the informant, or calculated by the authors.

On both occasions, the principal method was a series of face-to-face interviews with managers and workers. Seven case studies were undertaken which included private, voluntary, and local authority (LA) provision, chosen from across the sector to cover the care of old people, people with learning disabilities, and children. The cases were selected to cover a range of circumstances, as distinct from any statistical notion of representativeness.

Details of the case studies are summarised in Tables 1a and 1b. Interviews with managers and workers were taped and transcribed. In what follows, the initials of a home, along with a year, indicate that evidence was drawn from an interview with a particular home in that year. For example, OPH 1 2003 indicates that the evidence is drawn from an interview which took place at Old Person's Home 1 in 2003. The case studies were supplemented by interviews with representatives of key organisations, including government, various statutory bodies, employers' organisations, and trades unions. The interviews were also complemented by consideration of primary and secondary data and available literature and statistics.

4 Results: The Impact of Targets

The case studies indicated that employers have taken seriously their obligations under the regulations and have engaged in more training than in the past. While in 2003 only one of the homes visited was in compliance with all of the qualifications requirements specified in the NMSs (namely CH 2), by 2008 a majority of the original case study organisations were compliant: all of their registered managers possessed the relevant NVQ4 qualifications (or an equivalent); three of the four old people's homes originally visited had satisfied the requirement that at least 50 per cent of their care workers possess an NVQ2, as had the home for people with learning disabilities; while one of the two children's homes met the 80 per cent NVQ3 ratio. The two exceptions to this norm of compliance are as follows. One of the old people's homes visited in 2003, namely OPH 3, subsequently closed. This was replaced in 2008 by a closely matched home, in terms of sector, size, and location, which had itself come to surpass the 50 per cent NVQ2 ratio. Second, in the early 2000s CH 1 made a conscious decision to eschew NVQs and to adopt a training regime based on a psychoanalytical approach to childcare, validated by Middlesex University. This is deemed by the management of the home to be at least the equivalent of the NVQ3 in childcare specified in the NMSs and OfSTED inspectors have accepted it in practice.

Even so, with 70 per cent of staff possessing the Certificate as of 2008 (as opposed to 55 per cent in 2003), the home falls short of the 80 per cent qualifications ratio stipulated in the NMSs (although the remaining 30 per cent of the workforce are receiving training).

The increase in the qualifications ratios between 2003 and 2008 was widely attributed by the interviewees to the advent of the regulatory framework. As the manager of OPH 2 put it in 2008, the qualifications targets had 'pointed out how important it was that people were trained and … [had] put a boot up people's backsides', providing much-needed impetus for increased training. Similar views were expressed in 2008 by the manager of PLDH 1, for whom the NMSs were a 'real driver' of change in the personnel and training areas.

Such views are consistent with those expressed by representatives of various sector-wide organisations. The interviewees from SfC, for example, argued that the targets had been an important catalyst for change in the sector's attitude towards training. The conclusion towards which such testimony directs us, namely that the qualifications targets have had a significant impact on training, is in line with that reached by a recent Cabinet Office study of skills in adult care, according to which: 'Regulation has had an effect, resulting in a steady increase in the proportion of qualified people. Everyone we spoke to believes that far fewer employees would have been trained in the absence of regulation' (CO / IPA 2008: 16, 24).

However, the success of these homes in achieving the qualifications ratios may not be representative of the sector as a whole, where the evidence suggests that the impact of the regulatory framework has been less pronounced than in our sample. Here we set our case study findings in context by considering flow and stock measures of qualifications.

The flow measures are based on data for NVQ registrations and qualifications, which can be found in Table 2. The data in the Table reveal that the number of new registrations at both level 2 and level 3 increased each year between 2000 and 2005, tailing off only very slightly in 2006. In both cases, the number of new certificates awarded increases each year. Predictably, the biggest increase in the number of new registrations at level 2 came in 2003 and 2004, as homes for older people and for people with learning disabilities strove to meet the new 50 per cent target stipulated. In similar vein, the largest increases in the number of new registrations for level 3, childcare NVQs came in 2004, in the run-up to the 2005 deadline for achieving the 80

per cent target in children's homes. These findings testify to the impact of the NMSs on training in the sector.

