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Helpcare Desktop Research

A look at Care provision, Education and Training including Best Practice examples in the UK and the Netherlands

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Lancaster and
Morecambe College
Paul Ineson
ULANC
Sarah Edwards

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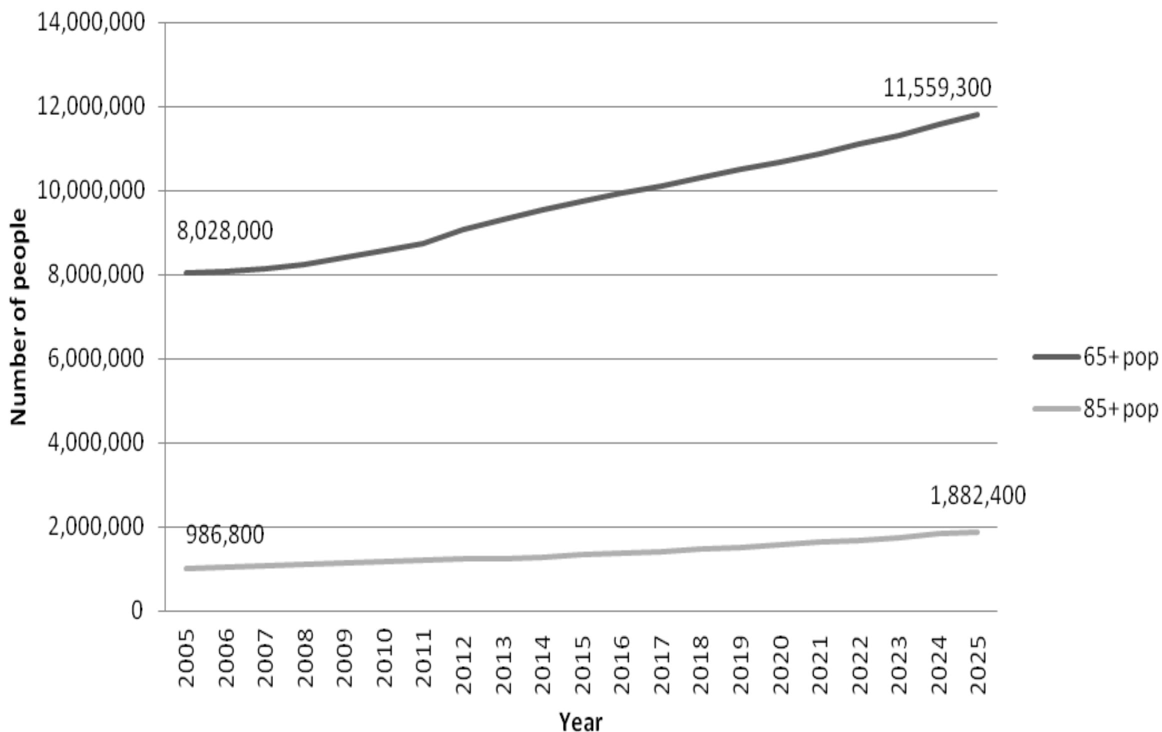
Aim/Introduction

The purpose of this report is to provide an account of the current situation relating to the provision of health and social care in the UK with specific attention to England. The report will also look at the training and education that is currently available to care workers and the differences between formal and informal care. It is important to note the changes in population trends and contractual arrangements for workers and these will be outlined in the overview section. Specific areas and examples of Best Practice from the south of England will be highlighted. The section on a best practice example from the Netherlands makes interesting reading and is included here as both a comparison and possible source of ideas for future practice, its inclusion is felt appropriate with Helpcare being an EU project.

Overview

The UK population's changing demographics predict an increase in the ageing population and its impact on social care will ultimately require a significantly higher number of employees in the adult social care sector in the future. By 2041, the number of people in England aged 85 is expected to increase by 2.5 times the 2010 figure to 3.2 million representing 5% of the total population (Skills for Care, 2015). There are near to seven million carers in the UK which equates to one in ten people. This figure is set to rise in the UK over the coming years (www.carers.org, 2015).

