



UK COMMISSION FOR
EMPLOYMENT AND SKILLS

Sector insights: skills and performance challenges in the health and social care sector

Evidence Report 91
May 2015

[This page is intentionally left blank]

Sector insights: skills and performance challenges in the health and social care sector

Colin Howat, Michael Lawrie

ICF Consulting

Rosie Sutton

Research and Technical Manager

UK Commission for Employment and Skills

May 2015

[This page is intentionally left blank]

Foreword

About the UK Commission for Employment and Skills

The UK Commission for Employment and Skills (UKCES) is a publicly funded, industry-led organisation providing leadership on skills and employment issues across the UK. Together, our Commissioners comprise a social partnership of senior leaders of large and small employers from across industry, trade unions, the third sector, further and higher education and all four UK nations.

Our vision is to create, with industry, the best opportunities for the talents and skills of people to drive competitiveness, enterprise and growth in a global economy.

Over the next three years our ambition is to see industry in the UK create “ladders of opportunity” for everyone to get in and on in work. This means employers improving entry routes into the labour market for young people, ensuring the existing workforce has the skills businesses need to compete and individuals need to progress, and deploying those skills in a way that drives productivity and growth. This is a collective agenda for employers working in partnership with government, trade unions, education providers, industry bodies and local organisations.

Our Research

Our research mobilises impartial and robust national and international business and labour market research to inform choice, practice and policy. We aim to lead the debate with industry to drive better outcomes for skills, jobs and growth.

Our ambition is to cement the UK Commission’s reputation as the ‘go-to’ organisation for distinct high quality business intelligence, and communicate compelling research insights that shape policy development and influence behaviour change.

In order to achieve this, we produce and promote robust business intelligence and insights to ensure that skills development supports choice, competitiveness and growth for local and industrial strategies.

Our programme of research includes:

- producing and updating robust **labour market intelligence**, including through our core products (the Employer Skills Survey (ESS), Employer Perspectives Survey (EPS) and Working Futures Series)
- developing an understanding of what works in policy and practice through **evaluative research**
- providing research **insight** by undertaking targeted thematic reviews which pool and synthesise a range of existing intelligence.

Our research programme is underpinned by a number of core principles, including:

- providing **business intelligence**: through our employer surveys and Commissioner leadership we provide insight on employers' most pressing priorities
- using evaluative insights to identify **what works** to improve policy and practice, which ensures that our advice and investments are **evidence based**.
- adopting a **longer term, UK-wide, holistic perspective**, which allows us focus on big issues and cross cutting policy areas, as well as assessing the relative merits of differing approaches to employer engagement in skills
- providing **high quality, authoritative and robust data**, and developing a consistent core baseline which allows comparison over time and between countries and sectors.
- being **objective, impartial, transparent and user-friendly**. We are free of any vested interest, and make our LMI as accessible as possible.

We work in strategic partnership with national and international bodies to ensure a co-ordinated approach to research, and combine robust business intelligence with Commissioner leadership and insight.

The overall aim of this project is to examine the skills and performance challenges in the health and social care sector in the UK, with a specific emphasis on a selected number of key occupations. In addition, the research assesses employer engagement with and use of national occupational standards. This project forms part of a wider suite of sector labour market intelligence (LMI) research undertaken by the UK Commission. The overall aim of the programme is to examine skills and performance challenges across a range of industry sectors of critical importance for the UK economy.

Sharing the findings of our research and engaging with our audience is important to further develop the evidence on which we base our work. Evidence Reports are our chief means of reporting our detailed analytical work. All of our outputs can be accessed at www.gov.uk/government/organisations/uk-commission-for-employment-and-skills

We hope you find this report useful and informative. If you would like to provide any feedback or comments, or have any queries please e-mail info@ukces.org.uk, quoting the report title or series number. We also welcome feedback on Twitter.

Lesley Giles

Deputy Director

UK Commission for Employment and Skills

Table of Contents

Executive Summary	xii
1 Introduction	1
1.1 Background and aims of the study.....	1
1.2 Purpose and content of the report.....	2
2 Methodology and sector definition	3
2.1 Introduction	3
2.2 Study methodology	3
2.3 Definition of the sector.....	4
3 Key Occupations	5
3.1 Introduction	5
3.2 Selecting five health and social care key occupations.....	5
3.3 Focusing the primary research on the selected occupations	6
3.3.1 Residential, day and domiciliary care managers and proprietors (SOC1242)	6
3.3.2 Medical practitioners (SOC2211).....	7
3.3.3 Physiotherapists (SOC2221).....	7
3.3.4 Nursing auxiliaries and assistants (SOC6141)	7
3.3.5 Care workers and home carers (SOC6145).....	8
4 The sector today	10
4.1 Introduction	10
4.2 Sector size and key characteristics	10
4.3 Current policy drivers in health and social care	12
4.3.1 Demographic change	12
4.3.2 Social and political factors	13
4.3.3 Technology and innovation.....	14
4.3.4 Patient and service user expectation	15
4.4 Skills challenges at sector level.....	16
4.4.1 Hard-to-fill (HtF) Vacancies.....	16
4.4.2 Skills shortage vacancies (SSVs)	18
4.4.3 Skills gaps	19
4.4.4 Training provided.....	20
4.5 Skills challenges at occupational level	21
4.5.1 Care workers and home carers	21

4.5.2	Care home managers and proprietors	26
4.5.3	Physiotherapists	28
4.5.4	Medical practitioners	31
4.5.5	Nursing auxiliaries and assistants.....	34
4.6	Conclusions	36
5	Future Skills	38
5.1	Introduction	38
5.2	Forecasting future skills and employment needs	38
5.3	Sector-wide findings	41
5.4	Occupation-specific findings	43
5.4.1	Care assistants	43
5.4.2	Care home managers	45
5.4.3	Medical practitioners	46
5.4.4	Physiotherapists	47
5.4.5	Nursing auxiliaries.....	48
5.5	Conclusions	50
6	Current and future interest in occupational standards	51
6.1	Introduction	51
6.2	Overview of occupational standards in health and social care.....	51
6.3	Overall awareness and use of occupational standards.....	52
6.4	Perspectives on NOS among social care employers.....	53
6.5	Perspectives on NOS among health employers.....	55
6.6	Conclusions	57
7	Conclusions and recommendations	58
7.1	Conclusions	58
7.1.1	Sector outlook.....	58
7.1.2	Current workforce and skills challenges	59
7.1.3	Future workforce and skills challenges	60
7.2	Recommendations.....	60
	Appendix A: Bibliography	62
	Key policy documents	62
	Documents on skills and training issues	62
	Wider context.....	64
	Data sources.....	67
	Appendix B: Methodological note	68

Appendix C: UK Standard Industrial Classification of Economic Activities 2007	69
Appendix D: Labour Force Survey occupation data.....	70
Appendix E: UK Commission’s Employer Skills Survey data.....	72

Executive Summary

Introduction

This report examines skills and performance challenges facing the health and social care sector. It provides a synthesis of evidence on the sector outlook, identifies major trends affecting skills demand, investigates employer perceptions of skills challenges facing specific occupations, and investigates employer awareness of, engagement with and interest in National Occupational Standards.

The study focuses on five key occupations in the sector: care assistants, care home managers and proprietors, medical professionals, physiotherapists and nursing auxiliaries.

Key findings

The health and social care sector is the largest sector in the UK, employing nearly four million people. It is wide-ranging, covering highly complex acute care delivered in hospital settings as well as personal care and support delivered in people's homes or in residential care settings. It is anticipated that over two million new workers will need to be trained and recruited into the health and social care sector between 2012 and 2022 as the sector grows and some members of staff retire. This is equivalent to over half of the existing workforce and presents key challenges for training and staff retention.

The sector plays a crucial role in supporting the economy by maintaining the physical and mental health of the wider workforce. The current workforce is predominantly female, has an older age profile, and is more highly qualified than the economy as a whole. The sector has a broad occupational mix encompassing a wide range of roles and types of work. Four occupations (including: care workers; nurses; nursing auxiliaries; and doctors) account for over 43 per cent of the workforce. There are also a number of large, non-clinical groups such as receptionists, cleaners and care home managers.

Developments within the sector are driven by demographic change (increased demand for care), social and political factors (including the push for resource efficiency), technology and innovation (advances in treatments and opportunities for patients manage their own health), and growing patient and service user expectations.

These drivers are generating skills and performance challenges in all of the key health and social care occupations, as the sector responds to changing demands. This can be seen, for example, in physiotherapists' growing role in delivering reablement support in community settings, and nursing auxiliaries' increasing specialisation and growth from providing primarily a support function to increasingly taking on additional clinical duties. Regulation and training can help support these changes.

Over the next five to ten years, the sector faces uncertainty due to rising demand and reduced availability of resources, as well as structural reform. Such changes are likely to lead to a more diverse set of employers operating in the sector and a more joined up approach to service delivery by health and social care staff. This will present opportunities for exchange of ideas, as well as challenges relating to differing traditions and working patterns. Existing occupations are likely to expand beyond their current parameters, and new roles are likely to emerge which fill gaps between the traditional health and social care professions. Training structures, professional identities and regulation will need to adapt to facilitate such changes.

Another dynamic is balancing the degree of specialisation with the need for a core occupational skillset, particularly among healthcare occupations. Balancing this to best meet patient and service user need is an ongoing debate, with widespread impacts. The sector also faces long-term questions about how best to recruit people who share and demonstrate the values required in health and social care work.

In addition, technological and medicinal innovation will enable service users to manage their own care to a greater degree, and will affect all occupations. There will be a culture shift as staff adopt higher level skills (for example, to facilitate enablement). The continual evolution of technology and medicine means that other skills implications are harder to predict. A responsive training and regulatory infrastructure will be needed to mobilise quickly and act upon any changes.

Awareness and use of National Occupational Standards (NOS) in health and social care is relatively high, which may indicate a recognition of the importance of standards more generally in health and social care. The central focus on regulated standards and quality of care provision in the sector mean that occupational standards are fundamental for employers. Often, this is driven by professions rather than employers, and the role played by NOS can remain relatively hidden to sector employers.

The sector could take a number of steps to address current and future challenges in the health and social care workforce. These include:

- designing dual route training opportunities and qualifications for new entrants to the sector, which would allow staff to pursue a health or social care career path
- sharing learning on recruitment and workforce planning to aid the delivery of personalised and integrated care
- sharing learning on how to engage lower skilled workers in workplace learning.
- undertaking exploratory scenario planning to examine the future shape of health and social care support jobs
- moving away from a narrowly-defined, task-orientated NOS and encouraging greater use of NOS by national and sector bodies in when developing training across the sector.

1 Introduction

ICF Consulting was contracted by the UK Commission for Employment and Skills (the UK Commission) to research the skills and performance challenges facing the health and social care sector.

1.1 Background and aims of the study

The UK Commission is a publicly-funded, industry-led organisation providing leadership on skills and employment issues across the UK. Together, its Commissioners comprise a social partnership of senior leaders of large and small employers from across industry, trade unions, the third sector, further and higher education and across all four UK nations. Its vision is to create, with industry, the best opportunities for the talents and skills of people to drive competitiveness, enterprise and growth in a global economy.

Innovative and insightful research is central to the UK Commission's role as a prime source of knowledge on how skills drive enterprise, create more and better jobs and deliver economic growth. Its programme of sector research includes a series of Sector Skills Insights reports (published in 2012), which focus on skills needs in specific sectors; and a rolling programme of sector-specific studies. The first round of these covered the role of technology in driving high-level skills in the digital, off-site construction, aerospace and automotive industries. The second addressed skills and performance challenges in the logistics and wholesale and retail sectors. The third round examines sector skills and performance challenges, with an emphasis on the mix of skills needed in specific occupations, as well as employer awareness of and engagement with National Occupational Standards (NOS).

This report focuses on the health and social care sector. It:

- synthesises evidence on the sector's labour market to identify the outlook for jobs and skills
- identifies major trends affecting the sector and how the mix of skills needs is likely to change over the next decade in response to these
- investigates employers' perceptions of the skills needs of specific occupations, and the challenges employers have in meeting those needs
- discusses current awareness of, engagement with and interest in National Occupational Standards in developing the sector's workforce
- draws out the implications for skills supply and workforce development.

In order to identify common skills issues across sectors, the projects in this third round of the sector insights programme share a common methodology where appropriate. This includes: a review of existing literature and data from the UK Commission's Employer Skills Survey, Employer Perspectives Survey, and Working Futures labour market projections; and consultations with sector bodies and sector employers. The focus on five key occupations represents a change from past UK Commission sector studies, and reflects the UK Commission's interest in assessing market demand for National Occupational Standards, as well as an opportunity to build on previous sector research and delve deeper into the operation of specific sector labour markets.

1.2 Purpose and content of the report

The report follows the UK Commission's common structure for its sector LMI projects:

- Chapter 2 sets out the definition of the sector and methodology
- Chapter 3 sets out the selected key occupations
- Chapter 4 sets out findings on the sector today
- Chapter 5 sets out findings on the future skill needs of the sector
- Chapter 6 sets out findings relating to current and future interest in occupational standards
- Chapter 7 sets out the study's conclusions and recommendations.

2 Methodology and sector definition

2.1 Introduction

This chapter provides an overview of the methodology for adopted for this study.

2.2 Study methodology

This report focuses on five occupations in the health and social care sector as follows:

- Care assistants
- Care home managers and proprietors
- Medical practitioners
- Nursing auxiliaries
- Physiotherapists.

Further details on how these were selected are provided in Chapter 3.

The research used a mixed-methods approach, including analysis of existing data sources and literature to understand the sector context and primary data collected from employers focused on their experiences and perceptions.

The research included:

- A review of recent literature relating to the health and social care sector
- Analysis of key national data sets, including the UK Commission's Employer Skills Survey, UK Commission's Employer Perspectives Survey, Labour Force Survey, and Working Futures forecasts.
- 53 in-depth, qualitative telephone interviews with employers and sector stakeholders (46 employer interviews and seven stakeholder interviews). A full breakdown of employer and stakeholder interviews is provided in Appendix B.

Each interview had a primary focus on one of the key occupations as follows: care assistants (eleven); care home managers and proprietors (eleven); medical practitioners (ten); nursing auxiliaries (eleven); physiotherapists (ten). Approximately a third of interviews also had a secondary focus on an additional key occupation, typically in social care.

Following completion of the fieldwork, additional structured discussions were undertaken with members of ICF's Health Insights Group to test and interpret findings.

2.3 Definition of the sector

Health and social care forms a single SIC¹ Code section called 'Human Health and Social Work activities'. This section includes the provision of health and social care services covering a range of activities, from healthcare delivered in hospital settings to social care delivered in the home or residential care settings. It also encompasses the provision of social work activities that do not involve the services of healthcare professionals (ONS, 2009).

The section is further divided (as outlined in Table C.1) into three main sub-sectors:

- **Human health activities:** This comprises the delivery of healthcare in primary, secondary and tertiary settings, by a range of healthcare professionals and support staff treating a wide variety of medical conditions.
- **Residential care activities:** This comprises the provision of residential care, which is combined with nursing, supervisory or other types of care as required by residents. The provision of residential facilities is a significant aspect of this sub-sector; and any healthcare provided is largely nursing (as opposed to medical).
- **Social work activities without accommodation:** This includes the provision of a range of social assistance services directly to clients (excluding any permanent residential services).

Health and social care is a crucial sector for the UK economy and encompasses a large segment of employment. A little over four million people across the UK work in health and social care (LFS, 2014), including some of the largest occupational groups within the economy (nurses and care assistants, for example). It also generated a net output of £92 billion in 2010 (UKCES, 2012).

The sector plays an important role in supporting the rest of the economy by maintaining the mental and physical health of the wider workforce. The services delivered also reduce the burden on families to provide informal care, thereby allowing them to be more economically active.

¹ Standard Industrial Classification categorising businesses and organisations by type of economic activity

3 Key Occupations

3.1 Introduction

This chapter outlines the rationale for selecting the five key occupations. It provides a description of each occupation; and describes the aspects of the role that provided the focus for the primary research, given the breadth of some groups even at the most detailed occupational level.

3.2 Selecting five health and social care key occupations

Occupations were defined according to the Standard Occupational Classification (SOC) at four-digit unit level, the most detailed level of the national classification. The aim was to ensure that occupations chosen appropriately reflected the diversity of the sector and would assist in understanding current and future skills and training issues for health and social care as whole.

The following criteria were used:

- **The size of the occupational group:** To ensure larger occupational groups were represented.
- **Occupational skill level:** To ensure chosen occupations represented a cross-section of skill levels, entry requirements and pathways into and through the sector.
- **Sector focus:** To ensure a balance between occupations that are primarily found in the health sector and occupations primarily found in the social care sector and that a range of subsectors are also represented.
- **Patient/service user focus:** To ensure that while primarily focusing on clinical/delivery-focused roles, the selected key occupations also include non-clinical roles (which are by far the largest number of occupations numerically, although not in terms of scale).
- The **public and private** sector are represented

Data from the Labour Force Survey (LFS) underpinned selection by occupational group size and occupational skill level. A full break down of the occupational rank, size and share of the sector workforce for the top 20 health and social care occupational groups can be found in Appendix D.

The 20 largest occupational groups account for more than two-thirds of the workforce and are predominantly clinical and service-user focused (Table D.1). The sector also includes a 'long tail' of small non-clinical and support occupations (e.g. call and contact centre occupations; IT business analysts; and company secretaries), and a small number of large, non-clinical groups such as receptionists, cleaners and care home managers. An important characteristic of the occupational mix in health and social care is therefore its sheer diversity.

Four occupational groups account for a substantial portion (over 43 per cent) of the workforce and are central to debates on the future shape of the workforce, namely: care workers; nurses; nursing auxiliaries; and doctors.