Table 2. New registrations and new certificates awarded, for selected Care Sector NVQs/SVQs, by level

	Level 2		Level 3		Level 4	
	Reg.	**Cert.**	**Reg.**	**Cert.**	**Reg.**	**Cert.**
2000	34416	19379	4038	7353	0	0
2001	43736	19725	5308	9544	0	0
2002	50876	23462	5954	12414	4265	187
2003	63583	28799	7293	14949	10192	1379
2004	79104	39616	9200	19144	8442	3609
2005	82857	52213	10109	23533	8890	5558
2006	80653	63732	9177	32272	8030	6045

Source: Calculated from: Local Authority Workforce Intelligence Group (2008: Table 2 and Table 6).

Note: Level 2 figures are the sum of registrations (or certificates) for NVQs/SVQs in Care (level 2) and for Health and Social Care (level 2). Level 3 figures are the sum of registrations (or certificates) for NVQs/SVQs in Caring for Children and Young People (level 3) and for Health and Social Care (Children and Young People) (level 3). Level 4 figures are the sum of registrations (or certificates) for the Registered Managers' Award (Adults) (level 4) and the award for Managers in Residential Childcare (level 4). Unfortunately, 2006 is the last year for which consistent data is available.

The data also indicate that the imposition of the requirement that registered managers possess an NVQ4 (or the equivalent) has had a considerable impact. The Registered Managers' Award (Adults) (level 4) and the Award for Managers in Residential Childcare (level 4) were introduced in 2002. After 4265 people registered for those awards in 2002, the number of new registrations more than doubled in 2003, with 10 192 additional registrations. The number of new registrations remained over 8000 per annum for each of the following three years. The number of certificates actually awarded rose from a cumulative total of just 187 in 2002 to 16 778 by the end of 2006. It is hard to see such interest as anything but a response to, and an effect of, the NMSs.

The stock measures are of various kinds and from various sources. We consider both the proportion of *staff* who possess the relevant qualifications and also the percentage of *homes* which have achieved the targets specified in the NMSs. So far as the former is concerned, what limited data are available present a picture of

mixed progress towards the NVQ2 target. According to a recent Cabinet Office report, 30 per cent of staff in adult care have 'relevant qualifications' (CO / IPA 2008: 10). A slightly different picture comes from SfC, which suggests that just 23 per cent of care workers, and 54 per cent of senior care staff, in adult care possess an NVQ2 or above. However, the SfC estimate is derived from the recently developed SfC National Minimum Dataset (NMD), which is based on voluntary returns from employers, a majority of whom have not reported information on qualifications. Therefore, it may well underestimate the proportion of staff who have achieved an NVQ2 or above (CO / IPA 2008: 16, 53). Although this represents a notable improvement on the situation at the inception of the 2000 Care Standards Act – when, as we have seen, just 20 per cent of staff had relevant qualifications – it clearly indicates that only limited progress has been made towards the 50 per cent target, casting doubt on the latter's feasibility.

A rather more favourable impression is provided by data on the percentage of homes for older people and for people with disabilities that are satisfying the 50 per cent NVQ2 target. Consistent with our case studies, the proportion of homes of both kinds which have achieved that goal has increased over time, from about 48 per cent in 2002/03 to around 78 per cent in 2006-07 in the case of care homes for older people, and from about 63 per cent to 80 per cent in the case of homes for people with learning disabilities (Eborall and Griffiths 2008: 94). However, around one fifth of homes of both kinds have fallen short of the target over a year after the deadline. While progress has been made, there remains considerable work to be done before all providers satisfy the qualifications standards.

A similar pattern can be found in children's homes. The percentage of children's homes satisfying the NMSs for staff training increased from 46 per cent in 2002-03 to 70 per cent in 2005/06. The corresponding figures for residential special schools are 52 per cent and 80 per cent (CSCI 2007: Tables H1 and H3). Once more, there is evidence of a significant increase in the percentage of homes complying with the standards, but with a significant minority of homes still failing to make the grade. Finally, the NMD suggests that around 57 per cent of the registered managers for whom information is available possess the NVQ4 stipulated in the NMSs. However, as was the case of care workers and the NVQ2, this figure seems likely to underestimate the extent to which staff have met the relevant standard, as around one quarter of the returns received for registered managers contained no information on

their qualifications. SfC concludes that the data suggest that there has been significant progress towards the target for registered managers (SfC: 2007a: 2).