Figure 1: 65+ and 85+ population estimates and projections between 2005 and 2025, England (Age UK, 2014)



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Formal Care

There are presently just over 1.6 million formal care workers (i.e. paid workers) in England, a workforce already larger than the 1.3 million-strong NHS. This has grown by 15 per cent in three years. A large proportion of the workforce are employed by very small organisations, some of which provide domiciliary care, or 'home help' as well as individuals with learning disabilities who live in a supported living environment and also includes others of whom operate residential/nursing care homes. Skills for Care (2015), estimates that the number of paid adult social care jobs could increase from the current 1.63 million, to between 2.1 million and 3.1 million by 2025 and over the next 30 years, the number of carers will probably increase by 3.4 million (around 60%). To cope with this predicted growth of adults requiring supported care, it will be necessary therefore to significantly increase the number of trained and qualified employees in the adult social care sector, or risk having inadequate care provision in the future.

Of the people currently employed in social care, 307,000 workers in England are employed on zero hours contracts (Norman Lamb, Care Minister, 2014). Zero hours contracts occur when 'people agree to be available for work as and when required, but have no guaranteed hours or times of work' (ACAS, 2012). According to the Office for National Statistics' Labour Force Survey (2012), the social care sector is well above average compared to other sectors in using zero hours contracts for formal care. In a report by Skills for Care (2011), the social care workforce (excluding managers and social workers) is relatively unskilled. In 2010 two-thirds (67 per cent) of people working as 'care assistants and home carers' claimed to be qualified to the basic NVQ Level 2 or above, and 7 percent had no qualifications at all.

Informal Care

Most people who need care rely on family members, friends and neighbours these are categorised as informal carers. National surveys estimate that there are approximately 6.4 million family carers in the UK, an increase of over 10% since 2001. This figure represents 12.6% of the adult population. It is predicted that this number of informal carers will soar to nine million by 2037 and that three in five adults in the UK will become a carer at some point in their lives. (www.communitycare.co.uk, 2012). With the increasing number of people taking on informal care roles, clearly there will be a need to provide greater help, information and guidance to support this growing area.

As well as support from the formal care workforce, informal carers may in the future need to access some of the existing training offered to the formal workforce to provide effective care. Justine Cawley, director of the Elizabeth Care project supports this view in a recent article in the Daily telegraph (2014), she states that 'To deal with our ageing population – and one with increasingly complex conditions, we not only have to train the existing workforce, we should include training unpaid carers too'.

Education and Training in care in England

National Framework

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are a body that provide training and support for Adult health care workers for the whole UK health sector and work alongside health and social care employers licensed by the Government. They generally work alongside Skills for Care in conjunction with the Qualification and Credit Framework (QCF)[1].

1. The Qualifications and Credit Framework (QCF) is the national credit transfer system for education qualification in England, Northern Ireland and Wales. The QCF is a national framework referenced to the European Qualifications Framework (EQF).

The main framework of Adult social care qualifications in England have been developed by Skills for Care. Skills for Care work with employers and other partners to create a qualifications framework and practical resources to develop the skills, knowledge and leadership of the workforce. Skills for Care specifically works in conjunction with the QCF and in partnership with a number of awarding organisations who provide the nationally agreed qualifications that Skills for Care have developed with the sector.

2. *Examples of different awarding organisations*

The qualifications are designed to provide a flexible ‘mix and match' approach to meet the different needs of the workforce. They are based on the National Occupational Standards (NOS) which describe best practice, bringing together skills, knowledge and values in care. There is a wide range of units that make up different levels of qualifications that reflect what workers should 'know' and 'do'.

There are three sizes of qualifications: Diplomas, Awards & Certificates. The larger diplomas demonstrate professional competence in the social care sector and the smaller awards and certificates demonstrate knowledge or competence in specific areas.

