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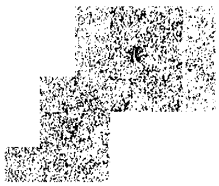

The recruitment and training of young workers in the National Health Service

Nick Bosanquet

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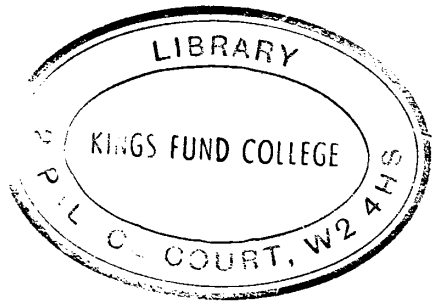

THE RECRUITMENT AND TRAINING OF YOUNG WORKERS IN THE NATIONAL HEALTH SERVICE

Nick Bosanquet

King's Fund Centre

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Introduction

This project paper summarises the results of a survey of youth training in the National Health Service. The survey looked both at the extent of involvement by the NHS in the Work Experience on Employer's Premises (WEEP) scheme sponsored by the Manpower Services Commission (MSC), and at the youth training being undertaken more generally.

The focus of the study which was limited to England is on the recruitment and training of young people for jobs other than those in the medical, nursing and associated professions. The groups are those covered by the Ancillary, Administrative and Clerical and Professional and Technical B Whitley Councils – about 350 000 employees in all. These carry out a range of jobs which are not for the most part specific to the NHS, in technical, maintenance, clerical and ancillary service areas. The survey aimed to look at the scale of the training currently being carried out and at the reasons for it.

The survey began with some case studies involving visits to seven districts. These are summarised in Chapter 1. A questionnaire was then sent to all DHAs in England and Wales and a respectable 53 per cent response was achieved. This survey is summarised in Chapter 2. The last Chapter looks forward to the Youth Training Scheme and draws out the implications of the survey results for the scheme.

I am most grateful to King Edward's Hospital Fund for London for giving me a research grant which made the survey possible. I am also grateful to Social and Community Planning Research (SCPR) for carrying out the survey and especially to Judith England for planning it. Helen Woods gave me useful help in sorting out the results. Jim George and Helen Walker kindly allowed me to sit in on various briefings for regional personnel officers about the Youth Training Scheme (YTS). Above all my thanks are due to many people in NHS personnel departments who put themselves out to collect the data for the questionnaire at a time when they were under great pressure.

1 The initial case studies

The first part of the research involved visits to seven districts as a reconnaissance for the wider survey. The districts were selected to give a fair regional balance and without any preconceptions about whether they had been heavily involved in WEEP schemes. The districts were of the following types:

		Average work experience (WEEP) intake 1982
1	Large city West Midlands	16
2	Medium-sized town in Yorkshire	8
3	Medium-sized town south coast	26
4	London suburb	4
5	Urban area North East	10
6	Rural area South	20
7	Inner London	45

In five cases the visits suggested a major involvement with the scheme while in two, the medium sized town in Yorkshire and the district in a London suburb, the commitment was rather less. For the districts with heavy involvement the main impulse had come from concern about the wider community problem of youth unemployment. The two districts with less involvement had relatively favourable local labour markets. In the committed districts, managers did come to think that there were advantages to the NHS from the scheme: but this view came with experience. The first impulse to develop the scheme came from conditions outside the NHS and from the desire to make some contribution to a wider community problem. The actual direction of the scheme then tended to be shaped by past experience with labour shortage. The trainees were often placed in areas where recruitment had traditionally been difficult, and so managers were well disposed to the scheme.

The committed districts found that at the beginning the schemes took up a good deal of management time. This was usually given by staff from the personnel department in addition to their normal duties.

In only one case, that of the Inner London district, were there full-time staff specially employed for the scheme. In that case staffing costs were met from Inner City Partnership funds.

The schemes usually had to overcome great inhibitions to start with about employing young workers: inhibitions which tended to weaken with experience. Union attitudes to the scheme were generally favourable, although problems later arose if a possible effect of the scheme was to reduce bonus earnings: but this was exceptional. The most major effort in diplomacy required at the beginning of the scheme was usually with departmental managers. Their interest was crucial to success – but once this was won the schemes went smoothly. The schemes thus started from an altruistic impulse to make a contribution to the community problem, and fitted uneasily at the beginning with normal ways of working. But once established, they caused little difficulty and met with a wide degree of acceptance and even at times a rare flash of enthusiasm.

District 1 was in a city in the Midlands. It had run a Work Experience scheme since 1979 with a capacity of 20. The actual intake had been about 16, of which half had been in the medical records department where managers had shown a strong interest. Four to five others were in catering and the rest in domestic work. Of 32 recent trainees for whom they had records, 10 had moved into permanent jobs in the NHS. Most of the applicants were girls with some educational qualifications at CSE or O Level. The link to formal training was clearest on the catering side where two former trainees had gone on to do catering courses involving day release. As a result of the scheme they had 'taken on people who they wouldn't normally have taken on' in catering and in clerical work. In general, managers had been rather unwilling in the past to take on young workers. They normally found middle-aged ladies more reliable and 'young people will come for interview not at all well prepared'. They were also unwilling to take on under 18s to work in patient areas. The personnel department felt frustrated with its lack of involvement in recruitment and saw the WEEP scheme as a way of remedying this. They were quite keen on the YTS in prospect and were willing to start with about 20 places. But they had little confidence in the way that the MSC had administered the old scheme: 'they had never seen the same person twice'. In

general the effect of the old scheme had been to increase local recruitment of the 16+ age group.