In addition to the above, we note that all our case study employers had adopted the TOPSS / SfC induction programme. Moreover, almost all of our interviewees, whether managers or workers, were favourably disposed towards the induction standards, which were widely seen as a success. Prior to 2002, induction training had been *ad hoc*, lasting for little more than a day and covering only a narrow range of topics (e.g. fire precautions and basic health and safety). Our case studies suggest that, as early as 2003 and to an even greater extent by 2008, induction training had increased in length, formality, and breadth, covering in a more detailed and systematic way a broader range of topics concerning the principles of care and the needs of care users. The new approach was often praised for inculcating in recruits a clearer understanding of their responsibilities and a better appreciation of what quality care involves. As a result, it is said to have helped to ensure that new staff are better prepared for work, being able to contribute more quickly and effectively than under the previous regime. Moreover, induction training is now better integrated with the NVQ, so that recently appointed workers can make a smoother transition to the latter, using induction as a basis for their NVQ portfolio.

In addition, all of the homes we visited seemed to be in compliance with the requirement that all staff should receive a minimum number of paid days training each year. It appeared that, in most cases, the days in question were used for mandatory training, designed to help employees maintain and update their skills and covering topics such as health and safety, handling and lifting, the protection of vulnerable adults, and infection control. Training in such mandatory topics now seems to be built into homes' routines as an ongoing process (e.g. OPH 1 2003, OPH 2 2008, OPH 3 2008, OPH 4 2008, PLDH 1 2008).

Overall, the evidence – both from our case studies and from other sources – suggests that the advent of qualifications targets has had a significant impact on the sector, with the number of registrations and qualifications achieved increasing significantly as a result of the regulatory framework introduced in 2002. There has been a significant increase in the proportion of homes which are in compliance with the NMSs, so that a majority of homes have achieved the requisite qualifications ratios. There has also been a significant, positive effect on induction and continuing training. Notwithstanding such changes, however, a large minority of homes in all

sectors have yet to achieve the required standards. Nevertheless, the fact that around two thirds of direct care workers are working for a relevant vocational qualification, mostly NVQs, suggests that – even given high turnover rates – the proportion of homes which are in compliance with the training standards can be expected to increase (Moriarty 2008: 21).

5 Impediments to Achieving the National Minimum Standards in Training.

Having outlined the impact of the NMSs, we consider some of the factors which have impeded efforts to increase training and achieve the qualifications ratios. We will then discuss the broad merits of recent attempts to increase the proportion of qualified staff in the care sector.

5.1 Factors that impede employers' efforts to meet qualifications targets

5.1.1 Cost of training / funding

In 2003, our case study employers portrayed financial considerations as a significant obstacle to achieving the 50 per cent and 80 per cent targets (Gospel and Thompson 2003: 61). At that time, while financial support was available to assist employers in meeting the explicit costs of offering training courses and assessing trainees' achievements, the implicit costs incurred, because of the need to replace staff who took time off work either to be trained and assessed or to assess junior colleagues, were borne largely by the employer.[3] In 2008, however, our interviews suggested that the advent of additional sources of government funding means that significant assistance with replacement wage costs is now available, reducing the percentage of the total costs which must be covered by employers. The upshot is that the net costs of the NVQ2 and NVQ3 to employers are now relatively small, leading to a significant easing of the financial constraint on training. As one manager put it in 2008, 'It costs me nothing ... NVQ2 comes free all the time' (OPH 2 2008; also see PLDH 1). Financial considerations, then, appeared to pose less of a problem in 2008 than in 2003.

[3] Accurate estimates of the cost of NVQs were hard to acquire in our sample, with some employers having little idea of the relevant costs. In 2003, and again in 2008, the direct costs of NVQ2s and NVQ3s (i.e. including course and assessment fees, but not replacement wage costs) were said to be between £600 and £1000 and £800-1000 respectively. In 2003, one of our case study employers, PLDH 1, had judged that the total cost of an NVQ2, including replacement staff costs, was somewhere in the region of £2750.

The impact of enhanced government funding would, however, have been even greater had the regime through which it is made available been less labyrinthine. Our interviews indicate that the multiplicity of funding sources accessible form a landscape of considerable complexity, the intricacies of which remain incomprehensible to many, especially small, employers (e.g. OPH 2 2003, OPH 3 2003). (Where external funding is used, employers often have little idea of its source, beyond saying that it was accessed by the external training provider or local further education college from which training or assessment services are obtained.) While it is indeed the case that funding is less of a constraint on employers' ability to offer training in 2008 than in 2003, there remains a need to simplify the funding process in order to increase uptake by employers. Employer consortia (brokered by SfC, the LSC, social services, and employers' organisations) and private training providers have assisted employers, especially smaller homes, to access funding and to organise training. However, more remains to be done (cf. CO / IPA 2008: 5, 17-20).