Proposals for key occupations were reviewed and agreed by the UK Commission and ICF's Health Insights Group. Table 3.1 below shows the agreed key occupations according to the selection criteria.

Table 3.1 Selected key occupations according to selection criteria

SOC four-digit unit group	Sector	Type	Level	Size
	Health / social care	Clinical / Non-clinical	Major Occupational Group	Rank (% of workforce)
1242 Residential, day and domiciliary care managers and proprietors	Social care	Non-clinical	Management	16 (1.2%)
2211 Medical practitioners	Health	Clinical / delivery	Professional	4 (5.3%)
2221 Physiotherapists	Health	Clinical / delivery	Professional	15 (1.2%)
6141 Nursing auxiliaries and Assistants	Health	Clinical / delivery	Caring and service	3 (7.0%)
6145 Care workers and home carers	Social care	Clinical / delivery	Caring and service	1 (17.7%)

Source: ICF (workforce data based on LFS four-quarter average, Q4 2013 to Q3 2014)

3.3 Focusing the primary research on the selected occupations

Some health and social care occupations contain a range of different job titles. We therefore provided employer interviewees with descriptions of the five occupations. An overview of each of the five selected occupations is also set out below.

3.3.1 Residential, day and domiciliary care managers and proprietors (SOC1242)

Residential, Day and Domiciliary Care Managers & Proprietors encompasses managers (including principal officers / officers-in-charge) of nursing homes, care homes, residential homes, old people's homes, sheltered housing and children's homes. It also includes community centre and day centre managers, managers of residential units/rehabilitation units run by local government (social services), and residential care home owners (ONS, 2014).

This occupation was crucial for the research as it is the only group selected that is not primarily patient or service-user facing. It was also the only occupation with a core management function. Interviews were targeted to engage employers running several care homes, as well as single home owners.

3.3.2 Medical practitioners (SOC2211)

Medical Practitioners encompasses general practitioners (GPs), hospital doctors and physicians (house officers, practice registrars, speciality registrars, consultants), plus specialists such as anaesthetists, cardiologists, dermatologists, gastroenterologists, gynaecologists, neurosurgeons, obstetricians, oncologists, paediatricians, psychiatrists and forensic medical examiners. It also includes academic-oriented roles such as clinical research fellows and medical lecturers (ONS, 2014).

Given the scale of this occupational group, the large public investment made in initial training and its importance to the health and economy of the UK, doctors formed an important element of the study. Medical practitioners working in hospital settings were the focus of the primary research, as these doctors were thought likely to be facing challenges in relation to responding to key policy agendas around quality of care, seven-day working and ensuring that the overall supply of staff meets demand.

3.3.3 Physiotherapists (SOC2221)

Physiotherapists is a clearly-defined occupational group (including physiotherapists, physiotherapy practitioners and electro-therapists). The inclusion of physiotherapists provided several opportunities for the research. It is an important occupation, often playing a coordinating role for patients, supporting patients across key transition points in their care pathways and delivering care which supports patients to remain in their home rather than being admitted to hospital. As a result, the focus of the research was on the physiotherapist's role in supporting patients across transitions in care, including in community settings.

3.3.4 Nursing auxiliaries and assistants (SOC6141)

Nursing Auxiliaries and Assistants encompasses:

- Nurse auxiliaries, ancillaries, assistants and orderlies, as well as healthcare assistants and various care/clinical/health/maternity support workers
- a wide range of assistant (and attendant or helper) roles in specialist areas, including surgery, operating theatre, radiography, clinical, chiropody, sterilising, occupational therapy and dialysis assistants (among others), as well as job roles such as phlebotomists, blood donor carers/attendants and sterile services technicians (ONS, 2014).

This occupation was selected to understand:

- how the variety of roles available affects skill needs / mobility within the occupational group)
- the interaction that nursing auxiliaries have with patients and whether there are particular skill needs in relation to this part of their job, given the amount of time they spend with patients
- the expansion of the clinical tasks that policy and research suggests nursing auxiliaries are able to undertake (and the implications for quality, safety and for other health professional roles).

The main focus of the primary research interviews was on nursing auxiliaries working in hospital, as this location makes up a large proportion of the overall workforce, although interviews also included discussions of their role in non-acute settings.

3.3.5 Care workers and home carers (SOC6145)

Care Workers and Home Carers encompasses:

- Care workers (and assistants) in community and residential care, including home carers, domiciliary carers and personal carers (or assistants). It includes health, mental health and community assistants, as well as healthcare workers in nursing homes and welfare services.
- Night, invalid or charge attendants (including in old people's homes or homes for the disabled), as well as residential officers (welfare services), shelter workers, nursing home orderlies, care enablers and old people's helpers.
- Support workers, such as health support workers (in nursing homes), home support workers, night support workers, as well as specialist learning disability support workers and mental health support workers.

- Activities co-ordinators (in nursing homes, old people's homes or residential homes), hobby therapists, care visitors and befrienders in social services (ONS, 2014).

All elements of the care worker and home carer workforce were included in the interviews, given the likely interplay between roles and common skill needs. The groups above were used as prompts to gauge any differences in how employers organise and define roles, particularly within larger employers offering a range of services to people with varied care needs.

4 The sector today

4.1 Introduction

This chapter focuses on the current challenges facing the health and social care workforce from a skills perspective. The chapter begins by looking at the key characteristics of the sector, before setting out the drivers of change impacting on skills across health and social care and the evidence in relation to current skill needs.

The skills challenges at occupational level are then explored in terms of each of the five key occupations. This includes employer perspectives in relation to recruitment, retention, staff development and progression for each occupation (as well as analysis of what this means for the sector as a whole).

4.2 Sector size and key characteristics

The Annual Business Survey (ABS) estimates that there were nearly 64,000 enterprises operating in the health and social care sector in 2013, and that the number of enterprises in the sector had increased by 24 per cent since 2008 (ABS, 2014). This represented just over three per cent of the total enterprises in the UK in 2013, up from just over 2.5 per cent in 2008. It was estimated that these enterprises generated over £30 billion of GVA in 2013.

However, this only provides a partial picture of health and social care employers, and not necessarily the core sites of employment. The ABS excludes all NHS Trusts, Local Authorities and Central Government bodies, meaning it underestimates the number of employers in the sector. In 2014, there were over 500 public sector health organisations and 203 local authorities with social care responsibilities in the UK.

The health and social care sector is the largest sector by employment in the UK economy, representing over 13 per cent of total employment in the year up to September 2014. The sector currently employs a little over four million people (LFS, 2014). The number of people employed in the sector has been consistently growing, increasing by over six per cent in the last five years up to September 2014.

The workforce is predominantly female, with male workers currently representing just over 20 per cent of the health and social care sector. This ratio has remained stable over the past five years. It compares to a gender profile of males accounting for 53 per cent of the workforce in the economy as a whole.

The age profile of the health and social care sector workforce also differs from the economy as a whole. There are fewer young employees (both 16-24 and 25-34 year olds) in the health and social care sector, and proportionally more workers aged 50-64 than in the economy as a whole. This has implications for future skills retention and places something of an onus on employers to develop strategies for the replacement of retiring staff.

The percentage of the health and social care workforce aged 16-34 has remained constant over the last five years, with the only change in age profile being a decrease in the proportion of the workforce aged 30-44 and an increase in the percentage of older workers. This change has been more marked in the health and social care sector than in the economy as a whole.

The health and social care sector workforce is more highly-qualified than the workforce for the whole economy, with over half of workers (54 per cent) having a highest qualification at NQF level four or higher. This compares to 41 per cent for the economy as a whole (LFS, 2014). The sector has kept pace with rising qualification levels across the economy. As the proportion of the workforce qualified at NQF level four or higher has increased in the economy as a whole, the proportion in the health and social care sector has increased by the same amount (in percentage point terms). The qualification profile reflects the concentration of professional jobs, especially in the health sector.

Despite the fact that the health and social care sector workforce has higher qualifications than the general workforce, the average weekly earnings in health and social care are lower than the whole economy average. In 2014, average gross weekly earnings in the sector were 11 per cent lower than the whole economy average (£373 compared to £418 for the whole economy). This reflects that, alongside the concentration of professional jobs, there are a large number of lower-skilled and lower paid jobs, especially in social care.

Average earnings in the health and social care sector have been lower than the whole economy average for the last five years, and the gap between average earnings in the sector and the economy as a whole has remained at between 9 and 11 per cent for the whole period. However, this disguises some differences within the health and social care sector. Earnings in health are higher and growing faster than the economy as a whole; whereas earnings in residential and social care are well below the whole economy average, and have not grown at all over the past five years in nominal terms (ASHE, 2014).

Some of the difference in average earnings in the health and social care sector and the economy as a whole can be explained by the average number of hours worked per week by employees. Employees in health and social care work, on average, for just under 30 hours per week, whereas the average for the economy as a whole is over 32 hours per week (LFS, 2014). This reflects a substantial amount of part-time and flexible working in the sector; something that is fairly closely associated with sectors that have a predominantly female workforce.

4.3 Current policy drivers in health and social care

Analysis of the literature has identified four main drivers currently shaping skills and performance challenges in the health and social care sector (see, for example, Health Education England, 2014; Skills for Care, 2014; UKCES, 2013a; UKCES, 2013b):

- demographic change;
- social and political factors;
- technology and innovation;
- patient and service user expectation.

4.3.1 Demographic change

The increasing size and average age of the UK population has resulted in growth and change in the nature of demand for health and social care services. The UK population is projected to grow by seven per cent to 68 million between 2012 and 2022. The number of people aged over 85 is projected to increase from 1.4 million to 2.4 million by 2027, and then to 3.6 million by 2037 (Health Education England, 2014a).

The main consequence of these trends is growth in the number of people with a single or (particularly) multiple long-term condition(s). Indeed, the Department of Health (2012b) predicts that the number of people experiencing multiple long-term conditions will increase from around 1.9 million in 2008 to 2.9 million by 2018.

The changing nature of demand is affecting service delivery across the health and social care sector. Demand for beds across all care delivery sites is likely to grow. For example, analysis from the Department of Health (2010) suggested that, at any one time, two-thirds of hospital beds are in use by people over the age of 65.

Similarly, domiciliary and residential care services are affected by the changing population age profile. At 65, the likelihood of men needing *residential* care at some point in their life is 19 per cent and for women it is 34 per cent. Similarly, at 65, the likelihood of men needing *domiciliary* care at some point is 33 per cent, while for women the figure is 15 per cent (Department of Health, 2012a).

4.3.2 Social and political factors

Given the relatively large public sector employer base, the health and social care sector is heavily impacted by wider social and political trends. The first main dimension to this relates to longer-term funding challenges. For example, the Five Year Forward View – a key strategy document detailing the future of the NHS in England – sets out that:

In order to provide the comprehensive and high quality care ... [key analysts have] calculated that a combination of growing demand if met by no further annual efficiencies and flat real terms funding would produce a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21 (NHS England, 2014).

Future funding challenges have also been identified in social care. Estimates developed by the Dilnot Commission indicate that, even without reform, in order to meet future demand, public spending on social care would have to rise from £14.6 billion in 2010/11 to £23 billion by 2025/26 (Charlesworth and Thorlby, 2012).

Options for addressing these funding gaps include improving efficiency, which tends to then link directly to service design and jobs / skills. For example, the Quality Innovation, Productivity and Prevention Challenge for NHS Trusts is an attempt to make efficiency savings in the NHS.

The health and social care sector is also subject to reorganisations of services resulting from substantial legislative change. For example, the Care Act 2014 has changed the role of local authorities in managing local markets of care providers; while the Health and Social Care Act 2012 abolished several types of organisation, opened the delivery of services to a more diverse mixture of provider types, and devolved power and responsibility for commissioning of services to the professionals that deliver them (primarily to GPs).

While structural reform may seem abstract to much of the sector workforce, it is very likely to have an impact on work. For example, a recent survey undertaken on behalf of Cancer Research UK (and, hence, focused on cancer services) found that a concern for healthcare staff was that the disruption and organisational change precipitated by recent reform had led to a “hiatus” in service development over the past two years. It was reported that staff required “headspace” to undertake these improvements, as well as staff capacity, resources which had been scarce recently (Brown, Ellins *et al*, 2014).

This hints at a widespread need for health and social care staff at all levels to have skills related to resilience, dealing with uncertainty and managing change. While these are skill areas that are pertinent across many industries, it is arguable that the nature of structural reform in health and social care often places a particular emphasis on them. Unsurprisingly, reacting to reforms and to system change was a running theme in the employer interviews in both health and social care.

4.3.3 Technology and innovation.

Changes to health and social care services are often driven by technological innovations, such as breakthroughs in medical science contributing to the advancement of treatments (Centre for Workforce Intelligence, 2013). Technological innovations have altered the type of care people receive and changed the level of demand for certain resources

For example, the number of in-patients has decreased over time, from around 180,000 in 1987/88 to around 120,000 in 2009/10. This has been attributed, in part, to advances in medical treatment, reducing the number of bed days and need for acute hospital care (Department of Health, 2010b). The implications are a long-term change in the balance of staff based in acute settings versus those in the community and increasing demand for medical generalists and specialists to work together with patients.

Advances in new medical and information technologies also put greater power in the hands of patients, changing *how* care and treatment is delivered, *where* it is delivered and *who* it is delivered by. For example, new devices for people with circulatory diseases allow patients to monitor their conditions and manage their medication at home, away from busy outpatient services (Imison and Bohmer, 2013).

The way that patient data are managed is also changing. The King's Fund's major programme of work examining future trends in health and social care service delivery, 'Time to Think Differently', predicts that by 2017 the use of electronic health records in most health and social care settings is likely to be routine (King's Fund 2014). This raises questions about how individuals can access and manage their own records (and by implication their own health).

In this context, the dynamics of patient engagement is changing. The role of clinicians and other health and social care staff is increasingly to enable patients and service users to manage their own health, as opposed to delivering curative care interventions. This change, which has been heralded in the health sector for over a decade, is arguably one of the most transformative for skill requirements across the sector as a whole

Innovations in technology and particular areas of medicine such as genomics may be especially influential. For example, advances in genomics are likely to enable patients to understand, in far greater detail, the illnesses and conditions they are most at risk of developing. There are initiatives in place at present which aim to raise awareness of genomics among non-specialist healthcare staff (Health Education England, 2014c). This supports a shift in services towards prevention of disease as opposed to the more reactive current model.

Technological advancements are also likely to play a role in future social care delivery. Currently, the use of care technology in the home is limited, however 'assistive technologies' are likely to become more common. Assistive technologies can help provide support to patients in their own homes at a time when human resources are stretched. This further embeds new skill requirements, as staff are required to act as enablers rather than direct carers (VODG and NCF, 2013). The Centre for Workforce Intelligence's Horizon Scanning programme notes that:

"Technology will allow staff to assess, diagnose, gain specialist advice, access multidisciplinary notes from all those involved, deliver drug treatments and monitor their effects, etc. to manage and deliver comprehensive home-based care safely and effectively. This may have implications on staff training" (Centre for Workforce Intelligence 2013b).

4.3.4 Patient and service user expectation

There is a growing focus on quality of care in the sector. The skills and attitudes of staff who deliver services are under greater scrutiny than ever. Partly initiated by the Francis Report, which was the result of a public enquiry into failings of staff and management at Mid-Staffordshire NHS Foundation Trust, the focus on the competencies and character of those who work in health and social care has grown.

The report made numerous recommendations, including improving standards of care and prioritising patient need. It also made specific reference to the NHS Constitution, calling for an ethos of 'putting patients first' to be embedded in all activities carried out by NHS staff (Francis, 2013).

There has also been a growing expectation from patients over the last decade that they can and should be involved in their care. There have been moves to increase patient choice and control, their access to information, and delivering patient-centred health and social care services. This has manifested itself in three main ways (under the broad umbrella of person-centred services):

- **Improving the patient experience of care.** The patient experience is increasingly recognised as a core means of defining the quality of healthcare, measured using tools such as the National Cancer Patient Experience Survey (NCPES) and the NHS Inpatient Survey. It is also increasingly linked to payments and incentives. For example, the CQUIN framework² ties a small proportion of providers' income to the delivery of a good patient care experience.
- **Encouraging patients to participate in their own treatment and care.** Practical programmes such as Co-Creating Health and the Year of Care focus on increasing the opportunities and ability for people to self-manage long-term conditions, to make shared decisions about their treatment with clinicians and to plan their care.
- **Involving patients in the design, delivery and improvement of services.** Patients have become more involved in service design through consumer champions such as HealthWatch.

User involvement in services has a more established tradition in the social care setting. The Government has legislated to afford people greater control over the care they receive. For example, personalised budgets present service users with the opportunity to choose how they receive and manage funding to pay for social care services and support (Age UK, 2012). While professionals still have an input into people's care and need to approve spending choices, decisions are increasingly made collaboratively, allowing both parties to understand the motivations behind the choices and decisions that are made. This has skills implications for care providers, such as the need to support people in developing care plans.

4.4 Skills challenges at sector level

This section analyses the UK Commission's Employer Skills Survey (UKCESS) 2013 to set out the scale and nature of skills challenges reported by health and social care employers, as well as to benchmark the sector against the UK economy as a whole. Additional data from UKCESS 2013 is included in Appendix E.

4.4.1 Hard-to-fill (HtF) Vacancies

In 2013, just under 30,000 employers in the health and social care sector across the UK reported that they had at least one vacancy (23 per cent of employers in the sector). The share of health and social care employers in Northern Ireland with at least one vacancy was slightly lower (18 per cent).

² The CQUIN payment framework, introduced in 2009/10, links a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

The proportion of health and social care employers with at least one vacancy has grown since 2011 and is higher than for the UK economy as a whole (15 per cent in 2013). The average number of vacancies per employer in health and social care is also higher than for the economy as a whole. In part, this simply reflects that the sector is growing and so employers are expanding their workforces.