These qualifications are available in three categories:

- **Entry into social care** – for those new to the sector considering a career in social care. Consisting of level 1 qualifications (certificates and awards) they provide the basic underpinning knowledge needed for employment. Students undertaking these qualifications do not need to be working in the health and social care sector.
- **Occupational competence** – ‘core’ qualifications that can be used to demonstrate professional competence. These qualifications can only be accessed whilst being employed in the health and social care sector. The new Level 2 & 3 Diplomas in Health and Social Care have replaced the Health and Social Care NVQs. There are options in these qualifications to take a generic pathway or a specialist dementia or learning disability pathway. Within this category there is also the Level 4 Diploma in Adult Care & the Level 5 Diploma in Leadership for Health and Social Care and Children and Young People’s Services.
- **Continuing professional development (CPD)** – ongoing learning opportunities that can be added after completion of a main general qualification in care. Consisting of certificates and awards that can be taken in specific areas such as: Dementia, Diabetes, End of Life etc.

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The Care Certificate

A minimum standard expected for all adult social care workers was originally through the completion of Common Induction Standards (CIS). It was recommended that the CIS was completed within 12 weeks of starting a new role. Lone working would not be permitted until they were completed. The manager had the responsibility of signing off these standards whether for workers starting a new role or for those workers new to the social care sector.

The CIS has now been replaced since the 1st of April 2015 by the Care Certificate. The Care Quality Commission (CQC) who are responsible for the inspection of care providers, expects providers to induct, support and train their staff appropriately. Their expectation is that those who employ health care support workers and adult social care workers should be able to demonstrate that staff have, or are working towards, the skills set out in the Care Certificate, as the benchmark for staff induction (CQC, 2015).

There are 15 standards within the Care Certificate which cover a wide range of subjects and topics:

- Understand your role
- Your personal development
- Duty of care
- Equality and diversity
- Work in a person centred way
- Communication
- Privacy and dignity
- Fluids and nutrition
- Awareness of mental health, dementia and learning disability
- Safeguarding adults
- Safeguarding Children
- Basic Life Support
- Health and Safety
- Handling information
- Infection prevention and control

Skills for Care, as was the case with the CIS, recommend that a new full time employee should complete the Care Certificate within 12 weeks of starting their new role. The employer issues the actual Care Certificate itself based upon being able to prove that the requirements of the Care Certificate have been properly achieved through demonstration of competencies and completion of a work book.

Apprenticeships

An Apprenticeship is a combination of on and off the job learning and development. As employees, apprentices work alongside experienced staff to gain job-specific skills, getting paid whilst working towards a number of qualifications and gaining experience. All Apprenticeship programmes are open to new entrants into the social care sector, as well as existing employees aged 16 and above. The programme is not restricted by an upper age limit.

Three levels of Apprenticeship are available in care:

- Intermediate Apprenticeship in Health and Social Care - level 2
- Advanced Apprenticeship in Health and Social Care - level 3
- Higher Apprenticeship in Care Leadership and Management - level 5

Traineeships

Traineeships provide an education and training programme which provides young people with the skills and work experience they will need to find employment in the care sector or to progress onto an Apprenticeship. Traineeships are targeted at 16 – 23 year olds who are not in employment. Young people up to the age of 25 with learning difficulties in academic assessments can also complete a Traineeship. Traineeship programmes in care are pitched at level 1 and cover areas such as safeguarding, health and safety, nutrition, communication and legislation.

Delivery of training & funding

Training in basic care for most formal carers is done through on-the-job training from their employers. This includes working closely with experienced colleagues. As previously mentioned care workers should also obtain the Care Certificate within the first 12 weeks of employment. Carers who wish to progress and see care work as a long-term prospect will often sign up for the level 2 diploma in health and social care and possibly progress to higher levels if given the opportunity. Delivery of many of the qualifications available can be done through Further Education Colleges, private training providers or even by the workplace themselves as long as they are registered and approved by the exam board they have selected.

To help employers, training providers and staff with CPD there are three important agencies that can be used for support and guidance:

- Skills for Care
- The National Skills Academy for Social Care
- Skills for Health

Skills for Care, as previously mentioned provides detailed information about standards and CPD. It has a career development tool called the Career Matrix, which helps carers identify appropriate training and qualifications based on the level of job they do. The National Skills Academy for Social Care also has details for employers and individuals about professional development, including coaching, leadership and commissioning services.