Financial considerations aside, it is also worth noting that employers still face the practical difficulty of rescheduling work rotas so as to release people who need either to be trained/assessed or to act as trainers/assessors. The problem of arranging cover for such staff remains a constraint on the ability of employers to engage in training, simply because it is often difficult for them to find a worker willing and able to fill in for those engaged in training and assessment.

5.1.2 Assessment

One potentially important constraint mentioned by a number of providers in 2003 arose from a shortage of assessors, which was thought likely to impede employers' ability to satisfy the NMSs. At that time, a number of our case study homes were attempting to address that problem by training managers to act as in-house assessors (Gospel and Thompson 2003: 61).

Things were rather different in 2008, by which time there had been a shift away from internal assessment towards the use of external assessors. The reason is that, while staff may prefer internal assessment, because they find it less intimidating, hard-pressed managers often simply do not have the time required to undertake proper assessment (e.g. OPH 3 2008). In order to relieve the burden on managers, a number of homes in our study have switched from a regime of in-house assessment to one where assessment services are purchased from external providers. For instance, both

OPH 4 and PLDH 1, which in 2003 relied on internal assessors, had by 2008 shifted to external assessment in order to free up scarce managerial time. Moreover, financing such external assessment is unproblematic for homes because, as we have noted, the cost is now largely covered by government grants. The upshot of these changes, then, is that assessment appears to be less of a problem for care homes in 2008 than in 2003.

5.1.3 Turnover

One of the major fears voiced by employers in 2003 was that, having incurred the cost of training staff, they would see newly trained workers poached by other employers, both within and outside the care sector (e.g. OPH 1 2003). The prospect of such turnover was described by employers as a deterrent to engaging in training (Gospel and Thompson 2003: 61).

The likelihood that trained staff would be poached by other employers was still described as a deterrent to training in 2008, with one employer referring to the NVQ as a 'passport to another job' (OPH 3 2008).[4] Another interviewee referred to the way in which turnover left managers feeling like they were 'painting the Forth Bridge – as soon as you skill people, they leave, and you have to start all over again'. Indeed, such is the concern about turnover that another of our employers attempted to deter trained employees from leaving by requiring them to sign a contract committing them to repaying part of the cost of the NVQ (£360) if they moved elsewhere within one year of receiving training (OHP 4 2008).

Whilst some employers thought that awarding formal qualifications would increase turnover, others argued that the advent of portable qualifications would not necessarily increase employees' propensity to quit. In 2003, management at PLDH 1 argued that, if certificated training were accompanied by the prospect of higher pay and better career prospects, then workers with new qualifications would not necessarily wish to move to another employer, so that training need not increase turnover, and might even reduce it. Such expectations appear to have been accurate in that particular case; during our 2008 visit, management stated that the NVQ had helped attract and retain staff and that turnover had fallen from 18 per cent in 2003 to 12 per cent in 2008. More generally, the data collected in the course of our case

[4] The jobs in question tend to be elsewhere in the care sector, or in the NHS, to which people are attracted by the superior pay and pensions (Eborall and Griffiths 2008: 10).

studies indicates that, excluding OPH 4 on the grounds that the original home had closed, turnover increased in only one home, namely OPH 1, and then only marginally, either staying the same or falling in the remaining five homes (see Tables 1a and 1b). On balance, it appears that employers' fears have not proven well founded; retention has not been harmed and may even have been improved by the training requirements, at least in those cases where qualifications were thought to enhance people's status and likelihood of career progression.

5.2 Factors that discourage staff from taking an NVQ

The main barriers to the take-up of NVQs by staff were as follows.

5.2.1 Time constraints

The problem of time constraints arises because many care workers have other, pressing commitments – for example, looking after children in the case of younger workers and caring for older relatives in the case of older workers – which leave them insufficient time to do the 'homework' required for the NVQ (e.g., OPH 2 2003, OPH 3 2003). Our interviewees suggested that, on average, an NVQ2 requires trainees to study for one to two hours per week in their own time. A lack of time was still felt to be a significant problem in 2008 (e.g. OHP 3 2008).

5.2.2 The academic demands of NVQs

A second barrier to the adoption of NVQs arises from the fact that many care workers do not have strong academic backgrounds and remain suspicious of formal instruction, often resulting from poor experiences at school. While the NVQ has the advantage of being practical, work-based, and mostly provided on-site and on-the-job, nevertheless in 2003 the presence even of some off-the-job training, and the requirement to produce portfolios of written work, intimidated many workers, making them reluctant to start an NVQ. This aversion to formal training is encapsulated in the sentiment, expressed by many interviewees that they did not want to 'go back to school' (cf. McFarlane and McLean 2000: 395-96).