In District 2, a medium-sized town in Yorkshire, there were eight people on the WEEP scheme. Half of these were in medical records and half in catering. The background had been one of labour shortage, especially in catering. They were in a labour market which even now had a relatively keen demand for labour and where the difficulty of recruiting cooks had led them to introduce another programme by which they took on six trainee cooks in a year. The most distinctive WEEP programme was in medical records. The presence there seemed to reflect the interest of the manager and the incentive of gaining an extra pair of hands. Other schemes had been negotiated but, mainly because of union opposition, had not been introduced. The scheme had had little effect on recruitment of young workers and managers spoke of the greater reliability of middle-aged workers.

In District 3, a medium-sized town on the south coast, cooperation with MSC schemes had begun early in 1978. They wanted to show that the NHS was discharging its community responsibilities as an employer. Until 1981 there had been a labour shortage locally so the scheme was also a useful way of attracting more staff. This was an unusual case: an area with low local unemployment but in which managers had a strong impulse to contribute to the local community. They were well aware of the NHS's position as a large employer in a small community. They had built up gradually to a 26 place scheme and they had found this about the maximum they could take. The trainees worked in a variety of departments – medical records, portering, CSSD, stores, domestic, x-ray, administration, engineers, OT. The only trouble had been in a scheme in the gardens where the presence of the trainees was seen as a potential threat to bonus earnings. As a result this part of the scheme had to be abandoned. Their main problem had been in supervision and making sure that the training element in the scheme was large enough after the initial induction. About a fifth of the trainees had found permanent jobs within the NHS.

In District 4, a London suburb, there were four WEEP trainees. Three were in administrative positions. There was little chance of their getting permanent jobs because of the general freeze on vacancies.

These four placements have to be seen in relation to a total workforce of 6000. There had been some difficulty with NALGO who took the view that full-time workers should be recruited instead. They had tried to get other types of placement established in nursing and elsewhere but had had no success. They had hoped to place one trainee in the grounds and gardens – but the implications for the bonus scheme had put paid to that. Generally, therefore, the picture was of little progress made against a background of difficulty.

District 5, an urban area in the North East, had ten WEEP trainees. The scheme had strong support from local shop stewards worried about job prospects for local young people. The programme was seen as a way into permanent jobs. The trainees worked in cleaning, catering and in medical records. As a result of the scheme the domestic department was now much more ready to take on 17 year-olds than they had been previously.

In the medical records section the manager spoke highly of their four current trainees: one of them was working on filing, one on preparing clinics, one on micro-filming and one on psychiatry and antenatal records. There was close supervision while they were doing the job. They had no complaints about their time-keeping or their work output. They had never had school leavers before. Because of their worries over the confidentiality of medical records they had always asked for people who were over 20. But now the manager would be quite willing to have younger workers. There were also successful placements in the cleaning and domestic department, which could have gone even further if it had not been for difficulty over bonus schemes. This district was unusual because of its interest in training other young workers. There was a special scheme unconnected with the MSC in the finance department, and in medical records people were encouraged to take further qualifications.

District 6, a large self-contained district in the south of England, was geographically isolated and had a high unemployment level. The main incentive here had always been that of making a contribution to the local community. Out of 71 young people who had gone through the scheme they had taken on 25 for permanent jobs. In the past they had taken no school leavers. The trainees had initially been in clerical work and later the scheme had been extended to ancillary work. Now they

even had trainees getting experience in building work. They had overcome various problems about health and safety in order to do this. They also had one particularly successful scheme in caring for mentally handicapped people which had helped them with their permanent recruitment. Until 1981 no scheme had had direct patient contact but now they had overcome that barrier. On the whole they were taking the more highly qualified school leavers. Generally they have been pleased with the results of the scheme. They now felt they had been wrong in the past not to take school leavers. Young workers had much to offer in terms of vitality, especially in the care of mentally handicapped people.

The most ambitious scheme was in an Inner London district. This was for 45 trainees and was partially funded by the Inner City Partnership. It had its own building, and Inner City Partnership funds had been used to renovate it. A further education college provides 'off the job' courses. The emphasis originally was on placements in ancillary work but has now shifted to a wider range of jobs. This initiative came from the desire of the NHS to be seen to be doing something in the local community. The scheme made it possible to take on school leavers whose qualifications were not so good. They were well aware of the trend towards higher qualifications in the NHS, which had made it more difficult for the unqualified to get jobs and had as a result reduced local recruitment.

The scheme was set up in partnership with the further education college and, of the schemes surveyed, it was much the closest in outline to the YTS. It had required a substantial capital spending to renovate a building. It was unusual, too, in the range of placements which covered nursing, clerical work, catering, domestic, portering, CSSD and even chiropody. About 62 per cent of the young people on the scheme had gone on to full-time jobs in the NHS, so the scheme had helped to break down the strong resistance to employing young people under 18. As a result of the scheme, people had become much more aware of the potential in the range of jobs within the NHS. It had a public image of providing 'semi-professional jobs for middle-aged white ladies' – but in fact there was a great variety of work there. Generally they had been 'amazed' at how receptive heads of departments had been. Greater resistance had in fact come from the trade unions.

This scheme was the only one to take on numbers of young people who did not have formal educational qualifications. This caused initial difficulties, as they had problems with simple tasks such as filing. But service managers, both in medical records and in chiropody, were most positive in their comments about trainee performance once this initial period was over. They were also much more willing to take on the trainees as permanent recruits. In the six months they were able to get a clearer view of work potential. This seemed to be the scheme which had set itself the hardest task but which had the resources and the commitment to succeed.