Employers reported that most vacancies were relatively straightforward to fill. However, around seven per cent of employers in the health and social care sector in the UK had at least one hard to fill (HtF) vacancy in 2013 (compared to five per cent for the economy as a whole). The share of health and social care employers reporting HtF vacancies increased between 2011 and 2013, and at a faster rate than for the economy as a whole (see Table 4.1). The proportion of employers reporting HtF vacancies was greater in England (eight per cent) than in other UK countries. Wales had the lowest proportion of employers reporting HtF vacancies (three per cent).

Caring, leisure and service staff' account for just over half of all HtF vacancies in the health and social care sector, compared to only 19 per cent for the economy as a whole. This is unsurprising given recruitment challenges for some lower-grade health and social care jobs, usually characterised by low pay, unpredictable hours, and poor career progression and job security. It also partly reflects the size of that occupational group compared to other groups. 'Professionals' account for just over a quarter of all HtF vacancies in health and social care (compared to a fifth of HtF in the overall economy).

Table 4.1 Hard to Fill vacancies in the health and social care sector

	Total economy		Health and Social Care	
	2011	2013	2011	2013
Number of employers with at least one HtF Vacancy	77,900	89,700	6,300	9,700
Percentage of employers with at least one HtF vacancy	4%	5%	5%	7%
Percentage of employers with at least one vacancy, who have at least one HtF vacancy	32%	35%	26%	33%
Average number of HtF vacancies per Employer	0.1	0.1	0.1	0.2
Average number of HtF vacancies per employer with vacancies	0.5	0.7	0.4	0.9
Average number of HtF vacancies per employer with HtF vacancies	1.6	2.1	1.7	2.6
Total number of reported HtF vacancies	127,800	189,300	10,700	26,200
HtF vacancies as a percentage of Employment	1%	1%	0%	1%
HtF vacancies as a percentage of Vacancies	22%	29%	17%	30%

Source: UKCES Employer Skills Survey, 2013

4.4.2 Skills shortage vacancies (SSVs)

Just under 7,000 employers (five per cent) in the health and social care sector reported a skills shortage vacancy³ (SSV) in the UK in 2013 (see Table 4.2). ‘Caring, leisure and other services staff’ accounted for nearly 60 per cent of SSVs in health and social care. This reflects the occupational distribution of the sector.

Table 4.2 SSVs in the health and social care sector

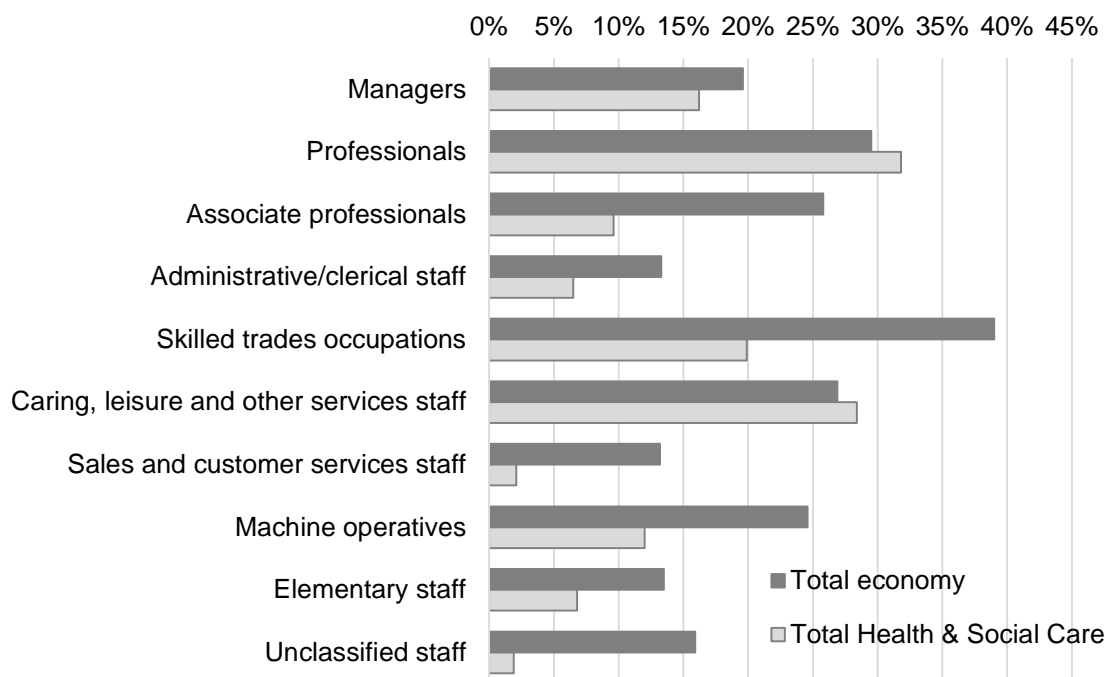
	Total economy		Health and Social Care	
	2011	2013	2011	2013
Number of employers with at least one SSV	59,300	70,500	3,800	6,700
Percentage of employers with at least one SSV	3%	4%	3%	5%
Percentage of employers with at least one vacancy, who have at least one SSV	25%	27%	16%	23%
Average number of SSVs per employer	0.1	0.1	0.1	0.1
Average number of SSVs per employer with vacancies	0.4	0.6	0.3	0.7
Average number of SSVs per employer with HtF vacancies	1.2	1.6	1.1	2.0
Average number of SSVs per employer with SSVs	1.5	2.1	1.7	2.9
Total number of reported SSVs	91,500	146,200	6,600	19,200
Percentage of vacancies reported as SSVs	16%	22%	10%	22%
Percentage of HtF vacancies reported as SSVs	72%	77%	62%	74%

Source: UKCES Employer Skills Survey, 2013

Controlling for the size of each occupational group within the sector, the density of SSVs in health and social care is highest among ‘professionals’, although this is only marginally above the economy as a whole (see Figure 4.1).

³ A skills shortage vacancy is a vacancy that is difficult to fill due to the establishment not being able to find applicants with the appropriate skills, qualifications or experience.

Figure 4.1 Density of SSVs by occupation, 2013



Source: UKCES Employer Skills Survey, 2013

In terms of the main reasons for SSVs, technical, practical or job specific skills appear to be slightly less of an issue for health and social care employers compared to the economy as a whole (Table E.2).

4.4.3 Skills gaps

Around 19 per cent of health and social care employers reported having skills gaps⁴ in 2013 (see Table 4.3). There is a concentration of skills gaps within certain geographic areas. In Scotland, 29 per cent of health and social care employers in the sector reported having skills gaps, compared to 13 per cent of employers in Northern Ireland.

In total, 144,000 health and social care staff were classed as ‘not fully proficient’ (four per cent of the workforce in the sector compared to five per cent in the whole economy). ‘Caring, leisure and other services staff’ correspond to 55 per cent of all health and social care skills gaps. However, ‘sales/customer service staff’ have the highest density of skills gaps compared to the economy as whole, reflecting that this is a relatively niche element of health and social care employment and possibly an area in which employers struggle to develop the skills of staff (Figure E.1).

⁴ A “skills gap” is where an employee is not fully proficient, i.e. is not able to do their job to the required level.

The introduction of new working practices is a more common cause of skills gaps in health and social care than elsewhere (Table E.3). This reflects the substantial change in health and social care work organisation, including re-structuring of services. The main impact of skills gaps tends to be an increased workload for other staff (Figure E.2).

There is a slight concentration of skills deficiencies in health and social care relating to planning and organisational skills and to team working skills (Table E.4). This may reflect an increased focus among employers on these areas, which arguably underpin many of the reforms within the sector. Health and social care employers are also more likely than employers elsewhere to take specific steps to tackle skills gaps (Table E.5).

Table 4.3 Skills Gaps in the health and social care sector

	Total economy		Health and Social Care	
	2011	2013	2011	2013
Number of employers with skills gaps	295,400	268,200	24,200	24,200
Percentage of employers with skills gaps	17%	15%	20%	19%
Number of staff who are not fully proficient	1,485,500	1,409,900	180,200	143,600
Percentage of staff who are not fully proficient	6%	5%	5%	4%
Average number of skills gaps per employer	0.9	0.8	1.5	1.1
Average number of skills gaps per employer with skills gaps	5.0	5.3	7.5	5.9

Source: UKCES Employer Skills Survey, 2013

4.4.4 Training provided

In 2013, nearly 120,000 establishments in the health and social care sector in the UK provided training in the last year. This is the equivalent to nearly 90 per cent of establishments in the sector, compared to only 66 per cent of establishments in the economy as a whole. Employers in Scotland were the most likely to provide training, with 95 per cent of sector establishments providing training, compared to 88-89 per cent of establishments in the other UK nations.

The large majority (70 per cent) of employers providing training offered both on-the-job and off-the-job training. Compared to the whole economy (53 per cent), employers in the health and social care sector were much more likely to offer both types of training. The large majority of employers in the sector offering training provided job-specific training and health and safety/first aid training (Figure D.3).

Overall investment in training by health and social care employers remained static from 2011 to 2013 (see Table 4.4). The average spend per trainee declined, although spend per employee was more stable – indicating that, as in the economy as whole, training investment is being spread across a wider cross-section of the workforce. The main reasons why employers did not offer more training both within Health and Social Care and the whole economy were:

- lack of funds for training/training expensive (69 per cent)
- being unable to spare more staff time / having them away on training (48 per cent)
- that it was hard to find the time to organise training (13 per cent).

Table 4.4 Training opportunities in the health and social care sector

	Total economy		Health and Social Care	
	2011	2013	2011	2013
Number of employers providing training in the past 12 months	1,140,800	1,147,800	109,600	116,100
Percentage of employers providing training in the past 12 months	65%	66%	89%	89%
Average number of training days per trainee	7.8	6.7	7.9	6.6
Average number of training days per staff member	4.2	4.2	5.2	5.3
Total spending on training	£45.3bn	£42.9bn	£5.1bn	£5.1bn
Spend per trainee	£3,080	£2,550	£2,190	£1,790
Spend per employee	£1,680	£1,590	£1,450	£1,420

Source: UKCES Employer Skills Survey, 2013

4.5 Skills challenges at occupational level

The sector-wide picture cannot reflect the nature of skills challenges at a detailed level. Current skills challenges at occupational level were also examined as part of the literature review and provided a major focus within the primary research with employers and sector stakeholders.

4.5.1 Care workers and home carers

Care workers and home carers are responsible for providing care and support in the UK's residential, nursing care homes, sheltered housing and children's homes. These homes typically specialise in offering personal and nursing care and support to specific client groups, such as older people, people with mental health problems, people with learning disabilities, young adults, people who are terminally ill and people with physical disabilities.

Recent government reviews (Cavendish, 2013; Francis, 2013) have noted the importance of, and increased the scrutiny on, the skills and competencies of care assistants. It is a large occupational group. Cavendish notes that the social care support workforce “dwarfs that of health” (2013, p. 14). Cavendish also emphasises that it is a skilled occupation and that care assistants are typically the staff that are expected to:

“Work the most independently, walking into the homes of strangers, and have to tackle what they find there, without any supervision. Calling this ‘basic care’ does not reflect the fact that it is a deeply skilled task” (2013, p 22).

This neatly summarises the fundamental skills challenge faced by employer interviewees: the tension between an increasingly complex skills mix required of care workers and their labour market position. Increased demand for skills results from increased scrutiny on the role, as well as increasing ‘customer’ expectations. Exploring current skills challenges with employers, it is clear that wider issues relating to the job role (such as pay, status, and working conditions) inhibit employers’ ability to recruit effectively-trained staff.

The occupational group can be split by the setting in which care is delivered. This can include service users’ homes, residential care and nursing homes, day care centres, rehabilitation facilities and other settings. Interviewees confirmed that the skills required of these workers are accordingly varied, putting a substantial onus on employers to quickly develop new entrants.

While the core skills for this occupation were reported to be centred on the provision of personal care to those in need of these services, interviewees also reported that care assistants can specialise in particular areas of need. This includes specialisms in dementia, learning disabilities, as well as more rehabilitation-focused role. It was noted that this specialisation was common from an early stage in an individual’s career and typically reflects the team to which the individual is assigned.

While care working is clearly centred on a transferable skill set, the need for specialist skills according to service user group should not be underestimated. In this sense, the evolution of care worker roles mirrors that of other health and social care occupations – notably nursing auxiliary roles. The difference is that investment in specialist ‘training’ among care workers is less formalised and does not precede entry into a role. It occurs in a more ad hoc fashion and is arguably less a career choice for the individual than elsewhere in health and social care.

Another key aspect of ensuring that staff are working safely is to ensure language proficiency. As demand for care workers increases, a key likely source of recruits will be foreign nationals. Skills for Care (2011) reported that 17% of the adult social care workforce is non-British. The proportions are particularly high within private sector providers and nursing home providers. These workers tend to be younger and are more likely to have flexible working arrangements.

There are two potential consequences of this (growing) reliance on migrant labour, both of which were echoed in employer interviews. First, reduced net migration may impact on the supply of staff. Second, employers report an increased need to test and develop literacy skills (particularly in relation to the more clinical aspects of the role).

The major skill challenge for employers of care assistants, in the face of growing demand for the role, is recruiting and retaining suitable individuals. As a result, there is a growing focus on recruiting individuals with appropriate skills and values, inducting them into care teams, and training them on an ongoing basis to provide safe and high-quality care to service users.

In line with national policy in this area, several interviewees emphasised their attempts to recruit for particular values (“empathy”, “delivering person-centred care”, and “resilience” were notable and frequent examples of these values). This focus on assessing the ‘values’ of potential staff during recruitment (over and above more quantifiable criteria such as qualifications and experience) arguably increases risk for employers. Interviewees reported that these values are difficult to assess.

This is a challenge being faced across the sector, but it is perhaps amplified in the context of care worker roles. It certainly underpins a need for support in being able to make judgements as systematically as possible. Health Education England is also developing the evidence base on what works in this area and employers report that guidance in this area would be valued.

A range of other barriers to high-quality recruitment were noted by employers:

- Employers in rural areas noted that difficulties in travelling to work cut down the pool of potential applicants (“People aren’t prepared to travel for these jobs”). This reflects that care workers are widely geographically-dispersed, which is typical of high volume health and social care roles.

- Applicants lacking appropriate competencies / attitude for the job being referred by employment support agencies. One employer reported that applicants are “well supported” or “coached” by agencies to respond most effectively to the likely questions asked by employers. This highlights the need for employers to be able to effectively screen applicants, something that interviewees were not necessarily confident to do.
- Applicants do not have the relevant employment paperwork attached to their application. Employers reported that it was sometimes difficult to follow-up on references for new recruits (largely due to the short-term nature of much of the employment in the sector), or to get certificates and other proofs of completion of training.

An important general theme mentioned by employers discussing the challenges of high-quality recruitment related to the public image of the social care jobs. There are two main dimensions to this:

- Employers reported competing against overriding negativity surrounding the social care workforce and lower-level caring roles in particular (partly attributed to recent scandals in social care). This is thought to be actually reducing the number of high-quality applicants for many roles at a time of increased need.
- A second interpretation is that the occupation is perceived as low-skilled with few progression opportunities. One domiciliary care employer reported that: “They [domiciliary care workers] are often still thought of as ‘home helps’... this is an old-fashioned phrased for care workers – it persists and is unhelpful”.

Several employers noted that the reputational issues for care assistants were highlighted most starkly when they were part of joint teams with NHS staff, who are perceived to receive better pay, benefits and progression opportunities, despite carrying out similar tasks in many cases. As these staff work together more often in future (a likely future scenario), there are risks and opportunities for the sector.

The NHS is one of the key destinations for staff leaving social care and increased joint working may increase the flow of staff from social care to health. Equally, as teams increasingly merge, there may be increased learning opportunities or shared delivery of training. An employer from the domiciliary care sector outlined how it benefits from relationships with the local college and hospital NHS trust to access NHS training for staff that would otherwise be unavailable. It was reported that these training courses had supported care assistant staff to develop leadership skills and progress within the organisation.

Several employers highlighted challenges with retaining staff. Key structural barriers well-known by policy makers were noted (for example, the generally low levels of pay). As a result, employers report that benefits are important to staff when thinking about longer-term career prospects (“perks are important in this role”). There is a perception that larger companies may be better-placed to offer these benefits (including those outside the social care sector, such as large retail firms). Similarly, marginal changes in hourly payment rates can affect retention.

Other factors, such as the time spent travelling to work, zero hours contracts, and pension arrangements were also highlighted as affecting retention rates. These are not necessarily skills issues, but nonetheless are important structural challenges facing the sector and widely felt by employers to contribute to churn in the workforce.

One of the key factors identified as contributing to the retention of high-quality staff was the nature of the work itself and the satisfaction derived from delivering care. However, a few interviewees felt that this had been eroded in recent years due to cost pressures. This has reduced the average amount of time available to care workers to spend with a service user. Furthermore, in an agency delivery model, there was often reportedly a lack of continuity between carer and service user.

These issues are most apparent in domiciliary care services, although are also present in residential care. They arguably serve to weaken an important area of job satisfaction for care workers, posing a further challenge to retaining skills in the sector (in addition to the well-known structural issues of status and pay).

These challenges also relate to the ‘culture’ of employers and the wider sector. The notion of the culture of an employer and the impact that this can have on outcomes for service users was identified as a key cause of poor care in the Francis Enquiry and Cavendish Review. As has been noted, it was cited by several employers as a barrier to quality recruitment and retention. However, poor occupational culture was also seen by interviewees as a factor which reduces scope for change. This is certainly the case for many of the care assistant employers interviewed for this study.

Progression was also identified as an ongoing skill challenge. Across different parts of the social care workforce, bottlenecks were reported, partly because of a limited number of potential career choices (“We struggle with offering a clear pathway for people who don’t want to be a registered manager”) and partly due to an overly-high level of demand for progression. One employer reported that it offered progression to ‘senior care worker’; however, there are relatively few of these opportunities per care worker.