Our interviews suggest that this constraint on training relaxed between 2003 and 2008. Staff now appear less apprehensive about the NVQ process, reflecting a number of developments. Some of the older workers who were least enthusiastic and confident have left the sector, whilst those who remain have become more accustomed to the pressures of the NVQ. Moreover, those requirements have been

relaxed in ways which make NVQs more appealing to the type of person who works in care. For example, whereas in 2003 NVQs were criticised for what was seen as a cumbersome, bureaucratic assessment process (e.g. OPH 3 2003, OPH 4 2003), such criticism had become more muted by 2008, thanks to a reduction in the volume of paperwork required to document competences (e.g. OPH 3 2008, PLDH 1 2008). In particular, a reduction in the size of the portfolio means that fewer people are now deterred from taking an NVQ by the requisite written work. Furthermore, the fact that standard practice now seems to involve most of the formal NVQ training and assessment taking place on-site, and in normal working hours, with only a limited amount of off-site training at local further education colleges, also helps to alleviate potential trainees' concerns about 'going back to school'. Additional encouragement to participate in training derives from the fact, widely recognised by younger workers, that career progression, both internally and externally, requires qualifications (e.g. OPH 4 2003, PLDH 1 2003, CH 2 2003), a point to which we return in section 5.2 (e) below.

5.2.3 Deficiencies of basic skills

A third, related constraint on the ability of a sizeable minority of care workers to take full advantage of the training offered, frequently mentioned both in 2003 and 2008, lies in their lack of basic skills (literacy and numeracy), which makes it harder for them to acquire and demonstrate the competences required for the award of an NVQ (e.g. OHP 2 2003, OHP 4 2003, OHP 3 2008). In particular, our interviewees suggest, the limited command of written English displayed by some trainees makes it hard for them successfully to exploit opportunities for training. Such problems are especially prevalent amongst older workers and those for whom English is a second language. While attempts have been made to address this issue, for example by integrating training in basic skills into the NVQ process, our interviews indicate that it remains a significant problem, not least because of the increasing reliance on immigrant workers (cf. Platt 2007: 24).

5.2.4 Weak financial incentives

Another significant constraint on employees' willingness to participate in training derives from the fact that in most cases they gain few financial rewards for obtaining qualifications. Staff at a number of the homes expressed disappointment that they were not paid more upon completion of the NVQ (e.g. OPH 1 2003, OPH 1 2008,

OPH 2 2008, PLDH 1 2003). This finding is in keeping with other research, which revealed that many employers do not increase the pay of their workers at all when the latter obtain qualifications and also that, in those cases where pay is increased, the pay increment tends to be very small. For example, evidence from the NMD indicates that in 2006/07 the average difference between the pay of care workers who had an NVQ and those who did not was just £0.15 per hour in the case of NVQ2 and £0.20 per hour in the case of NVQ3 (Eborall and Griffiths 2008: 83). The fact that the immediate financial rewards for achieving an NVQ are so small implies that there are only weak incentives for workers to achieve such qualifications.

There are, however, some exceptions to this pattern. In 2008, staff at PLDH 1 who achieved an NVQ2 saw their pay rise by £1/hour, just under a 15 per cent increase on their pre-qualification hourly wage. Workers in that home spoke positively about the enhanced pay and said that it provided a real incentive to gain an NVQ. Similarly, in OPH 2 2008 there are rewards for those achieving an NVQ2 with a 14 per cent increase in their hourly wage (a £0.75 per hour increase on a pre-qualification wage of £5.52). Given that care workers in private and voluntary sectors have been found to change jobs for increases of as little as £0.50 per hour, pay rises of this magnitude are far from trivial and constitute a powerful source of encouragement for workers to gain qualifications (CO / IPA 2008: 17).

5.2.5 Limited career prospects

Finally, one of the benefits of NVQs, interviewees told us, is that they help to promote in younger staff in particular a desire for progression and a belief that training will create better career prospects (e.g. OPH 1 2003, PLDH 1 2003, OPH 1 2008, OPH 4 2008). If that is the case, then although the award of an NVQ might not precipitate an immediate pay rise, the prospect of future promotion, and the accompanying higher wages, might still be sufficient to give staff an incentive to augment their skills. The problem, in practice, however, is that opportunities for progression to level 3 (in the case of eldercare workers) or level 4 (in the case of those working in children's homes), and for promotion, are rather limited. To see why, note that care staff are usually organised in a hierarchy, topped by a professional manager, and consisting, in ascending order of seniority, of (junior) care workers, senior care workers, and team leaders. Movement both within, and beyond, these levels is impeded by several factors.