Little information was available on the reaction of the trainees themselves. Most completed their placements, but given the severity of the recession this was hardly surprising. But many trainees in discussion did seem genuinely interested. One trainee in District 6 had in fact written a brief account of her views of the scheme and this probably gives as balanced a reaction as possible.

'The work experience scheme may be described as a recently devised experiment by the Government to counteract the high unemployment rates of the recession. Its main aim is to provide young school leavers with the chance to go out to work, thereby increasing the likelihood of their future employment. However, despite its limited success, it has led to a strong feeling of resentment amongst the workers on the youth opportunities programme. The minimal pay of £25 per week has been described as totally inadequate, and the attitude of employers, sometimes demoralising. However, the different experiences of such employees make it difficult to generalise and thus to make a firm decision as to whether or not the scheme has been a success from the point of view of the student.

'Despite the fact that students on the work experience scheme are not supposed to take over some of the work of full-time employees, this is often the case. This is naturally advantageous to the student because it extends their capabilities and their knowledge. Thus, at the end of the six month trial, their performance may be properly assessed and their chance of employment, heightened. Moreover, the six month period gives both the student and the employer a chance to decide whether or not the job is suitable for the prospective employee, a job may be found when previously either the student or employer

might have been too hesitant to proceed.

'A further advantage to the work experience scheme is that it keeps young people occupied and used to an active routine. Unemployment often leads to laziness and boredom and both of these symptoms help to reduce one's confidence and chance of finding a job. Violence and vandalism are sometimes the outcome of unemployment and the work experience scheme helps to curb this threat.

'The main disadvantage to the scheme is that it produces resentment. Basically the rate of pay is not only seen to be too low for the work expected of the student but, even more so, for the work he actually does. Further resentment results from the lack of responsibility delegated to the students. Sometimes skill and capability are not considered as important as the principles of the scheme, which is definitely a disadvantage to the student.

'The wide-spread publicity of the scheme by the Government means that it has become unmistakably labelled as charity to school leavers who are incapable of getting a job because they lack the intelligence and not as a result of the recession as well. Thus some students feel demoralised and degraded by taking part in the scheme and confidence is a vital ingredient in securing a job.

'One is forced to conclude that despite the heavy number of disadvantages to the student whilst taking part in the scheme, it is definitely more to his advantage. Some students find immediate success and happiness, but even for those who don't it helps them to mix with people and not to become isolated from the outside world, and maturity in this field is just as important as promoting one's own academic or practical career.'

2 Survey evidence on youth training

The initial visits had suggested a number of issues which could be explored through a postal questionnaire. Such a questionnaire was sent to district personnel officers in all districts in England in January 1983 and by the end of April usable replies to the full questionnaire had been received from 103 out of 192 districts. Much of the information was difficult to collect as records on trainees are not held centrally: many districts were also still being affected by the later stages of reorganisation. In such circumstances the response was an encouraging one and was distributed evenly between parts of the country and districts of varying size and type.

Table 1 shows the breakdown of respondents between regions. Health service regions cut across most of the normal regional boundaries and any division is bound to be arbitrary. The main purpose of this one was to bring out possible differences between the North as a whole and the South as a whole. The NHS regions included in Thames and South were the four Thames regions, Wessex, the South West and Oxford. Regions included in the North were Merseyside, North Western, Northern, Yorkshire and Trent. The Midlands covered the West Midlands and East Anglia.

Table 1 Response rate by region

	Number of DHAs responding	Total DHAs
Thames and South	46	89
North	39	74
Midlands	18	30

The NHS contribution to WEEP

Eighty-six per cent of respondents had offered places on the WEEP

scheme in 1982. This was perhaps a rather higher proportion than might have been expected. DHAs in the North and in the Midlands were rather more likely to offer places than those in Thames and South, reflecting response to higher local levels of unemployment (Table 2). During 1982, 1938 trainees entered placements with the NHS in the 89 authorities which took trainees. Thus, the average intake was about 11 every six months. Twenty-six per cent of the trainees were male and 74 per cent female.

Table 2 Did health districts offer WEEP places?

	Percentage of respondents	
	Yes	No
Midlands	94	6
North	97	3
Thames and South	74	26

The average is somewhat misleading as there was a considerable range in the size of intakes and the DHAs with large intakes were making a heavy contribution (Table 3). Male trainees were much more likely to be in small groups. Thirty-six per cent were in groups of 10 or less.

Table 3 DHAs and size of intake
Percentages of total trainees by size of annual intake

Size of intake	Number of DHAs	Percentages of total trainees
1–10	30	8
11–20	20	18
21+	34	74
(NA 5 N = 89)		

There were also regional differences in the size of intakes. The tendency to larger intakes was more pronounced in the North and in the Midlands than in the South. In general, the picture was one of a heavy contribution by a relatively small number of districts.

WEEP trainees: age and qualifications

Only a third of trainees were aged 16. It seemed likely that most of them had either stayed on at school beyond the minimum school leaving age or that they had a spell of work and unemployment before joining the scheme. The NHS was only taking a minority of people who were actual school leavers (Table 4).

Table 4 Ages of work experience trainees beginning placements in 1982

	Percentages of total	
	Male	Female
16	36	32
17	41	45
18	17	20
19	5	2
20+	1	1

The trainees were more highly qualified than the majority of young people joining MSC schemes. The educational qualifications are shown in Table 5.

The NHS seemed particularly able to attract well-qualified female trainees. Over one-quarter of girls on the Work Experience Schemes had O Levels and only a fifth had no formal qualifications at all. The level of qualification was generally higher in the South.