Many of the challenges outlined here are likely to be relevant for the wider health and social care sector, particularly some of the lower band roles in the health workforce (as reflected on in section 4.5.5). There is no shortage of policy responses and employers were generally quite aware of activity taking place at this level.

There are high hopes, in particular, for the emerging Care Certificate. This new induction training course, which has been developed by Skills for Health, Skills for Care and Health Education England, will provide new care assistants (and nursing auxiliaries) with a common 12-week induction programme. The intention is for the certificate to homogenise induction training. Social care employers emphasised their desire for the certificate to cover staff providing personal care services (including aspects such moving and manual handling), as well as those staff delivering more clinically-focused care (i.e. for a health employer).

4.5.2 Care home managers and proprietors

Care home managers and proprietors are responsible for the day-to-day running of the UK's residential, nursing care homes, sheltered housing and children's homes including overseeing the work of care workers and home carers.

Interviewees emphasised that the role has two main functions. The first is that care home managers and proprietors are also often the 'Registered Manager' for the premises. The Care Quality Commission has undertaken research emphasising the importance of this key regulatory function. It found that the differences in quality of care between care homes with a Registered Manager and those without one were "stark... Care homes with a Registered Manager in place were much better at meeting quality standards than those homes without a manager in place for six months" (Care Quality Commission, 2013).

Due to the importance of this role (both to the safety and quality of care delivered, and the success of businesses delivering care), there are stringent requirements relating to an individual's character and skillset. The CQC requires a registered manager to have a track record of working in a range of care and support settings. They must also have expertise and experience in safeguarding (CQC, 2013). They should:

Be of good character ... have the qualifications, knowledge and experience to manage the regulated activity... appropriately skilled including... effective communication skills to enable good communication with their staff and the people who use their service and basic management skills to ensure that the service is delivered to meet essential standards of quality and safety (CQC, 2010).

Interviewees' comments about the skills required for this occupation chimed with the CQC's description. A care home manager needs to be, in the words of one employer, a "jack of all trades". At the core of the role is "understanding the needs of residents" and therefore a background in caring or nursing is deemed essential.

The second function of the occupation emphasised by several interviewees is that care home managers and proprietors (particularly those who manage a single or a small number of homes), require strong commercial skills in order to sell the beds and maintain a viable business.

Current skills priorities for care home managers and proprietors very much stem from the two main functions of the role. Most interviewees emphasised that regulation was the key skill driver in practice. Typical comments included: "satisfying the regulator is the key skills challenge... you've got to record it and record it again," and, "[The role of care home manager] will become ever more dependent on paper".

Interviewees noted that responsibility for other regulations such as health and safety, employment law, safe staffing, and Deprivation of Liberty Safeguards and the Mental Capacity Act are also encompassed within the role. Retaining an up-to-date knowledge of these areas was reported to require a substantial personal development for care home managers, particularly as they are often responsible for the subsequent training of their own staff in these areas.

Interviewees also noted that skills relating to the commercial function of the role have become increasingly important. This is a result of tightening public funding, which interviewees suggest has driven down prices paid by local authorities. Key metrics, such as level of bed occupancy, the mix between private- and local authority-funded service users, and successful staff recruitment and retention, have taken on even greater importance.

The skills implications are that care home managers have to retain a focus on running a business, as well as delivering care. This is described as something of a balancing act. They require an understanding of the market for their services, the funding available from different types of purchaser and to ensure they have a balanced customer base. In this respect, the care home manager occupation is quite unlike the other key occupations. The unique nature of the role was commented on by most interviewees.

Interviewees reported that care home managers are typically promoted from within, particularly among small employers. A couple of interviewees noted that progression from senior care worker into a care home manager was a large step. A level 5 qualification in leadership and management of care services is required and this takes time and funding, which is not always readily available from the employer.

Larger employers reported developing more formal training academies to support the development of team leaders and care home managers. Employers report a relatively limited pool for selection because:

- Leadership skills often require development. Specifically, there is a need to develop individuals' abilities (and interests) to lead projects to redesign services.
- Literacy and numeracy were highlighted as a potential gap.

4.5.3 Physiotherapists

Physiotherapists operate across the health and social care economy. They work in teams ranging from those based in local authority home care services to teams meeting highly-acute care needs in tertiary hospital settings. One interviewee described the wide range of patient needs that physiotherapists can meet: “[They] are an essential part of healthcare, not just in acute settings but helping patients with long-term conditions”.

Physiotherapists deliver a range of services from initial assessment and diagnosis, optimising medication, providing advice and information to patients and families, through to treatment and discharge. As an allied health profession, physiotherapists are distinct from the nursing and medical workforce. As a result, they often operate as integral components of multi-disciplinary care teams, offering support for patients with numerous care needs. As such, they are a crucial part of meeting the current nature of demand for care; and arguably therefore provide something of a template in terms of what a multi-disciplinary care skillset looks like.

It was reported by several interviewees that there is a degree of homogeneity between the required skills mix and functions of physiotherapists and some of the other allied health professions. This relates to commonalities in working patterns, which involve delivering care in varied settings, and supporting a range of patient needs. Occupational therapy professionals, in particular, were reported to be facing similar skills and performance challenges.

Employers emphasised that physiotherapists contribute to a wide range of positive health outcomes (which also provide savings to the health and social care system). For example, a crucial and growing role for this occupational group is to support discharge from hospital into a community setting or a patient's home, and to reduce the likelihood of readmission to hospital. Physiotherapists also play a role in supporting people to return to / stay in work (or to make assessments as to whether this outcome is feasible).

As a result, there is scope for the role to expand beyond traditional healthcare provision, and to diversify the types of organisations employing physiotherapists. This potential dispersal of physiotherapist employment creates a challenge to having common employer approaches to supporting skills development. Associated risks are, however, somewhat mitigated by the fact that it is a regulated occupation.

Interviewees emphasised the different skill challenges facing physiotherapists based in community locations relative to acute settings. In general, interviewees reported that jobs in acute settings are more popular and easier to recruit into. This was reported to be particularly the case immediately following professional registration. "Skills consolidation" is deemed to be important by newly-qualified physiotherapists. It is also felt to be easier to achieve in acute settings, as a result of the likely greater acuity of patient need faced on a day-to-day basis and the more senior physiotherapy and medical support available for clinical oversight and mentoring.

However, interviewees also noted that demand for community provision relative to that offered in acute settings is growing. As a consequence, skills in working independently and developing confidence in making clinical judgements are becoming increasingly important. It was felt that, at present, many education programmes do not provide sufficient training in this area (for example, there are insufficient community-based clinical placements during pre-registration training).

In community settings, there is a growing role for physiotherapists to provide 'reablement' services (care and rehabilitation to support people who may have been in hospital to return to their usual activities following illness or injury), often working closely with or for social care providers. Physiotherapists delivering these services need to retain a generalist skillset in order to be able to provide care for patients with numerous health concerns. In effect, these physiotherapists need to be able to "view the patient as a whole".

In this reablement context, the physiotherapists' links with other occupations were noted. The ability to work effectively alongside non-clinically qualified staff in support roles (such as nursing auxiliary posts operating in the community) is likely to become increasingly important. In this context, while physiotherapist leads the reablement service, support workers are integral to its delivery.

Employers also provided perspectives on the supply of newly-trained physiotherapists noting that after a period in which newly-qualified physiotherapists were in high supply, there are now fewer applicants for jobs. This perception is backed up by a model developed by the Centre for Workforce Intelligence in 2010, which suggested that: “if current commissioning levels are maintained, the supply of physiotherapists in the NHS is forecast to plateau, increasing slightly over the next five years and slightly decreasing from 2015” (Beddow, 2010).

The NHS physiotherapy workforce is relatively young (in comparison to other clinical areas, such as nursing) meaning that there is no impending bulge in retirements. This may have contributed to interviewees reporting that career progression has flattened out, with professionals sitting longer at each band (which in themselves are viewed as being quite broad) and that there are fewer top jobs available.

Several interviewees also reported challenges with skills development at higher levels of the occupation. While CPD opportunities are generally thought to be available, several barriers to accessing them were identified. These include professionals at times having to fund the training themselves and to undertake courses in their own time. Arguably these challenges are common to most or all regulated health professions.

More significantly, the lack of a formal national structure for career development into ‘extended scope’ roles was noted. Typical comments included: “there isn’t really a career structure in place to take physiotherapists to the next level” and “there is a dearth of post-registration CPD opportunities that link to the needs of the labour market.”

Employers outlined that these extended scope practitioner roles allow physiotherapists to specialise within particular areas of practice (such as providing therapy and support for particular parts of the body or clinical needs) or moving into areas reported to be outside of their traditionally-defined roles. This can include radiology and independent prescribing, as well as other tasks handled by medical practitioners.

A couple of interviewees noted that they thought there was need for better national guidance and regulation on the definitions of these extended roles and development pathways to them. This would enable the production of job descriptions, progression pathways, training opportunities and to have additional qualifications recognised by different intra-physiotherapy specialist areas and other employers. Other interviewees disagreed and argued that fluid CPD structures are integral for the extended practitioner role, as it allows them to flexibly pursue their research and clinical interests.

4.5.4 Medical practitioners

Interviewees outlined the vital role doctors play in the delivery of healthcare services. They retain oversight over all aspects of medical care. They are responsible for diagnosis, setting a treatment and management plan and delivering key interventions. Doctors are also involved in medical education, research, service development and leadership roles within organisations.

The interviews focused primarily on specialist medical practitioners – doctors who, following completion of their medical degree, enter a training programme which, on completion, qualifies them for a consultant post. In order to manage the breadth of potential comments, general practice was omitted, given the likely differing skill challenges faced by this group.

However, given the obvious links, general practitioners' skill challenges were raised in some interviews. Indeed several interviewees noted that a current (and likely future) shortage of general practitioners was one of the key skills challenges facing the occupation at present.

Skills development in the medical profession is characterised by supporting doctors, after qualifying, to develop increasingly-specialised skills. This training period can last from seven years to more than a decade and culminates in a specialist consultant post. The post-graduate training period is generally shorter for those entering general practice.

The main debates about the development of the medical profession relate to exactly *how specialised* doctors should become within specialist areas. The current post-graduate training system is viewed as being designed to equip medical practitioners with the technical knowledge of medication, interactions and surgery to a highly-specialised level.

Some interviewees argued that this highly-specialist skill set may not be appropriate for all patients with multiple long-term conditions. They highlighted that patients increasingly demand that their carers view their needs holistically. Doctors, as the leaders of most care plans, need to ensure they can meet this demand. Three interviewees from different specialist areas, reported:

Secondary healthcare is fixed around large buildings with very specialised people working within [them]; the needs of the population do not fit with this type of healthcare provision.

The patients are not just [their] cancer, they have a whole life and they have other things wrong with them. They also want holistic care and they also get complications with treatment and drugs... so we are thinking of trying to appoint in the future not oncologists but general physicians to help manage the holistic care of people with cancer who may also have heart disease and diabetes.

I think it's the patient, because that's what we are here for at the end of the day...Because our patients are older and more complex – they have multiple pathology, they have poly-pharmacy, they are often on 10/12 medications for 4 or 5 pathologies.

Another interviewee reflected how the training system may need to adapt to meet these changing needs:

The wheel is turning and we probably need to broaden training so that people are able to look at a patients more holistically than we have trained them to do in the last ten years... I would envisage that they need more core skills training before they split and go into their speciality.

However, other interviewees presented an alternative argument, noting that a continued drive towards specialist training is necessary to drive the development of services. Indeed, while an overriding theme across all employer interviews was that there is a need to equip staff to deliver care outside of hospitals, there is a parallel countervailing move: in future there are likely to be larger specialist hospitals and the highly-specialist care delivered in these settings will require a continued supply of advanced specialist doctors.

There is therefore something of a tension between the drivers for medical advancement and those of patient expectations. A key challenge for the medical profession is to ensure that, from a skills perspective, this does not lead to a false opposition between specialist experts and the 'holistic doctor'.

Policy makers have responded to this ongoing debate. Several interviewees noted the potential impact of the 'Shape of Training' review, which reported in 2013 and proposed a shorter post-graduate training period for doctors (from a minimum of eight to ten years to a minimum of six to eight years). The review suggested that this would lead to doctors developing skills in broader specialist areas (such as children's health, mental health), with an option for doctors to continue their training to develop the speciality and sub-speciality skills which characterise the occupation currently (Greenaway, 2014).

The potential impact of these reforms is not yet known. However, several interviewees reported that, in addition to developing a cohort of specialist doctors with slightly broader skillsets, it will make the process of workforce planning – identified by most interviewees as among their most significant challenges – more straightforward.

At present, interviewees (primarily senior medical directors responsible for ensuring that their organisations have sufficient consultants and junior doctors in post) face difficulties in balancing the likely demand for these staff, which reflects the healthcare needs of the local population, and the supply of post-graduate doctors. This is challenging given that predicting future demand requires a thorough understanding of the epidemiology of the local population and the range of other services which could provide care (from primary care through to tertiary centres).

Predicting the supply of future specialist doctors also depends on several other factors, including:

- The choice of specialism taken by post-graduates. This is, in itself, influenced by each individual's academic interests, the likely future remuneration (from private and NHS practice) of different specialist clinical areas, and other more pragmatic factors such as the level of “predictable and controllable hours” that a specialist area will provide. The nature of patient need in certain specialist areas means that more services can be delivered in a normal working week. Dermatology was cited by interviewees as an example of this. Labour market considerations were also cited as a factor in this decision, including whether there are jobs available locally.
- The length of time taken by junior doctors to complete their training. This varies depending on leave taken (for example, for starting a family or for other reasons) and the number of hours worked per week. A few interviewees reported a noticeable increase in flexible training / working requests in recent years, anecdotally reported as the result of an increased number of female doctors and a younger age profile.
- Changing technologies mean that predicting future treatment options (and subsequent workforce implications) is difficult. As one interviewee noted: “It [medicine] is a fast-changing field, there are new discoveries every week, so it is quite hard to predict the specialisms we will need.”

As a consequence of the difficulty of balancing supply and demand, two interviewees summarised that: “in terms of workforce planning, we are probably already behind the curve” and “in workforce planning terms, it’s a nightmare to plan 10 years in advance”. This is not a new challenge within the health and social care sector, but emphasises the importance of ensuring that career paths do not become too rigid and a very early stage.

One of the main responses to variation in supply of specialist and trainee doctors is the use of locum staff to fill gaps. Most interviewees involved in workforce planning identified the use of locum medical staff as an ongoing issue (particularly in assuring the quality of care delivered and the financial expense of their use). Given the magnitude (and likely intractability) of the challenge of accurately modelling the future demand for and supply of medical professionals, other interviewees noted that this issue should be examined more closely by policy makers. There are likely to be a proportion of medical professionals who are very happy to act as locums in the longer-term. Ensuring that this career path is valid and supported may be an area for future action.

4.5.5 Nursing auxiliaries and assistants

The nursing auxiliary role ranges in both the skill levels required (commonly understood as bands 1 to 4 of the Agenda for Change framework used in England) and the areas of care they work in (including primary, community and acute settings, and provision of support for all nursing and allied health professions). Interviewees described that this occupational group plays a crucial role in delivering the majority of face-to-face care with patients:

It is them the patients tend to speak to... they are generally from the locality... they're more visible and accessible... patients often say 'I didn't want to bother the doctor or nurse;' which is why they have the relationship with the HCAs.

Nursing auxiliaries work with a range of registered nurses and allied health professions. They are reported to provide crucial support to these registered professions. For example, one interviewee noted that “nurses simply couldn't function without them... Nurses often say “they are our eyes and ears. ”

The occupational group has evolved substantially over recent decades. It was previously focused primarily on provision of personal care and support; providing for daily care needs such as feeding, hygiene, routine observations. Now, in addition to these tasks, the more senior levels of this occupational group, which have developed over the last decade (termed band 4 or Assistant / Associate Practitioners), undertake a range of clinical tasks which were previously the responsibility of the nursing or allied health profession staff they support.

This expanded role generally follows extensive training provided by the employer and is reflective of service demand. However, these professionals do not hold the same accountability, or regulatory status, as a registered nurse. Indeed a major skills debate in the context of nursing auxiliaries relates to whether and how this role could be regulated. Given that it crosses several clinical areas (including nursing and the allied health professions), which of the existing regulators could take on responsibility for these more senior nursing auxiliary roles is also in question.

As with the care assistant role, this occupation has come under increased scrutiny due to the policy focus on the lower level, patient / service user-facing roles. One of the key findings of the Cavendish Review was that:

“If the NHS wants to improve patient care, it should see healthcare assistants as a critical, strategic resource.” (2013, p. 6)

In general, employers noted that recruitment is a fairly straightforward process in terms of “getting the correct number of people in”. However, ensuring that new entrants have the correct values and skills can be challenging. Health Education England is leading a major national initiative to implement a values-based recruitment approach (linked to a similar set of resources being developed for care assistants as outlined in section 4.5.1).

Employers also noted an important geographic component to recruitment. The nursing auxiliary workforce is reportedly less mobile than other members of the healthcare workforce and so employers in rural areas, for example, often struggle to recruit adequate numbers. Again, this echoes some of the challenges faced in social care.

Several interviewees also noted that the nursing auxiliary workforce is ageing. This is reflected in Health Education England’s very recent strategic framework for the healthcare assistant role that establishes attracting young people and improving diversity in this part of the workforce as a key priority (Health Education England, 2014b). Related to this, employers noted that apprenticeships were currently a popular method for recruiting people into these roles (mainly because there is funding attached).