First, our case studies indicated that there are barriers to obtaining managerial experience and hence NVQ Level 3 qualifications. At both times in our research, interviewees suggested that one obstacle to progression from NVQ2 to NVQ3 in the adult sector is that the supervisory experience required for the latter is greater than that associated with most of the roles occupied by those wishing to take it, making it hard for trainees to acquire and demonstrate the competences required for the award (e.g. OPH 3 2003, OPH 3 2008, PLDH 1 2008). Similar problems arise in the case of NVQ4; interviewees from the children's homes in our sample reported that progression to level 4 was difficult because it was hard, especially in smaller organisations, to obtain the relevant managerial experience (e.g. CH 2 2008). These difficulties are not insurmountable – some homes have shown real flexibility in allowing staff to take on level 3 and 4 tasks before they assume the relevant job role in order to give them a start at accumulating the experience required for the higher level qualifications, while others had arranged for staff to be seconded to different homes in order to gain experience (e.g. OPH 3 2008). Nevertheless, they are widely perceived as a significant constraint on progression to further training.

Second, having equipped people with the skills required for more senior jobs and raised their ambition for promotion, it may be difficult for employers actually to satisfy those expectations, because of a paucity of senior positions into which newly trained workers can move. This difficulty is especially pronounced in small homes, whose flat organisational structures involve relatively few posts for higher positions, and so afford only limited opportunities for newly qualified staff to advance their careers (cf. McFarlane and McClean 2000: 396; CO / IPA 2008: 37). Moreover, in line with 5.2 (d) above, that even where promotion *is* possible, the pay differentials between junior and senior care workers are so small – there is only a £0.30/hour difference between their median pay – even the prospect of advancement to more senior positions provide only a weak incentive to acquire new qualifications (SfC 2007b; Eborall and Griffiths 2008: 83). Where employers cannot reward staff who have achieved a qualification, by satisfying the ambition for higher pay and/or promotion, trained staff are more likely to leave the employer with whom they were trained.

Third, advancement to higher-level jobs is often blocked by nursing and other professional requirements. For example, staff in the nursing home we visited felt that there was a ceiling beyond which people who were not qualified nurses could not pass

(OPH 4 2003). A similar problem arose in the case of the two children's homes in our study, at both of which we were told that progression beyond level 3 posts was difficult without a DipSW or a degree – 'You hit a ceiling' – both of which were seen as beyond the reach of most care workers (e.g. CH 2 2003, CH 2 2008).

The danger to which such obstacles to the promotion of newly qualified staff gives rise is that a failure to fulfil workers' hopes of career advancement and higher pay may lead to disillusionment about training, both on the part of the care workers themselves, who cannot see how training will help them to satisfy their ambitions, and also on the part of employers, who see newly qualified workers depart in search of higher pay and promotion. While this problem has not yet manifested itself – in both 2003 and 2008 we found many care workers who wished to do further training and take on extra responsibilities – it may well do so in future. We shall consider how it might be addressed in Section 6.2 below

6 Discussion

According to the case studies and background evidence documented above, while the NMSs for qualifications have not yet been universally satisfied, the regulatory framework implemented in 2002 *does* appear to have had a significant effect on qualifications ratios. However, while qualifications ratios have improved, there may remain grounds for scepticism about NVQs and concerns about how the training regime has intersected with broader HRM. We consider each of these possibilities in turn.

6.1 NVQs: training or the certification of existing skills?

One potentially important concern arises from the fact that, because an NVQ is an assessment process rather than a training programme, the award of an NVQ may involve no more than the certification of employees' *existing* competences rather than the acquisition of new skills which that will enable workers to offer higher quality care. There exists, therefore, the possibility that employers will adopt a *ceremonial* (Meyer and Rowan 1977) response to the regulatory framework which sees them strive to no more than *formal* compliance, simply by accrediting skills long possessed by their employees, as opposed actually to equipping workers with new skills, as *real* compliance would demand (Wolf *et al*. 2006: 555). Such behaviour contrasts with the approach adopted by those employers who display a genuine *commitment* to satisfying

the requirements of the regulatory framework: at a minimum, such a commitment to the NMSs would involve employers actually training their workers in order to improve their skills; a more thoroughgoing commitment would see employers use the impetus provided by the NMSs to support a more fundamental rethinking of how they manage labour, with regard not only to skills training but also embracing issues such as pay, career prospects, and job security.