Compared with entrants to the WEEP programme in general, the NHS had a higher proportion of females – 75 per cent as against 54 per cent nationally. Its trainees were rather better qualified. About

Table 5 Educational qualifications of work experience trainees in 1982

	Percentages of total	
	Male	Female
CSEs	47	45
O Levels	17	28
A Levels	2	2
Other	4	4
No formal qualifications	29	20

39 per cent of WEEP entrants nationally in 1980 had no formal qualifications.[1]

The questionnaire looked at whether DHAs had made any special effort to recruit disabled trainees. Few of the WEEP trainees in the NHS were disabled. However there were few disabled entrants to the WEEP programme generally: only 2 per cent on the WEEP programme were registered as disabled. The questionnaire also looked at whether many trainees were drawn from ethnic minorities. In fact only about 5 per cent were from ethnic minorities. Again this proportion is much the same as with the WEEP programme as a whole.

The work experience

What happened to the trainees once they started to work for the NHS? The majority (51 per cent) of trainees were working in white-collar jobs. Of the rest the highest proportions were in catering (9 per cent) and the rest working as care assistants. The picture (see Table 6) shows that the trainees were heavily concentrated in a relatively few areas. The administrative and clerical area account for less than 10 per cent of total NHS employment but has 51 per cent of total trainees. Work Experience Trainees were especially conspicuous by their absence in community work.

The majority of trainees spent most of their time in one department. Seventy-two per cent were in one department for the majority of their

Table 6 In which departments did the trainees spend the largest part of their placements?

	% of total trainees
Catering	9
Cleaning	5
TOTAL in ancillary	*14*
Medical records	22
Personnel	2
General administration	10
Other admin/clerical	17
TOTAL in admin/clerical	*51*
General nursing	6
Mental handicap care	3
Mental illness care	2
Other care assistants	2
TOTAL care assistants	*13*
Works and maintenance	*7*
X-ray	*2*
Community	*1*
CSSD	*1*
Other	*11*
	100.0

time as against 28 per cent who rotated between departments. Nor did the majority of DHAs provide some form of day release as part of their placements. Sixty per cent did not offer day release. The average placement seemed to be a low quality one confined to one particular type of work and without any element of 'off the job' training.

About 25 per cent of trainees left without completing their placements. The proportion was the same for males and for females. However there were some significant regional differences. In the South 51 per cent of entrants completed their placements as compared to 85 per cent in the Midlands and 74 per cent in the North (Appendix, Table 1). Again a minority of schemes were responsible for a high proportion of the total drop outs (Appendix, Table 2).

WEEP and managers

What demands did the WEEP scheme put on managers? In most cases the personnel department was responsible for the scheme. In two-thirds of the schemes they took the main responsibility. However the demands placed on the personnel department in terms of time were not large (Table 7).

Table 7 Time spent by personnel departments in administering WEEP schemes

Number of hours per week	Percentages of DHAs with schemes
0–4	65
4+	35

However, the time commitment could be much greater at the beginning of a scheme. The time commitment for departmental managers seemed to be rather higher. Only in 19 per cent of DHAs with schemes were departmental managers spending four hours or less on the scheme and in 25 per cent of the DHAs they were spending ten hours or more (Appendix, Table 3). Therefore, the presence of WEEP trainees seemed to involve a relatively heavy commitment for departmental managers and their staff. However, in no case was the presence of WEEP trainees felt to have caused major problems. In one-third of the cases their presence was felt to have caused no problems at all and in another one-third there were some minor problems. Managers rated the work output of trainees rather highly (Appendix, Table 4). Forty-six per cent of DHAs said that they did as much work as normal employees and 40 per cent said they did half as much.

Some indicator of managerial satisfaction is that a relatively high proportion of the trainees went on to take permanent jobs in the health district. Of those completing placements or leaving prematurely during the year, 19 per cent went on to take jobs within the health districts and a further 3 per cent took jobs within the NHS in other health districts (Appendix, Table 5). Thus about one-fifth of the trainees

moved into permanent jobs within the NHS. Another 20 per cent went into permanent jobs elsewhere: thus, about 40 per cent seem to have found permanent jobs. This compares quite closely with the proportions finding jobs from the Work Experience Scheme generally.

Trade union reactions

The survey also looked at trade union reactions to the scheme. Most commonly, DHAs had consulted informally about the scheme (Table 8).

Table 8 Nature of consultation with trade unions about the WEEP schemes

	DHAs as percentage of DHAs with schemes	
	Formal	Informal
Midlands	41	88
North	32	89
Thames and South	59	71
Total	44	82

Formal methods of consultation seemed to be rather more common in the South.

Levels of initial opposition to the schemes were also somewhat higher in the South. People were asked to say whether there has been trade union support for the scheme, minor opposition or opposition so serious that fewer places than possible were provided (Table 9). Support for the scheme seemed to be slightly stronger in metropolitan areas. Eighty-nine per cent of the DHAs in metropolitan areas registered strong union support for the scheme compared to 72 per cent in the non-metropolitan areas.

The survey also asked whether reactions had changed during the life of the scheme. The answers overall showed a slight shift towards greater hostility with a marked shift in the North (Table 10).