One of the current skills debates in the policy literature and also emphasised during the interviews is the extent to which nursing auxiliaries should progress into registered posts or whether the role should be framed as an end-in-itself. This is a complex debate, influenced by widely-differing skill levels within the nursing auxiliary occupational group. Findings from the interviews suggest there are different practices among different employers.

One employer suggested that supporting nursing auxiliaries to develop into assistant practitioners or registered nurses was a key aim for their organisation, and efforts were made to achieve this. Typical comments included:

“How do we identify those band 2s that want to become band 3s / band 4s, talent spot them earlier and get alongside in progressing them in that route?”

“We want to develop more structured progression pathways... We know that there are HCAs who will always want to be HCAs, but we may be losing people [healthcare assistants] who think they need to progress”.

Local education and training boards are the key training bodies for local healthcare staff operating in England. They offer salary support to employers for nursing auxiliaries progressing in this way. Other interviewees reported offering additional support for healthcare assistants to develop their maths and English skills where necessary in order to ensure they meet the entry criteria for nursing courses.

However, there appears to be substantial local variation, affected both by relationships with the local university and the availability of suitably flexible training posts. Several employers also noted that any discussion of progression from this occupational group should be wary of reducing the value of the nursing auxiliary role itself.

Either as an end-in-itself, or as a route to a more senior post, interviewees emphasised that this occupation is likely to grow in importance. The primary driver for this is the need to make savings on the largest expense for health and social care employers – their staff. Using healthcare assistants is increasingly seen as a more cost-effective approach to delivering care. In this context, ensuring that care teams retain an appropriate skill mix and balance between registered and non-registered staff is crucial from a regulatory and patient safety perspective.

The use of healthcare assistants to release nurses and other registered staff to do clinical work of higher complexity was also a common theme. As the registered roles continue to take on additional tasks from medical professionals (a trend also identified in the physiotherapist interviews), the end 'beneficiary', in terms of a growth in function, is likely to be healthcare assistants. In this context, there is a role for quality assuring the work being carried out, with occupational standards, regulation and training likely to be key aspects of this process.

As the need for this role expands, interviewees report that it will continue to split into specialist areas. Employers reported that specialisation is largely demand driven. For example, if a particular service needs greater capacity (the example of dialysis was provided by two employers), then it will train a healthcare assistant to provide this support and ensure they are carrying this out safely.

4.6 Conclusions

The key messages from this chapter are as follows:

- Given the size of the sector by employment, and its importance in keeping the UK population healthy and active, skills and performance challenges facing the health and social care sector can have a major impact on the wider UK economy. This is one of the drivers for the sector's major ongoing investment in workforce planning and training.

- Health and social care occupations are in flux, responding to demands of those who use services and employers. Regulation and training facilitate this fluidity.
- A key dynamic affecting occupations in the health and social care sector is their degree of specialisation (as opposed to a broader skillset). How best to balance the two to meet patient and service user need is an ongoing debate.
- All occupations require a balance between 'softer', patient-centred competencies, and technical or clinical skills and knowledge. Recruiting individuals who provide this mix is a priority for policy makers and employers.
- Encouraging progression and specialisation (particularly in lower-level occupations) is a priority for many in the sector. Facilitating this progression safely (either with or without regulation) is a key priority in this context.

5 Future Skills

5.1 Introduction

This chapter focuses on the future shape of the health and social care workforce. It sets out the forecast for jobs and skills at sector level, as well as sector-wide trends that are likely to influence future prospects. It then looks at future skills priorities in relation to the key occupations, as well as drawing out what this could mean for the sector as a whole. It chapter is based on analysis of the Working Futures forecast, a review of policy literature and the qualitative interviews with employers and stakeholders.

5.2 Forecasting future skills and employment needs

The UK Commission's Working Futures 2012-2022 report (Wilson et al., 2014) provides employment projections for the UK by sector and occupation to 2022. The forecasts can be broken down by Standard Occupational Class (SOC) at a four-digit level. A list of 36 four-digit occupations, which relate primarily to the Health and Social Care sector have been analysed to assess the future demand for employment in the sector. The five key occupations have also been analysed individually.

In 2012 there were 3.2 million people employed in one of the 36 occupations. This is expected to grow to 3.9 million people by 2022, an increase of 700,000 workers (22 per cent). In addition to this employment growth, it is anticipated that 1.4 million workers will leave these occupations and need to be replaced (replacement demand). This means that, over the period from 2012 to 2022, an estimated 2.1 million workers will need to be trained and recruited into the health and social care sector. This represents a flow of new workers that is equivalent to over half of the existing workforce.

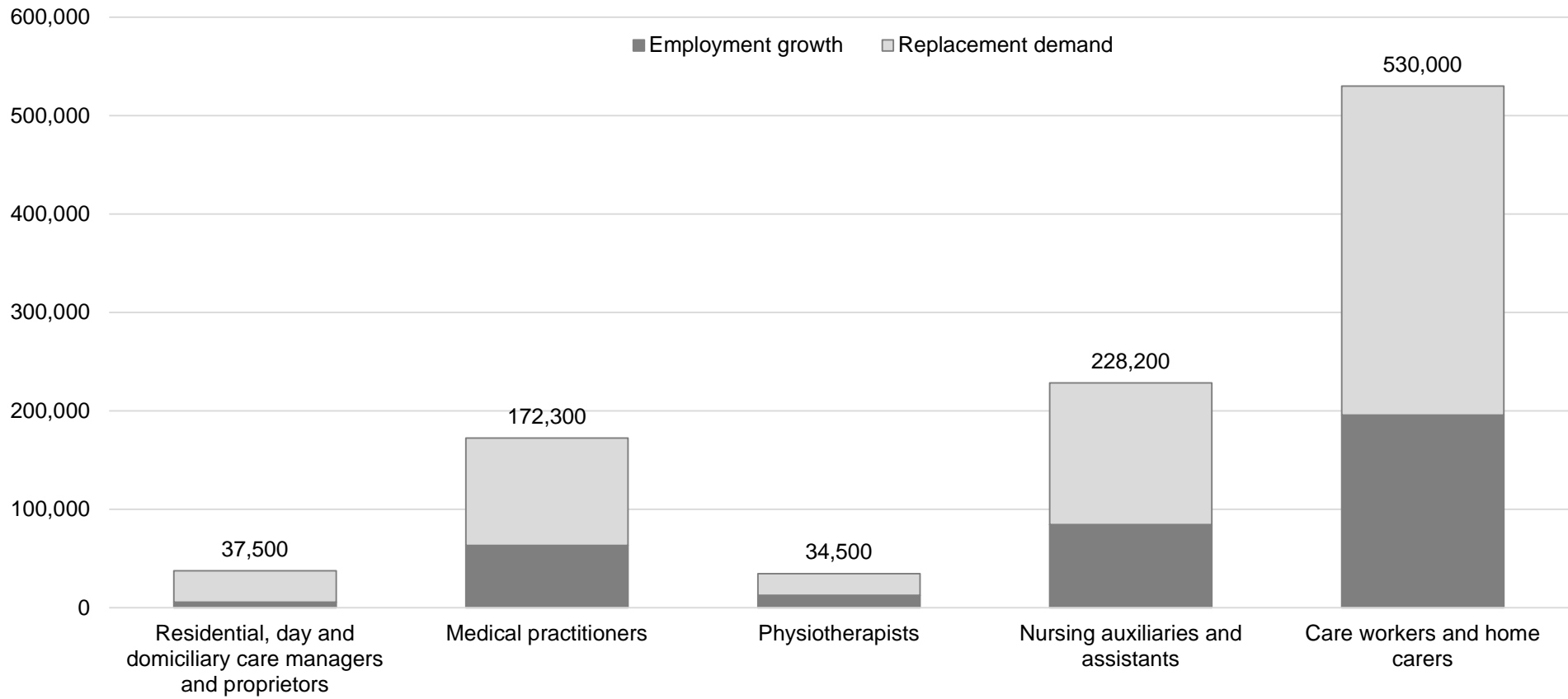
The number of people employed in each of the five key occupations is expected to increase by 2022 (see Table 5.1). The largest percentage increases relates to nursing auxiliaries and care workers / home carers (a 27 per cent increase in both occupations). In absolute terms, the total number of workers who need to be trained and recruited (employment growth and replacement demand) is largest in the care workers / home carers occupation, with over half a million new workers needed by 2022. The lowest levels of growth are expected in the residential, day and domiciliary care managers and proprietors group (see Table 5.1 and Figure 5.1).

Table 5.1 Employment projections for key occupations, 2012-2022

Occupation	Persons employed (2012)	Persons employed (2022)	Change persons employed	% change in persons employed	Replacement demand
Residential, day and domiciliary care managers and proprietors	66,657	72,208	5,552	8%	31,926
Medical practitioners	253,479	316,775	63,296	25%	109,042
Physiotherapists	50,788	63,470	12,682	25%	21,848
Nursing auxiliaries and assistants	313,742	398,032	84,291	27%	143,921
Care workers and home carers	728,634	924,390	195,757	27%	334,243
<i>Total selected occupations</i>	<i>1,413,298</i>	<i>1,774,876</i>	<i>361,577</i>	<i>26%</i>	<i>640,981</i>
Total Health and Social Care occupations	3,210,720	3,924,954	714,234	22%	1,410,206

UKCES Working Futures 2012-2022 (Wilson et al., 2014)

Figure 5.1 Expansion demand and replacement demand for key occupations, 2012-2022



UKCES Working Futures 2012-2022 (Wilson et al., 2014)

5.3 Sector-wide findings

The employer interviews and the review of the policy literature have identified several sector-wide trends that are likely to affect all of the key occupations and others across health and social care:

1) There is likely to be an increasingly diverse health and social care employer base in the future.

Over the past twenty years, the range of organisations delivering health and social care has grown increasingly diverse. While social care has traditionally had a much more mixed market of providers, with the voluntary and private sectors prominent employers, the delivery of health services has traditionally been dominated by a large publically-funded employer.

Following the Health and Social Care Act 2012, with its provisions for ‘any qualified provider’ able to contest to provide NHS-funded services, in England in particular, there is likely to be a growth in private and voluntary sector organisations delivering publically-funded health services. Interviewees discussing the health occupations noted that this future driver of change is likely to lead to health professionals increasingly working with varied organisations (or consortia) ranging from small charities to large private companies.

This is likely to mean that established job roles and demarcations will become more fluid and varied as the employer base diversifies (and more distinctive organisational structures become the norm). This may impact on the health sector labour market and on career paths, which have traditionally been structured in terms of staff grade progression. The implications of this are uncertain, but are likely to affect some occupations more than others (e.g. allied health professions rather than, say, medical practitioners).

2) Further integration of services not only impacts on skills needs, but could make some traditional distinctions between occupations redundant.

At the same time as an apparent fragmenting of the provider structure, it was also noted by most interviewees that the health and social care sector will need to offer a more integrated service to its users in order to meet the major service delivery challenges. This integration is likely to be ‘vertical’ – whereby specialist acute services will need to link more closely with community, primary and social care services. It is also likely to be ‘horizontal’, whereby groups of providers offering similar services may be brought together within a geographic area (Nuffield Trust 2011).

The drivers of this trend are the need to improve efficiency of service delivery and the experience of patients and users of services. The implications for the workforce, identified by interviewees, are enormous. It will require greater working outside of professional boundaries, and more teams comprised of staff from both health and social care employers. There are substantial possibilities for role re-design, for new forms of progression between previously distinctive occupations and for radical thinking in terms of how teams are structured. Service integration will create greater opportunities for learning and exchange of approaches across health and social care.

3) Pressure on resources will lead to further re-design of roles and an increased focus on outcomes.

Underpinning all other service delivery challenges is the continuing need to deliver services more efficiently. While there is uncertainty about future funding, there is a clear growth in future demand for services and concurrent slowing of the growth of public investment in health and social care.

The drive for efficiencies and a heightened focus on productivity is likely to lead to role re-design, the introduction of new roles (such as physician assistants), or remodelling the skill mix of teams to deliver the same standard of services with fewer resources. Interviewees noted the potential impacts of this on the sector's workforce, including maintaining morale and staff retention.

Interviewees also identified that all occupations will have to work in a more outcome-focused manner. Clinical and support staff and managers will have to collect more data, and develop a broader understanding of the possible impact of their work (including on other parts of the health and social care system). Commissioners will be under greater pressure to examine the contribution of health and social care staff and base funding decisions appropriately

4) As more care is delivered in community locations, the skills mix for a large proportion of the workforce will evolve.

While several interviewees identified that they expect to see a growing centralisation of health services in larger tertiary care centres, the imperative to deliver more services in locations closer to home is clear. It is driven by patient demand and a need to avoid expensive hospital admissions. There are several workforce implications.

Social care workers delivering a range of personal care and support services in the home, or in day care centres are likely to work more closely with primarily healthcare staff. The importance of staff in community settings having the 'holistic view' of patients / service users will grow. Although this is arguably already central to good quality care provision, this may become a more explicit requirement of a substantial number of social care roles (implying increased knowledge of healthcare delivery).

Workforce planners, professional regulators and training providers are also likely to have to react to the new demand by ensuring that they plan for, set standards for and train more staff operating outside of highly specialist centres of acute care.

5) There will be a growing focus on prevention and population-level health:

Driven by technology advances and longer-term efficiency goals, several interviewees noted that the sector will have to develop a greater ability to support the health of the wider public. Key public health issues such as smoking cessation and obesity reduction will remain high up the policy agenda, and interviewees highlighted that there are likely to be opportunities for all of the sector's staff to work in these areas. There may also be new roles emerging such as health coaches who support people to live more healthily.

5.4 Occupation-specific findings

5.4.1 Care assistants

Interviewees generally agreed with the main findings from the data analysis and policy literature review that this occupation needs to grow in order to meet the future demand for social care services and to replace those leaving the sector. In order for this to happen in the volumes required, major policy changes are likely to be required. One employer described this as follows:

“We need to recognise the lower levels of the workforce for the things they do. Professionalise it and motivate people to know they are a professional... they need to be given more respect and better pay”.

Some elements of this prescription are difficult to tackle (notably the pay question). However, the focus on professionalisation and motivation may provide the key to tackling the future potential shortfall in care assistants.

The importance of recruiting young people into these roles was also highlighted. However, interviewees were also aware that the costs paid for social care were being driven down and that this was suppressing wages and margins available to employers for investment in training and development. This trend was seen as long-term in nature, although it is not clear how sustainable it can be in future as overall demand increases and the focus on care quality becomes more acute.

Another future trend identified in the policy literature and through the interviews is increased acuity of the care needs of service users. Interviewees discussing the future of domiciliary care were particularly vocal about this. Reduced funding from local authorities for home care services is reported to have led to narrower eligibility criteria for accessing services. This means that the acuity of need of the average user of home care services in some areas is likely to have increased.

However, interviewees reported that the concurrent skills development to support care assistants meeting this greater need has not, in general, taken place. This was identified as a potential risk in the coming years. It could become a driver for increasing skill levels for more streamlined domiciliary care provision targeted at those in greatest need.

Domiciliary care providers also noted current and future uses of technology, such as use of tablet devices to record the work being undertaken. The use of such devices could reduce paperwork and increase efficiency, while also continuing to meet regulatory needs.

While greater regulation of services is likely to impact on the skill needs of care home managers more significantly, employers noted that they expected this to have a knock-on effect on care assistants. This might include a greater requirement to document work being undertaken, and a requirement for them to be more proactive in addressing issues which emerge from analysis of this documentation. This further supports the trend towards care assistants in the future becoming a more highly-skilled occupation.

The increasing personalisation of healthcare services, which is a long-standing policy theme, will continue to shape the skill needs of care assistants. Employers reported that, as policy shifts to a model of enablement of service users, this will require a culture change for many working in the sector. The skills required will be “to help people to help themselves” and to support people to live independently, as opposed to a more traditional model of care where the carer is trained to deliver a range of tasks and functions for the service user. This implies new and higher-level skills being required for care assistants in general, with an emphasis on communication and influencing skills.

5.4.2 Care home managers

Interviewees had mixed views on how the structure of the adult social care sector (where most care home managers are employed) will evolve in future. Possible models included a greater consolidation of the sector with larger and more corporately-owned care homes (partly because, as noted by a couple of interviewees, single-owned homes may become less financially viable). This could support a more co-ordinated approach to skills development for the sector as whole.

An alternative future model relates to the development of integrated health and social care facilities. These facilities “will become the norm... the role will require far more engagement with other local facilities, such as health services”. In this scenario, care home managers’ familiarity with the structure and working practices of health services / teams will come under greater scrutiny. Their professional backgrounds may help here. Employers noted that managers of nursing home facilities typically require a nursing background (or be able to delegate much of this responsibility to someone with this background). The implication is that more of a ‘mixed-use’ facility will require a broader set of experience. In this context, ensuring that managers have experience of both health and social care provision may be advantageous.

Similarly, as more care home residents take up personal budgets (a government priority being piloted), care home managers may hold responsibility for facilitating their use. This change will likely require care home managers to “face outwards more” to services outside of the care home. This may also lead to care homes’ revenue streams diversifying further, increasingly coming from outside the care home. An example provided includes supporting residents to access services such as hairdressing or podiatry. An improved knowledge of local services will therefore be beneficial to their business.

In general, interviewees thought that the occupation will grow in complexity and in its number of functions. As one manager noted: “the job is getting so vast... it’s got more complex”. The continued importance of regulation was seen as the major ongoing skill challenge. Interviewees reported that they expect regulators will focus more on the leadership and management processes. The care home manager role in inducting and training new staff will therefore come under closer examination.

5.4.3 Medical practitioners

Interviewees agreed that doctors will remain core to the healthcare system, directing care as well as leading policy and workforce decisions in healthcare providers. However, all agreed that care provision models are constantly evolving. For example, in some service areas, the role of the specialist physician may shift to become one setting the protocols / best practice for clinical procedures and processes delivered by other clinicians, such as senior nursing staff. In some service areas (such as dialysis), this is already in train.

