Employers Skill Survey:
Case Study
Health and Social Care

DfEE

**Department for
Education and Employment**

INVESTOR IN PEOPLE

EMPLOYERS SKILL SURVEY

Case Study - Health and Social Care

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FOREWORD

The Secretary of State for Education and Employment established the Skills Task Force to assist him in developing a National Skills Agenda. An important part of this remit was to provide evidence on the nature, extent and pattern of skill needs and shortages and their likely future development. The research evidence assembled by the Task Force was summarised in *"Skills for all: Research Report from the National Skills Task Force"*, **published in June 2000.**

An important contribution to the evidence was made by a major programme of new research. This included two employer surveys, detailed case studies in seven different industries and a review of existing surveys. We are grateful to all those who participated in this research and so contributed to the work of the task force. This report provides more detailed information on one element of this research. Details of associated reports are listed in the rear of this publication.

It should be noted that the views expressed, and any recommendations made, within this report are those of the individual authors only. Publication does not necessarily mean that either the Skills Task Force or DfEE endorse the views expressed.

Contents

SECTION A: EXECUTIVE SUMMARY

A1 INTRODUCTION

This report examines the relationship between service delivery strategies and processes, and the deployment of skills, recruitment problems and skill gaps within selected sub-sectors of health and social care. The sub-sectors within health are physiotherapy and radiography. Within social care the focus is on care of the elderly (both residential and domiciliary care).

Although subject to similar drivers and associated pressures, the two sub-sectors of health and social care display markedly different characteristics, particularly in terms of service delivery strategies, qualification frameworks and utilisation of skills. In simple terms, the health and social care sub-sectors considered within this report may be thought of as being situated at opposite poles of the 'skills spectrum': with radiography and physiotherapy characterised by high level skills, while care of the elderly is traditionally associated with low level skills. Hence, the two sub-sectors are discussed separately throughout this report. The greater complexity and range of skills required in the two health sub-sectors is reflected in the comparative length of the two sections of the report.

A2 HEALTH CARE

Policy context

There has been a steady growth in demand, that is expected to continue in the medium term, for the services of Professions Allied to Medicine (PAMs), which incorporates radiographers and physiotherapists as well as other professional groups. Factors contributing to this demand include the ageing population, rising expectations of patients and Government reforms, including a move toward care in the community and more integrated multi-disciplinary services. The emphasis on rehabilitation/whole systems approaches are requiring changes in working practice with skills implications, including skill sharing, flexible working and additional training for baseline assessments and team working. The introduction of clinical governance, with its focus on quality of care, and greater use of evidence-based practice are also starting to impact significantly on practice within the health sector. Since the change of Government in 1997, the emphasis has been more on partnership working, with the aim of replacing the internal market with an integrated system of care.

Strategic choices in relation to service delivery

Certain aspects of decisions made about the nature of the service to be delivered, such as the degree of specialisation of particular departments, may be taken at the level of regional or even national health policy. Thus the freedom of manoeuvre hospital trusts have in relation to strategic choices about the nature of service delivery may be significantly constrained. They do, however, have greater control over decisions about how the service is *delivered*, including choice over the model of care to be adopted. For example, within physiotherapy it is possible to offer client-centred, holistic treatment that seeks to empower clients to take greater responsibility for their own rehabilitation or to offer an approach where the professional maintains greater control, and treatment is seen primarily as the outcome of technical judgement. The choice over such issues is more amenable to local decision. The empowering approach is associated with greater capacity to deliver better quality of care, while the control approach is linked with the capacity to increase patient through-put and efficiency.

The empowering approach represents the ideal form of treatment, but if faced with particularly high demand for their services departments may opt for the more technicist approach as a means to reduce waiting times and waiting lists. Strategic choices over service delivery can also be influenced by tactical decisions made locally. That is the local staff will seek to optimise performance in relation to the above strategic considerations, increasing demand for services and the inherent constraints (e.g. available staff and technology) of the given context in which a department finds itself. The underlining policy driver in relation to skill development, however, is that staff should be capable of delivering a more integrated system of care, that also makes full use of technological developments, and this has clear implications for the deployment of professional knowledge and skills.

Implications for deployment of professional knowledge and skills

Skill implications for physiotherapists:

More physiotherapists will need training in baseline assessment, education and outreach work; inter-personal skills when dealing with the public will become even more important; the ability to communicate effectively across disciplines and services will be vital; and intra-hospital team working will be more strongly emphasised. Self-reflective learning through systematic reflection and review will continue to act as a driver of improvements in practice.

Skill implications for radiographers:

The work of radiographers is becoming more complex, with the technical and IT skill demands increasing and the underpinning knowledge base also expanding. The range of tasks radiographers have to perform has increased too. Particularly when on-call radiographers have to demonstrate basic expertise across a wide range of tasks, including the need to mark up X rays with issues for doctors to consider. Inter-personal skills when dealing with the public have become more important; and intra-hospital team working is now more strongly emphasised.

The skills implications for different grades of staff are summarised below:

Clinical staff:

- Move to *degree-level education*, requiring a more theoretical approach in initial training;

- Importance of *critical thinking* and *professional judgement* in professional practice;

- *Staff* are *expected to know more* (i.e. have a *greater breadth of skills*), as tasks are passed downwards to other team members and as a result of policies concerning a *more integrated service* for patients (so radiographers undertake intravenous injections as well as the subsequent x-rays);

- *New technology* in radiography, such as MRI scanners, means there is a need to master *more advanced techniques and processes*;

- *Learning while working* requires exposure to complex clinical cases and for this learning to be supported;

- Emphasis on *effective management of caseload*, particularly as staff reach senior levels.

Assistants:

- As clinical staff take on *more skilled tasks*, so basic radiography/physiotherapy tasks are handed down to assistants (i.e. assistants take on a wider range of skills, including more higher level skills);

- Within radiography in particular, changes to computerised systems require *new IT skills.*

Administrative and clerical:

- *IT skills* are in particular demand as a result of new equipment and changes to processes.

OVERALL: The picture is one of changes in technology and ways of working requiring:

- *a greater range of skills, and*

- *more higher level skills.* `

The increasing skill requirements of individual staff, however, are only part of the picture. There are other factors contributing to effective performance in health care:

- all staff have to cope with working in their *particular contexts*

- an organisational perspective also has to be adopted in a consideration of approaches to service delivery that are most likely to produce effective performance and continuing improvement - in terms of efficiency and quality of care.

Coping with work in particular contexts

Recruitment problems:

In both radiography and physiotherapy there is clear evidence of significant problems of recruitment - an absolute shortage of skilled staff means that some posts remain unfilled for some considerable time. Problems are more acute in some regions than in others and are more apparent in some specialist areas and contexts than in others. Recruitment problems were experienced particularly at clinical level in both radiography and physiotherapy departments and services. Within radiography there were certain specialist areas where recruitment difficulties were found, particularly paediatrics, mammography and ultrasound, due in the main to increased demand for these services and too few specialist staff available. Additionally, too few people are currently being trained as radiographers, and there are serious shortages of radiologists.

There were general recruitment problems in physiotherapy because other areas of physiotherapy are more popular than working in the NHS. There were serious shortages in particular areas of practice, particularly care of the elderly, because too few students opt to specialise in this area. There were difficulties in recruitment to community physiotherapy too, as this was seen as offering a wider range of lower level skills and being an isolated area of work.

Meeting departmental targets:

Strategic parameters for service delivery of both physiotherapy and radiography services are laid down at levels above the operational departments. Performance indicators on waiting lists, waiting times and quality of service were set for each department. Departments were then expected to meet their targets, although some targets were expressed in terms proportionate to the number of staff in post, in recognition of difficulties with staff recruitment in some areas. One general organisational change designed to help meet departmental targets was the introduction of more extended opening hours.

Caseload management:

Helping, teaching/coaching, clinical diagnosis and monitoring remain at the heart of professional expertise, but effective management of a caseload as a whole, as well as of individual cases, has become more important for both professions, and can make a significant difference to the overall efficiency of service delivery.

Approaches to service delivery that are most likely to produce effective performance and continuing improvement

Skill mixing:

Skill mixing was one means that both physiotherapy and radiography departments used to try to get a degree of control over service delivery, especially as a response to continuing recruitment difficulties. The degree of skill mixing was generally more limited in radiography than in physiotherapy departments.

In some cases radiographers undertook some tasks previously performed by radiologists, and assistants undertook some of the tasks usually performed by radiographers. For assistants, supporting the work of radiographers, interpersonal, practical and IT skills were particularly important. There were limits to their support as their work with X-rays still required supervision, so the presence and active support of radiographers was still required.

Skill mixing was easier to achieve in physiotherapy. In some instances physiotherapists specialised more and became specialist or extended scope practitioners. That is, they were promoted for taking on more demanding professional tasks, rather than for taking on more managerial responsibilities. The skills mix within physiotherapy was also changing where services were moving towards more holistic models of patient care, for example through merging physiotherapy and occupational therapy, as more advanced communication and inter-personal skills were required. Hence, the requirement was for a greater breadth of skills.

The use of assistants in physiotherapy was becoming much more widespread, particularly as in this area experienced assistants were allowed to work unsupervised. However, these developments have not been fully thought through in terms of their implications for supervision, training and progression of assistants and where the boundaries should lie between their work and that of physiotherapists.

Overall though, there was evidence that the development of the assistant role had contributed towards alleviating some of the constraints on service delivery caused by recruitment difficulties by freeing up valuable practitioner time to deal with more labour intensive cases. The quality and efficiency of the

service were clearly superior to that achieved when operating with shortages of professional staff, and staff felt that in some contexts the greater use of assistants provided the most realistic way of improving the effectiveness of service delivery for the foreseeable future.

Intra-team training:

Intra-team training involved bringing together all staff involved, across departments, disciplines and status levels, in delivery of a service. Where intra-team training was successful and all parties had confidence in the expertise of others, genuinely worked as part of a team and appreciated the different roles and challenges facing other members of the team, then a higher quality service was delivered to patients.

Management training:

This is a sphere where there is some evidence for current skills gaps or current skills deficiencies amongst existing staff. Many managerial staff received little formal training, and they reported they would welcome more support focused upon budgeting, human resources development, prioritisation, caseload management and time management. In those cases where more comprehensive staff development in these areas was given it resulted in the delivery of a more efficient service.

Support for newly qualified staff:

Some newly qualified graduates lacked sufficient understanding of how knowledge is used in practice. In particular, they sometimes lacked the 'coping skills' such as being able to prioritise caseloads. There is some evidence that this skill gap was partially unreported, although there was some recognition of this gap in all cases. The departments that made best use of their human resources seemed well aware of the need to allocate time for reflection and review, and that this was particularly important for new staff. It was clear that the learning of newly trained practitioners was facilitated if:

• regular mutual staff discussions were encouraged

• mentoring relationships were in place

• formal reviews of practice were held

• informal relationships led to work-related discussions at which more 'provisional' or 'riskier' comments could be made without pretending to be authoritative.

This was particularly important for those departments that regularly recruit newly qualified staff (because they do not get experienced applicants). They need to have in place mentoring, supervision or other support, so that the less experienced have opportunities to discuss and practise thinking about complex cases handled by their more experienced colleagues.

Importance of rolling reviews:

Those departments delivering effective performance were organised so as to ensure all significant service delivery issues were addressed over time (for example, three or four years) and that issues were tackled in an inter-related way, rather than responding reactively to each new pressure. Continuing change in health care delivery and the drive to enhance both efficiency and quality of care means that it is necessary to have continuing processes of review to address whether there are approaches to service delivery and skill utilisation and development that are likely to improve organisational performance. These rolling reviews seemed most likely to lead to continuing improvements in organisational performance in a way that acknowledged the particular constraints, challenges and choices that are faced in the particular context. They were an important mechanism for dealing with both reported and latent skills gaps.

Reflective practice:

The need for staff to be reflective practitioners is well established, but active reflection and review should not be confined to complex cases, but should also include the different ways practitioners seek to tackle their workload as a whole. By this means it should be possible to discuss and share ideas about the most effective ways to tackle a range of problems in practice. A greater emphasis on reflective practice and sharing of ideas calls for good team-working skills.

The value of reflective practice is now widely acknowledged, and practitioners reported that without this departments could lose their sense of shared purpose, and just react as individual practitioners, without any impetus being given to improve the quality of practice. The case studies bear this out, the more departments became over-loaded then the more important it was for colleagues to feel supported, and without that support retention of staff became much harder to achieve.

Spreading good practice:

Initial training in the operation of new equipment for the first radiographers to use the equipment is usually quite good. However, the most effective departments have procedures in place to ensure that such knowledge, and developing protocols learned from experience of the equipment in use, is cascaded to all relevant staff. Professional networks, regional collaboration and programmes of continuing professional development are all important in the dissemination of good practice, but more informal networks also played a significant role in spreading good practice. At departmental level it is important to ensure that all practitioners are tied into such networks.

Conclusions

There was increasing recognition within both services that holistic client-centred models of care should underpin service delivery, rather than relying upon more technicist approaches where provision was organised around the needs of the practitioners. However, staff considered it was often difficult to achieve the holistic approach at all times. That is they felt there were times when this approach was contextually unrealistic or had to be tactically compromised to some extent. Several factors appear key in the approach of organisations that have successfully battled with the constraints and kept pace with the drivers of change outlined in this report. These are:

- proactive rather than reactive management

- recognition of the benefits of investing in training

- willingness to evolve new models of service including developing collaborative arrangements with related service providers

- willingness of staff to work as part of a team and appreciate the different roles and challenges confronting other team members

- recognition of the centrality of learning through work for newly qualified staff and paying particular attention to the allocation of work and supporting these individuals.

In general, skills gaps in radiography and physiotherapy tend to be reported, rather than unreported or latent. Mechanisms and ways of working which are designed to deal with recruitment difficulties and reported skill shortages include greater use of assistants, more intensive team working and the implementation of a system of rolling reviews of departmental performance. The review system was conducive for enabling previously unreported skills gaps to come to the fore. The moves towards greater partnership and multi-disciplinary working are still in their infancy, and practitioners felt that these may reveal some latent skills gaps in relation to the need for very highly developed communication skills in all the prospective partners. The skills most likely therefore to make a significant difference to performance and service delivery in the immediate future will be those that underpin managing change and working effectively in cross-agency partnerships.

Summary of the relationship between skill utilisation and more effective performance within and between the two models of care:

Key skill sets involved in moving departments to a higher level of performance within the framework of a technical model of care:

- managerial skills related to budgeting, human resources development, prioritisation, caseload management and time management

- team-working skills: acknowledgement of the expertise of others; effective communication skills, such as active listening, the abilities to summarise and reflect back the views of others, and the inter-personal skills required to appreciate the different roles and challenges facing other members of the team

- support the learning of existing staff through active reflection upon practice and mutual sharing of experience

- support the learning of newly qualified staff through progressive exposure to more complex clinical cases and discussion of these cases, and through the discussion of the cases and ways of thinking of more experienced practitioners.

Key skill sets involved in moving health service providers from operation within a technical model of care to effective performance using a holistic approach to care within a partnership framework:

- managerial skills related to the management of change and the development of a more outward-looking perspective: including management of relationships with other departments, co-operation with external service providers and facilitation of multi-agency working in a partnership framework

- team-working skills: effective communication skills and the inter-personal skills required to work with others coming from a wide range of disciplinary backgrounds, organisational contexts and with different perspectives on how best to deliver care, support and treatment for patients

- support for mutual learning in developing new ways of partnership working

- ability to spread understanding and models of effective practice to other staff within their own departments

- supporting the learning of patients, especially in physiotherapy, in order to encourage them to take greater responsibility for their own care.

A3 SOCIAL CARE

Introduction

The social care sector provides personal and medical care, emotional, psychological and social support to individuals. It employs mainly women, who tend to be relatively low-paid and often working part-time. Within personal social services, 80 per cent of the workforce is unqualified and progress in increasing the take-up of training has been slow.

Residential care of the elderly primarily involves private providers, with local authorities now having a relatively minor role. The majority of care homes are small. Domiciliary care was traditionally provided directly by local authorities, but since 1993, there has been an increasing growth in private provision. It is characterised by a casualised workforce. In general, there has been a decrease in the supply of suitable applicants to care positions.

Service delivery strategies

Competition, resources and funding were key issues for organisations making decisions about service delivery in social care. In residential care, some organisations were attempting to attract 'niche' markets, through for example placing emphasis on choice and 'family' surroundings. Within domiciliary care, the principal service strategy was not necessarily to meet client preferences but to meet their perceived *needs*, generally specified by the contractor (usually the local Social Services Department). Some organisations involved in care of the elderly often found themselves struggling to maintain an existence and pressures on resources coupled with the need to provide continuing care coverage at all times made it difficult, especially for smaller organisations, to fund training and skills development for staff.

Good practice **within residential care revolved around:**

- value for money,

- standards of care, and

- provision of additional services for residents.

Private providers offering basic care services can be sure there will be continuing high levels of social demand for their services. The extent to which these service providers were likely to flourish in future was partly dependent upon the decisions made, nationally and locally, about funding.

One difficulty facing social care providers is that of increasing numbers of people, in absolute and relative terms, within the social care sector requiring more intensive care. This has implications for skills in terms of care workers requiring a greater range of skills and more quasi-nursing skills. The shift of policy emphasis from health care in institutional settings to social care has not been accompanied by a corresponding shift of resources. Providers of both residential and domiciliary care face an acute tension between funding constraints and the need to provide continuing quality care.

Influence of technology and work organisation upon service delivery

Although technological changes (such as new lifting equipment, the development of medical technologies) are not insignificant, work organisation tends to be the more important factor influencing service delivery in social care. One of the key aspects of work organisation concerns the changing boundaries between health and social care, coupled with changing ideas about the appropriate location for health care for the elderly. The changing boundaries revolve around issues related to roles, responsibilities and funding. Ideas about changing locations include a significant shift towards 'hospital at home', fuelled by patient choice and technological developments, such as the use of safe syringes.

Skill implications of service delivery strategies

In social care, human resource policies were varied and not necessarily related to a formal strategic or business plan. Large parts of the sector are characterised by a marked lack of career structures. Prior experience, which was often gained in voluntary or informal contexts, was often more important than qualifications in recruitment for care assistants. Employers also emphasised the value of qualities such as patience and positive attitudes to caring work. Interpersonal and communication skills for all levels of staff were considered to be vital, for dealing with relatives as well as residents with a range of physical and emotional needs. Basic practical care skills were needed, with nursing qualifications for certain levels of staff required in nursing homes. That some organisations had service delivery strategies based around high quality provision sometimes lead to demands for skills or training in excess of those provided by compulsory training.