Established large qualifications involve the use of assessors to develop underpinning knowledge and assess competency. The large national qualifications such as Apprenticeships and Diplomas are funded either through Skills Funding Agency (SFA) or the European Social Fund (ESF). It is the case at the moment that these qualifications can only be practicable when a person is employed as a carer. There are many other organisations that provide training courses to formal and informal carers such as Carers UK and Age UK. The courses can range from full qualifications to specialist short courses. The short qualifications can be classroom based or in some cases through e-learning.

Some short specialist courses may sometimes have to be funded by the work place or individual depending on their circumstances e.g. informal carers. However, Distance Learning courses (where written materials are sent to the student and assessed through written work books), are available through the NCFE awarding body which are funded entirely through the SFA and therefore are available to informal as well as formal carers at no cost to the individual. Distance Learning consists of short specialist modules that offer underpinning knowledge on a variety of areas such as issuing medication, dealing with dementia and infection prevention & control.

Best Practice Examples

Val Stevenson (representing Hertfordshire CC) a member of our advisory group attended our meeting on the 28th September 2016 and discussed a number of initiatives which are taking place in

Hertfordshire. One of these was the HCPA (Hertfordshire Care Providers Association) a forum for sharing best practice through partnership;

HCPA are a members association offering advice and guidance to all care providers in Hertfordshire. We manage over a million pounds of training funding for the county on behalf of the government, the local authority, the NHS and other funding agencies.
We exist simply to help care organisations raise their standards of quality and anyone who provides adult social care in Hertfordshire is a member. Including residential care homes, home care, day services, voluntary organisations, social enterprises and charitable bodies
http://www.hcpa.info/About-Us

HCPA promise to:

- Work on behalf of our members to provide up-to-date information and act as a collective voice
- Work in partnership with HCC, the NHS and other key partners
- Enable private, independent and voluntary care providers to keep up-to-date with local and national drivers
- Seek funding for care providers to grow the skills of the workforce and to assemble targeted projects

Being a member of HCPA shows how far you engage with local and national drivers in care, how much you value leadership and how you quality assure your service. There are three levels of membership – bronze, silver and gold.

SMILE (Support Me In Life Engagement) is a project that has been launched by Hertfordshire Care Providers Association. SMILE can provide support to everyone in the health and social care sector, regardless of age or ability to engage in meaningful activities and promote well-being.

The SMILE team are able to deliver sessions both on a one-to-one basis and to groups of people in their own homes, within the community, day services and in residential care settings.

Iain MacBeath - Director of Health and Community Services Hertfordshire County Council talks about the award ceremony this year and comments:

"In social care, sometimes it's easy to focus on the bad things and on 'improvement'. But it's also crucial to look back and celebrate our successes, give three cheers for the fantastic staff who work in Hertfordshire's care sector - and thank them on behalf of the people who use our services and their carers. We need to raise the positive profile of our sector and let people know about the terrific and rewarding jobs on offer. I never cease to be inspired by the people I meet on the judging panel. So do nominate your colleagues and let's spread the word about great care in Hertfordshire!"

The HCPA also organize awards for care in a number of categories:

- The Inspirational Leader Award
- The Motivational Team Leader Award
- The Compassionate Care Award
- The ‘Made a Difference’ Award
- The Care Newcomer Award
- The Engagement and Wellbeing Award
- The Complex Care Team Award
- Most Innovative Care Team

Key successes in Hertfordshire have included the local council paying providers a higher hourly rate which is ring-fenced money to go directly to improving the pay of care workers. Another initiative aimed at raising the profile of care as a profession has been the designation of workers as care practitioners and a comprehensive programme of training and development opportunities for workers to enable specialisms to be developed.

Devon County Council have piloted a coaching programme to support carers wishing to return to work which proved to be successful on the whole although relatively small numbers of carers took part, there are plans to extend this. Whilst this is perhaps primarily seen as a supportive measure, it could be used to ensure that 'care' is the right profession for them, thus improving quality of service provision.

