

Sector Skills Insights: Health and Social Care

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**Penny Tamkin, Felix Behling
Institute for Employment Studies**

**Rebecca Jones, Richard Garrett
UK Commission for Employment and Skills**

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Foreword

The UK Commission for Employment and Skills is a social partnership, led by Commissioners from large and small employers, trade unions and the voluntary sector. Our mission is to raise skill levels to help drive enterprise, create more and better jobs and promote economic growth. Our strategic objectives are to:

- Provide outstanding labour market intelligence which helps businesses and people make the best choices for them;
- Work with businesses to develop the best market solutions which leverage greater investment in skills;
- Maximise the impact of employment and skills policies and employer behaviour to support jobs and growth and secure an internationally competitive skills base.

These strategic objectives are supported by a research programme that provides a robust evidence base for our insights and actions and which draws on good practice and the most innovative thinking. The research programme is underpinned by a number of core principles including the importance of: ensuring '**relevance**' to our most pressing strategic priorities; '**salience**' and effectively translating and sharing the key insights we find; **international benchmarking** and drawing insights from good practice abroad; **high quality** analysis which is leading edge, robust and action orientated; being **responsive** to immediate needs as well as taking a longer term perspective. We also work closely with key partners to ensure a **co-ordinated** approach to research.

This report contributes to the UK Commission's work to transform the UK's approach to investing in the skills of people as an intrinsic part of securing jobs and growth. It outlines the performance challenges faced in the **Health and Social Care** sector, the 'real-life' skills solutions implemented by leading and successful businesses to overcome them, and the benefits from doing so. Similar reports are available for the following sectors: Advanced Manufacturing; Construction; Digital and Creative; Education; Energy; Professional and Business Services; Retail; Tourism. Each report is summarised by an accompanying PowerPoint slide pack. By understanding the key performance challenges employers face and the skills solutions available to address them on a sector-by-sector basis the UK Commission can make better use of its investment funds to support economic growth.

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. Each Evidence Report is accompanied by an executive summary. All of our outputs can be accessed on the UK Commission's website at www.ukces.org.uk

But these outputs are only the beginning of the process and we will be continually looking for mechanisms to share our findings, debate the issues they raise and extend their reach and impact.

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.

Lesley Giles

Deputy Director

UK Commission for Employment and Skills

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GLOSSARY

This report uses data from several sources and uses a definition of the sector depending upon which data sources are available.

PRINCIPAL DATA SOURCES

Employer Perspectives Survey 2010

The UK Commission's Employer Perspectives Survey 2010 (Shury et al., 2011) gathered the views of approximately 14,500 employers on the UK's employment and skills system. The aim of the survey is to provide evidence to stakeholders operating in the system across the four UK nations to inform policy and improve service delivery.

<http://www.ukces.org.uk/publications/er25-employer-perspectives-survey>

The UK Commission's UK Employers Skills Survey 2011

The UK Commission's UK Employer Skills Survey (Davies et al., 2012) provides UK-wide data on skills deficiencies and workforce development across the UK on a comparable basis. It was undertaken at the establishment level and involved over 87,500 interviews, with a follow up survey of over 11,000 employers focusing on employers' expenditures on training.

<http://www.ukces.org.uk/publications/employer-skills-survey-2011>

Working Futures 2010-20

Working Futures 2010-2020 (Wilson and Homenidou, 2011) is the most detailed and comprehensive set of UK labour market forecasts available. The results provide a picture of employment prospects by industry, occupation, qualification level, gender and employment status for the UK and for nations and English regions up to 2020. The database used to produce the projections is held by the University of Warwick Institute for Employment Research and Cambridge Econometrics.

<http://www.ukces.org.uk/assets/ukces/docs/publications/evidence-report-41-working-futures-2010-2020.pdf>

Labour Force Survey

The Labour Force Survey (LFS) is a quarterly sample survey of households living at private addresses in the United Kingdom. Its purpose is to provide information on the UK labour market that can then be used to develop, manage, evaluate and report on labour market policies. It is conducted by the Office for National Statistics. Figures quoted in this report are based on a four quarter average.

<http://www.ons.gov.uk/ons/guide-method/surveys/respondents/household/labour-force-survey/index.html>

SECTOR DEFINITION

For the purpose of data analysis the health and social care sector is defined in SIC (2007) as 86, 87 and 88. The sector comprises two subsectors; health (SIC 86) and social care (SIC 87 and 88). Health encompasses all hospital activities, medical nursing homes, GP services, specialist medical and dental practices and other human health activities. The social care sector includes residential nursing care, residential care activities (including for the elderly, children or those with mental health care needs), child day care and non-residential social care.