The way work was organised, and the type of technologies used, in the care of the elderly in residential care, and to an extent in domiciliary settings too, meant care assistants needed:

- basic caring skills - such as feeding, washing, hygiene, etc.;

- quasi-medical and nursing skills - for care assistants, this included basic knowledge of illnesses and use of drugs, first aid;

- interpersonal skills - including the ability to listen, basic counselling skills and the ability to motivate and encourage;

- a positive and supportive approach and attitudes - for example to the notion of customer choice.

For those performing the whole range of traditional helping duties, the following had become more important:

- general monitoring (and, if appropriate, referral to supervisor, other care professionals etc.)

- the ability to represent the client's interests (including through the use of negotiation and advocacy skills).

Capacity to meet skill needs

Training and development in the sector was generally quite limited and mainly on-the-job. Certain statutory requirements had to be fulfilled, but the cost of training was such that some organisations were reluctant, or (in the cases studied in this report) unable to engage in training above these requirements. The incidence of training in social care organisations varied considerably and was highly contingent upon factors such as the size of the organisation, its client group, funding, and management ethos. Some providers were reluctant to release staff for logistical reasons, if they felt this compromised their ability to provide continuity of care.

External recruitment difficulties

Recruitment and retention are generally problematic in this sector, although the extent of difficulties varied according to geographical location and local labour market conditions. Wages in the sector were generally low and competition from other sectors that used non-specialist labour in the local area was a continuing problem. Particular difficulties were experienced in recruiting trained nurses for residential homes providing total nursing care, care assistants, and catering staff in larger establishments. In London and in other multi-ethnic communities, carers with culturally-specific knowledge were in demand - this included those with an understanding of White British as well as other cultures.

Internal skills gaps

Care assistants are often perceived as requiring few skills, and so the care sector may be seen as an attractive employment opening for individuals with poor skills. *Basic skills* such as literacy were lacking in some instances (particularly in domiciliary care), which created increased pressures on managers to ensure that requirements for reporting were fulfilled. Among some of the larger care providers with a wider range of client needs to address, care assistants were increasingly expected to exhibit *pseudo-nursing skills* such as tube feeding and terminal care.

As a more client-focused approach has become increasingly important in the care system, new skill demands have been placed on care staff. Many staff were perceived to lack (and found themselves lacking) communication skills in particular contexts. The skills required included the skills of listening, understanding, negotiation, taking decisions and upon occasion acting as advocate for the client: complex skills which have not been fully recognised. They were, however, perceived to be fundamental to adapting attitudes that occur in more structured and rigid approaches to the delivery of care. There were few instances of staff receiving support to develop these advanced communication skills.

Impact of skill deficiencies

Skill deficiencies themselves create further problems. For example, the use of agency cover to deal with temporary or longer-term staff shortages was relatively expensive, and therefore increased pressure on resources in other areas, as well as conflicting with the desire to provide a degree of continuity of care. Similarly skill shortages led to work intensification for staff. In cases where the number of clients nearly always exceeded the time available to provide effective care, then for the individual carer there was a gap between what they could do or would like to do and what they actually had time to do.

The general increase in skill demands of carers exacerbated these tensions, particularly those relating to:

- *Quasi-medical skills*, particularly within care homes, as older people are staying in their own homes for longer and thus require more care when they enter a residential home;

- *Increased communication skills*, as a result of policy changes and customer demand;

- Increased demand for *literacy skills*, as reporting is required.

Approaches to service delivery and skill utilisation likely to improve organisational performance

Focus upon caring for the individual

As treatment at home is getting more complex and protracted, coupled with the increasing influence of the client in the care system, so the focus of care is becoming the individual rather than the institutional providers of care. Increasingly the key service delivery issue is how to handle the fundamental *tension* between *efficiency* and *quality*. Efficiency is focused upon 'getting the job done': that is, performing the required support tasks and meeting performance targets. Quality relates to issues such as the extent to which care should involve 'feelings and authentic concern'. Trying to resolve this tension is complex. Ironically, those working in health and social care may be seen as 'uncaring' by the general public, if they become too focused upon efficiency. So a caring approach needs to be cultivated as an integral part of staff development and training: care based on feelings, not just thought. This requires an emphasis to be given to care-related knowledge (about relationships and contexts) rather than just upon treatment-oriented knowledge (and judgement divorced from context). One way of achieving this was to encourage the use of 'learning conversations' with a supervisor, mentor or peer (reflections on their own practice and that of others) in order to seek understanding through dialogue.

The most pressing 'skills needs' for carers therefore often relate to *communication skills*, such as:

• listening to clients;

• reflecting back clients thoughts, feelings etc.;

• understanding of emotions as underlying what we do and think; and

• the need to cultivate the practical stance of 'being reasonable' in particular working contexts.

These require the additional skills and qualities of self-reflection by carers upon their own practices and actions, as well as reflection on the practice of others and critical analysis of actions in context (both of one's own actions and those of others). That some of these skills are high level is in contrast with the stereotype of care assistants as doing relatively demanding work, but needing relatively few skills. Some carers are aware of skills gaps in this regard, and were keen to have the opportunity to extend their knowledge and expertise. Others were seemingly unaware that effective performance may be improved, and job satisfaction enhanced, by the development and utilisation of such skills.

Using care workers to do first-line monitoring for potential client problems

The most important aspect of effective performance in social care relies upon effective monitoring of client wellbeing. Although formal health screening and monitoring can play a role, those offering regular social care, particularly domiciliary care, are in a unique position to monitor and review client wellbeing on an informal basis. In order to do this effectively carers need to be able to communicate effectively with clients and health professionals.

Conclusions

Shifts in health and care policy, facilitated (at least in a small way) by technological developments, have led to an *increase in the range of skills* required in social care. In this respect, developments in social care are analogous to those noted for the health sub-sectors. The traditional characterisation of the sector as unremittingly 'low skilled' is increasingly inaccurate. Again, as in radiography and physiotherapy, the trend is towards *upskilling* - albeit from a lower base.

From the case studies it was apparent that many care providers were committed to providing a quality service - over and above the statutory minimum. However, the need to provide continuity of care, combined with funding constraints, meant that many providers in this sector found it difficult to make provision for the training they would like for their staff to enable the efficiency and quality of the service provided to be enhanced. These providers then seemed locked into a situation where they were aware that current skill deficiencies prevented them from moving to higher levels of organisational performance, but felt that logistically it was just too difficult to organise the type of training required to address their skill deficiencies. These providers when faced with high staff turnover and major skill deficiencies adopted a policy of controlling costs as a means of survival, rather than trying to upskill their workforce.

The quality of the workforce therefore played a key role in how effectively the service was delivered. There were examples of providers that had through their position in the market and/or through their use of programmes of staff development been able to recruit and retain staff such that they were able to deliver higher levels of organisational performance. These organisations were also in a much stronger position to be able to respond to the increasing demands for cross-agency partnerships, with the need for care staff to communicate effectively with a range of staff from other disciplines, backgrounds and organisational contexts. Which organisational strategy, controlling costs or upskilling, is more viable in the longer term depends partly upon market position and partly upon the criteria used by purchasers of the provision. If fairly high levels are set for the minimum quality of care then those organisations with more highly skilled staff delivering a higher standard of care will have the edge. If the minimum standards are set quite low then those organisations whose emphasis is upon controlling costs are more likely to be more successful.

The above analysis of strategies of either staff development or cost control as a key organisational tool are both framed within an institutional approach to social care. Within this approach the emphasis is upon how the organisation can improve its performance, principally either in terms of efficiency or quality of provision. However, just as in health care an alternative perspective threatens to transform how provision of care is conceived. The alternative approach is client-focused, paying greater attention to the needs of the client rather than of the providers. Its most obvious manifestation is in the need for collaboration between organisations in multi-agency partnerships, but the key driver is the intention to improve the coherence and quality of care as experienced by the individual. The cost control approach is a survival strategy that pays little attention to the use of skill development as a means to improve organisational performance. However, the relationship between skill utilisation and more effective performance within an institutional approach to care delivery and that involved in the move towards a more client-focused model of care delivery are represented in summary form as follows:

Key skill sets involved in moving organisations to a higher level of performance within an institutional approach to care delivery through use of an upskilling strategy:

- communicating with clients and relatives with patience and understanding
- inter-personal skills involved in understanding the emotions and emotional needs of clients.
- team-working skills involving a willingness to engage in a wide range of tasks
- quasi-medical and nursing skills like tube feeding and terminal care
- application of care-related knowledge of dementia and effects of different medical conditions of clients
- skills involved in the general monitoring of clients, especially being alert to when it would be appropriate to call upon more specialist staff

Key skill sets involved in moving care service providers from an institutional approach to care delivery to effective performance using a client-focused approach to care delivery:

- managerial skills related to the management of change and the development of a more outward-looking perspective: including management of relationships with a range of other agencies in a partnership framework

- team-working skills: being able to co-operate with other partners coming from a wide range of disciplinary backgrounds, organisational contexts and with different perspectives on how best to deliver care, support and treatment for clients

- quasi-medical skills like catheter care

- application of care-related knowledge about handling relationships in different contexts and culturally specific knowledge about different client groups

- skills involved in the general monitoring of client well-being, particularly in relation to when to call upon the skills, knowledge and resources of other staff

- displaying feeling and authentic concern for clients and having a situational awareness of the different types of behaviour appropriate in different contexts

- communication skills involving active listening to clients; the ability to reflect back clients' thoughts, feelings and emotions; being able to act as an advocate on behalf of clients; being able to handle confrontation through techniques of de-escalation.

SECTION B: THE EXTENT, CAUSES AND IMPLICATIONS OF SKILL DEFICIENCIES IN THE HEALTH AND SOCIAL CARE SECTORS

B1 INTRODUCTION

The health and social care sector: This report examines the relationship between service delivery strategies and processes, and the deployment of skills, recruitment problems and skill gaps in selected sub-sectors in the Standard Industrial Classification category *health and social care.* This is a sector that has witnessed faster than average employment growth during the 1980s and 1990s, and which is projected to see continuing expansion of employment at a greater than average rate over the medium-term.

The sub-sectors focused on are:

- in ***health:***
  - radiography;
  - physiotherapy, and;
- in ***social care:***
  - care of the elderly - encompassing both residential and domiciliary care.

The greater range of skills and complexity of service delivery in the health care sub-sectors than in social care of the elderly is reflected in the comparative length of sections C and D.

Position on the 'skills spectrum' and changes in employment demand: In simple terms, these sub-sectors may be thought of as being situated at opposite poles of the 'skills spectrum'. Radiography and physiotherapy are characterised by high level skills. *Professions Allied to Medicine (PAMs)*, of which radiography and physiotherapy form a part, have been undergoing substantial changes in recent years. Entry into the professions is now graduate-level. The increasing 'professionalisation' of the employment structure is projected to continue over the medium-term, as professional occupations and associate professional occupations witness amongst the fastest growth rates of any occupational group.

Care of the elderly is traditionally associated with low level skills, although the reality is one of a variety of skills being required. With the ageing of the population and major changes taking place in the legislative framework surrounding social care, care of the elderly has been the subject of increased attention. Demand for social care services is set to increase, although the extent to which this demand will be met across public, private and voluntary arenas remains to be seen.

Differences and similarities between health and social care sub-sectors: As the two sub-sectors of health and social care display markedly different characteristics, particularly in terms of service delivery strategies, qualification frameworks and utilisation of skills, they are discussed separately in this report. (See section C for the case studies of radiography and physiotherapy within health care and section D for care of the elderly within social care).

Despite these differences, there are some important similarities between the health and social care sub-sectors, particularly in relation to:

- the policy environment within which they operate, and

- the major drivers affecting the balance of services.

(See Table 1 for the implications of and issues relating to the main generic drivers within health and social care).

Table 1: Key drivers and their implications in health and social care

Driver	Issue	Aspect	Implications
Demographic change	Ageing of population	Changing pattern of demand for services	• In general, demand for health services, and need for social care, increases with age > need for more staff engaged in health and social care
Expectations of clients	Satisfying client demands	More demanding clients	• Expectations for 'quality' health and social care increase > greater emphasis on client choice and quality service • More 'knowledgeable' clients > wanting more information on 'options' and more likely to question specialists /carers, so placing greater emphasis on 'communication skills'
Government policy	Key policies	Care in the Community	• Need for more domiciliary care • Those in residential care are more dependent > greater emphasis on basic nursing care
		Partnership	• Emphasis on multi-disciplinary teams involved in health & social care
	Funding	Pressures on funding	• Emphasis on 'value for money' and delivery of most basic services at minimum cost > lack of money for training, leading to 'squeezing' of training
	Legislation	Health and safety	• Basic thresholds have to be surpassed > basic skills prerequisites
		Minimum wage	• In low wage sectors wages have been increased across the board to meet legislative requirements and preserve differentials
		Working Time directive	• Related to hours of work, holiday pay and benefits, including for agency staff > higher costs
Technological change/ New developments	New machinery/ new medicines/ new techniques	Need for continual updating	• Need for 'top up' training
		Changing skills mix	• New ways of working > need for 'broadening' skills • development of communication skills
		Rise of holistic/ alternative medicine	

B2 CONTEXT OF THE CASE STUDY INVESTIGATIONS: METHODOLOGICAL ISSUES

Broad geographical context: The case studies were undertaken in London, the South East and the North West, reflecting a mix of high- and low-waged economies, with potentially varying skill needs and labour market conditions.

Characteristics of case study establishments / organisations and rationale for selection: Care of the elderly, particularly in residential settings, typically takes place in relatively small establishments. The size of physiotherapy and radiography departments varies, but many also have fewer than 100 staff, particularly in community Trusts. The research team visited establishments and departments that offered a reasonably wide range of services, and employed a range of staff at different levels. A mix of specialisms were also studied, including general and specific services in radiography, NHS Trusts providing services in the community and predominantly hospital-based care in physiotherapy, and organisations providing residential and domiciliary care of the elderly in the independent sector.

Various professional and umbrella organisations were contacted before the case studies were undertaken, including the National Training Organisations for Health and Social Care, the Chartered Society of Physiotherapy, the College of Radiographers, Carers National Association, National Care Homes Association, and the King's Fund. These organisations supplied the team with relevant contextual information on skills and contacts within the sub-sectors. Interviews with managers and staff took place at twelve establishments or departments. The case studies achieved were broadly representative of the two sub-sectors in terms of size, and range of services offered (see Table 2).

Table 2: Outline of case studies within the health and social care sector

Sector	Sub-sector	Type of service	Size of organisation
Health	Radiography	• Diagnostic and/ or therapeutic (adult) • Diagnostic and/ or therapeutic (adult)	• One medium, one large • One small
	Physiotherapy	• Acute • Combined • Community	• One medium • Two medium-large • One medium
Social care	Residential	• Total nursing • Care homes	• One large • Two small
	Domiciliary	• Total service • Limited service (meals, general help, befriending)	• One large • One large

Issues of comparability and generalisability across the case studies: In health care, the radiography and physiotherapy departments visited reflected the range of departments and services offered. However, because of specialities, coupled with institutional and geographical differences, in some instances generalisability is limited. For example, in physiotherapy, the research team visited one acute, two combined and one community Trust. Some of the departments visited were recommended as being particularly interesting or innovative in some respects, so there may be a *slight bias in favour of good practice* in the health sample as a whole. However, staff seemed well aware of skills problems outside their immediate specialisation or locality. Many common skills issues were presented, but there were also specific issues raised relating to the departmental or service specialisms. In radiography, two general services and one paediatric service were visited. The latter, being a smaller service, experienced particular problems.

Within the social care sector, the research team focused on domiciliary and residential care in the independent sector. The range of case studies undertaken incorporated two establishments (medium-to-large) in domiciliary care and three (two small and one large) in residential/nursing care. These reflected the different size of establishments found within the sector. These cases were at the *more enlightened end of the spectrum* of a sector in which the quality of service delivery and the extent to which staff were trained and sufficiently skilled to undertake their work varied. Hence, we might expect to see greater recognition of skills issues, and more willingness and action to attempt to overcome skills gaps, in these cases than would be the case across the sector as a whole.

Wider perspectives concerning skill needs and skill deficiencies were generally in accord across the case studies (with some specific issues being raised in relation to particular specialist services, such as paediatric radiography and community physiotherapy). In health, views concerning service delivery tended to be relatively consistent, probably due to shared beliefs about the way national health policies constrained service delivery in significant respects, whereas in social care perspectives on service delivery, business performance, human resource policies, and skill utilisation were more varied.

Overall, our assessment is that the case studies in health care and social care were coping remarkably well in achieving their goals of providing an efficient and high quality service in the face of recruitment and retention difficulties and the financial constraints under which they were operating. Those case studies that were delivering high levels of performance shared two major characteristics. First, they had been successful in managing change and, second they shared a commitment to the development of their workforce. Both these characteristics will continue to be important in order to meet the challenge of working effectively in cross-agency partnerships.

Range of interviews conducted: Within each case study, interviews were undertaken with a range of respondents. In physiotherapy and radiography departments, these included the department's service manager (and, in larger departments, senior clinicians responsible for managing a particular aspect of the service such as community physiotherapy), clinical staff at different levels of experience, including some newly-qualified graduates, assistants, and a member of the clerical support team. In social care organisations, interviews encompassed the service managers, care staff, and nursing auxiliaries.

SECTION C: HEALTH CARE: RADIOGRAPHY AND PHYSIOTHERAPY

C1. CONTEXT TO THE CASE STUDIES IN RADIOGRAPHY AND PHYSIOTHERAPY

C1.1 Broader changes within the NHS

The internal market in the NHS: The NHS has undergone substantial reforms since the late 1980s. Major reorganisations followed the publication of the White Paper Working for Patients in 1989 which emphasised patient choice and value for money, through the introduction of market mechanisms and commercial principles (Francome and Marks, 1996). The major elements of this change were the introduction of the 'internal market' in health care, decentralisation (for example, NHS Trusts becoming self-governing units) and the 'purchaser/provider split', with 'providers' tending to be at Trust level and health authorities becoming 'purchasers' (Moon, 1997). The strategy was also one of cutting costs, which had implications for skill development as training came under pressure (Grimshaw, 1999). The over-riding *emphasis* was *on efficiency*. The system of the internal market has been criticised for the way in which it fragmented services, led to inequalities in provision and diverted resources from improving quality via more research and evidence-based services (Francome and Marks, 1996; Mohan, 1997).