Some interviewees were particularly keen to see this process continue. As one noted, this development would require:

“Describing the competencies and skill sets that are required for particular clinical situations and then to map a workforce with those competencies and skills to deal with those situations...then you can decide who in that workforce has the necessary skills to do that.”

This development may give rise to new (or the mainstreaming of currently peripheral) occupations. In this regard, several interviewees noted the potential emergence of a physician assistant as a key future development.

There are several opportunities for this new role. One medical director noted that medical schools are currently over-subscribed. Some of the unsuccessful applicants could be trained as physician assistants instead. The main barriers to this development at present are regulatory (employers are reluctant to employ physician assistants under the current system) and the higher education system (only a small number of universities offer training supporting the development of this role). Interviewees highlighted that these roles are currently used to good effect in some European and North American healthcare systems. Presenting evidence on the impact of the role on care and resource use may be a useful step to proving if these roles can be safe and add value.

One of the main skill challenges for medical practitioners (outlined in Chapter 4) was the optimal degree of specialisation (as opposed to a general medical skillset) for doctors working in hospital settings. Interviewees noted that a future area of development may be to develop service delivery models to make specialists more accessible, including in GP practices. In general, most interviewees agreed that “more multidisciplinary working” was likely, and necessary.

Analysis of the policy literature has identified a wide range of potential developments – primarily technology driven – within this occupation, including:

- Genomics: the development of technology and approaches to improve the prediction of the likely incidence of hereditary disease. This may lead to a greater focus on the likely lifestyle factors that can contribute to these diseases and an increased focus on prevention. Health Education England has argued that developing the skills of specialist staff to deliver these potentially new services and the awareness of more general staff will need to accompany the technological developments. Medicine will be at the forefront of this; and Health Education England is examining developing a Masters degree in Genomics Medicine alongside CPD in the area (Health Education England, 2014c).
- As new technologies enter routine practice, the demand for technically complex care, such as metabolic testing and computer-assisted surgery, is likely to increase. The development of new medical technologies emphasises the crucial continued role of medical specialism. The useful application of these new technologies and the development of accompanying service models will emphasise the importance of working with medical generalists and other clinicians (Imison and Bohmer, 2014).

5.4.4 Physiotherapists

Interviewees emphasised the *existing* role of physiotherapists in service delivery models that are likely to *grow in importance in future* as demand for services changes. This includes:

- Working in intermediate care teams (for example, supporting hospital discharge)
- Providing secondary prevention services (for example, providing interventions to reduce the likelihood of falls and subsequent hospital admissions)
- Having a growing role in improving public health (for example, supporting people to be more active and to reduce obesity rates).

Most substantively, perhaps, physiotherapists may play an increasing role in supporting patients to self-manage long-term conditions (for example, through the provision of pain management or acupuncture services). As one interviewee noted:

“We know that it is no longer adequate to just treat the patient – we need to equip the patient with the tools they need to manage their own condition and encourage them to be proactive in managing their own condition.”

Physiotherapists are seen as ideal facilitators of this approach given that they often support patients in a process of rehabilitation rather than treatment. As a result, many of the contemporary skills debates in physiotherapy are about what additional roles they can possibly take on from other clinical staff, and whether they can do so to the same standards and with greater efficiency than medical professionals, for example.

Over the coming years, the employer base of physiotherapists is likely to diversify further than other health and social care professions. This is partly related to commissioners purchasing more physiotherapy services from private and voluntary sector providers. It was also noted that there is a potential role for experienced physiotherapists to work directly in GP practices or community clinics, potentially with the ability to refer patients on to specialist services and take on independent prescribing rights. One interviewee also outlined the model of a physiotherapy clinic that patients could refer themselves to directly (removing primary care from the pathway).

Both of these models would increase the capacity of primary care – a key current need given GP shortages. Another example of current and potential future diversification is for physiotherapists to move away from traditional healthcare roles including, for example, carrying out ‘fit for work’ assessments.

Away from their clinical role, a few interviewees emphasised that physiotherapists could up with an expanded role in managing and commissioning services. The fact that the occupation crosses the health and social care economy was deemed to be an advantage in this regard. This will require a wider assessment of the potential impact that physiotherapists can have, including beyond the health and social care sector (for example, on supporting people to re-enter or remain in work).

5.4.5 Nursing auxiliaries

Interviewees’ perceptions reinforce the evidence from the Working Futures analysis. This occupation is thought to be one which will grow in size and importance in the coming years. It is seen as a flexible occupation, able to adapt to meet the evolving needs of patients and to do so in a cost-effective manner.

Several of the sector-wide policy drivers were identified by interviewees as drivers of change in this occupation:

- Technology is likely to become a central part of nursing auxiliary roles in the future. For example, the use of telehealth (such as consulting with patients via skype) may become an increasingly common role for these staff. An interviewee reported that “we have neglected HCAs in this regard so far”.

- Several interviewees reported that nursing auxiliaries can play a key role in improving the degree to which patients experience healthcare services as being effectively integrated. They are well-placed to work flexibly, to “follow patients across care pathways”. The subsequent skill need is that nursing auxiliaries will require improved knowledge of “the complex network of support that is available outside of the hospital ... they can help create a bridge between the hospital and the community.”
- Interviewees noted that there was a potential emerging role for nursing auxiliaries in ‘care liaison’. This would involve supporting users of health and social care services who wish to use a personal budget to develop care plans and ‘navigate’ the system and potential providers of services. This is already taking place in some locations.

The other major theme identified in the interviews was the general ‘pushing down’ of clinical tasks to nurse auxiliaries from their registered professional colleagues. They will be delivering more services (including increasingly clinical services) which will require greater guidance from registered professionals. As they take on additional tasks, interviewees speculated that there would be further specialisation of the role, particularly at band 4.

As a consequence of the expansion and evolution of this broad occupation, interviewees considered there to be a need for greater validation of skills and competencies. It was noted in a few interviews that greater regulation of the role would be required or, at minimum, clearer guidance for deployment. Two employers summarised this as follows:

“I definitely envisage regulation of the HCAs’ role... I think HCAs would welcome it.”

“HCAs will be working more to protocol-driven services [protocols set by consultants and nurses]”

It was noted, however, that regulating the occupation would bring its own challenges. First, by attaching it to an existing professional regulator, the flexibility and cross-professional working which characterises the role at present would be endangered (“they need to be working multi-professionally. HCAs are able to help with a lot of different roles not just nursing.”)

The likely growth in size and importance of this occupation may also require regulation at the service level. Questions over supervision of these staff, and safe staffing ratios will grow in importance, particularly for employers where registered nursing staff are in short supply (an issue noted by a few of the employers interviewed). One employer summarised that: “finances are tight and so employers are looking for cheaper ways of doing things”. However, they noted that this cannot be done at the expense of patient safety.

The introduction of the Care Certificate will affect this occupation. Employers generally welcomed this policy change, seeing it as “the beginning of a level playing field in inducting these staff”. They reported that there is more to be done in ensuring that these posts are consistently developed and supported across employers.

5.5 Conclusions

The key messages from this chapter are as follows:

- Several sector-wide trends will shape workforce and skills debates over the next decade. Most significantly, there will be greater diversity in the organisations providing care, and the need for efficiency savings will focus minds on working in an outcome-focused manner.
- The continued closer working between health and social care providers will present skills development and best practice exchange opportunities. Higher level professions will need adapt to managing increasingly multi-disciplinary teams.
- Existing occupations are likely to expand beyond their current parameters, and new roles are likely to emerge which fill gaps between the traditional health and social care professions.
- Training structures, professional identities and regulation will need to flex in order to facilitate these workforce changes, particularly where they relate to traditional lower-level occupations expanding towards the professional levels of the sector.
- Technological change will affect all occupations. The workforce will need to become resilient to changes in working practice, however, the overall impact on workforce and skills is hard to predict. As a result, the training and regulatory infrastructure will need to be responsive and able to mobilise quickly to position the future workforce to take advantage of new technologies.

6 Current and future interest in occupational standards

6.1 Introduction

This chapter sets out findings relating to employers' current and future interest in national occupation standards (NOS).

6.2 Overview of occupational standards in health and social care

National Occupational Standards (NOS) describe the knowledge, skills and understanding an individual needs to be competent at a job. They are UK-wide, demand-led, evidence-based benchmarks of competent performance which underpin vocational learning and development, apprenticeships and qualifications across all sectors, occupations and parts of the UK.

NOS can be used in many different ways. For example:

- awarding bodies can use NOS to create qualifications (which can be used in Apprenticeships) to train individuals for a job
- employers can use them to create a job description to recruit new staff or a training plan to develop their skills
- individuals can research and identify different types of jobs which match their skills and experience.

The vision for NOS is to ensure they are employer demand driven and based on informed analysis of current and future labour market need. The UK Commission is working with networks of employers (including through professional bodies, sector skills organisations and industrial partnerships) to ensure that NOS articulate the ambition and aspiration of their workforces clearly and effectively.

The NOS for the health and social care sector are split into those that relate primarily to health occupations and those relating primarily to occupations in social care (although some NOS are common to both sectors). They are developed and maintained by the two relevant sector skills councils, Skills for Health and Skills for Care and Development.

There are key seven suites of NOS in the social care sector. They are inter-related in terms of occupational relevance. The largest suite, called 'Health and Social Care', contains over two hundred standards and is the most important suite for frontline care providers.

The other six suites of NOS for social care cover either specific occupations in the sector (Inspectors; Social Work), particular areas of practice (Sensory Services; Mental Health), or particular skill areas (Commissioning, Procurement and Contracting; Leadership and Management). In effect, the major health and social care suite “lends” standards to the other more specialist suites for the development of training courses and job descriptions. The two social care occupations under examination in this study relate closely to the health and social care and the leadership and management suites.

The occupational standards relating to the health sector are organised into many more suites than those in social care. As such, they are typically narrower in focus, covering skill areas. The connection between the suites of health NOS and the key health occupations in this study are therefore arguably less direct.

6.3 Overall awareness and use of occupational standards

The 2014 UK Commission’s Employer Perspectives Survey (UKCEPS) indicates that employers in health and social care have a relatively high level of awareness of NOS compared to the economy as a whole. Over half (55 per cent) of health and social care employers have some awareness of NOS, compared to 40 per cent of employers in general (see Table 6.1). A quarter (25 per cent) of health and social care employers have made use of NOS in some way, compared to one in ten (10 per cent) of all employers (UKCEPS, 2014).

Table 6.1 Employer awareness and use of National Occupational Standards

	Total economy	Health and Social Care
<i>Awareness of NOS:</i>		
Have a good knowledge of NOS and what they include	5%	12%
Aware of NOS and have knowledge of what they include	14%	20%
Aware of NOS but do not know what they are	21%	22%
Not heard of NOS	60%	45%
<i>How NOS are used:</i>		
To develop training plans to meet your establishment's skills needs	7%	19%
For staff appraisals or performance management	6%	19%
To develop job descriptions or guide recruitment criteria	6%	18%
For succession planning or competency frameworks	5%	16%

Base: All establishments

Source: UK Commission’s Employer Perspectives Survey, 2014

Awareness and use was less common among the interviewees for this study. This perhaps reflects a greater focus within the interviews on clinical practitioners with a workforce-occupational focus, rather than HR professionals. Even interviewees that were relatively knowledgeable about NOS did not necessarily have a firm sense of whether their organisation has used the standards in some way.

Among the interviewees, awareness of NOS was also generally higher in the non-regulated occupations that we examined, and particularly in social care. It is important to emphasise, though, that given the limited awareness of NOS across the piece, the perspectives provided below are illustrative and indicative of the sorts of responses that some employers have. They may not be representative of the sector as a whole. What they highlight thematically, however, is:

- A widespread interest in standards and an acknowledged recognition of the importance of standards.
- A direct connection between occupational standards (however framed) and regulation. The former is an important tool of the latter.
- A focus on competence-based standards that may or may not align to the detailed NOS model.

6.4 Perspectives on NOS among social care employers

In social care, employers reported that there are three main sets of 'standards' that are used to support the recruitment and development of staff:

- First, the CQC's essential standards are used. These are the 16 standards that relate to quality and to the safety of care service users. When services are inspected by the CQC, employers have to provide evidence that these are being met. They cover issues such as respecting and involving people who use services, cleanliness and infection control, and staff numbers and competence.
- Second, NOS were reported to have some relevance, although they were seen by two employers as a minimum standard and that "the bar needs to be raised".
- Third, standards set by local authorities were reported to be influential in shaping the services delivered and the skills of those delivering them.

One employer operating in a relatively specialist area of social care reported that it had developed its own “checklist of competencies that staff need to be meeting”, illustrating the need for these tools and, perhaps, that employers with a specialist viewpoint are more likely to seek bespoke products.

Where social care employers had sufficient knowledge to comment on the existing NOS, some suggested they were “too long to be of practical day-to-day use”, such as in job descriptions. For social care service users with particularly complex or acute needs, for example, some employers felt that the current training based on NOS was too basic. However, most interviewees who had a working understanding of NOS had a consistent view that they were a necessity: “We need some sort of basis and Skills for Care, Skills for Health and NOS are as good as anyone [for this]”. In addition, social care interviewees were also able to identify where NOS had been used to develop tools that are of use to the sector’s employers. For example, the Common Induction Standards and the Manager Induction Standards, developed by Skills for Care, were identified as useful products, although these were perceived to more directly reflect the Care Quality Commission’s Essential Standards of Quality and Safety.

As much as anything else, this highlights the potential confusion inherent where standards overlap or have been developed for slightly different purposes and by different organisations. The inter-relationship between standards is not always clear to employers (although, arguably, that does not matter to employers).

The Care Certificate, which is likely to become central to the induction of lower-levels health and social care staff, is part of the response to the Cavendish Review and, as such, has a degree of regulatory ‘weight’ behind it. Notably, the Care Certificate has been mapped to NOS, highlighting the useful role that national standards can have in underpinning this kind of quality-based initiative. The Care Certificate will be used in the first instance for the induction of new health and social care support workers. The initiative was generally welcomed by interviewees, primarily as it will create greater consistency across the sector. It will require new recruits to undergo a 12-week training programme with a focus on values, dignity and hands-on care, and “will show that employees are properly prepared for the role that they are being employed in”.

Employers infrequently made any connection between programmes such as these and NOS. This illustrates how, even where NOS has an influential design role, employers may well not be aware of the connection (quite understandably). As part of the skills ‘wiring’ and relatively hidden, employer views on the use and value of NOS can therefore be difficult to bottom out.

6.5 Perspectives on NOS among health employers

In relation to awareness and current and future use of NOS among the health occupations, the picture is more mixed. For nursing auxiliary posts, some employers reported that occupational standards are used to inform initial training (something that the Care Certificate will build on and formalise) Other interviewees also recognised that NOS can support training and development of staff and, in effect, “can be used to turn into educational currency”.

However, as roles become increasingly specialised, an interviewee from the NHS noted that training programmes will need to be developed internally to meet the skill needs of these new roles. It was also reported that employers developed their own competency frameworks and assessments to ensure that healthcare assistants can safely undertake new tasks (as described earlier in the report).

This could include demand for the development of new standards, or a need for a new approach to standards. One interviewee, knowledgeable about NOS and involved in the redesign of nursing auxiliary roles suggested that NOS had sometimes been used as part of a task-driven approach to the delivery of healthcare:

“We’re trying to move people away from being a task-driven profession. The problem with ‘tasks’ is that it removes context... It is often not the doing of the task that is difficult... it is deciding when it’s appropriate”.

An illustrative example was provided of a common care task. Catheterisation is a relatively routine task for which healthcare assistants are increasingly responsible, although it was previously a task only delivered by registered nurses. Context is important to this task being delivered successfully by a healthcare assistant. It would not be appropriate for a healthcare assistant to deliver this intervention to a patient presenting in the accident and emergency department who has never been catheterised before. However a healthcare assistant could deliver the treatment to a patient receiving such an intervention regularly; for example, as part of the treatment plan for a long-term condition. Task-based occupational standards do not always capture the subtlety and professional experience required to judge the context in which a particular task could be appropriately delivered by a less senior member of staff.

In addition, for some occupations such as nursing auxiliaries, there are so many potential tasks that they may have to carry out that it is difficult for very detailed task-based standards to cover them all.

For the registered occupations examined in this study (medical practitioners and physiotherapists) interviewees generally commented that the respective professional regulator set “the minimum baseline” for their profession. Employers providing feedback on standards for physiotherapists reported that the regulatory standards (set by the Health and Care Professions Council) were more closely related to safeguarding the public from bad practice as opposed to pushing up standards. They are mostly referred to when poor care is reported.

The importance of Royal Colleges, the Chartered Society of Physiotherapy and professional associations in establishing standards in their respective fields was also emphasised by interviewees. These organisations aim to improve practice in their areas of care, and are seen by employers as reputable providers of continuing professional development: “They [and their standards] tend to be more aspirational ... they hold up the virtues that a doctor should aspire to”.

Interviewees discussing physiotherapists and doctors also reported that there are common approaches to ensuring resourcing standards across the NHS. This is due to Agenda for Change, which was introduced to create greater consistency in pay, grading and job profile across different employers. One physiotherapy interviewees commented that NOS units were too specific:

“It is overly input and task focused... the NOS got bogged down in task-driven activity and missed the broad type of skillset... [It was based on the belief that] if you distil everything down to a small enough task then anyone can do it.”

This goes against the overriding policy direction in healthcare delivery, which emphasises that professionals, particularly those that are professionally registered, should be able to practice their skills autonomously and bring personal judgement and experience to their care decisions. This is especially important given some of the major future themes identified in Chapter 5, including the likely increase in demand for community care. This will require greater independence and autonomous working from both registered clinicians and support staff. Similarly, the integration of services will require more staff to operate flexibly and autonomously across different care settings.