Table 9 Initial trade union reactions

	Percentages of DHAs with Schemes			
	Support scheme	Oppose but not jeopardize	Oppose and as a result fewer places	NA
Midlands	76	18	6	
North	89	8	3	
Thames and South	68	15	9	8
Total	79	12	6	3

Table 10 Trade unions' current reaction

	Support scheme	Oppose but not jeopardize	Oppose fewer places	NA
Midlands	82	6	12	
North	66	18	11	5
Thames and South	65	15	9	11
Total	65	15	10	10

Table 11 Number of DHAs experiencing opposition

	TOTAL	COHSE	NUPE	TGWU	ASTMS	NALGO	RCN
Midlands	3	3	2			2	2
North	11	2	7		2	4	
Thames and South	8	2	3	1	1	4	1
Total	22	7	12	1	3	10	3

The conurbations remained distinctly more favourable in their later reactions as well as in the earlier ones.

The actual opposition came from a number of different unions with NUPE and NALGO as the most prominent as might be expected from the position of the trainees (Table 11).

Thus, there were 12 DHAs which experienced opposition in various forms from NUPE and 10 which experienced opposition from NALGO. Generally the opposition seemed to increase as familiarity with the scheme grew.

There was regular contact with the MSC in 65 per cent of the schemes – a surprisingly low proportion. Threequarters rated the service they got from the MSC as satisfactory. Most also had regular contact with the careers office and maintained regular contact with the office. Again about threequarters found the service from the careers office to be satisfactory.

Other youth training

The survey also looked more generally at recruitment and training. DHAs were asked to state how many trainees had been recruited in 1982, and whether they had done any recruitment at all. The general picture was of a very low level of recruitment. The average and total numbers of recruits per DHA over the period are shown in Table 12.

Table 12 Recruits in 1982

	Total	Average recruits per DHA	Number of DHAs recruiting
Cooks/catering	116	2.5	47
Craft apprentices	81	2.1	39
Professional and technical B	458	6.1	75
Administrative and clerical	104	4.2	25
Other training grades	80	2.9	28

The answers related to posts involving formal training excluding recruitment for medical training, nursing or the professions supplementary to medicine.

Out of 103 DHAs:

39 per cent had recruited no trainees for catering in 1982;

45 per cent had not recruited any craft apprentices;
54 per cent had not recruited any trainees for administrative and clerical positions;
43 per cent had not recruited for other forms of training.

The detailed results are set out in the Appendix (Table 6). It was only for the professional and technical grades that the picture was rather different: in that case there were only 13 per cent DHAs without some professional and technical recruits.

The survey looked at the ages of the recruits. In the case of catering trainees and craft apprentices they were mostly young. For recruits to professional and technical B and for administrative and clerical the DHAs showed a pronounced tendency to take on older recruits (Appendix, Table 7).

There were few surprises about the length of training periods: three years was the most common length for catering courses and three for craft apprentices. The professional and technical B courses were more variable with 17 DHAs offering two year courses, 25 three year courses and 20 four year courses (Appendix, Table 8). There seemed to be a college based element in many cases (Appendix, Table 9). There were also few surprises about the level of qualifications required ranging from CSEs or below for catering trainees to A Levels for recruits to professional and technical B. Trainees generally amounted to under one per cent of total employees in the relevant groups so that the number was well below the retirement and quit rate.

The survey also looked at the NHS's general attitude to the recruitment of young workers. The results here were generally in line with those already produced for the Trent region with about 15–20 per cent being recruited in the age group 19 or under (Appendix, Table 10). It is likely that the proportion in the age group 17 or under would have been very small indeed. In the Trent case, ten per cent of ancillary starters, six per cent of admin and clerical and two per cent of professional and technical starters were under 18. Thus, the NHS is mainly recruiting older workers. Districts were asked whether they operated a formal age barrier. Sixty per cent of districts operated a policy by which people under 18 were not employed in jobs involving direct contact with patients. Even in other types of job, 28 per cent operated a

minimum age of entry. About 28 per cent said they would prefer on balance to recruit older workers while the rest would be as willing to recruit younger workers and especially school leavers.

Districts were also asked to comment freely on the scheme. Many comments were positive as seen in the following:

> 'The WEEP scheme has been in operation in the HA works department for the past three years during which seven people have been offered placement. [Some] people have been offered full-time employment within this HA following the placements, and the one still in the placement will be offered full-time employment in June 1983. One of the people not offered full-time employment with this authority is in full-time employment with the local authority. I consider this scheme to have been a complete success and would be pleased to participate in any future schemes of this type.'

> 'We have supported these schemes and have recruited permanent staff from the trainees. Most have worked well, although one or two trainees have caused problems. On the whole trainees have left the schemes either for permanent employment in the NHS or for permanent jobs elsewhere.'

> 'The presence of young people has had a significant effect on the attitude of departmental heads and has resulted in more young people being recruited to those departments/areas.'

> 'Although we have not had any WEEP trainees in the year under consideration we have had them in earlier times and have found them beneficial both from the employees and the young persons point of view. There is a certain administrative commitment to cope with the weekly pay arrangements, but this at best helps to keep the central management in regular touch with the trainees' progress.'

Other districts reported less happy experiences.

> 'Personally, I cannot get excited about work experience schemes on a large scale for 2 reasons:
>
> 1 It is highly unlikely that the Authority would be able to take on

any significant proportion of trainees. They will, therefore, tend to be returned to unemployed status. This benefits nobody, least of all the individuals concerned. Short-term palliatives are no solution to unemployment during a deep recession – they do nothing for the individuals' self esteem (and probably very little to their skill level).

2 To organise, 'sell' and administer such schemes, consumes considerable resources with little return. I can see very little benefit to the Authority from WEEP etc.'

'Schemes are made available; however, few candidates (particularly suitable ones) are available to fill vacancies. Unless improvements can be made to conditions we pay to encourage young people the schemes will not be very successful.'