Partnership: Since the election in 1997 of a Labour government, the emphasis has been more on partnership, with the aim of replacing the internal market with an integrated system of care (the 'Third Way') (Department of Health, 1997). The aims of the current government are to renew the NHS as a service with national standards, although responsibility will remain at the local level. Local Health Improvement Programmes, involving all those engaged in planning and providing health and social care services, replace the internal market. Hence, there is greater emphasis on the need for inter-agency working and associated communication and team-working skills. The full implications for practice and service delivery of the need to work effectively in cross-agency partnerships are only now starting to be explored in many cases.

The 'professional manager': A further feature of the NHS reorganisations has been a change in styles and structures of management and the rise of the 'professional manager' (Gillespie, 1997). Since the reforms following the Griffiths report in the early 1980s (DHSS, 1983), which introduced new management arrangements based on commercial principles, new initiatives have been introduced, such as codes of conduct, management training schemes and the development of a professional body, the Institute of Health Service Management. Senior managers within the NHS are less likely to come from the health professions and more likely to have been finance and administrative staff (Ackroyd and Bolton, 1999).

C1.2 Upskilling of professions allied to medicine within the NHS

Skills implications of integrated approaches to health care: There has been a steady growth in demand for the services of Professions Allied to Medicine (incorporating physiotherapists, radiographers and others) and this is likely to continue in the future (Professions Allied to Medicine and Related Grades of Staff Council, 1997). This is part of a more general trend towards the 'professionalisation' of occupational structures. Factors contributing to this growth in demand include those outlined in Table 1: the ageing population, rising expectations of patients, and Government reforms, including a move toward care in the community and more integrated, multi-disciplinary services (Department of Health, 1997).

The emphasis on rehabilitation and more integrated approaches requires changes in working practice with skills implications, including:

- skill sharing,

- flexible working,

- additional training for baseline assessments, and

- team working.

The introduction of clinical governance - to assure standards at local level (e.g. through dissemination of good practice, systems to ensure continuous improvements and risk avoidance strategies), with its focus on *quality of care*, is also likely to impact significantly on practice within the health sector. Hence, in the drive to achieve both *efficiency* and *quality* of health care services, recent developments have tended to emphasise quality. These developments also go beyond what can be achieved through improvements in individual practice. They also require departmental and organisational commitment to the effective management of change. For example, the position of radiographers and physiotherapists within organisational structures continues to be subordinate to that of doctors, and this constrains patterns of work organisation and the utilisation of skills in significant respects. This highlights how the extent of the development of the communication, inter-personal and team-working skills of highly qualified staff have consequences for how effectively other staff perform. Some of our case studies therefore put particular emphasis upon staff development designed to facilitate multi-disciplinary team-working.

The graduate route: Radiographers and physiotherapists are predominantly women, in common with other 'semi-professional' groups and in contrast with the 'key' professional medical groups (Cockburn, 1986; Gillespie, 1996). Their professional position has changed to *graduate status* and they have a degree of autonomy over occupational practice through their professional bodies. The demands upon practitioners in both professions have increased, as they have had to cope with an *expanding knowledge base* and calls for a shift towards *evidence-based practice* (i.e. learning through evidence provided by research and examples of good practice). This calls for both a greater range of knowledge, and emphasises the need to update knowledge on a continuing basis.

C1.3 Professional standards

Regulation: Professional standards apply in most areas of health care, and these govern significant aspects of the training, practice and professional development of radiographers and physiotherapists. There is a high degree of regulation with professional bodies such as the Chartered Society of Physiotherapists prescribing technical competencies and minimum levels of continuing professional development (CPD). Hospitals and other health care organisations are therefore obliged to provide a minimum amount of training and support for the CPD of staff in the professions allied to medicine. The presence of such regulations, and requirements for training in the use of new equipment, mean updating in terms of technical aspects of the professional role is generally adequate. It is in areas like caseload management that moves to higher quality service delivery strategies were most likely to reveal latent skills gaps.

C1.4 Typicality of case studies

Commonalities between cases: The organisation of work and patterns of skill utilisation in NHS physiotherapy and radiography departments and services are subject to a series of common regulations, constraints, and pressures. This means that, although the specific environments and skills of particular groups of staff varied, the common influences are such that there was no reason for us to doubt that, from a focus upon skills utilisation, our seven case studies are broadly typical of the sector as a whole. Similarly, individual differences in approach to the utilisation of their skills related more to their training, age and overall experience rather than their experience of work in the case study establishment per se.

Variations: Table 3 gives details of our case study establishments/departments and services, and it shows variation in terms of the numbers of people employed, range of services, location and whether the department is expanding or declining.

Table 3: Case study establishments/departments and services in health sector

Case study no.	Region	Number employed in dept. or service	Growth/ Decline	Single site or multi-site	Main product/ service	Type of main customer/ end user
S1	London & South East	50	Growth	Single site	All radiography services except for cardiac. Also radiotherapy	Hospital patients
S2	North West	27	Growth	Multi-site	Full range of radiography services (paediatric)	Hospital patients
S3	London & South East	118	Growth	Single site	Radiography	Hospital patients
S4	London & South East	35	Growth	Single site	Range of physiotherapy services	Hospital patients
S5	London & South East	111	Growth	Single site	Range of physiotherapy services	Hospital patients
S6	North West	40	Stable	Single site	Range of physiotherapy services	Hospital patients
S7	London & South East	54	Decline (reorganisation and recruitment problems)	Multi-site	Outpatients and community physiotherapy services	Hospital patients

C1.4.1 Radiography

The role of radiographers: Radiographers are primarily based within the National Health Service, although a small proportion may work outside, for example, in sales teams within X-ray or therapy equipment companies. The two branches of radiography within NHS Trusts are diagnostic and therapeutic, with the latter being based in large urban centres. Diagnostic radiography uses X-rays to produce images of the body's anatomy and physiology, whereas therapeutic radiography involves the use of ionising radiation to treat disease. Its primary use is in the treatment of cancer.

The importance of technological developments: Technological developments, particularly in recent years, have led to increasingly sophisticated equipment and processes in radiography. The training for radiography is highly technological. New technologies require new skills, so there is a need for continual updating of skills in line with technological developments. Besides a general commitment to CPD, there is also an expectation that staff will be trained in the use of new equipment, with technical aspects of that training often being given by the equipment manufacturers.

Accreditation: Radiographers have to be State Registered to practise, accreditation being given by the College of Radiographers on successful completion of the requisite training. Initial training has moved towards degree-level education that encompasses both diagnostic and therapeutic radiography. This has the advantage of expanding the theoretical knowledge base to provide a broader platform from which to deliver services.

Awareness of skill needs: The nature of radiography as a *'community of practice',* that makes extensive use of professional networks, meant that although staff might be working in particular contexts they did seem well aware of skills problems outside their immediate specialisation or locality. This meant that they were able to form comparative judgements about the nature of 'good practice' in the profession as a whole. It may also point to an emphasis on reported rather than latent skill gaps.

C1.4.2 Physiotherapy

Work settings: Physiotherapists work in a number of settings:

- in the NHS - in:
  - major 'acute' hospitals (where medical and surgical care is provided mainly in the hospital),
  - smaller community Trusts/services,
  - 'combined' Trusts (combining both acute and community services),
  - health centres, and
  - GP practices,
- private practice, and
- industry.

While physiotherapy practice outside the NHS tends to be largely musculo-skeletal (i.e. relating to injuries, back problems etc), within major Trusts, physiotherapists may practise in a range of environments. These include outpatient services, respiratory care, orthopaedics, paediatrics, health care of the elderly, neurology, primary and community care, women's health, mental health and so on.

The role of physiotherapists: The work of physiotherapists has both clinical and psycho-social aspects, including prevention of disease and injury, diagnosis, assessment and treatment of patients and management of rehabilitation.

Graduate route: Physiotherapy is a popular degree choice, but there are wide variations of popularity of the specialisms within the subject, with few students specialising in care of the elderly - so generating reported skills shortages in this field. Undergraduate and postgraduate courses are normally certified by the Chartered Society of Physiotherapy, and provide opportunities for work-based learning.

C1.5 Summary of skill implications of this section

- **Policy drivers:** national and regional initiatives towards care in the community; integrated multi-disciplinary services; emphasis upon rehabilitation and whole system approaches; and a focus upon quality of care for individual patients.

- **Skill implications for physiotherapists:** more physiotherapists will need training in baseline assessment, education and outreach work; inter-personal skills when dealing with the public become even more important (than that required to support an expert treatment-centred model of practice); the ability to communicate effectively across disciplines and services is vital.

- **Skill implications for radiographers:** inter-personal skills when dealing with the public become even more important (than that required to support an expert treatment-centred model of practice); intra-hospital team working is more strongly emphasised.

- **Implications of shift to graduate status of initial training:** graduates are better able to cope with the demands of an expanding technical knowledge base and the need to rely upon evidence-based practice. Weaknesses are that too few people are being trained as radiographers; there are shortages of students opting to specialise in the care of the elderly; and other areas of physiotherapy are more popular than working in the NHS.

C2 SERVICE DELIVERY STRATEGIES

C2.1 Service delivery strategies of the case study departments

The discussion in this section relates to the service delivery strategies of the case study departments, key drivers of those strategies and responses.

Strategic choices in relation to service delivery: Certain aspects of decisions made about the *nature* of the service to be delivered, such as the degree of specialisation of particular departments, may be taken at the level of regional or even national health policy. Thus the freedom of manoeuvre hospital trusts have in relation to strategic choices about the nature of service delivery may be significantly constrained. They do, however, have greater control over decisions about how the service is to be *delivered*, including choice over the model of care to be adopted. For example, within physiotherapy it is possible to offer client-centred, holistic treatment that seeks to empower clients to take greater responsibility for their own rehabilitation or to offer an approach where the professional maintains greater control, and treatment is seen primarily as the outcome of technical judgement. The choice over such issues is more amenable to local decision. The empowering approach is associated with greater capacity to deliver better quality of care, while the control approach is linked with the capacity to increase patient through-put and efficiency.

The empowering approach represents the ideal form of treatment, but if faced with particularly high demand for their services departments may opt for the more technicist approach as a means to reduce waiting times and waiting lists. Strategic choices over service delivery can also be influenced by tactical decisions made locally. That is the local staff will seek to optimise performance in relation to the above strategic considerations, increasing demand for services and the inherent constraints (e.g. available staff and technology) of the given context in which a department finds itself. The underlining policy driver in relation to skill development, however, is that staff should be capable of delivering a more integrated system of care, that also makes full use of technological developments, and this has clear implications for the deployment of professional knowledge and skills.

Formulation of service delivery strategies: At the strategic level the nature of service provision is decided in accordance with national, regional and Trust policies. The *scope for manoeuvre* at the level of the department is therefore *limited*. However, the radiography and physiotherapy departments visited tended to have *business plans,* generally in line with the NHS Trust's business plan[1], although in some cases with specific objectives relating to the services to be offered or the department as a whole. *Performance indicators* related to issues such as waiting lists and times, activities against number of staff in post, and quality of service (monitored, for example, through the use of protocols and audit). A *training plan* was often incorporated within the local departmental/service business plan.

Balancing efficiency and quality: Demand for services was generally channelled through GPs and consultants. The level of demand for services continues to be high, and so the emphasis is on delivering services rather than on generating a market for those services. Service strategies focused on *efficiency and cost effectiveness,* as well as providing a high *quality* of care, with inherent tensions in the two strands, largely due to funding constraints.

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1 Trust business plans relate to issues such as recruitment and retention, quality of service, professional development, workload of services, admissions policy, equipment, health and safety and marketing.

Issues informing service strategies: The key issues informing service strategies were:

• customer/patient demand;

• patient-focused care;

• pressure of waiting lists and times, caseload demands and other performance indicators; clinical, operational and health and safety protocols for procedures and practice;

• replacement of equipment, particularly in radiography, since optimum treatment depends on having up-to-date technology;

• skill mixing (i.e. scrutinising and adjusting the balance of roles and skills relating to particular areas of work), and;

• evidence-based practice.

Multi-disciplinary working or specialisation?: In some cases, multi-disciplinary working had developed and in others services had become more specialised. The impetus for these developments reflects changing service strategies and greater partnership working both between agencies and between professionals.

Partnership arrangements: In most case studies, partnership arrangements were incorporated within the Business Plan or Service Strategy of the unit. In physiotherapy, such partnerships reflected the increased emphasis on health promotion and frequently involved local authority Social Services departments, health promotion specialists, and the voluntary sector. For example, Case S7 was piloting a number of projects that were designed to co-ordinate service provision between the Trust, the local authority, and local care providers. Projects sought to identify patients who could be treated outside the acute unit, if they also had access to enhanced care services, provided either on a residential or domiciliary basis. This improved service quality and efficiency by minimising the disruption caused to elderly patients by hospitalisation, offering patients a more *holistic treatment* involving care as well as physiotherapy services, and allowing the hospital to focus its in-patient resources on the most acute cases. The switch to a more holistic view of health care also has skill implications for practitioners requiring a substantive knowledge base, self-confidence and credibility if those in the caring professions are to be effective patient advocates (Logan and Boss, 1993).

C2.2 Changes to service delivery strategies

The political and legislative framework: Political decisions about resources and staffing of the NHS, as well as a range of other government initiatives (e.g. concerning clinical governance, clinical effectiveness, evidence-based care/practice, patient-focused care, and targets for time spent on waiting lists), set the framework for decision making in this area. Recognition also had to be taken of European legislation (e.g. EU handling directives and the Working Time Directive) and any particular local demands from patients or staff. Additionally, the mix of skills of existing staff and the relative difficulty of recruiting particular types of staff (which was greater in some areas than in others) influenced the type of strategic choices made about service delivery. Overall then, *virtually all departments have to balance calls for improved quality and greater efficiency with the pressures of coping with increased demand.*

Trust strategies: The overall Trust strategies in radiography and physiotherapy influenced policy and forward planning. Service delivery strategies have changed significantly in the recent past and further changes are in prospect with continuing calls for the modernisation of health care services. In radiography, key drivers of change have included greater attention being given to patient-focused care and patient care standards, the introduction of new medicines and equipment and the development of new techniques. In physiotherapy, service delivery strategies have been influenced by the requirements of primary care groups, changing ideas about clinical governance, and financial and human resources constraints. Service delivery strategies also have had to respond to increasing demand.

Strategies for coping with recruitment difficulties: In many departments there were periodic recruitment difficulties, and in extreme cases where continuing recruitment problems due to an absolute shortage of skilled personnel were encountered respondents spoke of rationing treatment in order to meet patient demand with the staff resources available. For example, one physiotherapy department had reduced the average number of treatments per patient by placing greater emphasis on *patient self-management* (as outlined below). Such a response raises important issues relating to the tensions between efficiency and quality of service in the short-term and the longer-term. It also raises important equity issues regarding the differential ability and scope for some patients to maintain their treatment programme given constraints such as time or the amount of space in which to do exercises at home. Selecting patients likely to benefit from such an approach also calls for highly developed caseload management skills on the part of the physiotherapists concerned.

Patient self-management has become increasingly important in physiotherapy, as a preventive mechanism and a means of 'empowering' patients to participate in their own treatment and also as a means of reducing waiting lists in the longer term (although in the short term, greater time may be required from the physiotherapist, who is taking on an educational role in addition to her/his customary clinical tasks). For example, patients experiencing certain back problems are encouraged to reduce dependency on experts through an exercise programme, which is initially supervised by a physiotherapist and which they can then continue at home.

Good practice in service delivery: Examples of good practice included attempts to monitor quality of service through patient, GP and consultant satisfaction surveys, and outcome measurement for patients. Provision of information leaflets on services, self help, and home exercise programmes; advice sheets; suggestion boxes; and a robust patient complaints procedure were also important indicators that there were opportunities for users to understand and comment upon service provision. Such feedback procedures are important in ensuring that user perspectives can be fed into discussion of service delivery strategies alongside the range of top-down initiatives and concerns.

C2.3 Sustainability of service delivery strategies and possibilities for alternative strategies

Limitations on the scope for alternative strategies in providing an efficient and high quality service to more people: The scope for market responses, such as putting up prices, generating more revenue or moving into a higher quality niche market, are ruled out by the very nature of the NHS. Thus at a strategic level the key imperatives are quality, efficiency and meeting increased demand. Staff in physiotherapy and radiography departments were well aware of the need to improve the quality and efficiency of their services. However, significant aspects of the service delivery strategies of particular departments are influenced by decisions, about clinical procedures and resource allocation between departments, taken outside the department. For example, major investment in new technologies, designation as a regional centre, specialising in particular forms of therapeutic treatment (e.g. paediatric), and links with higher education training institutions transformed aspects of the service delivery strategy of a radiography department. Similarly, hospital physiotherapy service delivery strategies in the medium term will be significantly influenced by the extent to which physiotherapy services are decentralised and delivered in partnership with General Practitioner practices. The development of community physiotherapy and working with other agencies led to changes in the siting of many physiotherapy services, such that hospital services deal predominantly with in-patients.

Tactical choices: The particular service delivery strategies followed by the case study departments were therefore concerned with tactical choices to cope with the immediate range of pressures they face and their understanding of which of these pressures are most pressing at any given time. For example, there is scope for making different decisions about how work should be organised, skill mixing, multi-skilling, at what level to recruit staff and the nature of training and support offered to staff.

Overview of strategies and tactics: Overall, the major decisions affecting service delivery are taken at Trust, regional or national level. While at department level, there is more scope for variation in the approaches to service delivery, for example in relation to choices in terms of models of care or development and utilisation of skills. Hence at departmental level there is limited scope to influence service delivery strategies, but alternative forms of delivery within the strategic parameters set elsewhere are possible.

Sustainability in the face of ongoing reported skills gaps: All the services we studied were currently sustainable, but subject to increasing pressures, including rising demand, partly due to the ageing of the population. The extent to which the departments were likely to flourish in future was dependent upon the interaction between the actions of their own staff and the structures within which they had to operate, not least the resources available and the skills formation and development strategies pursued nationally and locally. For example, nationally one in four radiology posts were difficult to fill and the numbers of radiographers currently in training were not sufficient to fill actual and projected vacancies.

Tensions between efficiency and quality: The increasing demand for services coupled with the pursuit of higher standards of service provision and quality control had an impact on workload, working procedures and staff development. Some departments had responded to these pressures by seeking to become more efficient in terms of patient throughput. There were perceived to be certain limits to this process, however, as patients were now more likely to require information about treatments and procedures, and there was a general perception that 'patients are becoming more questioning'. This put limits on the speed with which patients could be processed. Further strains between the drive for efficiency and the desire for improved quality were seen in the conflicts that sometimes arose as a consequence of multi-disciplinary working. In one department this compromised attempts to reduce waiting times because of a dependence on other departments to co-operate in the delivery of the service. For example, in Case S2 radiographers were now working closely with staff from other areas in theatre. The problem was that the shortage of trained nurses providing theatre support impacted upon the delivery of a cardiac support service during normal working hours, leading to longer waiting lists. The response was to extend appointment times beyond the standard finishing time of 5.00 p.m., with overtime payments becoming necessary to maintain the service.