Across all interviews, a major theme was that “standards are a key way of restoring public confidence in light of recent scandals”. This presents a potential opportunity both for improving the workforce and public’s understanding of occupational standards. Interviewees noted that key sector stakeholders, such as Royal Colleges, promote occupational standards heavily already. However, occupational standards in the health and social care sector need to “get to the nub of the softer skills” that these staff require. In the context of greater personalisation, and a growing focus on care quality and patient experience, these softer skills become more important. Translating this into a NOS structure is an ongoing challenge.

6.6 Conclusions

The key messages from this chapter are as follows:

- The interviews for this study indicate an awareness of standards relating to the workforce in general. Despite the fact NOS remained relatively hidden to the interviewees, NOS-linked developments such as the Care Certificate are widely seen to be crucial for certain occupations.
- The various standards and Frameworks in health and social care suggest that there is clear demand for standards (and, indeed, there are various well-established models which are driving workforce improvement). The central focus on regulated standards and quality of care provision in the sector mean that occupational standards are fundamental for employers.
- Employers that were knowledgeable about NOS commented that they could be too detailed and task-orientated. Future NOS could be more broadly framed to meet the needs of health and social care employers.
- It is also worth noting that interest in (developing / influencing) standards is, in practice, linked to occupations/professions rather than employers. Clearly, this is the model for the regulated professions in health, but it may provide an approach (based on communities of interest) for currently non-regulated occupations as well.

7 Conclusions and recommendations

7.1 Conclusions

7.1.1 Sector outlook

The health and social care sector is a large and important sector of the UK economy. It is the largest sector by employment and has grown over recent years. By maintaining and improving the health of the population, the sector also contributes to wider UK economy by supporting people to remain economically active.

Employment in the health and social care sector is predicted to continue to grow in the coming few years, primarily to meet the demands of an aging population with more complex, numerous and longer-term conditions. This will affect most parts of the sector, require a re-shaping of many services and occupations, and provide recruitment challenges. The challenges for employers dealing with high-churn, high-volume social care occupations are radically different those relating to the workforce planning of long lead-time, high-skilled health professions.

The way that the public engages with health and social care services is also changing. At a minimum, they want a safe and compassionate service, but also one centred around their personal care needs and aspirations. Policy makers and employers have striven to meet this need using market-driven responses such as personal budgets, or workforce-driven initiatives such as developing new roles to facilitate more personalised service.

There are long-term funding challenges facing a sector which is supported heavily by public resources. Staffing is the major expense for health and social care employers, so work organisation is likely to be substantially affected. Changing the way money is distributed and managed within the sector, as well as integrating health and social care services, is also likely to be part of the response. At present, services in different parts of the sector do not necessarily work together as efficiently and effectively as they could. There are a number of funding initiatives (such as the Better Care fund), as well as local responses such as training agreements between hospitals and social care providers. Ensuring a more integrated health and social care sector is a policy priority in all parts of the UK.

At the same time, the structure of the sector's employer base is changing. Government reforms will lead to a diversification of employers, particularly in the health sector. This presents opportunities for new providers with innovative ideas and practices to enter the sector. The contestable commissioning of services also has the potential to improve the standards of care. As the sector diversifies, there is likely to be an increasing role for regulation to safeguard those who use the services, as well as to drive an improvement in care. The role of the regulatory standards in this context will be as important as ever.

Examining the sector through the occupational lens brings these high-level trends into stark relief. While different parts of the sector face different skill challenges, in general, employers across the sector are seeking to find ways to integrate with other services, meeting the growing expectations for person-centred and compassionate care, and doing so with fewer resources available.

7.1.2 Current workforce and skills challenges

Employers emphasised that regulation of services and professions was a key driver of skills development for staff. For the registered professions, the regulator and its core standards are viewed as the bedrock of their professional competence. For the other occupations, the Care Quality Commission's regulatory regime was identified as a key driver of skills development.

The demographics of the workforce influence career decisions as well as workforce planning: for example, the proportion and location of migrants working as care assistants and the age and gender profile of medical professionals require different training and workforce planning responses. While there is a shift towards specialist roles in many occupations (supporting career progression, upskilling and general improvements in care provision), there is also a need to provide flexible career paths. Integrated services may help provide such progression paths, including staff moving between health and social care.

There is an increasing focus on the values and softer competencies of the sector workforce (as opposed to the clinical and technical skills which may define their occupation, and take up much of the training). A range of approaches are being used including regulation, training and financial incentives.

7.1.3 Future workforce and skills challenges

In addition to the anticipated growth of the workforce, there will be a need to replace over one million current health and social care staff as they reach retirement or leave the sector.

Future drivers relate to the increasing diversification of sector employers and a growing focus on prevention and public health. This is likely to result in more flexibility within traditional roles, the emergence of new roles, increased multi-disciplinary working, and occupations expanding beyond their traditional parameters.

A range of technological developments are also likely to have an impact on sector skills needs. Advances in communications technology are already re-shaping the way that patients engage with care providers, and can be used to facilitate more rapid, convenient and cost-effective access to clinicians. In addition, monitoring and assistive technologies are affecting where and how care services are delivered. Effective use can support people to remain in their homes for longer.

7.2 Recommendations

Developing a flexible workforce able to work comfortably across different health and social care settings will help in developing integrated and coordinating services for users. Building on the Care Certificate, the sector should **develop additional qualifications for new entrants to the sector – including apprenticeships – which offer staff the opportunity to follow both a health or social care career path**. In addition, employers from different parts of the sector should be **encouraged to undertake more joint training opportunities, including sharing resources and approaches**.

Different occupations face common skills and performance challenges. This is particularly true in relation to workforce planning, values-based recruitment, supporting non-registered staff to progress within organisations, and developing flexible workforces able to deliver personalised and integrated care. **There is an opportunity for occupational groups in the sector to learn more from the experience of other groups**.

Sharing information on how to **engage lower skilled workers in workplace learning (UKCES, 2012b) could be of particular value to a sector which faces challenges in this respect**.

There is **support for a move away from the narrowly-defined, task-orientated NOS** among health and social care employers. Whether this will be catalyst for increased ownership of NOS among employers is an open question. It may be that because regulation drives skills development across health and social care, and because many key professional occupations are regulated, it is more difficult to gain traction with employers for the NOS programme than it is elsewhere.

However, it does not follow from this that national standards are unimportant. Paradoxically, they are arguably more important than ever in a sector that has a high-profile focus on care quality and the patient experience. This should provide the mechanism for greater use of NOS, building on the model underpinning the NOS-based Care Certificate. **National and sector bodies should explore how NOS can facilitate regulation-driven training across the sector.**

Certain occupations in health and social care, especially in the caring and other service occupations group, appear on the cusp of potentially radical change. Employers do not necessarily have a handle on the ten-year horizon for these occupations, because, as in the case of nursing auxiliaries, there is no consensus for how the role will evolve, or, as in the case of care workers, the day-to-day challenges of recruitment and retention require focus. **Exploratory scenario planning looking specifically at the future shape of health and social care support jobs, could provide a catalyst for employers to develop a consensus about future needs.**

Appendix A: Bibliography

Key policy documents

Cavendish, C (2013), The Cavendish Review: an independent review into healthcare assistants and support workers in the NHS and social care settings. Department of Health, London.

Department of Health, NHS England (2014), Transforming Primary Care: Safe, proactive, personalised care for those who need it most. Department of Health, London.

Department of Health (2013a), Mid Staffordshire NHS FT public inquiry: government response. Department of Health, London.

Department of Health (2013b), NHS Outcomes framework 2014 to 2015. Department of Health, London

Department of Health (2012a), Caring for our future: reforming care and support. Department of Health, London.

Department of Health (2010a), Equity and Excellence: liberating the NHS. Department of Health, London.

Francis, R (2013), Report of the Mid-Staffordshire NHS Foundation Trust Public Enquiry. HM Government, London.

Department of Health (2013), NHS Constitution: the NHS belongs to us all. Department of Health, London

NHS England (2014), Five Year Forward View. NHS England, London.

Documents on skills and training issues

Centre for Workforce Intelligence (2014a), Mapping the core public health workforce. Centre for Workforce Intelligence, London.

Centre for Workforce Intelligence (2014b), In-depth review of the general practitioner workforce. Centre for Workforce Intelligence, London.

Centre for Workforce Intelligence (2014c), Horizon 2035: International responses to big picture challenges. Centre for Workforce Intelligence, London.

Centre for Workforce Intelligence (2013a), Big Picture Challenges - The Context. Centre for Workforce Intelligence, London.

Centre for Workforce Intelligence (2013b), A strategic review of the future healthcare workforce – Informing the nursing workforce. Centre for Workforce Intelligence, London.

Centre for Workforce Intelligence (2013c) Future nursing workforce projections: Starting the discussion. Centre for Workforce Intelligence, London.

Centre for Workforce Intelligence (2013d), Horizon 2035: Health and Care Workforce Futures. Centre for Workforce Intelligence, London.

Centre for Workforce Intelligence (2011), Shape of the medical workforce: starting the debate on the future consultant workforce. Centre for Workforce Intelligence, London.

Clark, H. (2010), Recruiting the foster care workforce of the future: A guide for fostering services. The Fostering Network, London.

Eurofound (2012), White jobs? Employment potential of the care sector. Eurofound, Dublin.

Greenaway, D (2014), Shape of Training: Securing the future of excellent patient care. Shape of Training Review, London.

Health Education England (2013), Investing in people for health and healthcare: workforce plan for England – proposed education and training commissions for 2014/15. Health Education England, Leeds

Health Education England and Work Psychology Group (2014), Evaluation of values-based recruitment (VBR) in the NHS. Health Education England, Leeds.

Health Education England (2014a), Framework 15: Health Education England Strategic Framework 2014-2029. Health Education England, Leeds.

Health Education England (2014b), The Talent for Care: a national strategic framework to develop the healthcare support workforce. Health Education England, Leeds. Available at: http://eoe.hee.nhs.uk/files/2014/11/HEE_Talent-for-Care-A-National-Strategic-Framework-Nov-2014.pdf [Accessed 2nd February 2015].

Health Select Committee (2012), Education, training and workforce planning. The Stationary Office, London.

Imison, C. and Bohmer, R. (2013), NHS and social care workforce: meeting our needs now and in the future? King's Fund, London.

ONS (2009), UK Standard Industrial Classification of Economic Activities: Structure and explanatory notes. Office for National Statistics, Newport.

ONS (2014) Standard Occupational Classification 2010 Volume 2: The Coding Index. Version 2 released 21 January 2014. Office for National Statistics, Newport.

Royal College of Physicians (2013), Hospital workforce. Fit for the future? Royal College of Physicians, London.

Skills for Care (2014), The size and structure of the adult social care sector and workforce in England, 2014. Skills for Care, Leeds.

Skills for Care (2013), NMDS-SC Briefing: Meeting the future workforce challenges of adult social care. Skills for Care, Leeds.

Skills for Care (2011), Adult social care workforce: recruitment and retention strategy. Skills for Care, Leeds.

UKCES (2012a), Sector Skills Insights: Health and social care – Evidence report 52. UKCES, Wath-upon-Deerne.

UKCES (2012b), Engaging low skilled employees in workplace learning. UKCES, Wath-upon-Deerne.

UKCES (2013a), Health: Sector Skills Assessment 2012. UKCES, Wath-upon-Deerne.

UKCES (2013b), Care: Sector Skills Assessment 2012. UKCES, Wath-upon-Deerne.

Wilson R, Beaven R, May-Gillings M, Hay G, and Stevens J (2014), UKCES Working Futures 2012-2022, UKCES, Wath-upon-Deerne.

Wider context

Age UK (2014), Care in Crisis 2014. Age UK, London.

Age UK (2012), Personal budgets in social care: A new way to arrange your care and support. Age UK, London.

Barnett, K., Mercer, S., Norbury, M., Watt, G., Wyke, S. and Guthrie, B. (2012), 'Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study'. *The Lancet*, Vol. 380: pp. 37-43

Beddow, A. (2010) Physiotherapy Workforce Review. Centre for Workforce Intelligence, London.

Brown H, Ellins J et al (2014), Measuring up? The health of NHS cancer services. Cancer Research UK, London.

- CQC (2010), *Guidance about compliance: Essential standards of quality and safety*. CQC, London.
- CQC (2013), *Supporting information and guidance: Qualifications and continuing professional development requirements for registered managers and for the practitioners they supervise*. CQC, London.
- Charlesworth, A. and Thorlby, R. (2012), *Reforming social care: options for funding*. Nuffield Trust, London.
- Coulter, A. and Richards, N. (2007), *Is the NHS Becoming More Patient-Centre? Trends from the national survey of NHS patients in England 2002-07*. Picker Institute Europe, Oxford.
- Curson, J.A., Dell, M.E., Wilson, R.A., Bosworth, D.L. and Baldauf, B. (2008), 'Who Does Workforce Planning Well? Workforce Review Team Rapid Review Summary'. *International Journal of Health Care Quality Assurance*, Vol. 23, No. 1., pp. 110-119
- Department for Education (2014), *Children's Social Work Workforce: Key numbers as at September 2013*. Department for Education, London.
- Department of Health (2010b), 'Average daily number of available beds, by sector, England, 1987-88 to 2009-10'. Department of Health, London.
- Department of Health (2012b), *Long Term Conditions Compendium of Information*. Department of Health, London.
- Department of Health (2012c), *The new public health role of local authorities*. Department of Health, London.
- Department of Health (2012d), *The power of Information: Putting all of us in control of the health and care information we need*. Department of Health, London.
- Department of Health (2011), *Research and development work relating to assistive technology 2010-11*. Department of Health, London.
- Department of Health (2014), *Care and Support Statutory Guidance - Issued under the Care Act 2014*. Department of Health, London.
- Department for Education (2014), *Statistical first release: Children looked after in England (including adoption and care leavers) year ending 31 March 2014*. Department of Health, London.

Federation of the Royal Colleges of Physicians of the UK (2014), Census of consultant physicians and medical registrars in the UK, 2012: data and commentary. Royal College of Physicians, London.

Franklin, B. (2014), *The Future Care Workforce*. International Longevity Centre, London.

Freemantle, N., Richardson, M, et al (2012), 'Weekend hospitalization and additional risk of death: an analysis of inpatient data'. *Journal of the Royal Society of Medicine*. Vol. 105, No 2., pp. 74-84

Ham, C. Dixon, A. and Brooke, B. (2012), *Transforming the delivery of health and social care: The case for fundamental change*. King's Fund, London.

Health Education England (2014c), *The HEE Genomics Programme* [Unpublished presentation].

Health and Social Care Information Centre (2014), *NHS Workforce: Summary of staff in the NHS: Results from September 2013 Census*, HSCIC, Leeds.

Ipsos MORI (2013), *Public Perceptions of the NHS and Social Care Tracker Survey: Winter 2013 wave*. Department of Health, London.

Lamb. N. (2014), *Care Bill becomes Care Act 2014*. Department of Health, London.

The Lancet: UK Policy Matters, 2012, 'QIPP Programme (Quality, Innovation, Productivity and Prevention). Lancet UK Policy Matter, London. <http://ukpolicymatters.thelancet.com/qipp-programme-quality-innovation-productivity-and-prevention/> [Accessed on 2nd February 2015].

LGA and Adass (2014), *Care Act: regulations and guidance – LGA and ADASS joint consultation response*. [Unpublished consultant response].

Nesta (2013), *The business case for people powered health*. Nesta, London.

NHS Employers (2014), *NHS Qualified Nurse Supply and Demand Survey – Findings*. NHS Employers, Leeds.

NHS England (2013), *NHS Services, Seven Days a Week Forum: Summary of Initial Findings*. NHS England, London.

NHS England (2013), *Better Care Fund (BFC). Support and Resources Pack for Integrated Care* [Unpublished slide pack]

Nuffield Trust (2011), What is integrated care? An overview of integrated care in the NHS.

Nuffield Trust, London.

Office for Budget Responsibility (2012), Fiscal Sustainability Report. The Stationary Office,

London.

Office for National Statistics (2013), Full story: The gender gap in unpaid care provision: is

there an impact on health and economic position? ONS, London.

Office for National Statistics (2012), Population Ageing in the United Kingdom, its

Constituent Countries and the European Union. ONS, London.

Office for National Statistics (2011), 2009 General Lifestyle Survey. ONS, London.

Skills for Care (2011), NMDS-SC Briefing: Migrant Workers. Skills for Care, Leeds.

Skills for Care (2013), Why are some employers more successful than others in retaining

their workforce? Skills for Care, Leeds.

Stevenson, F.A., Cox, K., Britten, N. and Dundar, Y. (2004), 'A systematic review of the

research on communication between patients and health care professionals about

medicines: the consequences for concordance', *Health Expectations*, Vol 7 No. 3,

pp. 235-45

The Voluntary Organisations Disability Group and The National Care Forum (2013), Using

assistive technology to support personalisation in social care. VODG, London.

Wittenberg, R., Hu, B., et al (2011). Projections of Demand for and Costs of Social Care

for Older People in England, 2010 to 2030, under Current and Alternative Funding

Systems. PSSRU, Canterbury.

Data sources

ABS (2014), Annual Business Survey 2014. ASHE (2014), Annual Survey of Hours and

Earnings 2014. Office of National Statistics, Newport

LFS (2014), Labour Force Survey 2014. Office of National Statistics, Newport

UKCEPS (2014), UK Commission's Employer Perspectives Survey data, 2014

UKESS (2013), UK Commission's Employer Skills Survey data 2013. UK Commission for

Employment and Skills, Wath-upon-Deerne

Appendix B: Methodological note

This appendix provides a breakdown of interviews undertaken. A total of 53 interviews have been undertaken with representatives from 50 organisations. These interviews are split between employer and stakeholder organisations: 46 employer and seven stakeholder organisation interviews have been undertaken.