Some of our homes complained that the NVQ 'does not teach much – it is a confirmation, which could be had in other ways with less money', and that 'it is not learning, but a verification exercise' (PLDH 1 2008, OPH 1 2008, CH 1 2003, and CH 2 2008). Notwithstanding such comments, however, the interviewees also acknowledged that for some staff, with some assessors, there is 'real advice and training' (PLDH 1 2008; OPH 2; and CH 2 2008). Even CH 1, which has so far managed to avoid NVQs in favour of an alternative approach, admitted that the 2008 version of NVQs have come to incorporate more 'real material' and induce more 'self-reflection'. Many interviewees report that in practice NVQs involve training as well as assessment, sometimes through assessors 'tutoring' students to provide them with 'underpinning knowledge' (OPH 3 2003), in other cases via off-the-job 'theory' training at local colleges (e.g. OPH 1 2003, OPH 2 2008). The case studies suggest that while some certification of existing skills has undoubtedly taken place, in many cases there has also been real training and learning associated with NVQs (cf. Roe *et al*. 2006; Cox 2007).

Moreover, the training that appears to be a part of NVQ provision in many homes does bring benefits. In many cases, staff who have acquired an NVQ are said, by both themselves and their managers, to have a better understanding of the needs of their charges and a clearer idea of high quality care. As a result, staff are more reflective, more willing to question current practices, and more able to contribute to the provision of better services (e.g. OPH 1 2008, OPH 2 2008, PLDH 1 2008, CH 2 2003) (cf. Sargeant 2000: 648).

Overall, then, the impression gained from the majority of our interviews is that, for all their faults, NVQs provide real benefits to both employers and employees. By 2008, most of the managers and staff we interviewed felt that NVQ training and assessment was better than what had gone before, which in many cases was very little, and that NVQ targets should not be relaxed.

6.2 Broader HRM issues: high performance work systems?

The government has expressed the hope that the NMSs will encourage employers to think more strategically about training as part of a broader array of HRM practices, including those governing pay, promotion, job design, and career structures. For example, *Options for Excellence* states that improved training should form part of a 'whole systems model' for workforce development and, as such, needs to be accompanied by greater support for learners, the design of new job roles and career paths, and improved pay (DH 2006: 17-20, 44-45; DH 2000: 36-37, DH 2005: 66).

The HRM literature on high performance work systems (HPWS) gives a sense of what such an 'integrated' approach to training might entail. The strategic HRM approach focuses on the degree of compatibility or 'fit' between an employer's training programme and other HRM practices. In the case of the service sector, the literature suggests that the impact of a training programme on the quality of services will be greatest if that training is combined or 'bundled' with a variety of complementary practices which help employees to develop the type of organisation-specific human capital – knowledge of the firm's products, customers, and work processes – which enables them to interact effectively with customers (Batt 1999, 2002; Boxall and Macky 2009).

In the case of care services, previous research has identified an association between a particular bundle of HR practices and high quality care. These practices include: (a) the provision of training, along with (b) supervision and feedback on the effects of their work, (c) job security (as indicated by the share of the workforce which is permanent); (d) the importance of informing workers about the condition of the people for whom they are caring, (e) teamwork (so that care workers can undertake difficult tasks together and share information); and opportunities for (f) higher pay and (g) career advancement (Eaton 2000; Hunter 2000).

None of our case study homes have moved very far in this direction. The most significant positive development is provided by the fact that most of the homes seemed both to provide genuine training and also to have integrated the various types of training into a relatively coherent whole (with induction training dovetailing with the NVQ process and with training on mandatory topics incorporated in homes' routines). Also in a positive vein, job security does not appear to be a problem; the case study homes all expressed a reluctance to use agency workers, preferring (on grounds of cost and quality) to rely on their own permanent (albeit often part-time)

staff. Indeed, the employers in our sample were centrally concerned with persuading workers to remain with them in order to reduce turnover, especially in the light of the increased training now being provided.