Medium-term planning and the role of rolling reviews: We have emphasised the wide range of issues, targets and goals that affect service delivery of radiography and physiotherapy. These cannot all be addressed at the same time, but they do all need to be tackled over time. One way to achieve this is through medium-term planning and rolling reviews with a time horizon of three or four years. This helped staff make informed decisions in a broader institutional context about how best to optimise service delivery and skill development.

C2.4 Summary of skill implications of this section

Strategy and tactics: Strategic parameters for service delivery of both physiotherapy and radiography services are laid down at levels above the operational departments. Performance indicators on waiting lists, waiting times and quality of service are set for each department. Departments are then expected to meet their targets, although some targets are expressed in terms proportionate to the number of staff in post, in recognition of difficulties with staff recruitment in some areas. Demand for departmental services is dependent upon referrals from consultants and GPs. Departments tended to be reactive to the immediate pressures they were facing, as their scope for independent action was severely constrained.

Skill mixing as a response to recruitment difficulties: Skill mixing was one means that both physiotherapy and radiography departments used to try to get a degree of control over service delivery, especially as a response to continuing recruitment difficulties. In some cases departments sought to develop a reputation for expertise in particular specialisms. Active consideration of skill mixing was most likely in larger health care units. Skill mixing involved examining both job content and the internal structure of the department in order to address service goals more effectively in the light of recruitment difficulties. The key elements of this entailed the development of staff at assistant and senior assistant level who increasingly took on some of the more routine practitioner responsibilities. The key issues with the introduction of such staff were demarcation between professionals and support staff and lack of accredited training and structured career progression for the support staff concerned. However, there was evidence that the development of the assistant role had contributed towards alleviating some of the constraints on service delivery caused by recruitment difficulties by freeing up valuable practitioner time to deal with more labour intensive cases.

Managing numbers of treatments and treatment times: Some physiotherapy departments actively reviewed overall workload to see whether in each individual case treatment time within the department could be reduced. In some cases, following referral, patients were treated outside the acute unit, while in other instances the department was able to reduce the number of treatments, especially where they encouraged patients to play a greater role in self-management of their condition. Such approaches were successful, particularly if they were combined with monitoring of the quality of service through active ways of seeking patient and GP feedback.

Skill implications for radiographers: radiographers have to balance the need to increase patient throughput with coping with patients often adopting a more questioning attitude. This emphasises again the importance for radiographers of advanced communication skills when dealing with the public. Multi-disciplinary working, involving radiographers as appropriate, was seen as vital to improve the quality of patient care, but from a departmental perspective this increased dependence upon other departments. There were therefore increased demands for effective management of these relationships, so that an improvement in the quality of care was not achieved at the expense of a considerable reduction in efficiency.

Skill implications for physiotherapists: multi-disciplinary and inter-agency working has meant that the ability to communicate effectively across disciplines and services has become more important; similarly inter-personal skills when dealing with the public have also become even more important.

C3 INFLUENCE OF TECHNOLOGY AND WORK ORGANISATION UPON SERVICE DELIVERY

C3.1 Technological development and changes in work organisation

Increasing demand for technical and IT skills: Technological developments, particularly in recent years, have led to increasingly sophisticated equipment and processes in radiography. New scanners have opened up possibilities of a range of new techniques and processes in radiography. They can transform significant elements of practice, have profound implications for the speed and quality of diagnosis and require staff to develop new skills. The work of radiographers is becoming more complex as they are expected to use a wider range and variety of equipment, while working at the interface between patient and clinician. Within radiography, the underpinning knowledge required to carry out the full range of radiographic techniques and technical skills is rising, and knowledge of IT is becoming increasingly important.

Broadening and deepening of skill requirements: Clinical staff within radiography in particular, but also physiotherapy in some cases, are now required to undertake a wider range of tasks, including some which were previously within the remit of consultants (see example in box below). For example, in Accident & Emergency in one radiology department, half the work involved reporting of films, as previously, but clinical staff were now also expected to identify issues for consideration by doctors, which was a new responsibility. In physiotherapy, *'extended scope practitioners'* (somewhat equivalent to the concept of the 'Super Nurse') or clinical specialists were developing higher level clinical skills.

Changing skill needs: Radiography

In Case S3, junior staff on call needed to be able to perform a range of tasks at basic level, so as to be able to respond to whatever they were required to do: *'they need to be competent in a range of areas'.* This meant that such staff were not able to concentrate initially upon a few areas and then gradually build up their experience in other areas. This had important implications for training and the pattern of support from more senior staff during the time when newly qualified staff were developing their expertise.

New roles for radiography staff were also required, including administering barium enemas - a role which had previously been undertaken by radiologists, and giving IV (intravenous) injections: *'radiographers are becoming more invasive'.*

Helpers within the department required interpersonal skills and practical skills, but it was also reported that they would soon require computing skills as processing work became computerised. There had also been some discussion at national level concerning training helpers to undertake specific tasks, such as administering basic x-rays, in order to deal with the problem of recruiting trained radiographers, but this was on a limited basis, as they still required supervision.

Within administrative and clerical grades in this department, the main changes taking place related to upgrading information/IT systems, and this required some staff to develop additional skills.

Development of the assistant role: As a result of the upgrading of skills for some clinical staff, and also as a consequence of the policy to free up time for staff to develop their own specialisms and engage in research-based practice, some departments had introduced assistants to undertake some of the more basic tasks previously performed by clinical staff. Some assistants were experienced and worked unsupervised in certain circumstances, but others required more supervision and guidance and training from senior staff, in addition to initial on-the-job training. A key issue for both the radiography and physiotherapy professions was where the boundaries should lie between clinical staff and assistants.

Reorganisation of work patterns in response to technological change: Reorganisation of patterns of work following technological innovation and investment in major capital equipment was fairly common in radiography departments. The pace of technological innovation is much less in physiotherapy, and there is more of a culture of optimising service delivery in the light of what equipment is available.

Changes in work organisation more generally: The effect of different patterns of work organisation, unrelated to technological change, can impinge directly upon service delivery in a number of ways. In Case S7, the introduction of new structures for clinical governance involved the appointment of suitably qualified staff to implement the changes. The establishment of a new model of in-patient rehabilitation was accompanied by plans to change the mix of clinical skills to treat patients by creating more senior level clinical posts in elder care.

Extended opening hours: Moves to extended opening of services led to a pattern of work organisation that required a single member of staff to take responsibility across the specialism as a whole. The

need to fulfil on-call duties created uneasiness in some staff as to whether they were sufficiently trained to cover the full range of possible duties, and in some instances they felt this compromised the quality of service delivery. Patterns of work organisation that involved increased multi-disciplinary work and team working also affected service delivery and led to challenges to established organisational cultures and (hierarchical) ways of working.

Family friendly policies: The predominance of women in physiotherapy in particular required managers to look at 'family friendly' policies and individuals' needs for part-time hours, which had to be balanced against the provision of a service catering for individual patient need.

Job rotation to gain experience: Patterns of work organisation also took account of the needs of new entrants to either specialism to gain experience and development through a process of job rotation.

Upskilling of the assistant role: Within clinical and also some assistant/helper occupations, there was evidence of up-skilling, as tasks were taken on which had previously been undertaken by higher-graded staff. For staff doing on-call duties, multi-tasking was also required. The change to these jobs was a mix of job enhancement and job enlargement, depending on the specific tasks and human resource policies of the departments concerned. In common with Ackroyd and Bolton (1999), we found little evidence of de-skilling as a result of changing skill mixes within the sector. Where helpers/assistants had been introduced, the main purpose was to alleviate some of the pressures on clinical staff facing increased workloads, who themselves were taking on additional, sometimes higher-level tasks.

The increasing role of assistants: Physiotherapy

The role of the physiotherapy assistant was being actively developed in all of the departments visited, generally as a response to the combination of increased workloads and recruitment problems. However, for those more experienced physio assistants there was already a real issue in terms of progression routes available, and expanding their role still further highlighted the lack of career structure at this level. One physiotherapy assistant commented on 'being stuck' at the top of her grade, while another spoke of the difficulties of starting a physiotherapy degree:

> *I would love to train as a physio but they don't offer part time courses and I couldn't afford to do it full time. I have family commitments to attend to as well, which would make it very difficult.*

In one department, managers were considering creating two new Senior Therapy Assistant posts, funded from the budget for physiotherapists, which was underspent because of recruitment problems. This enabled the department to expand its caseload and undertake more outreach work in the community while offering career progression to the existing highly experienced physio assistants. In another physiotherapy department, based in a Community Trust, management were seeking to develop an NVQ for assistants involving modules from both physiotherapy and occupational therapy, encapsulating the more holistic approach to rehabilitation within the Trust.

C3.2 Summary of skill implications of this section

Technological developments as a driver of increasing demand for technical and IT skills: The work of radiographers is becoming more complex, with the technical and IT skill demands increasing and the underpinning knowledge base also expanding. The range of tasks radiographers have to perform has increased too, including the need to mark up X rays with issues for doctors to consider.

Team working: Skills associated with intra-hospital team working have become more important and this is a particularly sensitive issue for some radiographers, as they felt this presented a challenge to existing hierarchies and traditional ways of working, as it required doctors to recognise their expertise. These changes therefore had implications for the training and skill development of other staff, such as consultants.

Increasing breadth of skills demanded: Particularly when on-call, radiographers have to demonstrate basic expertise across a wide range of tasks, and some staff do not feel confident about working across such a wide range. This lack of confidence stemmed from a feeling that they had not sufficient training to develop expertise across such a broad skill range and reflected latent skill deficiencies in moving to a mode of delivery that required such a breadth of expertise from all those on-call. These issues were only satisfactorily addressed with more comprehensive training and support, but in some cases it was difficult for senior staff to find sufficient time to provide the necessary degree of support.

Skill mixing and the development of the assistant role: All departments engaged in skill mixing in an attempt to cope with increasing work pressures and recruitment difficulties. The use of assistants also enabled clinical staff to engage more fully with their own specialisms and research-led practice. Radiographers undertook some tasks previously performed by radiologists, and assistants undertook some of the tasks usually performed by radiographers. For assistants interpersonal, practical and IT skills were particularly important. There were two barriers to the much more widespread use of assistants. The first was that agreement would need to be obtained at national level as to what work they could do that involved patients. The second was that even where they could help with X-rays they still required supervision, so the presence and active support of radiographers was still required.

Skill mixing was easier to achieve in physiotherapy. In some instances physiotherapists specialised more and became extended scope practitioners. That is, they were promoted and undertook more demanding professional tasks, rather than taking on managerial responsibilities. The skills mix within physiotherapy was also changing where services were moving towards more holistic models of patient care, for example through merging physiotherapy and occupational therapy, as they required more advanced communication and inter-personal skills.

The use of assistants in physiotherapy was becoming much more widespread, particularly as in this area experienced assistants were allowed to work unsupervised. However, these developments have not been fully thought through by service managers in terms of their implications for supervision, training and progression of assistants and where the boundaries should lie between their work and that of physiotherapists. For example, there were limited opportunities for physiotherapy assistants to study for relevant qualifications, and many of the more experienced staff at this level had reached the top of their pay scale with no subsequent progression route. Some of these staff were undertaking

semi-professional level tasks such as running a hydrotherapy class and assisting with the prioritisation of caseloads: while they were keen to undertake further training in physiotherapy, they could not afford to give up work to take a full-time degree course.

Enhanced working time flexibility: A more general organisational change was the introduction of more extended opening hours and this sometimes conflicted with the move towards a greater degree of part-time working for staff, particularly if such staff had school-age children.

IT and information-handling skills: Other organisational changes increased the extent to which clerical and administrative staff needed to have IT and information-handling skills.

C4 SKILLS IMPLICATIONS OF SERVICE DELIVERY STRATEGIES
C4.1 Translation of service delivery strategies into skill needs

Considering professional skill needs in an organisational context: Strategic decisions about service delivery can feed through to skill needs at the departmental level in two ways: organisational and professional. For example, in some of the case studies there were close links between Trust strategies, departmental business plans and human resource policies in this sector, especially relating to filling of posts, appraisal and performance review and skill mix reviews. In these cases organisation-wide concerns impacted upon skill development at departmental level, as in Case S1 where particular attention was given to actions concerning performance appraisal, training and intra-team communication. The concern with intra-team communication was considered vital, because although radiographers were being given greater responsibilities for interpretation and marking up X-rays, consultants did not always recognise their expertise. Also radiographers had to work with others to establish the most effective ways of presenting information (especially as there is variation in the local preferences for how information is presented). Where this type of training was successful and all parties had confidence in the expertise of others, genuinely worked as part of a team, and appreciated the different roles and challenges facing other members of the team, then a higher quality service was delivered to patients. In order to achieve such success across the board there is a need to enhance team-working skills. It is also worth noting the necessity of not considering the training of radiographers in isolation, but rather focusing upon the skill needs of the team as a whole if they are to deliver an efficient, high quality service.

Different models of practice: At the professional level, decisions to opt for particular models of practice affected skill utilisation and development profoundly. For example, where a physiotherapy department encouraged an 'empowering' approach to care, the individual patient took increasing responsibility for her or his own care, but this was sometimes very time intensive in the early stages, even if it eventually requires fewer interventions. This is because the 'empowering' approach relies upon the establishment of trust, with a focus on support and development; taking time; listening to and dealing with problems, as the individual takes on greater responsibility. The 'control' approach, where the practitioner is much more directive, may be used as a means to cope with large numbers of patients. A shift to a holistic approach to rehabilitation encompassing the 'empowering' approach involves a professional decision that may have profound organisational characteristics if it involves changing the skill mix and undertaking different types of activities, such as more outreach work. Overall, a shift towards more holistic models of care suggests a need for broadening of skills and enhancement of team-working skills at intra- and inter-organisational levels.

Significance of team-working skills: From the case studies it is clear that an organisational commitment to improving the quality of service, accompanied by staff development to support team-working across disciplines and hierarchical levels, leads to higher quality service delivery. A question remains, however, as to whether this results in a more efficient service as well. The answer to this links back to the model of care adopted within the organisation and departments concerned. A shift to a more holistic model of care will not be successful without more effective team-working, since the essence of this approach is that staff take pains to ensure that their individual and collective expertise is used co-operatively in an integrated approach to the treatment of the patient. If this approach is to be efficient it also requires staff to recognise the contribution others can make. For example, through allowing staff with the requisite knowledge, skills and experience to make decisions and take action within their field of competence rather than referring decisions upward through the hierarchy.

However, where the organisation as a whole is still operating with a technical model of care, and reinforces the importance of each department meeting its separate performance targets and the central role of individual clinical expertise, then the consequences of a greater emphasis upon team-working are more mixed. Team-working within the department that leads to greater co-operation between clinical and support staff can still lead to improvements in the quality and efficiency of service delivery. However, without a comprehensive approach to tackling all issues associated with team-working, including those linked to work and information flows between departments, the results of attempts at inter-departmental co-operation were disappointing. In particular, although time spent on inter-departmental co-operation improved aspects of service delivery, like reducing the possibilities of patients receiving 'mixed messages' about their treatment, staff felt that in some cases this led to a reduction in departmental efficiency.

The technical model of care, with its emphasis upon clinician control within each department, does seek to maximise the number of individual cases treated within a department. So from this rather narrow perspective efficiency, in terms of number of cases treated per member of staff, may go down when time and resources are spent on inter-departmental co-operation. Such co-operation may deliver benefits to the overall quality of patient care, but the benefits may be more difficult to see from a purely departmental perspective, particularly if they make it more difficult to reach departmental targets. The key lesson here is that inter-departmental co-operation can only deliver improvements in quality and efficiency if wider issues of work organisation and skill utilisation are tackled, and if the benchmark against which quality is judged is the service delivered to the individual patient by the organisation as a whole. Where technical models of care and departmental concerns remain dominant staff development and changes in practice aimed at improving inter-departmental co-operation raised the quality of care, but were seen to reduce departmental efficiency slightly in terms of patient throughput.

C4.2 Implications of use of technology and organisation of work

The importance of customer-facing skills at the interface between clinician and patient:
The work of radiographers includes using a range and variety of equipment, solving problems arising under pressures of time and limited space, managing patients under varying circumstances and working as part of a team. Technical and professional knowledge, interpersonal skills and sensitivity are required. Radiographers are at the interface between patient and clinician, and need well-developed inter-personal skills to deal with internal and external customers. The increased sensitivity to the

need to recognise individual difference in patients means that skills of patient management have increasingly come to the fore, as radiographers have to deal with patients with very different levels of tolerance and anxiety under varying medical circumstances. All those who come into contact with patients are now expected to explain or reassure, as appropriate.

Generic management skills: Skill requirements within case study departments were varied. For managerial staff, these included generic skills, such as time management and interpersonal skills, within the professional context. At clinical level, for example at junior level in physiotherapy, technical skills gained during study and in subsequent rotational training were essential, but communication and interpersonal skills had gained importance in both physiotherapy and radiography over recent years. Prioritisation, caseload management and time management were all skills needing some development in order to achieve an efficient high quality service.

Technical and IT skills: New entrants to departments were sometimes required to demonstrate evidence of training or experience in addition to their professional training. Within radiography, knowledge required included basic radiographic techniques and technical skills, physiology, physics (for magnetic resonance imaging [MRI]) and anatomy, with manual dexterity and spatial skills also being important. Knowledge of IT was becoming increasingly important for radiographers and helpers. At senior clinical level, skills depended very much on the specialism. At clerical level, literacy skills and understanding of basic procedures were required. IT was becoming used more extensively in some departments, particularly in radiography. Lack of integrated IT was seen as a particular problem in community settings. Even where IT systems were integrated, as in hospitals, so as to speed up processes such as inter-departmental transfer of information, technical staff were not always familiar as to how to do this, with the result that new equipment or software was not always being used effectively.

Summary: The skills implications of new technology and changes in the organisation of work for different groups of staff are summarised below:

Clinical staff:

- Move to degree-level education, requiring a more theoretical approach in initial training;

- Importance of critical thinking and professional judgement in professional practice;

- Staff are expected to know more, as tasks are passed downwards and as a result of policies concerning a more integrated service for patients (so radiographers undertake intravenous injections as well as the subsequent x-rays);

- New technology in radiography, such as MRI scanners, means there is a need to master more advanced techniques and processes;

- Learning while working requires exposure to complex clinical cases and for this learning to be supported;

- Emphasis on effective management of caseload, particularly as staff reach senior levels.