'The administration of WEEP schemes can outweigh their advantages.'

'Our major problem has been finding trainees of a suitable standard. Most of our openings demand youngsters with 4 O levels or equivalent and our places have been unfilled because young people of that calibre in this Borough either get jobs or seek further education, eg, we have four places unfilled, in finance where two numerate people are needed, and in works where we want two people who can do a PPM survey and input information to a computer. We are in touch with the MSC about the Community Programme for older unemployed people – such places could be taken up by people on that scheme.'

'They can be most useful to both trainee and employee but those placements which do not prove to be a success can discourage managers from continuing to contribute the great amount of time and effort needed. Therefore I feel it is important that trainees are carefully matched to the right placements which requires close co-operation between employer and careers office. Our 'successes' have encouraged more participants in the scheme but our 'failures' have meant that some managers are not willing to take on further trainees. My criteria for a successful placement are that it either leads to the trainee obtaining a suitable job or it teaches the trainee

skills or habits that will improve his/her chances of obtaining work while not disrupting unduly the activities of the workplace.'

'1 The length of the scheme is too short especially as the trainees tend to be looking for a permanent job within the last 2 months which only leaves approximately 4 months for training, and depending on the complexity of work may be inadequate.
2 The odd one or two trainees have shown little interest in their work even with encouragement from management. The selection procedure by careers officers is sometimes below par.'

'Of the three attachments the capabilities have been varied. One was excellent and obtained a substantive post in the District. One left after a short time as she obtained a post outside the NHS. The other tried hard but did not have the abilities required and needed a considerable amount of supervision and "training".'

Some authorities were planning to move on actively to the YTS scheme.

'I have previously operated a WEEP scheme with some success and based on that experience will pursue the establishment of trainees under the new YTS scheme.'

'The authority to date has not had a large commitment to the WEEP scheme. However we are hoping to be fully involved in the new Youth Training Initiative.'

'We have not been very involved with this scheme as you will see by our answers. We are however very actively looking at the YTS scheme and there is some very positive response to it – so I am optimistic we may take more trainees in future. In addition we have been involved in Community Action Programmes and Job Experience through schools.'

But there was at least one pessimist.

'The Youth Training Scheme involves too many administrative resources for us to run such a scheme. The WEEP scheme was far

more realistic and if it had not been brought to an end we would have taken on several WEEP trainees.'

Conclusions

The NHS is at present doing little youth training in terms of its own recruitment to regular employment. It prefers to take on older workers and thus by inference to rely on the training being given by others. This is perhaps more typical of a small employer than of one of the size of the NHS. The NHS is in fact in the position of poaching skills and training from others rather than making any large contribution to the available supply of trained labour.

The most hopeful development has been with the WEEP schemes. Here the NHS has been making a contribution, even though one that is a long way short of its current importance in the national workforce as a whole. Its trainees have tended to be more qualified than most, so its contribution to the problem of unemployment among unqualified school leavers is smaller still. Nevertheless a start has been made.

The number of placements has been less than would provide an adequate base for the Youth Training Scheme and the quality of induction and supervision of the trainees has often been suspect. The range of placements has also been small, with many types of work untouched or available only to a handful of trainees. However, a start has been made in breaking down powerful taboos against the presence of younger workers, and there have been some encouraging signs of willingness to recruit trainees into permanent positions. The results so far may seem modest but they have to be measured against very great difficulties and even to get this far represented a high quality of commitment by some personnel officers and departmental managers. The most encouraging change has been in the increased commitment to youth training which often developed in those districts which gained experience. The early motivation may come from outside in the wider community, but managers came to see that the scheme could have advantages for the NHS.

3 Conclusions

The Youth Training Scheme has a strong logic in terms of the social and economic problems arising from high levels of youth unemployment. Without this and its predecessor programmes the 'policy off' level of youth unemployment would be about 50 per cent.[2] The problem arises not just from the recession but from the long-term decline of those sections of the economy, such as manufacturing, which used to offer training and employment to school leavers. Unless some of the deficit can be made up through an improved recruitment rate by public and private services, the long-term outlook is bleak. The shift to the services has been part of a structural change in the economy with ominous consequences for youth unemployment, and to this the recession has added the strong immediate effect of deterring recruitment. Employers are possibly more unfavourable to young workers than before. Employers certainly have a general long-term interest in a more highly trained workforce. However, there may be compelling short-term reasons why a particular employer could have difficulty in making a major contribution to help deal with this rather general problem. The National Health Service is currently in this uncomfortable position. As a large source of what has been in the past relatively secure employment, the NHS will be under great pressure to contribute towards resolving these general problems. However, in order to do this, the NHS faces some intense short-term difficulties. Some of these difficulties include the following.

Current pressures are to reduce manpower, especially in managerial and administrative jobs. Such pressures mean greater suspicion of schemes which might dilute full-time employment. They also make it more difficult to find management time to run the YTS.

The NHS takes on very few 16 year-olds at present and there are resistances to doing so, especially in work involving direct contact with patients.

The cash incentive which could stimulate other employers to provide more schemes is not likely to be effective for the NHS. Under this incentive the so-called principle of additionality – the employer undertakes to recruit three additional young people in addition to two normal recruits. He then gets the training grant for all five. This is an important incentive where employers already take on young people, but does not work nearly so well for employers who do not have any trainees to start with. The YTS involves a commitment to 'off the job' training involving at least 13 weeks in the year. The NHS would have great difficulty in arranging all this. The YTS also involves a greater variety of placements and stronger supervision than has been the case in the past.