These 53 interviews can also be split by the primary occupational focus. These are as follows: Care Assistants (eleven); Care Home Managers and Proprietors (eleven); Medical professionals (ten); Nursing auxiliaries (eleven); Physiotherapists (ten).

The employer interviews also included speaking with organisations from different parts of the UK. These interviews are broken down as follows: UK-wide (three); England (36); Scotland (three); Wales (two) Northern Ireland (two).

The employer interviews also involved speaking with organisations from different parts of the sector. These interviews are broken down as follows: public (28); private (14); voluntary sector (four). Stakeholders interviewed included a range of professional organisations, Royal Colleges and regulators.

Appendix C: UK Standard Industrial Classification of Economic Activities 2007

Table C.1 UK Standard Industrial Classification of Economic Activities 2007 – Health and Social Work activities

Division	Group	Class / sub-class
		86.10 Hospital activities
	86.1 Hospital activities	86.10/1 Hospital activities
		86.10/2 Medical nursing home activities
86 Human Health Activities	86.2 Medical and dental practice activities	86.21 General medical practice activities
		86.22 Specialist medical practice activities
		86.23 Dental practice activities
	86.9 Other human health activities	86.90 Other human health activities
87 Residential care activities	87.1 Residential nursing care activities	87.10 Residential nursing care activities
	87.2 Residential care activities for learning disabilities, mental health and substance abuse	87.20 Residential care activities for learning disabilities, mental health and substance abuse
	87.3 Residential care activities for the elderly and disabled	87.30 Residential care activities for the elderly and disabled
	87.9 Other residential activities	87.9 Other residential activities
88 Social work activities without accommodation	88.1 Social work activities without accommodation for the elderly and disabled	88.10 Social work activities without accommodation for the elderly and disabled
	88.9 Other social work activities without accommodation	88.91 Child day-care activities 88.99 Other social work activities without accommodation

Source: ONS (2009)

Appendix D: Labour Force Survey occupation data

Table D.1 Top 20 health and social care occupational groups by workforce size

SOC four-digit unit group	Rank	Size	Share
		Number of Persons	Percentage of sector workforce
6145 'Care workers and home carers'	1	721,200	17.7%
2231 'Nurses'	2	554,300	13.6%
6141 'Nursing auxiliaries and assistants'	3	286,700	7.0%
2211 'Medical practitioners'	4	217,700	5.3%
6122 'Childminders and related occupations'	5	101,900	2.5%
2442 'Social workers'	6	86,500	2.1%
4216 'Receptionists'	7	85,900	2.1%
4159 'Other administrative occupations n.e.c.'	8	83,600	2.1%
6121 'Nursery nurses and assistants'	9	77,900	1.9%
3239 'Welfare and housing associate professionals n.e.c.'	10	76,700	1.9%
9233 'Cleaners and domestics'	11	76,300	1.9%
6146 'Senior care workers'	12	70,800	1.7%
4211 'Medical secretaries'	13	61,400	1.5%
6143 'Dental nurses'	14	50,500	1.2%
2221 'Physiotherapists'	15	50,300	1.2%
1242 'Residential, day and domiciliary care managers and proprietors'	16	49,800	1.2%
2215 'Dental practitioners'	17	44,300	1.1%
2232 'Midwives'	18	42,600	1.0%
4131 'Records clerks and assistants'	19	37,800	0.9%
2222 'Occupational therapists'	20	36,700	0.9%
Total Health and Social Work	-	4,072,300	100%

All numbers rounded to nearest 100

Source: Labour force Survey, Four-quarter average (Q4 2013 to Q3 2014), Industry section in main job, Q Health and social work, Person weight.

Table D.2 Health and social care employees by major occupational group

Major occupational group	Number of persons	Share	Share
	Health and social work	Health and social work	(All industries)
1 'Managers, Directors And Senior Officials'	221,900	5.4%	(10.1%)
2 'Professional Occupations'	1,351,500	33.2%	(19.9%)
3 'Associate Professional And Technical Occupations'	390,800	9.6%	(14.0%)
4 'Administrative And Secretarial Occupations'	425,000	10.4%	(10.7%)
5 'Skilled Trades Occupations'	56,400	1.4%	(10.8%)
6 'Caring, Leisure And Other Service Occupations'	1,408,600	34.6%	(9.3%)
7 'Sales And Customer Service Occupations'	37,500	0.9%	(7.9%)
8 'Process, Plant And Machine Operatives'	19,300	0.5%	(6.3%)
9 'Elementary Occupations'	161,300	4.0%	(11.0%)
Total	4,072,300	100.0%	(100%)

All numbers rounded to nearest 100

Source: Labour Force Survey, Four-quarter average (Q4 2013 to Q3 2014), Industry section in main job, Q Health and social work, Person weight.

Appendix E: UK Commission's Employer Skills Survey data

Table E.1 Vacancies in the health and social care sector

	Total economy		Health and Social Care	
	2011	2013	2011	2013
Number of employers with at least one vacancy	241,200	257,200	24,200	29,500
Percentage of employers with at least one vacancy	14%	15%	20%	23%
Average number of vacancies per employer	0.3	0.4	0.5	0.6
Average number of vacancies for employers with vacancies	2.4	2.5	2.6	2.8
Total number of reported vacancies	586,500	655,000	64,000	86,600
Vacancies as a percentage of employment	2%	2%	2%	2%

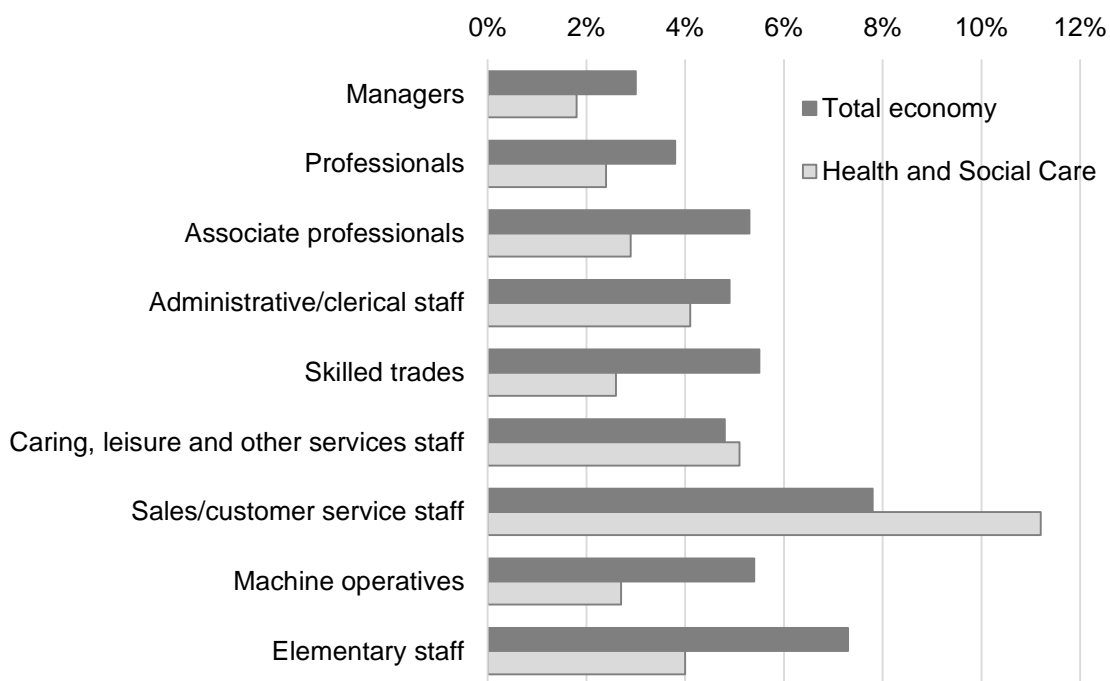
Source: UKCES Employer Skills Survey, 2013

Table E.2 Top reasons for SSVs in the health and social care sector, 2013 (as a percentage of employers with SSVs)

	Total economy	Health and Social Care
Technical, practical or job specific skills	63%	56%
Planning and Organisation skills	45%	46%
Written communication skills	39%	41%
Customer handling skills	43%	38%
Team working skills	34%	37%
Problem solving skills	41%	37%

Source: UKCES Employer Skills Survey, 2013

Figure E.1 Density of skills gaps by occupation, 2013



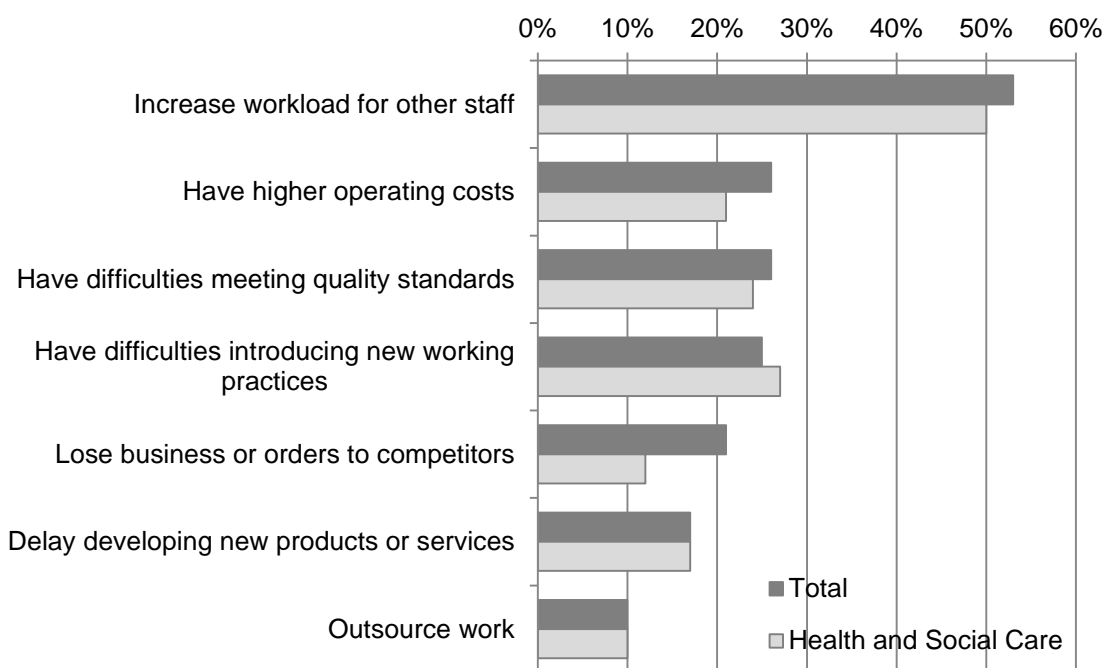
Source: UKCES Employer Skills Survey, 2013

Table E.3 Main causes of skills gaps among employers, 2013 (as a percentage of employers reporting skills gaps)

	Total economy	Health and Social Care
Their training is currently only partially completed	60%	60%
They are new to the role	59%	61%
Staff lack motivation	34%	33%
They have been on training but their performance has not improved sufficiently	31%	31%
They have not received the appropriate training	28%	30%
The introduction of new working practices	28%	33%

Source: UKCES Employer Skills Survey, 2013

Figure E.2 Type of impact of skills gaps on establishment performance



Source: UKCES Employer Skills Survey, 2013

Table E.4 Main skills which need improving as reported by employers with skills gaps, 2013 (as a percentage of employers reporting skills gaps)

	Total economy	Health and Social Care
Technical or practical skills or Job specific skills	60%	61%
Planning and Organisation skills	57%	61%
Team working skills	44%	51%
Problem solving skills	48%	48%
Customer handling skills	47%	47%
Technical or practical skills or Job specific skills	60%	61%

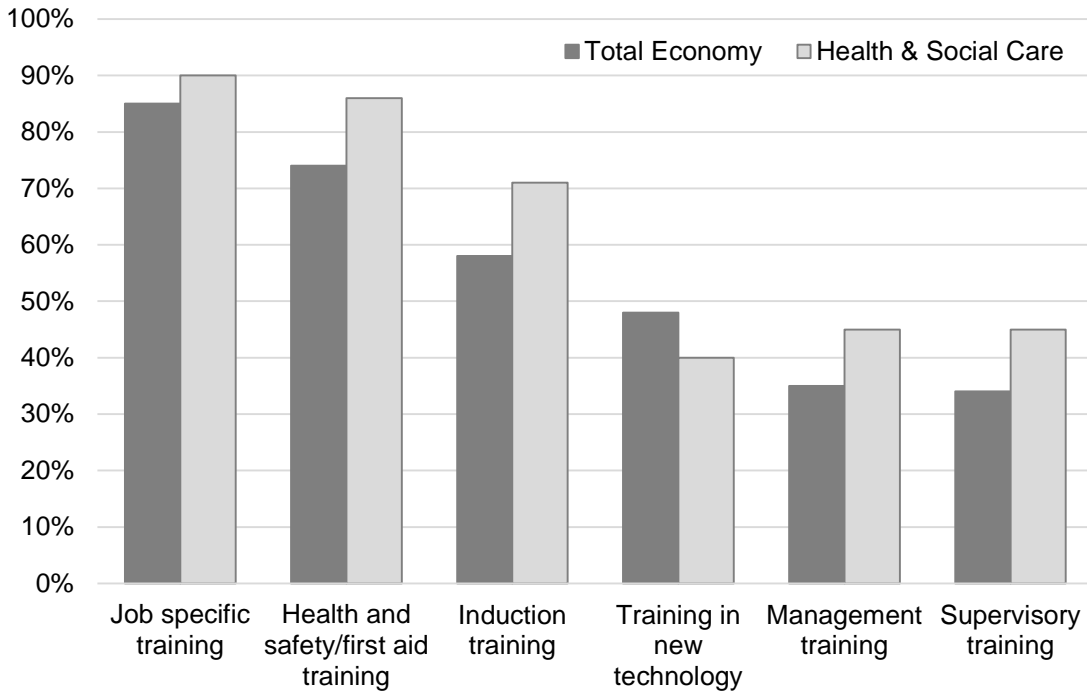
Source: UKCES Employer Skills Survey, 2013

Table E.5 Steps taken to address skills gaps, 2013 (as a percentage of employers reporting skills gaps)

	Total economy	Health and Social Care
Increase training activity / spend or increase/expand trainee programmes	68%	74%
More supervision of staff	60%	71%
More staff appraisals / performance reviews	51%	61%
Implementation of mentoring / buddying scheme	47%	58%
Reallocating work	37%	44%

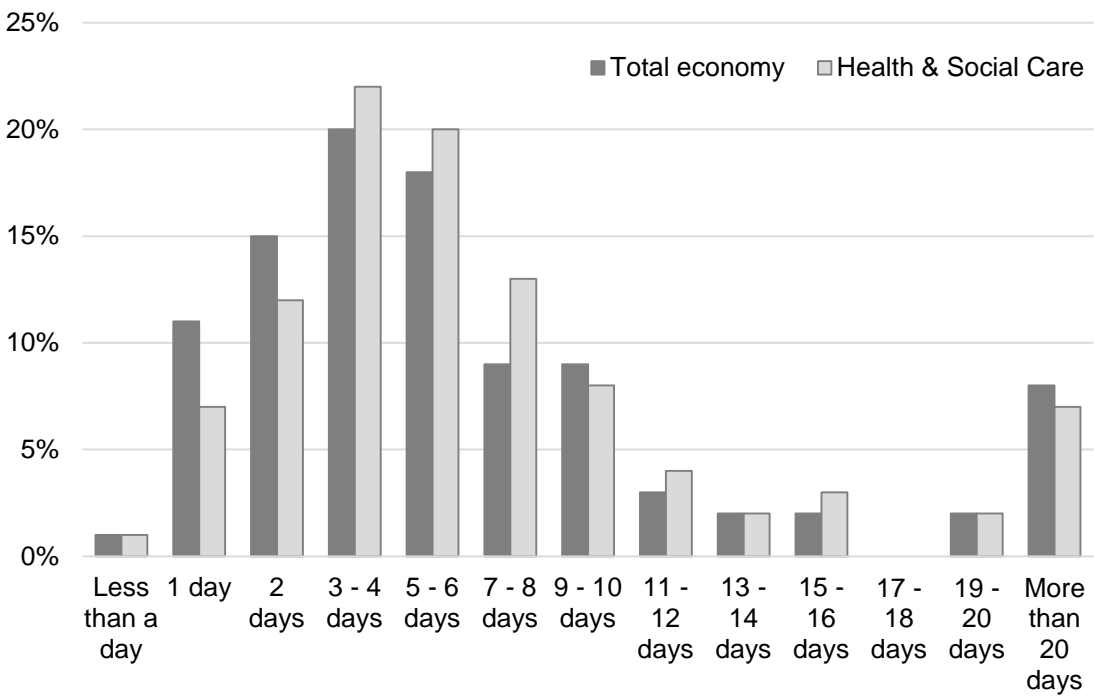
Source: UKCES Employer Skills Survey, 2013

Figure E.3 Types of training offered, 2013



Source: UKCES Employer Skills Survey, 2013

Figure E.4 Number of training days per trainee, 2013



Source: UKCES Employer Skills Survey, 2013

Evidence Reports present detailed findings of the research produced by the UK Commission for Employment and Skills. The reports contribute to the accumulation of knowledge and intelligence on skills and employment issues through the review of existing evidence or through primary research.

UKCES
Renaissance House
Adwick Park
Wath-upon-Deerne
Rotherham
S63 5NB
T +44 (0)1709 774 800
F +44 (0)1709 774 801

UKCES
Sanctuary Buildings
Great Smith St.
Westminster
London
SW1P 3BT
T +44 (0)20 7227 7800

This document is available at
www.gov.uk/ukces

ISBN 978-1-908418-79-1
© UKCES 1st Ed/05.15