Assistants:

- As clinical staff take on more skilled tasks, so basic radiography/physiotherapy tasks are handed down to assistants;

- Within radiography in particular, changes to computerised systems require new IT skills.

Administrative and clerical:

- IT skills are in particular demand as a result of new equipment and changes to processes.

C4.3 Capacity to meet skill needs

Initial training and the role of CPD: The capacity of the hospitals to meet their skill needs depended upon the extent and effectiveness of initial training, learning through work and continuing professional development (CPD). Higher education and professional bodies also had a stake in these issues. Degree-level entry is now the norm at clinical level and this was seen by managers as meeting a need for more research-based training. Skills needs in radiography depended partly on the equipment used and the service provided (for example, whether the Trust provided therapeutic as well as diagnostic radiography). Specialist skills were required for recruitment to individual specialisms, such as mammography, ultrasonography, skeletal reporting and paediatrics in radiography and musculo-skeletal, cardio-respiratory, neurological, paediatrics, rehabilitation, elderly care and community care in physiotherapy. National professional guidelines relate to job descriptions of clinical staff, and the guidelines also require that all staff are appropriately trained.

Evolution of the assistant role: The roles of assistants in physiotherapy and radiography were evolving, and specific qualifications tended not to be required, although previous health care experience was sometimes seen as useful. On-the-job training had to be provided and sometimes led to qualifications at NVQ level 2 or 3. The key qualities sought in recruits were communication, patience, teamwork, and adaptability.

Administrative and clerical staff: No particular qualifications were required for administrative and clerical grades, although certain qualities and skills were sometimes sought: for example, skills in communication and information-handling. The hospitals had the capacity to deliver the requisite training for non-clinical staff, although such training was not always forthcoming.

Appraisal systems and identifying training needs: In physiotherapy and radiography, appraisal systems and training plans were in place, as part of Trust-wide requirements, in the departments/ services visited and these generally related to the Trust-wide human resources and business strategy. The level of training in this sector depended on funding available and often departments needed to bid to secure additional funding in order to sustain training levels. Training included continuous professional development/lifelong learning, as well as statutory training requirements such as fire, manual handling and health and safety. The capacity to provide formal training was therefore generally in place, although reluctance to release staff when departments were under-strength and working at full stretch meant that there was often a reliance upon learning through working. This was effective where the requisite support was available for on the job learning. However, in those departments where this was not always forthcoming staff at all levels felt there were times when they were working at the limits of their knowledge and understanding, and that this may have compromised their effectiveness to some degree and resulted in slower patient throughput.

The training plans were generally part of the overall Trust policies, but tailored to individual departmental needs. Some clinical training and management training in human resource practices tended to be organised at Trust level, making use of outside courses or delivered in-house using Education Consortia. In some cases it was felt that management training for departmental staff was limited and difficult to access because of cost and time pressures. Project management and business skills such as budgeting and negotiating contracts were areas where managers felt they needed more training. Senior staff in some departments also felt there were times when their own pressures of work meant that it was difficult to give sufficient time for supervision and support to more junior staff.

Continuing professional development: At clinical level, two-year rotations for junior staff were the norm and any training was normally provided in-house during this period. There is a strong tradition of learning through work with the expectation that you do not become fully experienced until several years after formal qualification. Continuing professional development (CPD) was seen as important, especially at senior level, although funding for this can be a problem. CPD included training through projects, audits, giving presentations, one-to-one supervision, peer review and reading, as well as through attendance at more formal courses. Short courses within departments were available for all staff and higher qualifications such as postgraduate diplomas and Master's degrees were also encouraged for clinical staff, in order to update and extend knowledge and to meet CPD requirements for increased specialisation. In most cases there was greater demand to participate in further training such as Masters courses than there was funding available. Generally staff undertook postgraduate qualifications on a part time basis and funded at least half of the costs themselves. Departments where staff had attended specialist courses or completed Masters programmes were perceived as offering more opportunities and potentially a higher level of in-house training. It was reported that in some cases this was regarded as an important factor in achieving success in external recruitment.

The existence of a learning culture: In health care, the drive for CPD and further training creates a strong lifelong learning culture within the practitioner community. To some extent, the existence of such a culture means the skills gaps are more likely to be reported than unreported or latent. However, the learning culture is not always complementary with meeting the full range of demands on the service. Budgetary constraints as well as quality and efficiency targets in meeting patient demand resulted in the 'rationing' of training particularly among intermediate level staff. However, this in itself may cause tensions both between staff and management and among staff themselves due to increased workloads. This is an area that seemed particularly amenable to rolling review. All departments had to live with examples of training being squeezed because of more immediate pressures, but the more effective departments did not allow this to become standard practice, rather after cancellations in one period they moved training up their list of priorities for a subsequent period.

Training and opportunities for career progression: Progression for clinical staff had traditionally tended to be into managerial roles, although the creation of clinical specialist roles in recent years in some case study departments/services had given greater opportunity for career development. At assistant level, there were few external training opportunities and training tended to be on-the-job, although in some cases staff were working towards NVQs. Some staff at assistant level felt that they received training on a regular basis and were able to take advantage of external training opportunities if appropriate courses arose and if departmental funding was available. Others found development opportunities to be relatively poor. For example, one helper was expected to pick up IT skills after a 'very brief training session'.

Progression opportunities at assistant level tended to be very limited, although in some instances it was possible for an assistant to move into a technician grade. Lack of progression opportunities was a major issue for some assistants who had developed their role by taking on extra responsibilities and, in physiotherapy in particular, were undertaking some of the more basic professional tasks such as running a hydrotherapy class. In one case where a department was particularly stretched due to staff shortages, an assistant was liaising between the department and the wards and assisting the physiotherapist in prioritising the caseload. Many of these more experienced assistants were at the top of their grade and had been there for several years, leading to a degree of frustration with the lack of career progression and qualification structure available to them.

Training for clerical and administrative staff was also on-the-job, again with some possibility for NVQ level training, although this tended to be rare and some departmental managers reported lack of interest in NVQs among staff at this level. Opportunities for progression tended to be limited. At Trust level, organisations were often working towards, or had Investors in People. Examples of good practice included support for moves towards evidence-based practice and skill mix reviews being undertaken when posts became vacant.

C4.4 External recruitment difficulties

Nationally, there are perceived to be increasing problems of recruitment within both radiography and physiotherapy departments/services.

Recruitment problems and responses in radiography

Within radiography in certain specialist areas it was difficult to recruit, including paediatrics (staff with two years general radiography experience were required in this area and were only recruited at senior level), mammography and ultrasound, due to increased demand for these services and too few specialised staff available. Other reasons for difficulties in recruitment related to the location of the establishment: for example, its distance from other services, expense of living in the area and so on.

Responses to recruitment difficulties included in-house training or funding of courses in particular specialist areas, skill mixing and waiting list initiatives (for example, opening later hours in particular services). Making greater use of in-house training, however, impacted upon the workload of senior staff, as this extended their supervisory duties.

Recruitment difficulties: Radiography

In department S2 there have been recruitment problems at senior grades, with only one applicant for the most recent vacancy. Getting applicants with the required level of specialist paediatric experience is problematic because there is no specialist qualification. Generally radiographers with two years experience are taken on and trained in-house, but because the field is narrow many applicants are deterred by the limited opportunities available.

At the moment staff shortages are covered by waiting list initiatives such as extending examinations into the evening, but this may conflict with family-friendly working arrangements within the department, over the longer term. One potential solution to this issue is to recruit entry grade radiographers and train them in-house in techniques such as immobilisation and distraction. However, this will increase the burden on senior level staff, particularly because juniors are not permitted to work unsupervised for their first two years.

Recruitment problems and responses in physiotherapy

General recruitment problems in physiotherapy were exacerbated in particular areas of practice, particularly care of the elderly, perceived by many potential applicants as a less attractive option, and community physiotherapy, which is seen as offering a wider range of lower level skills and being an isolated area of work. Problems in recruiting at senior level in physiotherapy related particularly to lack of opportunities for progression within the NHS, especially if staff wished to continue clinical practice. There was competition from the private sector and from employment agencies, where the pay offered was higher. One department was actively addressing the issue of senior level recruitment difficulties via the introduction of succession training. This had resulted in staff feeling more highly valued and may aid retention, but as the policy has only recently been introduced it is too early to judge its success at this stage.

In physiotherapy, it was perceived that the increased emphasis on health promotion and rehabilitation within service strategies (prompted by national initiatives and by the increasing proportion of elderly patients) might lead to future recruitment and skill problems. Several respondents felt that the rehabilitation specialism was less attractive than other areas, offering limited career opportunities (with little scope for practice outwith the NHS), and requiring highly developed communication skills and specialised training which was expensive and difficult to access in some locations.

In more than one department/service, a response had been to develop clinical specialist posts as described earlier, where staff progressed to a senior (superintendent) level and retained their professional responsibilities and developed their clinical expertise rather than becoming more generalist managers. The fact that the profession continued to be largely female also created particular problems for recruitment and retention if family-friendly policies had not been sufficiently developed within the organisation. Another response of some departments/services to staff shortages had been to recruit junior and senior staff from overseas, particularly from certain European countries, where the training is similar. Locum staff were also used but, as they are extremely expensive[2] and given limited resources, this meant that services were further squeezed.

General issues relating to recruitment

Some respondents in physiotherapy departments felt that (national) workforce planning did not address the problems faced. The numbers entering physiotherapy and radiography training each year were limited and workforce planning did not address the issues of regional and service preference. Nor was allowance made for the fact that many junior physiotherapists stay in the NHS for only 18 months to two years, while they gain experience during rotation, and then travel and/or work with agencies or move into private practice. Numbers in radiography training have gone down in 1999, which will have implications for subsequent recruitment. Now that radiography and physiotherapy training is at degree-level, some graduates may choose not to pursue these specialisms on graduating, but to enter other traditional graduate careers. In addition to the general recruitment issues at national level, there were also regionally-specific difficulties which exacerbated the overall problems. In radiography, London and the South East appeared to experience greater problems than in the North West, considered to be primarily to do with cost of living.

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2 Approximately twice the cost of an equivalent NHS staff member.

Impact of recruitment difficulties

Staff shortages sometimes resulted in a more limited service being provided, or to increased waiting lists, as well as creating greater stress for existing members of staff. Many staff interviewed found themselves under increasing pressure due to the requirement to reduce waiting lists in the context of low levels of staffing, accompanied by the growing expectation of many patients that their needs will be dealt with speedily and effectively. With the additional impact of recruitment problems on the degree of training possible, many staff felt that they were unable to deliver service of the optimum quality. A Senior physiotherapist commented:

'You get used to working at a certain level with vacancies: projects don't get done, or get half done, audits and research aren't done at the level you would want and you don't get time to reflect on what you're doing and how you are working with patients'.

Chronic recruitment difficulties on this scale are perhaps only amenable to national policy initiatives.

C4.5 Internal skills gaps

Introduction: A skill gap relates to any discrepancy between the objectives an organisation wishes to achieve in relation to its service strategy and the degree to which the workforce is qualified, skilled or trained to achieve those objectives. For example, with the new emphasis on clinical governance in the sector, the question is whether existing staff alone have the capacity to deliver the requirements of clinical governance.

Skill gaps reported in case study departments and services

Skills needed to implement evidence-based practice: The call for greater use of evidence-based practice as a basis upon which to make clinical judgements requires greater attention to be given to an understanding of the nature of research and what constitutes clinical evidence (including issues of validity, reliability and generalisability). Some departments found particular attention and support needs to be given to those practitioners who did not possess a degree or equivalent qualifications and were less likely to be familiar with research. The increased demand for evidence-based practice has therefore had an impact on skills demand. Those who have come through the non-graduate route, particularly in physiotherapy, were often seen as not possessing the same degree of research training and were perceived to be less 'self-reflecting' on how and why they are following certain techniques or procedures. Conversely, the issue raised by some managers was that new entrants, particularly to physiotherapy, may have insufficient experience of exercising the *practical* skills they need to do the work, resulting in the need for very intense on-the-job training once they were qualified. In the context of a pressurised workplace environment, however, such training does not always coalesce with the 'reflective practice' approach instilled within degree-level training. Hence absolute shortages of skilled personnel were a factor fuelling skills gaps, since working practices meant staff had little time for the reflection that was so important for the development of their expertise.

Supporting less experienced professional staff: Most case study departments were acutely aware that newly qualified staff were 'less expert' in some of their judgements than more experienced staff. This is important in that those departments that regularly recruit newly qualified staff (because they do not get experienced applicants) need to have in place mentoring, supervision or other support. This is in order that less experienced staff have opportunities to discuss and practise thinking about the complex cases handled by their more experienced colleagues.

Relative merits and deficiencies of the graduate physiotherapy route: Skills deficiencies of recently qualified graduates may relate to their relative lack of knowledge of the particular contexts in which they are working. The shift of professional training into higher education may lead to rather less emphasis being given to 'practical knowledge' and greater emphasis on (academic) scientific knowledge. Hence, mentoring and support are likely to become more important in future.

New graduates may be less proficient at some practical tasks, simply because they have had much less practice than those trained under the old system. The profession as a whole is of course aware of this in the sense that it is aware that new graduates require additional training and that is one reason for widespread use of job rotation in the first two years following graduation. Experienced practitioners, however, may feel that they are increasingly stretched by other duties to give as much time to supervision and support as they should in more ideal circumstances. Hence, although there is recognition of the fact that skills deficiencies of new graduates needed to be addressed through further work-based practical training, the opportunities for them to achieve the training and support needed in a pressurised work environment is limited. However, as outlined in the example below, access to CPD is an important consideration for new graduates in making employment decisions, so the existence of good mentoring and training schemes offers the potential for a 'virtuous circle' of enhanced continuing skills development, coupled with minimising recruitment difficulties.

The graduate perspective: physiotherapy

Some new entrants to the profession felt overwhelmed by the transition between their undergraduate course and professional training once in-post. One commented:

> *You think you know your stuff when you come out of university but it's just the tip of the iceberg. The list of things you need to know is immense.*

The most difficult and also the most rewarding aspect of the transition was the contact with patients. Communication and judgement were felt to be the key skills that were developed more on-the-job than they were at university. Access to CPD was an important consideration when considering a job offer, with the specialisms of existing staff playing a major role in attracting new recruits:

> *You look to see what training people have done, where their interests are...what they can do for you in terms of their knowledge.*

Development opportunities for existing staff thus impact upon future recruitment of new graduates seeking to enter a department where there is a strong training ethos.

New practitioners need to develop further their skills of reflection and review: Departments and services are increasingly operating with a model of the reflective practitioner. However, in order to be effective this requires time to be made available for professionals to reflect upon their experience, actions and thinking as a basis for continuing to develop their expertise. In particular, newly qualified practitioners have to learn to distinguish when they should consider cases in greater detail, including when to discuss these with colleagues. This in turn requires a readiness for experienced practitioners to discuss their interesting cases as well as those of the novice, if the novice is to learn to model appropriate patterns of thought. The lack of time for such discussions meant that novices took longer to reach the stage where they were able to make such discriminating judgements, with the consequence that service delivery was adversely affected by slower patient throughput than would otherwise have been achieved.

Professional emphasis is given to continuous learning through systematic review of cases. Constraints on implementation of this approach were influenced in some cases by pressures of practice such as time constraints and the number of patients. This led to particular problems for newly trained practitioners who were often found to be lacking in the 'coping skills' needed in the face of such pressures, such as time management and being able to prioritise caseloads. This was particularly the case in organisations where there was a shortage of intermediate level staff (a key problem in some of the physiotherapy departments visited). The departments that made best use of their human resources seemed well aware of the need to allocate time for reflection and review, and that this was particularly important for new staff. It was clear that the learning of newly trained practitioners was facilitated if:

- regular mutual staff discussions were encouraged

- mentoring relationships were in place

- formal reviews of practice were held

- informal relationships led to work-related discussions at which more 'provisional' or 'riskier' comments could be made without pretending to be authoritative.

Need for more formal management training: The active involvement of manager-practitioners and other senior staff was required for such policies to be successful. In some cases it was felt that more extensive management training was required, for example in human resources and budgeting, to support professional practice most effectively, rather than relying solely upon on-the-job development, which (particularly in smaller departments) appeared to be the case for most staff at management level.

Growing breadth of knowledge: The need to fulfil on-call duties creates a growing need for staff to become knowledgeable, at least at basic level, in a range of areas. In some of the case study departments, recruitment problems had led to difficulties in ensuring that staff on-call were sufficiently trained in the full range of duties they might have to perform. Staff members sometimes reported not feeling confident that they were skilled at the level required to undertake some of the work effectively.

Multi-disciplinary and team-working: Increased multi-disciplinary work and team-working placed communication demands on staff in addition to those required for dealing with patients. For example, in radiography department S2, where a new MRI scanner had been recently introduced, there was a need for radiography staff to 'educate' other professionals in the potential dangers of using the equipment incorrectly and the need to adhere to protocols. This sometimes created problems if the other professional was in a superior position and the situation required assertive handling by the junior, as this presented a challenge to established organisational cultures.

Technology and IT: New machinery had also caused temporary skill gaps in some radiography departments, although these are generally being remedied by training initiatives, sometimes accessed through equipment manufacturers. Lack of integrated IT was seen as a particular problem in community settings. In one department, there was evidence of a skill gap in relation to IT systems introduced to speed up processes such as inter-departmental transfer of information, used by staff at technical level. Training in this case appeared to have been minimal and thus new equipment and software was not being used effectively.

Planning and prioritising in the context of work intensification: Work intensification and the sheer volume of work to be completed have meant that organisational or departmental difficulties have become more intense. Both radiographers and physiotherapists have to learn to deal with complexity, contradictions and uncertainty. This in turn means a consequent emphasis upon planning, acceptance of responsibility, independent action and social skills. Helping, teaching/coaching, clinical diagnosis and monitoring remain at the heart of professional expertise, but effective management of a caseload as a whole, as well as of individual cases, has become more important.

Facilitating the role of assistants: Partly as a consequence of continuing skills shortages and recruitment difficulties, and the pattern of skill ownership of existing staff, all departments were thinking about the use of assistants and other support staff. Decisions about where the boundaries of responsibilities should lie are subject to both national and local negotiation. Similarly, the shift of responsibility from consultants to radiographers meant that the latter had to perform a wider range of tasks that required them to use more highly developed clinical and inter-personal skills. Both these sets of changes also reinforce the need for training and support for intra-team working.

Summary: Although there will always remain scope for broadening and deepening of professional skills, in general, and new practitioners needed to develop some of their skills, the main skills gaps in radiography and physiotherapy related to:

• communication skills,

• team working, and

• generic management skills.