Various levels of responsibility are possible under the YTS. At one level an employer can become a managing agent with full responsibility for organising 'on the job' and 'off the job' training. Alternatively, an employer can simply provide some places and exercise a day-to-day responsibility for trainees. The trainees would be able to appeal to their traineeship agreement with the sponsor. DHAs taking part in the programme are likely to be managing agents and would be taking on major responsibilities.

The NHS lacks the record and the philosophy of training which would be helpful as a background to the scheme. Training is usually something imposed on the NHS from outside by professional bodies rather than an activity which managers have chosen for themselves. Nor will it ever be easy to measure the effects of training in terms of quantity or quality of output, even where it is established. Thus, managers in the NHS are going to have to face difficult decisions about whether to invest in training at a time when they are under extreme pressure to contain costs.

It may not be easy to measure the effects of training in each particular case, but there are some general reasons for thinking that they may be considerable.

Large private organisations such as Marks and Spencers, ICI and Sainsbury's undertake a good deal of staff training and tend to have training strategies of a more developed kind than the NHS has for

non-professional staff. Training is usually associated with strong and consistent management efforts to make more use of work time and to measure and to raise levels of output. It is clear that the NHS has not been a leader in such activities.

There is a correlation between training and pay. The more trained earn more and this reflects higher productivity where a marketable output is produced. Pay, productivity and training go together. This is particularly relevant to the NHS with its problem of 'low pay'. There may be other reasons for low pay, but certainly improved training and productivity would make a contribution to raising pay levels.

The NHS is faced with pressures both to reduce manpower and to maintain service levels. It can only reach these inconsistent objectives if it can do the job with a smaller labour force but one that is more highly productive. It is highly likely that such a labour force would be more highly trained. At present the NHS lacks identity as an employer. It is really more a series of small employers loosely linked by computer print-outs of pay slips. If it is to meet these new challenges it has got to show a more effective response as an employer.

The YTS could be a vital stimulus to change in the NHS's more general approach to training. It is unlikely to work very well if it is simply stuck on, but it could work if it is the beginning of rather more basic changes in approach to training and recruitment. These would involve first of all a commitment to fill a much higher proportion of vacancies with younger recruits. The investment required for the YTS only makes sense if at least a proportion of the trainees remain as permanent employees. It is likely that motivation will be much higher both among trainees and among managers where this is the case. There must be, too, a commitment to the very considerable amount of organisation required to get the YTS going.

The YTS should be seen in terms of a three-year plan. In the first stage there should be more schemes of a pilot kind – perhaps two in each region. These should take place in districts which have not shown much interest in the past as well as in those which have. These would help in the development of course programmes and of placements.

Districts elsewhere would then be encouraged to develop the scheme. At the beginning the scheme would involve a considerable investment. But there would be gains: most immediately in terms of the work output of the trainees and later through the more general changes in training philosophy. But the YTS as it stands presents substantial difficulties for the NHS, so a heavy investment especially in management time will be required. The YTS will only be workable for the NHS as part of a more general change in approach to training.

Many NHS districts have made a contribution to the WEEP scheme: but even in those the scheme will need a great deal of improvement to meet YTS standards. The quality of placements offered to WEEP trainees is much below what would be required for YTS, and the commitment to 'off the job' training is much greater than the NHS has offered before. However, the NHS has the advantage of a big range of interesting work to offer trainees.

The YTS requires a heavy investment on the part of the NHS, even though districts would be able to claim the block grant of £1850 for each filled place on a programme. This amount covers the allowance of £1300 paid to each trainee but the remaining £350 will not cover the real costs to the NHS of getting the programme going even with the additional managing agents' fee of £100 per trainee. The case for making the investment is, however, a strong one. In the short-term, the service would benefit from the work output of the trainees. The service gains a much more intensive and effective method of recruitment by which recruits' work potential can be assessed over a whole year before they become permanent employees. The NHS could also benefit from the potential for career development and adaptability of younger workers. Above all the YTS could be an important step towards the more appropriately trained, more productive workforce which the NHS must now seek.

Even if the case for this investment is accepted, then many questions remain about how to get the scheme launched in the autumn of 1983 which promises to be one of great difficulty for the NHS. Many districts would not be able to get the scheme going from their own resources. Regional personnel officers and their staff could certainly make a contribution towards getting pilot schemes going. But it is unlikely that this would in itself be enough. The MSC should consider an element of

special funding to the NHS to help it with the additional investment. This can be justified in terms of the special difficulties faced by the NHS as a service which has done little youth training in the past. The principle of additionality would be an important incentive where youth training is already developed but will be of little help where it is not. The NHS can make a major contribution to youth training in the longer-term – but only if the size of the initial investment in management time and money is faced. The special MSC contribution could be done through the funding of pilot schemes and programme development.

Recommendations

1 The DHSS, RHAs and the MSC should cooperate on a special three-year plan to establish the Youth Training Scheme in the NHS.
2 In the first year every effort should be made to get pilot schemes going. Districts should also be encouraged to get useful experience by acting as sponsors within programmes where others are the managing agents. Thus, some county councils are providing a framework which could be very useful.
3 The community services should be encouraged to develop placements.
4 The FPCs should be encouraged to take part in the YTS and to provide some placements.
5 Within districts, the main effort in the first year should be towards involving departmental managers in the YTS, especially in departments which did not play much part in the WEEP scheme. The YTS is likely to work better if a small number of trainees are attached to various departments rather than if trainees are crowded into a few traditional areas.
6 DHAs should be encouraged to recruit a higher proportion of younger workers to their permanent staff.