Proud to Care South West (Devon County Council) this was launched to help health care service providers to recruit and retain high quality care and support workers.
"The Proud to Care campaign was a much needed and very well received initiative, as Devon County Council recognised and acted upon concerns and challenges raised by domiciliary care providers in terms of recruiting and retaining staff….
Sadly, care does not portray itself as an attractive job, and is often a last resort when nothing else is available. The campaign has paved the way to position care as an appealing/career of choice. It has also started to promote the many different "flavours" of care (learning disability, mental health, physical disability, enabling), not simply the traditionally thought of tasks of older personal care, to show the diversity of the positions available.
It was apparent that the industry itself faced challenges, and needed to attract and appeal to wider audience in order to fill the many unfilled vacancies in the sector – a trend that is set to grow. The initiative to reach those returning to work, retirees and forces wives has been refreshing as it relates to attributes/values of wanting to put something back into society/their community" Operations Manager Okehampton www.proudtocaredevon.org.uk

Ideas from the Netherlands

There is a policy briefing from The Royal College of Nursing and International Department which looks at The Buurtzorg Nederland (home care provider) model and details its observations for the United Kingdom. Please see the link below for the full report:
https://www2.rcn.org.uk/__data/assets/pdf_file/0003/618231/02.15-The-Buurtzorg-Nederland-home-care-provider-model.-Observations-for-the-UK.pdf

The Buurtzorg model came about as a result of difficulties faced in the effective provision of care in the Netherlands (not dissimilar to those experienced in the UK) for example; financial tensions which led to cost cutting, which in turn meant the employment of a poorly skilled workforce which was felt to have contributed to a decline in patient health and satisfaction.
A key feature of this model is to encourage employees to have far greater control of patient care. It appears that the Netherlands nurses (equivalent of the UK's district nurses) manage teams of carers for a specific area generally working with 40-60 patients/clients.
It is believed that the Buurtzorg model has been particularly effective in its ability to provide excellent patient care at competitive prices because of its emphasis on patient self-management:

"How this works is that each new patient relationship begins with high levels of support provided by the team. This is then gradually withdrawn as self-management aids and supports from social care, voluntary and third sector organisations are identified, assessed and put in place. This approach is believed to cut long-term care costs by between 30 to 40 per cent and supports a national policy aim of delivering care closer to home or in a homely setting" (page 4)

In addition it is felt that good working relationships are developed with GPs and other health service providers because the nurses are well known in the (often small) communities where they work:

"In the Netherlands, integrated care has been cited as easier to deliver because district nurses tend to be well known in the small neighbourhood/community in which they work" (page 4)

It is the view of the RCN that this 'fresh look' can only achieve meaningful results if the central plank of the Buurtzorg model – its emphasis on nurses as self-managing agents of change – is maintained throughout.

Conclusion

With the rising predicted numbers of carers needed to cope with the ageing population, the need for competent and valued care workers in the UK has never been greater. It is also clear that there is greater reliance on informal care to cope with this increasing demand. The current framework of qualifications, training and CDP surrounding health and social care is complex and primarily aimed at formal carers. Funding is available for main qualifications and apprenticeships but can only be accessed once a care worker is employed. Short specialist courses often have to be fully funded by the individual or employer. There is an impetus by the Government to raise the standard of basic formal care with the introduction of the care certificate, but training and help for informal carers appears to be very limited in the sector.

However, it seems that there are many inconsistencies within care provision and practices throughout England. It appears that some areas in the South are developing excellent examples of 'Best Practice' both in terms of education, training and person-centred care but it could be argued that the funding for these services is more readily available in these areas. The ideas from the research carried out on the Netherlands model are interesting and inspiring but may not be easily replicated in all areas of England or the UK. Until care work is seen as a more valued and respected profession, it is unlikely that employers or many employees would be comfortable with the autonomy needed for such a model. In addition, the low levels of pay currently offered to most care workers in the UK would not be commensurate with the level of responsibility expected in the Netherlands. It also appears that the geography of the catchment areas in the Netherlands which enable the effectiveness of their approach might only work in rural or semi-rural areas of the UK.

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