Two employer led sector skills councils operate to cover the sector: Skills for Health (www.skillsforhealth.org.uk) and Skills for care and Development (<http://www.skillsforcareanddevelopment.org.uk>).

Executive Summary

Introduction

This report contributes to the UK Commission's work to transform the UK's approach to investing in the skills of people as an intrinsic part of securing jobs and growth. It outlines the performance challenges faced in the Health and Social Care sector, the 'real-life' skills solutions implemented by leading and successful businesses to overcome them, and the benefits from doing so.

The sector comprises two subsectors; health care and social care. Health care encompasses all hospital activities, medical nursing homes, GP services, specialist medical and dental practices and other human health activities. The social care sector includes residential nursing care, residential nursing facilities, residential care facilities (eg for the elderly, children or those with mental health care needs), child day care and non-residential social care.

The importance of the sector

The health and social care sector makes a significant direct and indirect contribution to the UK economy.

- The net output of the sector in 2010 was £92 billion, nine per cent of the UK total having grown by 2.5 per cent per annum over the previous ten years, faster than the economy as a whole.
- The sector is a major employer employing just under four million people across the UK, with a high proportion of females in the workforce and high rates of part time working. The sector also has some of the biggest occupations in the UK, such as nurses, care assistants and home carers, as well as some of the fastest growing for example paramedics and social services managers.
- Historically the sector has grown faster than the whole economy in terms of output and employment although growth to 2020 is expected to be slower than the economy as a whole.
- In the future there will be a need to replace substantial numbers of workers leaving the sector due mostly to retirement. This replacement demand combined with the sector's social and economic importance means its performance challenges and skills needs merit closer attention.

- It is expected that future growth will be constrained by budgetary restrictions which although less than in many parts of the public sector will still require significant efficiency savings.
- As a major consumer of innovative products and services from the life sciences industry, improving the adoption and diffusion of innovation within the sector is likely to provide economic benefits for other sectors too.

The health sub-sector workforce is much better qualified than average. Almost a third work in professional occupations compared with a fifth in the labour market as a whole. Within health, employment is concentrated in the public sector / NHS, but is more evenly distributed in the social care subsector. There are a relatively small number of self-employed workers across the health and social care sector.

Key challenges

A key challenge facing the health and care sector is to meet increasing demand for services whilst operating with constrained resources. Over recent years there has been a significant injection of staff and money to close the performance gap with other developed nations and one that would appear to have contributed to raising the quality of care. Although the sector has been protected to some degree from the public sector spending cuts, the result is a much smaller increase than has been the case previously. This smaller increase sits alongside rising demand for health and care services from a growing, ageing and more demanding population which is increasingly adopting unhealthy lifestyles. Technology offers both a solution and a problem in this regard. Historically, improving technology has bought the opportunity for better treatment but at increased prices. However, technology can also offer a solution through new ways of working which enable the sector to deliver care more efficiently and there is considerable effort across the sector to maximise innovation and its uptake.

Another challenge for the sector is to reduce its long term reliance on migrant labour. In certain roles and in certain parts of the UK the proportion of migrant workers is significant. With the government committed to reducing rates of migration into the UK it is important that skill shortages do not result from any restrictions on migration.

Research has demonstrated that management skills are correlated with financial performance and better patient outcomes, at the same time as other challenges are increasing the demands made on managers. Both Skills for Health and Skills for Care and Development sector skills councils have highlighted the relative importance of up-skilling the management and leadership population for the future wellbeing of the sector.

Skill demand

A key driver of skill demand in the sector is likely to be demographic change (especially a growing and ageing workforce) and the associated rise in long term health conditions and the need for care for older people. This increasing demand is coupled with the impact of the financial downturn and the consequent public sector spending constraints. New technology is expected to have wide ranging impact across the sector with assistive technologies shifting the delivery of care towards the home and local providers. Technology will also increase demand for high level skills.

Employment projections for the sector as a whole indicate that there will be a growing need for high level skills and caring skills. It is expected that there will be 126,000 (nine per cent) more caring, leisure and other service jobs between 2010 and 2020 as the sector grows. Jobs for managers, professionals and associate professionals are expected to increase by over nine per cent by 2020, (160,000) compared with the average of 15 per cent for the whole economy. There will also be an increased demand for people qualified to first degree level or higher; the health sub-sector is projected to need an additional 256,000 people qualified to first degree level or above by 2020, while the care sub-sector is projected to need an additional 234,000.