However, the cases suggest that few of the other HRM practices which complement training have been widely adopted. Only a minority of homes offer their workers a financial reward for attaining qualifications. Care workers appear to enjoy only limited discretion (for example, typically they have little if any input into the personal care plans devised for users, and must refer to senior workers even when it comes to relatively mundane tasks, such as when to move patients). Progression is often problematic, both in terms of moving on to higher-level qualifications and also when it comes to promotion to more senior positions. Moreover, while a number of employees expressed a wish to undertake a wider range of activities – most notably those involving basic medical tasks, such as changing dressings and catheters and administering some medication, attempts to design the type of new, expanded job role which would be required to satisfy such aspirations are conspicuous by their absence (e.g. OPH 1 2008 OPH 3 2008, OPH 4 2008). Certainly, in the case studies, there was no evidence of the type of creative human resource planning identified by Cox (2007) in her study of care workers in the NHS, whereby expanded jobs have been designed in order to give assistants the opportunity to undertake simple medical tasks and to assist their progression to further professional training.

However, there are a number of reasons why this state of affairs may well have to change in the future. First, the demand for multi-skilled workers of the type who would occupy 'hybrid' job roles is likely to increase in the future, as the average age at which people enter care homes and hence the complexity of the care they require increases. Second, on the supply side of the labour market, the care sector faces the prospect of increasing problems with recruitment because the pool of workers from which it has drawn in the past – middle-aged women, with few if any educational or professional qualifications – seems likely to decline, relative to demand. Faced with a situation in which fewer women are leaving school without qualifications than in the past, in which those women may be more ambitious for a career than their predecessors, and in which there is also likely to be increasingly fierce competition for their services from other sectors, it is becoming more important for care employers to offer potential recruits a realistic prospect of a career if they are to have a chance of hiring the volume, and quality, of workers they need (Simon *et al*.

2003). As the government recognises (DH 2008), it is important – both in the light of the considerations mentioned above and also given the increasing emphasis currently being placed on the role of domiciliary care and the personalisation of social services, both of which may generate increased demand for more flexible, multi-skilled workers – that such innovative, hybrid roles be adopted more widely (SfC 2009). The evidence collected from our case studies suggests that there is an appetite for such roles within the care workforce.

Overall, then, while there is some evidence that the NMSs have provoked broader, strategic thinking about some aspects of labour management – in particular, the coordination of the various types of training (induction, NVQ, and mandatory) and in some homes the links between pay and qualifications – the extent to which new training regimes have been accompanied by a wider set of complementary HRM practices is limited. The homes in our sample still have a long way to go before they approximate the type of HPWS to which the government aspires.

7 Conclusions

The implementation of the regulatory framework in social care from the early 2000s onwards constituted a major development for the sector. The linking of regulation to training was innovative and has had positive effects on the level of training and qualifications in the sector. Both management and staff in our case studies are mainly supportive of the present framework and, if anything, favour a tightening up of some of the arrangements, in the area of targets, inspections, and registration.

However, change is afoot, for the Government is in the process of re-fashioning the regulatory arrangements for care. The impetus for these changes has come from some perceived shortcomings of the current regulatory regime and from the recent emphasis on the importance of 'personalising' care services, via direct payments to users and the provision of individual budgets, so that users enjoy greater choice, independence, and control over the care they receive (DH 2005, 2006, 2008; DfES and DH 2006). In addition, recent years have witnessed a move towards a 'lighter touch' approach to regulation. Whereas homes used to be subject to two inspections each year, inspections are now said to be 'risk-based' and 'output-driven', being informed by homes' self-assessment reports and triggered by factors such as a poor past record or the lodging of complaints. The aim of such changes has been to reduce the regulatory burden on providers, whilst not endangering the welfare of

users. This change has been accompanied by a shift in the focus of regulators' attention away from 'inputs' and 'processes' towards 'outcomes', intended to increase providers' and inspectors' focus on the needs and welfare of care recipients. As part of these changes, a revision of the NMSs is under way. While the 50 per cent qualifications target is still formally addressed by inspections, discussions surrounding the proposed revisions have included as yet formally unsubstantiated talk of downgrading it.[5]

In conclusion, in 2003, one of the organisations in the care sector referred to the regulatory arrangements as 'a new and exciting form of regulation', whilst another interviewee from one of the key organisations spoke to us of 'the brave new world of regulation in social care'. Undoubtedly, there have been problems and challenges in making the system work, but there are some indications that it has been an effective vehicle for workforce development and better service delivery. The danger is that the recent changes may undermine the scope for further improvement.

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[5] Perhaps significantly, the box which used to be ticked if the home under inspection met the 50 per cent targets has been excised from inspection reports.

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