These are the types of skills that were most required in order to enhance the efficiency and quality of service delivery in the context of the shift towards a more integrated approach to care. At the operational level, and given the constraints within which they were operating, our assessment was that the case study departments were coping remarkably well at the current time and had a good understanding of the skill needs required to enhance the efficiency and quality of services. The challenge tended to be more one of finding the time and space to implement strategies to enhance skills, rather than a lack of recognition of the need for continuous improvement *per se.*

C4.6 Latent skills gaps

Introduction: Latent skill gaps are those that are not necessarily readily identifiable by practitioners focusing upon current practice. Rather they are concerned with the additional skills required to deliver a higher quality service. Traditionally the focus of professional competencies in the health sector has been upon skills, methods and techniques. The professional skills of developing and implementing therapeutic plans and negotiating client goals continue to be required. Recent changing expectations of service delivery had also increased the need for organisational (and administrative) competencies necessary to improve performance in the organisation. The need for enhanced interpersonal skills for working with patients and colleagues is also apparent in order to deliver more holistic treatment, for example through the adoption of different models of in-patient rehabilitation, as in moves linking physiotherapy and occupational therapy.

Partnership working: The next major move to raise the quality of care relates to the attempt to shift to a more integrated form of care that will require greater co-operation among all those involved in the planning and delivery of health and social care. The intention is to increase markedly the extent of multi-disciplinary working within hospitals and partnership working with other services. Such shifts have implications for the mix of clinical and other skills needed to treat patients, and require further development of the inter-personal and communication skills emphasised earlier in this report. That is, even when professionals are able to communicate effectively with those from their own or related disciplines, the challenge of communicating with those operating from very different disciplinary backgrounds and organisational contexts may reveal some latent skills gaps in this area. These are the types of skills that will most probably be required to enhance the efficiency and quality of service delivery in the context of the shift towards a more integrated model of care delivered within a partnership framework.

C4.7 Impact of skills deficiencies

Flexible working practices for whom?: Skill gaps and recruitment difficulties lead in some cases to attempts to introduce 'family friendly' policies to meet individuals' needs for part-time hours. On the other hand, policies designed to give patients greater access to services sometimes limited the capacity of departments to meet flexible working arrangements tailored to individual staff requirements. Debate about different patterns of work organisation had emerged in several of the departments/ services within the study, generally where a combination of increased patient numbers and recruitment problems had resulted in escalating waiting lists. These departments had implemented policies such as extending the working day into the evening or introducing weekend working so that more patients could be seen. In most cases, however, there appeared to be scope for part-time working. In one physiotherapy department, the unit manager post was split into a job-share, while several staff in other departments worked part time in order to meet family commitments. There was some evidence of implicit pressure on some individuals to extend working hours due to escalating demand, particularly in support functions such as clerical and nursing where generally only one member of staff was employed in a unit.

Ensuring service cover: Another work organisation issue with implications for skills utilisation was related to the issue of cover for emergency respiratory patients in physiotherapy. In one department, the twenty-four hour coverage policy had resulted in a degree of unrest among non-specialist respiratory staff, who felt that they lacked the specialised skills to fulfil certain tasks required in a respiratory

emergency. This concern was recognised by the department managers who were seeking to re-organise the shift system as a consequence. Similarly, in another department the impact of recruitment difficulties was manifest in the delivery of on-call services, where the demands meant that the small group of fully trained staff was increasingly stretched. They then had problems in ensuring that all staff providing cover were trained and updated regularly. In radiography departments in particular, not having a sufficient level of competence may lead to problems with safety in on-call services.

Recruitment difficulties compromising holistic and reflective approaches: Additional support required for new entrants coming through the graduate route, in the context of recruitment difficulties, creates increasing pressure on existing staff. In the longer-term, if recruitment problems do not ease, the gap between the quality of professional care expected through clinical governance and clinical excellence policies, as well as professional training programmes, and the health care which it is possible to give to each patient in the circumstances, will grow. The holistic and reflective approach, which is becoming emphasised in policies, will be increasingly difficult to maintain. Hence, the need to address reported skills gaps and unfilled vacancies is paramount.

C4.8 Relationship between service performance and skill utilisation and development

Competition: It is important to remember, that hospital departments are operating in contexts and facing constraints that influence organisational performance and over which, at department level, they may have relatively little control. Professional standards, financial constraints, access to the latest technology, general fitness and health of clients and location of services can all significantly affect organisational performance in the delivery of services. Even in responding to competitive pressures hospitals have to react to what other providers do. Hence competition from the private sector for contracts and clients impacts upon hospital services and subsequent skills strategies as other providers seek out niche markets.

Benefits of a proactive approach by management: On the other hand, the existence of so many external constraints means that the effective organisation and management of departments, within those constraints, had an effect upon the overall performance in terms of service delivery. For example, those departments that were performing particularly well within their constraints developed strategies where they were able to review their performance over a range of issues over time. That is, they were not trying to move towards meeting all their goals and targets at once, but they were able to implement a system of rolling reviews in order to ensure that over say a three-year period all significant issues were addressed. Those departments delivering effective performance were also able to address issues in an inter-related way, rather than responding reactively to each new pressure. Managers in reactive departments felt they had had insufficient training and support in a number of key areas, including budgeting, human resources development, prioritisation, caseload management and time management. Without such support they felt driven by events and acknowledged that departmental performance and efficiency were lower than they would otherwise be.

Designing skills strategies within constraints: There were regional differences in the severity of recruitment difficulties, but those departments that had taken a more comprehensive approach to skill utilisation and development were performing effectively and delivering a quality service. That is, radiology departments that adjusted the skills mix according to whether they were able to recruit radiologists, experienced radiographers or the newly qualified, then needed a plan for the effective utilisation of the particular skills mix they had. Intra-team skills development was particularly important in achieving this flexible response. It was even more apparent in physiotherapy that the training and development of both physiotherapists and assistants was a vital component in the recruitment and retention of staff, and hence contributed significantly to overall organisational performance.

Continuing change: In some physiotherapy departments it was felt that fund-holding GPs may establish their own physiotherapy centres in competition with hospital-based services and staff. This raised issues for service delivery and skill requirements, particularly if such GP based services were to focus provision on certain areas of practice and leave other services such as rehabilitation and general physiotherapy (which are already perceived as less attractive specialisms) to the hospital to provide. This then increased the likelihood that many staff would see hospital practice as a stage through which they pass, as they are developing their expertise, before moving into other areas of practice. In such circumstances access to continuing training and development acted as a key factor in the initial recruitment of staff.

The above serves to illustrate that continuing change in health care means that it is necessary to have continuing processes of review to address whether there are approaches to service delivery and skill utilisation and development that are likely to improve organisational performance.

C4.9 Summary of skill implications

- Where intra-team training was successful and all parties had confidence in the expertise of others, genuinely worked as part of a team and appreciated the different roles and challenges facing other members of the team, then a higher quality service was delivered to patients.

- Moves towards more 'empowering' approaches to care in physiotherapy, where the individual patient takes increasing responsibility for her or his own care, were more effective with some client groups than others. This approach can be very time intensive in the early stages, as it relies upon the establishment of trust, with a focus on support and development; taking time; listening to and dealing with problems, as the individual takes on greater responsibility. Hence in some contexts there is an implicit trade-off between quality of service and effectiveness, as a treatment-centred approach can result in a faster initial patient throughput, although recurrent problems (and return visits) are more likely. The skills implications of this approach are that staff need highly developed interpersonal skills and support in helping them decide in which contexts and with which groups adopting an empowering approach is most effective.

- For community physiotherapy outreach work and relations with GP practices will become more important in delivering a more decentralised and comprehensive service. The ability to communicate effectively across services and disciplines has therefore become a core competence and inter-personal skills when dealing with the public, for education and prevention as well as treatment, have become even more important for those working in this area.

- The increased sensitivity to the need to recognise individual difference in patients means that skills of patient management have increasingly come to the fore, as radiographers have to deal with patients with very different levels of tolerance and anxiety under varying medical circumstances. All those who come into contact with patients are now expected to explain or reassure, as appropriate.

- For managerial staff, the skills most in need of further development were those such as budgeting, human resources development, prioritisation, caseload management and time management. These skills were those that underpinned a more proactive and strategic approach to departmental management that in turn resulted in the delivery of a more efficient service.

- Learning while working is important in both professions is and requires exposure of staff to complex clinical cases and for this learning to be supported.

- Hospitals had the capacity to provide formal training, although reluctance to release staff when departments were under-strength and working at full stretch meant that there was often a de facto reliance upon learning through working. This was effective in those cases where the requisite support was available for on the job learning. This too was not always forthcoming and staff at all levels in some departments felt there were times when they were working at the limits of their knowledge and understanding, and that this may have compromised their effectiveness to some degree and resulted in slower patient throughput.

- Nationally, there are major problems of recruitment in radiography and physiotherapy services, with some specialist posts being particularly difficult to fill. Responses to recruitment difficulties included in-house training or funding of courses in particular specialist areas, skill mixing and waiting list initiatives. Making greater use of in-house training, however, impacted upon the workload of senior staff, as this extended their supervisory duties.

- Where there were continuing recruitment problems and limited external career opportunities as with the rehabilitation specialism in physiotherapy, which required highly developed communication skills and specialised training, one effective response had been to allow progression to promoted clinical specialist posts.

- Some staff in physiotherapy departments felt that (national) workforce planning did not address issues such as the relatively short stay of many newly qualified staff in the NHS. The numbers entering physiotherapy and radiography training each year were limited and workforce planning did not address the issues of differential regional and specialist preferences. Staff in some specialist areas and particular locations have learned to live with a certain level of vacancies, and adjusted the organisation of their time and resources accordingly.

- There were skills gaps insofar as some existing practitioners were not sufficiently reflective upon their own practice, and this meant that the quality of the service provided did not always improve as quickly as it might otherwise have done. On the other hand, some newly qualified graduates lacked sufficient understanding of how knowledge is used in practice. In both these cases the provision of supervision and support made a significant difference, but in other cases senior staff sometimes felt too stretched to provide the degree of support required.

- Professionals learn from each other, as when radiography staff 'educate' each other in the most effective way to use new equipment.

- Helping, teaching/coaching, clinical diagnosis and monitoring remain at the heart of professional expertise, but effective management of a caseload as a whole, as well as of individual cases, has become more important for both professions, and can make a significant difference to the overall efficiency of service delivery.

- Those departments delivering effective performance were organised so as to ensure all significant service delivery issues were addressed over time and that issues were tackled in an inter-related way, rather than responding reactively to each new pressure. One way this was achieved was through the implementation of a system of rolling reviews in order to ensure that over say a three-year period all significant service delivery issues were addressed.

- Continuing change in health care delivery means that it is necessary to have continuing processes of review to address whether there are approaches to service delivery and skill utilisation and development that are likely to improve organisational performance. *Several factors appear key in the approach of organisations that have successfully battled with the constraints and kept pace with the drivers of change outlined in this report.* These are:

- proactive rather than reactive management

- recognition of the benefits of investing in training

- willingness to evolve new models of service including developing collaborative arrangements with related service providers

- willingness of staff to work as part of a team and appreciate the different roles and challenges confronting other team members

- recognition of the centrality of learning through work for newly qualified staff and paying particular attention to the allocation of work and supporting these individuals.

C4.10 Relationship between skills and organisational performance

The first point to acknowledge in any consideration of the relationship between skills and organisational performance is that at the individual level health services are delivered by staff with high threshold levels of skill. Many of these staff also have an interest in their own continuing skill development. Indeed within the technical model of care individual expertise is the driver of the whole system, with staff expected to relate to each other and to patients according to their formal position within the skills hierarchy. When efficiently organised at a departmental level, this system can deliver high levels of patient throughput. It is also a reasonably high quality system, if one key aspect of quality is defined as the number of patients who get to see highly qualified staff for initial diagnosis.

From our analysis it is clear that there are three broad sets of skills that lead to more effective performance while operating within a paradigm based upon a technical model of care. The same broad sets of skills, but with different individual skill configurations, underpin the shift from operating within a technical model of care to effective performance while adopting a more holistic approach to care. The three broad sets of skills relate to the skills associated with effective management, team working and supporting the learning of others.

Current skill deficiencies relate to those skills that, if developed further, are required to move an establishment to higher levels of performance, while still operating largely with a technical model of care. The management skills required relate to budgeting, human resources development, prioritisation, caseload management and time management. Possession of these skills underpinned efficient delivery of services at a departmental level. More effective team working within the department was associated with a higher quality of service provision. In order for the different grades of clinical and support staff to co-operate most effectively each member of the team had to have had confidence in and acknowledge the expertise of others, rather decision making being driven by reference to hierarchical position. This in turn required effective communication skills, such as active listening, the abilities to summarise and reflect back the views of others, and the inter-personal skills required to appreciate the different roles and challenges facing other members of the team.

The skills associated with supporting the learning of others were particularly important in two respects. First, the greater use of assistants, changes in the skills mix and a broadening of the range of duties performed by radiographers and physiotherapists created situations where existing staff felt they required additional support for learning while working. Where staff were able to offer support for learning of others through active reflection upon practice and mutual sharing of experience, then a higher quality of service was delivered to patients. Second, support for the learning while working of newly qualified radiographers and physiotherapists was important to help them reach the level of expertise associated with more experienced practitioners, with consequent effects on the quality and efficiency of the service offered. This requires particular attention being given to the allocation of work to newly qualified staff and to their exposure to more complex clinical cases and for their learning from such cases to be supported, including through the discussion of the cases and ways of thinking of more experienced practitioners.

These sets of skills are particularly important in those contexts where there are continuing shortages of highly skilled staff, due to external recruitment difficulties and posts remaining vacant for relatively long periods. Skills associated with effective management, team-working and supporting the learning of others can alleviate some of the negative consequences that would otherwise be expected from such skill shortages and the skill deficiencies associated with recruitment of less experienced staff. However, the skills shortages do nevertheless have a direct impact on performance: the department has to deal with fewer patients and/or offer a poorer quality of service to those it does handle than if it were fully staffed.

The above analysis relates to the performance of departments and services within hospitals that are operating primarily with a technical model of care. However, current government policy seeks to promote more holistic forms of care, where the total experience of the individual patient is the driver of the system. If health service providers are to achieve this goal, they need to adopt key aspects of the skills development strategies of those hospitals that were attempting to move in this direction and are also currently delivering high levels of organisational performance. These strategies made use of the same three broad skill sets mentioned above, but they were configured in a different way.

The skills associated with effective management within a holistic approach to care were much more concerned with the management of change and the development of a more outward-looking perspective. These included management of relationships with other departments, co-operation with external service providers and facilitation of multi-agency working in a partnership framework. The team-working skills of staff required were of a higher order than those required for effective intra-departmental co-operation. Some departmental staff had to use highly developed communication skills and inter-personal skills in order to work with others coming from a wide range of disciplinary backgrounds, organisational contexts and with different perspectives on how best to deliver care, support and treatment for patients.

In such circumstances skills in supporting the learning of others were critical in three respects. First, in developing new ways of partnership working support for mutual learning was vital. Second, as new models of partnership developed those most directly involved had to spread understanding and models of effective practice to other staff within their own departments. However, the most challenging skill requirement for supporting the learning of others, especially in physiotherapy, related to encouraging patients to take greater responsibility for their own care, linked both to outreach work and in teaching patients appropriate routines to aid recovery and help prevent recurrence of certain problems.

Both current and latent skill deficiencies, involving either internal skill gaps and/or continuing problems with external recruitment difficulties and posts being vacant for long periods of time, were likely to be major factors in an establishment adopting a less empowering model of care than would otherwise be the case. From our case studies it appears that effective performance, and the development of the skills that underpin effective performance, while operating within the technical model of care is in many respects a prerequisite for any successful transition to the effective delivery of a more holistic form of care. For those organisations that have not yet attempted to make this transition then these are the latent skill deficiencies as they constitute the skills required to move from a technical model of care to a more holistic approach to the delivery of care.

The relationship between skill utilisation and more effective performance within and between the two models of care is represented in summary form as follows:

Key skill sets involved in moving departments to a higher level of performance within the framework of a technical model of care:

- managerial skills related to budgeting, human resources development, prioritisation, caseload management and time management

- team-working skills: acknowledgement of the expertise of others; effective communication skills, such as active listening, the abilities to summarise and reflect back the views of others, and the inter-personal skills required to appreciate the different roles and challenges facing other members of the team

- support the learning of existing staff through active reflection upon practice and mutual sharing of experience

- support the learning of newly qualified staff through progressive exposure to more complex clinical cases and discussion of these cases, and through the discussion of the cases and ways of thinking of more experienced practitioners.

Key skill sets involved in moving health service providers from operation within a technical model of care to effective performance using a holistic approach to care within a partnership framework:

- managerial skills related to the management of change and the development of a more outward-looking perspective: including management of relationships with other departments, co-operation with external service providers and facilitation of multi-agency working in a partnership framework

- team-working skills: effective communication skills and the inter-personal skills required to work with others coming from a wide range of disciplinary backgrounds, organisational contexts and with different perspectives on how best to deliver care, support and treatment for patients

- support for mutual learning in developing new ways of partnership working

- ability to spread understanding and models of effective practice to other staff within their own departments

- supporting the learning of patients, especially in physiotherapy, in order to encourage them to take greater responsibility for their own care.

SECTION D: SOCIAL CARE: CARE OF THE ELDERLY

D1 CONTEXT FOR THE CASE STUDIES IN THE SOCIAL CARE OF THE ELDERLY

D1.1 Introduction

Overview of the social care sector: The social care sector provides personal and medical care, emotional, psychological and social support to individuals. It employs mainly women, who tend to be relatively low-paid and are often working part-time. Within personal social services, 80 per cent of the workforce is unqualified and progress in increasing the take-up of training has been slow. In the past there have been relatively few opportunities for substantive training and development in the independent sector and relatively few qualified staff. The Social Care NTO is involved in promoting occupational standards and training and development, but NVQs and similar qualifications have had very modest take-up in the sub-sector.