Industrial relations in the NHS have so far been much more developed in the negative sense. The future of youth training should be seen as one part of the more general effort to develop positive employment policies.

References

1 Great Britain. Manpower Services Commission. Young People on YOP. London, MSC, 1981, p 9.
2 Great Britain. Manpower Services Commission. Youth Task Group Report. London, MSC, 1982.

Appendix

Table 1 Completion rates against size of intake by region

	Size of intake	Number completed	Percentage completed
Midland	357	305	85
North	902	666	74
Thames and South	412	211	51
Total	1671	1182	71

Table 2 How many of these trainees dropped out without completing their placements in that period?

MALE		
Number of trainees	Number of districts	Percentage of total dropouts
0	45	0
1–2	25	27
3–5	8	23
6+	8	50
DK/NA	3	0

FEMALE		
Number of trainees	Number of districts	Percentage of total dropouts
0	21	0
1–2	24	10
3–5	16	18
6+	24	72
DK/NA	4	0

TOTAL		
Number of trainees	Number of districts	Percentage of total dropouts
0	0	0
1–2	28	8
3–5	17	15
6+	29	77
DK/NA	4	0

Table 3 How many hours per week do departmental managers or their staff spend on supervising WEEP trainees?

Number of hours	Number of DHAs	Percentage of total DHAs
0–4	17	19
5–9	23	26
10+	22	25
DK/NA	27	30

Table 4 To what extent does the work output of WEEP trainees vary from that of the permanent employees in this health district?

	Number of DHAs	Percentage of total DHAs
Do as much work as normal employees	41	46
Do half as much work as normal employees	40	45
Do a third as much work as normal employees	4	4
Not answered/don't know	4	5

Table 5 How many trainees completing placements, or who left before completing placements, in the period 1 January 1982 to 31 December 1982 took permanent jobs in the NHS in this health district?

	Number taking permanent job in same health district	Number of WEEP trainees	Percentage of those taking jobs to number of trainees
Midland	107	357	30
North	134	902	15
Thames and South	79	412	19
Total	320	1671	19

Table 6 DHAs and recruitment

Districts with varying levels of recruitment as percentage of surveyed DHAs in region

Cooks/catering

	Midland	North	Thames and South	Total
0	50	38	35	39
1–5	33	44	46	43
6+	0	3	4	3
NA/DK	17	15	15	15

Craft apprentices

	Midland	North	Thames and South	Total
0	50	46	41	45
1–5	28	41	37	37
6+	0	0	2	1
NA/DK	22	13	20	17

Professional and technical B

	Midland	North	Thames and South	Total
0	28	8	11	13
1–5	33	54	43	46
6+	17	26	33	27
NA/DK	22	12	13	14

Table 6 continued

Administrative and clerical

	Midland	North	Thames and South	Total
0	56	67	43	54
1–5	17	15	24	19
6+	6	3	7	5
NA/DK	21	15	26	22

Other training grade

	Midland	North	Thames and South	Total
0	50	41	41	43
1–5	11	28	24	23
6+	6	0	7	4
NA/DK	33	31	28	30

Table 7 Recruitment in health districts by region

Administrative and clerical

	Total number recruited	Aged 19 or under	Those aged 19 or under as percentage of total recruited
Midland	623	161	26
North	1435	261	18
Thames and South	2347	334	14

Professional and technical B

	Total number recruited	Aged 19 or under	Those aged 19 or under as percentage of total recruited
Midland	253	60	24
North	613	120	20
Thames and South	1330	134	10

Ancillary

	Total number recruited	Aged 19 or under	Those aged 19 or under as percentage of total recruited
Midland	957	239	25
North	2275	265	12
Thames and South	2829	688	24

Table 8 How many years does the training period last?

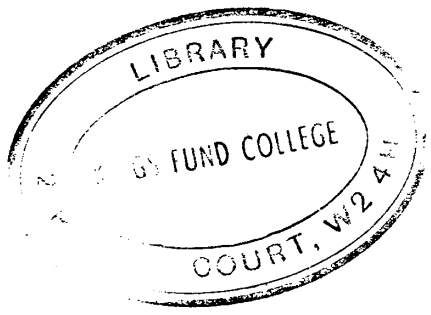
Number of years	Number of DHAs (percentage of total number of DHAs)				
	Cooks/ catering	Craft apprentices	Professional and technical B	Admin/ clerical	Other training
Less than 1	0(0)	0(0)	0(0)	3(3)	0(0)
1	4(4)	2(2)	0(0)	3(5)	3(3)
2	8(8)	0(0)	17(17)	10(10)	14(14)
3	29(28)	9(9)	25(24)	3(3)	5(5)
4	6(6)	26(25)	20(19)	0(0)	2(2)
5	0(0)	3(3)	2(2)	0(0)	0(0)
6	0(0)	0(0)	3(3)	0(0)	0(0)
NA/DK	56(54)	63(61)	36(35)	82(80)	79(77)

Table 9 Is there a college based element?

	As percentage of total replies		
	Yes	No	Not answered
Cooks/catering	43	3	54
Craft apprentices	38	1	61
Professional and technical B	71	1	28
Administrative and clerical	17	5	78
Other training	18	6	76

Table 10 How many trainees were aged 19 or under, how many were aged 20 and above?

	Total recruits	Percentage 19 or under	Percentage 20 and above
Cooks/catering	110	71	29
Craft apprentices	76	92	8
Professional and technical B	442	59	41
Administrative and clerical	98	43	57



NICK BOSANQUET is Lecturer in Economics, The City University, London

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