In addition to meeting this expansion demand as the sector grows, there will also be the need to replace individuals leaving the sector. By 2020 replacement demand for the sector as a whole is anticipated to be approximately 41 per cent of its 2010 employment level compared 1.3 per cent growth in the number of jobs in the sector over the period. replacement demand for the economy as a whole is expected to be similar at 40 per cent. Occupations in the sector with particularly high replacement demands are managers, professionals, associate professionals (39 per cent of their combine 2010 employment level) and caring occupations (42 per cent). .There is a total requirement for these four occupational groups of more than 1,380,000 between 2010 and 2020.

Skills supply

Applications to health and social care courses have risen slightly in recent years and acceptances are reasonably stable although some have declined slightly (medicine and subjects allied to medicine) and others have risen slightly (social studies). The very latest figures (April 2012) show a slight reduction in applications to medicine and dentistry and more significant reductions in social studies. This raises concerns over future skills shortages in the sector. Women make up 58 per cent of graduates in medicine and dentistry, 80 per cent of allied professions and just over 60 per cent of social studies graduates. Apprenticeship numbers have risen rapidly in recent years, particularly at advanced level and for older people.

Investment in training is relatively high with over 80 per cent of employers arranging training for their staff in the sector compared to 59 per cent in the economy as a whole, and the proportion of the workforce receiving training (66 per cent) is also above average (54 per cent) but declining in line with all sectors. For employees in managerial, professional or associate professional jobs the proportion in receipt of work-related training is particularly above average.

To balance these positive indicators, average training days per trainee is slightly below the all sector average as is average expenditure on training per employee and per trainee.

In certain parts rely on migrant labour. Over a third of medical staff are non-UK qualified and as are approximately 20 per cent of residential care workers. Use of migrant labour is more common in the sector in certain areas of the UK such as London.

Skills mismatches

The evidence is that skill demand broadly matches supply in the health and social care sector with hard to fill and skills shortage vacancies both below the whole economy average. There is however evidence of particular unmet demand for caring staff, professionals and managers. There is also evidence that certain pharmacy, physiological sciences and respiratory physiology specialisms are suffering from skills shortages and there are several occupations on the MAC shortage occupation list.

Part of the problem would appear to be the design of health and social care work. Employers in the sector are more likely than those in the whole economy to mention problems such as poor terms and conditions, poor locations or difficulties in public transport, as contributing to skills shortages.

Conclusion: growth through skills

Employers can play a significant role in meeting these challenges through:

- Changing working practices and roles by reworking traditional approaches to provide greater flexibility, embrace new technology and deliver more appropriate patient care.
- Developing new entry routes into the sector for example through apprenticeships
- Encouraging innovation and using the opportunities afforded by technology to develop new services and ways of working
- Raising engagement to maximise productivity, retention and minimise absence
- Developing management and leadership capability.

1 The Economic and Policy Climate

Increasingly, the competitiveness of advanced industrial nations is explained with reference to the capabilities of their respective labour forces. Hence, national education and training systems are seen as providing comparative economic advantages. It is notable that over the recent past education and training have taken centre stage in policies designed to foster the UK's competitiveness and lie at the heart of the current Government's plans to kick start the recovery against a backdrop of challenging global economic conditions. To understand the role skills development might play in stimulating growth within the health and social care sector requires some consideration of the current economic situation and current skills policy.

In 2012 the UK economy, and indeed the global economy, is still coming to terms with the repercussions of the 2008/9 economic recession. By comparison with previous recessions, 2008/9 was relatively deep and it continues to cast a long shadow over the country's medium-term economic prospects (see Table 1.1). The economic climate at the time of the 2008/9 recession and in the period afterwards has been characterised by low interest rates and a depreciation of sterling against other currencies, notably the dollar and the euro. Whilst these would usually be sufficient to give a fillip to the economy by boosting demand and, given time, increasing output, the potential for export led growth has been seriously undermined by continuing weak demand conditions across the global economy, especially in the Eurozone and the USA. As banks have sought to increase their capital, households and businesses have had difficulties gaining access to finance which has restricted growth. Moreover, the markets' continuing disquiet over developments in the Eurozone has contributed further to the climate of uncertainty in the global economy thereby further dampening demand.

Table 1.1 Four recent periods of recession in the UK

Start date	Date of bottom of recession	Length of period from start to bottom of recession	Total decline in GDP (%)	Time taken for GDP to recover to level at start of recession
1 1974 Q4	1975 Q3	4 Quarters	3.8	7 Quarters
2 1980 Q1	1980 Q4	4 Quarters	5.9	13 Quarters
3 1990 Q3	1992 Q2	8 Quarters	2.3	11 Quarters
4 2008 Q2	2009 Q1	6 Quarters	6.3	?