The sector faces major challenges, with recent drives to improve standards in the workforce following on from the White Paper: *Modernising Social Services* (1998), which emphasised the importance of getting heads of care homes suitably qualified. The national minimum wage has raised staffing costs, particularly in northern England. While trade union organisation within the local authority sector has had impact on pay and conditions, organisations in the independent sector are less likely to be unionised and thus the terms and conditions of employment are more variable. There are two types of care covered in this report:

i) Residential care: Residential care of the elderly primarily involves the independent sector, consisting of a large number of private providers. Local authorities now have a relatively minor role in the delivery of care, but they still have responsibilities for purchasing and monitoring provision. The majority of care homes are small, with the average number of places being provided 37.

ii) Domiciliary care: Domiciliary care (that is, care based within the homes of individuals) was traditionally provided by local authorities. Since the National Health and Community Care Act (1990), there has been an increasing growth in private provision, with a casualised workforce and a decrease in the supply of suitable applicants to care positions (Ford *et al*, 1998). Voluntary provision has also increased, particularly for some of the lighter home care tasks. A reduction in state funding is likely to depress employment growth in this area and larger companies have recently been withdrawing from the sector. This places greater pressure on the voluntary sector, where there are concerns about the ageing of volunteers and increasing difficulties in attracting younger volunteers.

A greater role for social care: An emphasis in policy is on 'care in the community' and enabling people to remain in their own homes for as long as possible. This requires the necessary support services, which may be provided through domiciliary care organisations, particularly those in the private sector, but also by those recruiting volunteer staff. Private domiciliary care providers are more likely to be involved at the more intensive end of the support spectrum, whereas volunteers may be involved with a range of light tasks over a shorter period of time, such as helping with shopping, housework and providing meals.

Overview of skill requirements: Skills required include those involved in:

- personal care (e.g. lifting and handling),

- basic medical care (e.g. first aid and knowledge of drugs and illnesses),

- awareness of hygiene and food handling, and

- interpersonal skills (e.g. ability to deal with bereavement, understanding the needs of terminally ill patients, etc).

Literacy skills are also increasingly important as reporting and recording requirements to meet legislative and policy demands are becoming more stringent (Dench *et al*, 1998). The emphasis on independent living for individuals may also have implications for the level and range of skills needed by care workers (Young, 1999).

D1.2 Typicality of the case studies

Basic characteristics of case study establishments/organisations: The case studies were focused upon domiciliary and residential care in the independent sector (see table 4).

Table 4: Case study establishments and services in social care

Case study no.	Region	Number employed in establish.	Growth/ Decline	Single site or multi-site	Main product/ service	Type of main customer/ end user
S8	London & South East	100	Growth	Multi-site	Total nursing care	Elderly people
S9	London & South East	27 in-house + 1300 care staff registered	Growth	Single site with outreach services	Domiciliary, with some residential care	Elderly people
S10	London & South East	29	Growth	Single site	Residential care	Elderly people
S11	North West	17	Growth	Single site	Residential care	Elderly people
S12	North West	104 employees + 1200 volunteers	Growth	Multi-site	Domiciliary, with some residential care	Elderly people

The case studies involved two establishments (medium-to-large) in domiciliary care and three (two small and one large) in residential/nursing care. These reflected the different size of establishment found within the sector, although a more representative sample would have included more small establishments. This is a sector where there is a relatively large turnover of establishments and a relatively large proportion of family businesses. Hence, the sector is subject to continuing change. Given the ageing of the population and the increasing emphasis on social care, there is a continuing demand for social care for the elderly.

Awareness of skills utilisation issues: The chosen cases are at the more enlightened end of the spectrum of a sector in which the quality of service delivery and the extent to which staff were trained and sufficiently skilled to undertake their work varies widely. The small companies who invested little in training and skills development were not interested in participating, it is not known if their resources were already stretched and they thought that a case study investigation would show them in a poor light. All our case study organisations were at least aware of issues around skills utilisation, rather than being almost exclusively concerned with reacting to the latest crisis.

Range of interviews conducted: Within each residential care case study, interviews were undertaken with a range of respondents. Typically interviewees included the owner/manager of the care home, the person with responsibility for training (if different), a senior nurse and managers of separate functions (if appropriate) and senior and more junior care assistants. In domiciliary care achieving a range of interviews is more difficult since workers are 'in the field', so here the main focus was on service managers.

D2 SERVICE DELIVERY STRATEGIES
D2.1 Service delivery strategies of case study organisations

Competition and co-operation: *Competition, resources* and *funding* were key issues in organisations making decisions about service delivery in residential care. Organisations within the social care sector, however, were less likely to have a formal business plan or written service strategy than those in the health sector. Service strategies varied according to the type of establishment. In residential care, some organisations were attempting to attract *'niche' markets* through, for example, placing emphasis on choice and 'family' surroundings, or catering for customers with similar interests and backgrounds (for example, those with professional backgrounds), whereas others aimed to provide a hotel-like service.

Voluntary sector organisations were less likely to be in direct competition with other care providers, having identified a 'niche' for themselves which dove-tailed with rather than duplicated existing services, in order to maximise the most efficient use of resources. An important part of their strategy was to co-operate with other agencies in the sector in order to establish protocols for referrals and share policies and procedures.

Quality focus: Because of competition within the residential sector, high quality strategies centred on high standards of care, such as provision of *en-suite* facilities for all residents, high staff to resident ratios and quality assurance mechanisms, while also attempting to offer 'value for money'. Additional services, such as leisure facilities and 'recreation therapies' were also offered by many establishments, with those catering for particular clients ensuring that the services offered fit the general *ethos* of the home. Continuity of care was also seen as an important aspect of provision. Because of increased costs and the relatively low levels of local authority funding, many homes in the independent sector had taken on more private residents to remain in business and some were thinking seriously about focusing solely on private clients.

Meeting client needs in domiciliary care: Within domiciliary care, the principal service strategy was not necessarily to meet client preferences but to meet their perceived *needs,* generally specified by the contractor (usually the local Social Services Department). In some instances such assessments were thought by the care provider to be inappropriate. Cost pressures were an increasing issue in this sector, with the financial constraints on local authorities resulting in very low benchmark prices which were on occasion felt to be incompatible with providing a satisfactory standard of service. Such cost pressures impacted upon training as providers felt they could only offer as much as the local authority would pay for (over and above the training required to meet minimum quality standards). Some organisations involved in care of the elderly often found themselves struggling to maintain an existence and pressures on resources made it difficult, for smaller organisations particularly, to fund training and skills development for staff.

D2.2 Changes to service delivery strategies

Reacting to change: At the level of the individual organisation there was little evidence of changes to service delivery strategies. This was in part because some of the organisations tended to be reactive rather than strategic, often believing that strategic decisions affecting their provision were influenced by national, regional or local policies to which they responded. Those organisations that had a significant component of their business where they were paid directly for providing services to individuals were able to decide to make some adjustment to the services they offered in the light of their perceptions of market demand. These changes were designed to consolidate their niche position as providing high quality, high cost services. On the other hand, organisations that bid to provide services for groups of clients on a contractual basis often felt they were locked into providing services that met the contractor's specification and that their market was very cost sensitive.

Interactions between the public and private sectors: What service strategies are effective in the private sector also depends upon what happens in the public sector, even though public sector provision is greatly reduced in terms of size and influence. Services for the care of the elderly provided by the public sector may become more specialised, as local authorities may believe the only viable option is to offer the more highly skilled care required by clients with more specialised needs. They cannot expect to compete against low cost competitors from the private sector in the provision of basic care. Increasingly local authorities are also seeing their primary role in this area as facilitating co-ordination with health authority, primary care groups, and others over the care of the elderly.

D2.3 Sustainability of service delivery strategies and possibilities for alternative strategies

Factors influencing sustainability: Staff from the case study organisations felt the extent to which their current service delivery strategy was sustainable was dependent upon a number of factors, including:

- funding;

- customer demand, particularly in the independent sector (including choice, standard of service and range of activities - customer demand is also frequently expressed through intermediaries such as relatives, rather than individual residents themselves);

- legislation (for example, the Working Time Directive, which impacts on holiday pay for casual staff and the minimum wage in some homes, especially in northern England);

- need for continuity of care and constant cover in residential care;

- future introduction of national standards in training and quality of care;

- Social Services Inspectorate requirements;

- competition from other providers;

- location (this affects availability of staff and whether it is perceived as a desirable location for clients).

Tensions between cost constraints and quality of care: Good practice within residential care revolved around value for money, standards of care and provision of additional services for residents. Reports from visiting professionals, e.g. doctors, also helped to inform managers of satisfaction with their services, compared to those provided by other homes. Public expectations of improvements in social care and new general social care council (GSCC) regulations that stipulate requirements of registration and qualification for staff may put additional pressure on providers offering low cost, low quality provision. On the other hand, if homes are tied to particular properties and/or locations, as is often the case with family-run homes, then there may be limits to how far it is a realistic option to move up-market.

The primacy of funding constraints: Private providers offering basic care services can be sure there will be continuing high levels of social demand for their services. The extent to which these service providers were likely to flourish in future was dependent upon the interaction between the actions of their own staff and the structures within they had to operate, not least those decisions made, nationally and locally, about funding. Some respondents pointed out that one difficulty facing social care providers was that the policy shift of emphasis from institutional health care to home-based health-related social care was not coupled by a corresponding shift of resources.

D3 INFLUENCE OF TECHNOLOGY AND WORK ORGANISATION UPON SERVICE DELIVERY

The 'blurring of boundaries' between health care and social care: One of the key aspects of work organisation concerns the changing boundaries between health and social care, coupled with changing ideas about the appropriate location for health care for the elderly. The changing boundaries revolve around issues related to roles, responsibilities and funding. Ideas about changing locations include a significant shift towards 'hospital at home', fuelled by patient choice and technological developments, such as the use of safe syringes.

Holistic thinking: The changing patterns of work and responsibilities means that those working in both health and social care need to develop their skills in relation to whole systems thinking, including an emphasis upon prevention and health promotion rather than cure. This also means it is important to recognise that decisions about care are less likely to be seen as the sole responsibility of individuals, rather individual carers will need to see their work in the context of being members of a wider (multi-disciplinary) team.

The importance of size: The size of an organisation had implications for the pattern of work organisation and skill utilisation. For example, a secretary or receptionist might be expected to fulfil some caring duties too, particularly when dealing with enquiries from relatives or other organisations about the

health and well-being of an elderly person. Additionally, because many homes had relatively few staff, the secretary often found herself [3] undertaking more complex tasks than normal secretarial duties, including bookkeeping and personnel duties. In one small residential home, all staff engaged in 'caring' were also expected to fulfil other tasks such as cleaning and cooking. This 'general care role', as it was termed, was felt to avoid the demarcation problems that could arise in a small workforce, if certain tasks were left for other members of staff to do because people felt that it 'wasn't their job'.

Larger homes were likely to have more demarcation of tasks than smaller homes. For example, one home had Housekeeping and Catering departments. Skills in larger homes were more likely to relate directly to particular areas of work. In a large nursing home, for example, hotel experience was required for the Housekeeper, and chefs were expected to be fully qualified specialists.

D4 SKILL IMPLICATIONS OF SERVICE DELIVERY STRATEGIES

Range of formalisation: In social care, human resource policies were varied and not necessarily related to a formal strategic or business plan. Large parts of the sector are characterised by a marked lack of career structures.

D4.1 Translation of service delivery strategies into skill needs

'Caring qualities' for delivering a 'care' service: The service being delivered in both residential and domiciliary contexts is 'care' and many people therefore assume that those working in this sector should display 'caring' qualities. Respondents believed that ideally recruitment in residential homes was related to perceived essential 'caring' qualities. The social care sector is staffed mainly by women and perceptions of skill related to the qualities that women are thought to possess 'naturally'. Hence more than one home stressed that the preferred recruit was 'a mother'. There was a feeling in some cases that the ability to care is an innate quality, which cannot be taught through training and qualifications. One manager expressed the opinion that the caring workforce was largely working for 'pin money', which has often been the perception of women working part-time, although this view generally tends not to be borne out by the evidence [4]. There is thus some circularity in arguments forwarded, in that the perceived nature of the workforce may influence recruitment and training policies.

Personal attributes and experience: Prior experience, which was often gained in voluntary or informal contexts, was more important than qualifications when recruiting to establishments. Employers also emphasised the value of qualities such as patience and positive attitudes to caring work. *Interpersonal and communication skills* for all levels of staff were considered to be vital, for dealing with relatives as well as residents with a range of physical and emotional needs. Basic practical care skills were needed, with nursing qualifications for certain levels of staff required in nursing homes.

That some organisations had service delivery strategies based around high quality provision sometimes lead to demands for skills or training in excess of those provided by compulsory training. Organisations with different strategies emphasised the importance of different qualities in staff. For example, where the emphasis was on individual choice, then staff needed to be flexible enough to accommodate this and in some instances this was a problem where the staff came from a background where provision had been more structured and 'rigid'.

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3 This role is still predominantly performed by women.
4 Including that provided in these case studies, i.e. women interviewed were clearly working because they needed to.

D4.2 Implications of use of technology and organisation of work

Skills needed by care assistants: The way work was organised, and the type of technologies used, in the care of the elderly in delivering residential, and to an extent domiciliary care, meant that care assistants needed:

- basic caring skills, such as feeding, washing, hygiene, etc;

- quasi-medical and nursing skills: for care assistants, this included basic knowledge of illnesses and use of drugs, first aid;

- interpersonal skills, including the ability to listen, basic counselling skills and the ability to motivate and encourage;

- a positive and supportive approach and attitudes, for example to the notion of customer choice.

The importance of inter-personal skills in all work organisation contexts: For those performing the whole range of traditional helping duties, the following had become more important:

- general monitoring (and, if appropriate, referral to supervisor, other care professionals etc.)

- the ability to represent the client's interests (including through the use of negotiation and advocacy skills).

Within domiciliary care and particularly for volunteers, the pseudo-nursing skills required were not necessarily at as high a level as in residential care, although the need for interpersonal skills was as great. Within this sub-sector, there was also a particular need for personal qualities such as integrity and trustworthiness, as jobs involved helping, and going into the homes of vulnerable people. Paid and voluntary domiciliary care staff needed to be backed up by specialist support workers and advisory staff and were required to use their judgement as to when it was appropriate to call on the knowledge and resources of these back-up staff.

Communication skills: The need for good communication skills relates not only to care workers, but also other staff within establishments. For example, the secretary or receptionist role was seen as the key first point of contact for enquiries to organisations, particularly from relatives making the difficult decision of how and where care for an elderly person can be provided. The responses of the receptionist were seen as influential in whether enquirers investigated the organisation's services further.

Even where larger homes sought specialist skills and experience of, for example, housekeeping and catering, such staff were expected to have the ability to communicate with patience and understanding, so for kitchen assistants the qualities sought were mainly communication skills and cleanliness. Some small residential homes took this a stage further expecting all 'caring' staff also to carry out other tasks such as cleaning and cooking. This approach to the organisation of work therefore involved an element of de-skilling as well as skill broadening.

Within this sub-sector, there had been little change to certain roles, such as nursing and administrative/ clerical support. In the case of care staff, there had been up-skilling in some cases, with an increased focus on communication and the need to perform quasi-medical tasks. In some instances this had led to job enhancement for the individual concerned, although this was not often recognised in terms of pay or promotion.

Reporting requirements and literacy skills: For domiciliary care staff who had contact with clients in their homes literacy requirements were increasing as they were often expected to be able to give advice on issues such as paying bills and even to take on an advocacy role. The growing emphasis on reporting and recording in the sector as a whole highlighted the issue of basic skills such as literacy, numeracy, and communication. This was particularly an issue in the London area: in one care agency there, over ninety per cent of carers were from an ethnic minority and had English as a second language. This was an advantage in some respects, given the diverse client group, but it was also reported to have given rise to problems with sensitivity to, and awareness of, different cultural traditions (including 'White British'). This meant that general multi-cultural awareness and respect for difference were recognised as important qualities in terms of meeting the expectations of a wide range of clients.

D4.3 Capacity to meet skill needs

Limitations on training: Training and development in the sector was generally quite limited and mainly on-the-job. Certain statutory requirements had to be fulfilled (for example, training in manual handling, health and safety, first aid and fire evacuation), but the cost of training was such that some organisations were reluctant or unable to engage in training above these requirements. The incidence of training in social care organisations varied considerably and was highly contingent upon factors such as the size of the organisation, its client group, funding, and management ethos. Some providers were also reluctant to release staff for logistical reasons, if they felt this compromised their ability to provide continuity of care.

Formal qualifications: Larger organisations tended to be more involved in staff training and were more likely to offer structured qualifications such as NVQs. Those organisations dealing with a range of clients that included those with medical needs were also more likely to engage in staff training. For example, in Case S9, management took the view that their approach to service delivery was intrinsically dependent upon the quality of their staff and they took a positive approach to human resource development. Thus training was high on the company agenda: all staff were required to undergo basic company training and at least ten external courses were operated every term, on issues such as confrontation and de-escalation, record keeping, and dementia. The company was an NVQ awarding body in its own right and staff development was a high priority. The availability of training was perceived not only to improve quality standards by raising the skill levels of employees but also to improve staff retention, leading to more continuity of care.

Some smaller establishments adapted to their lack of resources by sharing the costs of training through consortia arrangements. Others ensured that a member of staff was proficient to undertake all training in-house, with the use of supporting printed and audio-visual materials. Some smaller establishments had sent staff on specialised training (for example, in dealing with bereavement) and NVQs had been adopted in some organisations, primarily for care assistants.

Variations in staff attitudes to training: Some staff saw training and work experience in this sector as useful steps towards another career (for example, fulfilling the necessary experience requirements prior to training to become a paramedic). There was a perception of some managers that a proportion of the care workforce is reluctant to train. This partly related to the fact that workers in this sector are likely to move between elementary jobs in different sectors dependent upon job availability, wages offered and other conditions of work. It was therefore accepted that some staff were transitory.

Other reasons offered as to why staff were reluctant to train included that the timing of training may not be convenient, because of childcare responsibilities, or perhaps that staff did not want to commit themselves[5]. There may be some circularity in this argument, in that the perceived reluctance of staff to train may be used as a reason for not offering training. The 'value' given to a job may also have some impact on the decision whether to invest in relevant training for particular individuals.

Case study: Residential home

Within Case S10, the key issue among care staff was perceived to be the divide between those who did the work for vocational reasons and those who were 'in it for the money'. It was felt that training would only be taken up by those interested in pursuing a long-term career in the sector. The interviewees felt those who perceived care work as 'a job' were much less likely to be interested in training as they were more likely to leave the sector if they could find work elsewhere (in retail, for example, where wages were as much as £2 per hour higher). The existence of a 'core nucleus' of staff who were committed to the work and who provided continuity of care was perceived as very important to the well-being of residents, and thus training for this group was a highly important factor in retaining them. One care assistant had undergone mostly on-the-job training to NVQ level 2, and was aiming to gain further qualifications and eventually to train as a paramedic. Another senior care assistant had worked her way up 'from scratch' and was now responsible for supervising other care assistants and liaising with District Nurses and GPs. She has also undergone NVQ level 2 training as well as specialist courses in catheter care, dementia, and care of the dying.

D4.4 External recruitment difficulties

Recruitment and *retention* are generally *problematic* in this sector, although the extent of difficulties varied according to geographical location and local labour market conditions. Recruitment problems were mainly related to pay: wages in the sector were generally low and competition from other sectors that used non-specialist labour (e.g. supermarkets, fast food establishments etc) in the local area was a continuing problem.

Particular difficulties were experienced in recruiting:

- Trained nurses for residential homes providing total nursing care, due to the national shortage of trained staff, the lower wages offered within residential care compared with pay levels in agencies, as well as perceptions of the work as being 'less exciting' than hospital care;

- Care assistants, due in part to the low wages and also perceptions of the role as low-skilled, even though the work itself was often physically and emotionally demanding, for which not all individuals have the necessary attributes and skills;

- Catering staff in larger establishments, due to a general shortage but also to relatively low wages and the need to work shifts.

5 The majority of staff interviewed, in fact, expressed some interest in training: the main problem cited was the conflict with other responsibilities, particularly in terms of lack of convenient times for training. Staff were likely only to undertake training if it was funded by their organisation and provisions for childcare/other care responsibilities outside of normal working hours was met by the employer.

D4.5 Internal skills gaps

Greater skills gaps in social care than in health care sub-sectors: Skill gaps were more likely to be reported in this sub-sector than in the health sub-sector, reflecting the fact that formal entry requirements into the social care sector, particularly for care assistants and cleaners are low. Some interviewees (both managers and employees) reported that they saw the sector as an attractive one for individuals with no/few formal educational qualifications. Hence, it was one of the sectors they perceived as open to them, and problems of lack of basic skills (in some instances) and limited interest in continuing learning were 'imported' into the sector.

Basic skills: Basic skills such as literacy were lacking in many instances, which created increased pressures on managers to ensure that requirements for reporting were fulfilled. Difficulties were also experienced with staff struggling with some of the more basic care tasks, such as moving and handling in different settings. Certain basic medical knowledge was now required, such as knowledge of the different medical conditions affecting residents and use and abuse of drugs. Because training in the sector currently tended to be limited, respondents reported that many care staff lacked this knowledge.

Need for broader and higher level skills on a 'skills continuum': Among some of the larger care providers with a wider range of client needs to address, care assistants were increasingly expected to exhibit pseudo-nursing skills such as tube feeding and terminal care. The blurring of the boundary between nursing auxiliary and carer meant that there was a need for development of a 'skills continuum', rather than separating caring and nursing skills.

Skills to undertake a monitoring role: Effective performance in social care relies upon effective monitoring of client wellbeing. Although formal health screening and monitoring can play a role, those offering regular social care, particularly domiciliary care, are in a unique position to monitor and review client wellbeing on an informal basis. To do this effectively requires quite advanced use of a range of processes from situational awareness through to continuous monitoring. 'Situational awareness' means being sensitive to (differences in) context and being able to adjust performance accordingly: what is appropriate behaviour in one context may be inappropriate in another. The ability to monitor continuously is important in that care workers can be the first to pick up signs of clients developing problems, such as dementia.

Communication, counselling and negotiating skills: As a more client-focused approach has become increasingly important in the care system, new skill demands have been placed on care staff. Many staff were perceived to lack (and found themselves lacking) communication skills in particular contexts. A key area was dealing with bereavement (handling not only other residents, but also relatives and other members of staff), and staff may require some basic counselling skills. An important focus of social care was the element of choice and ensuring that the client's interests were heard and acted upon where possible. This required the skills of listening, understanding, negotiation, taking decisions and upon occasion acting as advocate for the client: complex skills which have not been fully recognised. There were few instances of staff receiving support to develop these advanced communication skills.

D4.6 Latent skills deficiencies

Individual-focused approach to care: As treatment at home is getting more complex and protracted, coupled with the increasing influence of the client in the care system, so the focus of care is increasingly the individual and their needs.

This has important implications for organisations involved in domiciliary care in that their organisational performance cannot be judged in isolation from what other interested parties do. If the quality of care delivered to the individual is the key criterion against which to judge organisational performance, then effective inter-agency working will increase the likelihood that this is achieved. The same shift in focus towards the individual is part of 'best practice' in residential homes involved in the care of the elderly.

Such an emphasis is not unproblematic, however, as a special tension arises between the demand for a more efficient business-like approach and a client centred approach. Some carers may put greater emphasis upon the tasks and routines to be performed and avoid direct communication with clients, while others stress this aspect and encourage greater interaction and a more 'personal' relationship, calling for greater communication skills on the part of carers. With an increasing emphasis on independent living, the care worker may also be expected to assume a greater facilitating or educational role in the future, such that the client learns skills to reduce their dependence upon others.

Efficiency and 'caring': How to handle the fundamental tension between 'getting the job done' (performing the required support tasks and meeting performance targets) and whether care should involve 'feelings and authentic concern' is a complex issue. Ironically, those working health and social care may be seen as 'uncaring' by the general public, if they become too focused upon efficiency. So a caring approach needs to be cultivated as an integral part of staff development and training: care based on feelings, not just thought. The most pressing 'skills needs' for carers therefore often relate to communication skills, such as:

- listening to clients;

- reflecting back clients thoughts, feelings etc.;

- understanding of emotions as underlying what we do and think;

- need to cultivate the practical stance of 'being reasonable' (not trying to apply the standard of universal reason).

More higher level skills: That some of these skills are high level is in contrast with the stereotype of care assistants as doing relatively demanding work, but needing relatively few skills. Some local authority job evaluation exercises have shown that some care staff do indeed possess and apply some high level skills.

The need to instill confidence and promote a learning culture: From an organisational point of view any 'skills gaps' are likely to be seen as the 'gap' between what is required and what individuals have shown they can do. From an individual point of view, a person may believe he or she has 'untapped capability'. Perhaps the major shortcoming in relation to skills deficiencies among the staff we interviewed related to their lack of belief in the untapped capability of many staff working in social care, as they felt such staff would not respond to opportunities for further training and

development.

A key issue is whether existing employees are given the time, space and opportunity to make up some of the identified skill deficiencies. There is evidence from earlier work by trade unions and local authorities that people lacking formal qualifications can be encouraged back onto an active learning ladder, and that such learning can address issues around motivation to learn and remediation of basic skills. Without such attention the offer of formal training may be interpreted as an 'opportunity to fail' - reluctance to train may therefore be because the training does not address the most pressing learning needs of individuals with basic skills problems.

D4.7 Impact of skill deficiencies

Managers taking on routine tasks: One of the impacts of a lack of basic skills in some instances was that managers were increasingly performing required reporting tasks instead of being able to leave this to care staff. If the policy of a lack of commitment to training and development is continued in the independent sector, such problems are likely to be exacerbated as demand for quality assurance increases. The ability to deliver a quality service, especially in the context of increased demand for 'customer care', will also be reduced. The degree of training given partly depends on resources which managers are prepared to allocate to this aspect of care, but also relates to perceptions of the level of skill required and the capacity of their existing workers to learn new skills.

Perceptions of skills required and actual skills required: A contributing factor to these problems is that the skills required of care assistants can be quite high and yet the job is widely perceived and rewarded as if it was relatively unskilled. The under-valuation and social construction of skill levels in this kind of work may well be because it is generally performed by women workers and is seen by many as a 'natural' extension of their caring role in the home: a general problem for such caring professions. The social construction of skill, particularly as it relates to gender, is highly relevant to consideration of perceived skill needs and deficiencies in the social care sector. That the care role is perceived as low-skilled, as well as the general low wages and the casualised nature of the sector, ensure that potential care staff continue largely to be drawn from a particular pool of local people possessing relatively low levels of skill. They then have a tendency to move between sectors according to the financial benefits on offer. Because the role is traditionally seen to be appropriate to women and thus of relatively low value, it tends not to be seen as an attractive option by men (Young, 1999). The generally low levels of training within the sector also contribute to the poor image of care work.

Attracting new recruits by offering training: It is likely to remain the case that social care attracts only some people with a strong interest in caring for others. Some workers may use it as a means of gaining experience for other related work, but more continuity was likely to be achieved if the work was appropriately remunerated (thus enabling the sector to compete more effectively with others). The provision of higher quality training leading to some form of certification might also stimulate recruitment and retention, as well as contributing to overcoming skill deficiencies. S12 was considering providing specific training in order to attract more younger volunteers.

The need to integrate staff training into individual development: The perceived lack of interest in training of many staff may also relate to the low value placed upon the work, as relatively few people are looking for a long-term future in the industry. Relatively few current staff are committed to this form of work. Others stay for a relatively short time, either because they do not like, or cannot cope with, the type of work involved, or because of the attraction of higher wages in jobs at a similar level in other sectors. Training alone is not likely to encourage retention of this latter group. Whereas if the training were part of an integrated package of development for staff, with proper recognition of the value of the work and the skills demanded within it (including financial recognition), care work might become a more attractive option than is currently the case. Given the feminised nature of the care workforce, attention needs to be paid to the timing and nature of training and development offered, in terms of enabling staff to combine such opportunities with their other commitments.

How some responses exacerbate problems: Skill deficiencies themselves create further problems. For example, the use of agency cover to deal with temporary or longer-term staff shortages was relatively expensive, and therefore increased pressure on resources in other areas, as well as conflicting with the desire to provide a degree of continuity of care. Similarly skill shortages led to work intensification for staff. In cases where the number of clients nearly always exceeded the time available to provide effective care, then for the individual carer there was a gap between what they could do or would like to do and what they actually had time to do. The general increase in skill demands of carers exacerbated these tensions, particularly those relating to:

*   quasi-medical skills, particularly within care homes, as older people are staying in their own homes for longer and thus require more care when they enter a residential home;

*   increased communication skills, as a result of policy changes and customer demand;

*   increased demand for literacy skills, as reporting is required.

As with health care, so there is not only one way of delivering social care against which it is possible to judge 'skill deficiencies'. The whole area of the shape and direction of social care is trying to come to terms with relational and caring constructs, and there are major social, economic and political dimensions to attempts to pay greater attention to the quality of caring relationships. Ethics and values are therefore necessarily involved in assessment of skill development, skill deficiencies and so on. That is ideas about what are the appropriate skills required for service delivery are inevitably connected to views about how the service should be delivered, and clients, professionals, managers and the general public may all have views on that.

D4.8 Relationship between skills and organisational performance

Shifts in health and care policy, facilitated (at least in a small way) by technological developments, have led to an *increase in the range of skills* required in social care. In this respect, developments in social care are analogous to those noted for the health sub-sectors. The traditional characterisation of the sector as unremittingly 'low skilled' is increasingly inaccurate. Again, as in radiography and physiotherapy, the trend is towards *upskilling* - albeit from a lower base. It is important to acknowledge in any consideration of the relationship between skills and organisational performance that at the individual level social care services are delivered by staff with very major differences in the range of skills they use in their work.

From the case studies it was apparent that many care providers were committed to providing a quality service - over and above the statutory minimum. However, the need to provide continuity of care, combined with funding constraints, meant that many providers in this sector found it difficult to make provision for the training they would like for their staff to enable the efficiency and quality of the service provided to be enhanced. These providers then seemed locked into a situation where they were aware that current skill deficiencies prevented them from moving to higher levels of organisational performance, but felt that logistically it was just too difficult to organise the type of training required to address their skill deficiencies. These providers when faced with high staff turnover and major skill deficiencies adopted a policy of controlling costs as a means of survival, rather than trying to upskill their workforce.

The quality of the workforce therefore played a key role in how effectively the service was delivered. There were examples of providers that had through their position in the market and/or through their use of programmes of staff development been able to recruit and retain staff such that they were able to deliver higher levels of organisational performance. These organisations were also in a much stronger position to be able to respond to the increasing demands for cross-agency partnerships, with the need for care staff to communicate effectively with a range of staff from other disciplines, backgrounds and organisational contexts.

Which organisational strategy, controlling costs or upskilling, is more viable in the longer term depends partly upon market position and partly upon the criteria used by purchasers of the provision. If fairly high levels are set for the minimum quality of care then those organisations with more highly skilled staff delivering a higher standard of care will have the edge. If the minimum standards are set quite low then those organisations whose emphasis is upon controlling costs are more likely to be more successful.

The above analysis of strategies of either staff development or cost control as a key organisational tool are both framed within an institutional approach to social care. Within this approach the emphasis is upon how the organisation can improve its performance, principally either in terms of efficiency or quality of provision. However, just as in health care an alternative perspective threatens to transform how provision of care is conceived. The alternative approach is client-focused, paying greater attention to the needs of the client rather than of the providers. Its most obvious manifestation is in the need for collaboration between organisations in multi-agency partnerships, but the key driver is the intention to improve the coherence and quality of care as experienced by the individual.

So, again as in health care, there is a need to distinguish between those skills required to improve performance within the dominant paradigm of an institutional approach to the delivery of care and those required for effective performance within a new paradigm: a client-focused approach to the provision of care.

From our analysis it is clear that there are six broad sets of skills that lead to more effective performance while operating within a paradigm based upon an institutional approach to the delivery model of care. The same broad sets of skills, but with different individual skill configurations, underpin the shift from operating within an institutional approach to care to effective performance while adopting a client-focused approach to care delivery. The six broad sets of skills are in the areas of communication skills; inter-personal sills; team-working; quasi-medical and nursing skills; the application of care-related knowledge; and general monitoring of well-being of clients. A seventh set of skills, those skills associated with the effective management of change, will be required in order to transform the basic approach to care delivery.

Current skill deficiencies relate to those skills that, if developed further, are required to move an establishment to higher levels of performance, while still operating largely with an institutional approach to the delivery of care. The communication skills required relate to communicating with clients and relatives with patience and understanding. The inter-personal skills required involve understanding the emotions and emotional needs of clients. Possession of these skills underpinned a higher quality of service delivery. More effective team working, involving a willingness of all staff to engage in a wide range of tasks (not saying 'that is someone else's job'), was associated with delivery of a more efficient service. The increasing emphasis upon more health-related care in both residential and domiciliary settings was leading to more demanding skill requirements even for those still operating largely with an institutional approach to the delivery of care. These health-related skills included quasi-medical and nursing skills like tube feeding and terminal care; application of care-related knowledge of dementia and effects of different medical conditions of clients; and skills involved in the general monitoring of clients, especially being alert to when it would be appropriate to call upon more specialist staff.

These sets of skills are particularly important in those contexts where there are continuing shortages of staff, due to external recruitment difficulties and posts remaining vacant for relatively long periods. The skills outlined above can alleviate some of the negative consequences that would otherwise be expected from such skill shortages and the skill deficiencies associated with recruitment of staff with little experience of the sector or with problems with basic skills. However, staff shortages and skill deficiencies do nevertheless have a direct impact on performance: the organisation will offer a poorer quality of service to clients than if it were fully staffed by experienced, trained workers.

The above analysis relates to the performance of organisations that are operating primarily with an institutional approach to the delivery of care. However, current government policy seeks to promote more holistic forms of care and support, where the total experience of the individual patient is the driver of the system. If care service providers are to achieve this goal, they need to adopt a stronger client-centred focus. To do this will require providers to adopt key aspects of the skills development strategies of those organisations that were attempting to move in this direction and are also currently delivering high levels of organisational performance. These strategies made use of the same six broad skill sets mentioned above, but they were configured in a different way, plus skills associated with effective management.

The skills associated with effective management of a client-focused approach to care were concerned with the management of change and the development of a more outward-looking perspective, that included management of relationships with a range of other agencies concerned with the care of the

individual clients. Care providers needed to link into patterns of multi-agency working within a partnership framework. As a consequence the team-working skills of staff required were of a higher order as they needed to be able to co-operate with other partners from a range of disciplinary backgrounds, organisational contexts and with different perspectives on how best to deliver care, support and treatment for their clients. The skills associated with general monitoring of client wellbeing were also more developed, particularly in relation to when to call upon the skills, knowledge and resources of other staff.

A client-focused approach to care meant that the quasi-medical care skills were extended to cover areas such as catheter care. The application of care-related knowledge about handling relationships in different contexts and culturally specific knowledge about different client groups became more important as care became more tailored to individual needs. This approach also required significantly higher demands upon the communication and inter-personal skills of staff. For example, staff needed the inter-personal skills to be able to display feeling and authentic concern for clients and have a situational awareness of the different types of behaviour appropriate in different contexts. The communication skills included active listening to clients; the ability to reflect back clients' thoughts, feelings and emotions; being able to act as an advocate on behalf of clients; being able to handle confrontation through techniques of de-escalation.

Both current and latent skill deficiencies, involving either internal skill gaps and/or continuing problems with external recruitment difficulties and posts being vacant for long periods of time, were likely to be major factors in an organisation making little progress in adopting a more client-centred approach to care delivery. From our case studies it is clear that effective performance within an institutional approach to care delivery is only a prerequisite for a successful transition to the effective delivery of a more client-focused form of care delivery, if it is accompanied by an upskilling strategy rather than one based upon controlling costs. The cost control approach is a survival strategy that pays little attention to the use of skill development as a means to improve organisational performance. However, the relationship between skill utilisation and more effective performance within an institutional approach to care delivery and that involved in the move towards a more client-focused model of care delivery are represented in summary form as follows:

Key skill sets involved in moving organisations to a higher level of performance within an institutional approach to care delivery through use of an upskilling strategy:

- communicating with clients and relatives with patience and understanding

- inter-personal skills involved in understanding the emotions and emotional needs of clients.

- team-working skills involving a willingness to engage in a wide range of tasks

- quasi-medical and nursing skills like tube feeding and terminal care

- application of care-related knowledge of dementia and effects of different medical conditions of clients

- skills involved in the general monitoring of clients, especially being alert to when it would be appropriate to call upon more specialist staff

Key skill sets involved in moving care service providers from an institutional approach to care delivery to effective performance using a client-focused approach to care delivery:

- managerial skills related to the management of change and the development of a more outward-looking perspective: including management of relationships with a range of other agencies in a partnership framework

- team-working skills: being able to co-operate with other partners coming from a wide range of disciplinary backgrounds, organisational contexts and with different perspectives on how best to deliver care, support and treatment for clients

- quasi-medical skills like catheter care

- application of care-related knowledge about handling relationships in different contexts and culturally specific knowledge about different client groups

- skills involved in the general monitoring of client well-being, particularly in relation to when to call upon the skills, knowledge and resources of other staff

- displaying feeling and authentic concern for clients and having a situational awareness of the different types of behaviour appropriate in different contexts

- communication skills involving active listening to clients; the ability to reflect back clients' thoughts, feelings and emotions; being able to act as an advocate on behalf of clients; being able to handle confrontation through techniques of de-escalation.

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