Source: Office of National Statistics Quarterly Economic Accounts 1975, 1981, 1993, and 2010

As a consequence of the above developments, the rapid acceleration in growth observed after the recessions of the early 1980s and 1990s has failed to materialise. Nevertheless the economy is expected to resume its long-run growth path over time (see Chart 1.1) but in order to do so there are specific steps the UK economy needs to take. The UK Treasury has identified a number of weaknesses which need to be addressed if a sustained recovery is to be achieved (BIS, HM Treasury 2011):

- i. the level of debt funded household consumption;
- ii. the share of the economy accounted for by the public sector;
- iii. weak business investment;
- iv. an over-dependence upon financial and business services; and
- v. unbalanced regional growth.

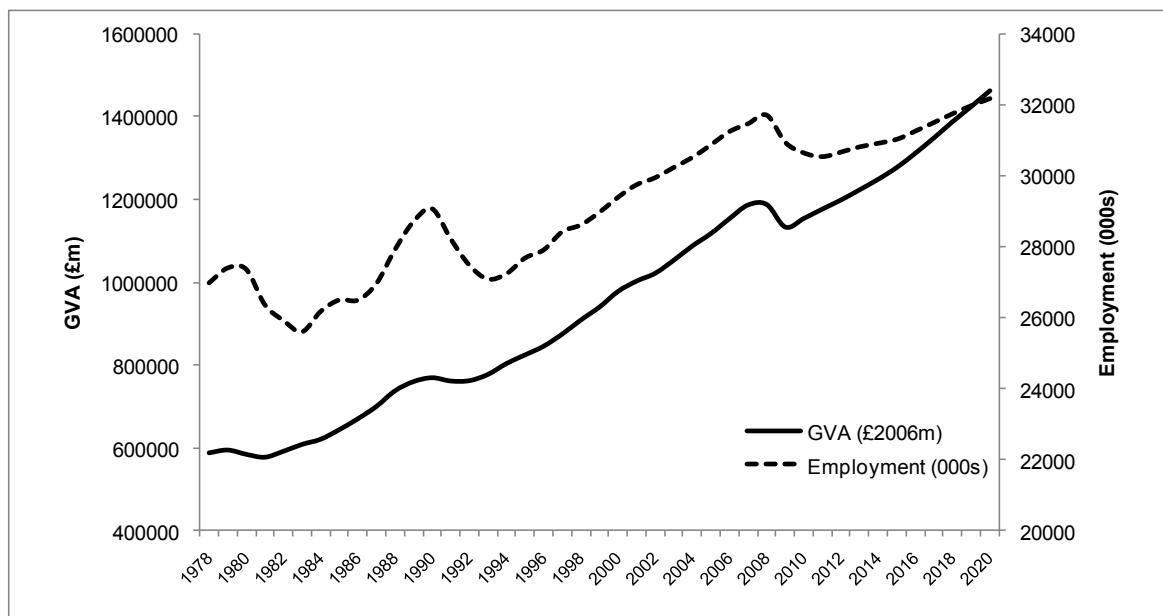
Government has identified four ambitions which need to be realised in order to restore long-term sustainable growth (BIS, HM Treasury 2011):

- i. creating the most competitive tax system in the G20;
- ii. making the UK one of the best places in Europe to start, finance and grow a business;
- iii. an over-dependence upon financial and business services; and
- iv. creating a more educated workforce that is the most flexible in Europe.

Therefore, the role of skills in national economic policy is clearly an essential one; to bring about recovery and sustainability by creating jobs and growth.

From the employer's perspective there is a need to adapt to both global demand side conditions and the consequences which are likely to arise from policies designed to rebalance the UK economy. Depending upon the sector there are likely to be a number of skill-related performance challenges which employers will need to address as they seek to consolidate existing markets, develop new ones, and introduce technical and organisational changes to improve their competitiveness. The importance of these challenges become even more apparent if one considers the role of skills in the economic cycle. Evidence demonstrates that the recovery from previous economic recessions was hampered by skills shortages, and that these skill shortages then contributed to further downturns in the economy (Blake *et al.*, 2000). Therefore, the message is clear: a failure to invest sufficiently in skills now has the potential to dampen future growth.

Chart 1.1 Employment and gross value-added 1978 - 2020



Source: Wilson and Homenidou (2011)

At a time when capital investments are constrained as a consequence of problems in the global banking system, investments in skills, and human resources more generally, may be more attractive to employers. The Growth and Innovation Fund (GIF, www.ukces.org.uk/gif) helps employers develop and implement their own innovative, sustainable skills solutions which have the potential to transform growth in their sector, region or supply chain. For example proposals can range from skills solutions for those entering the sector, increasing the uptake of apprenticeships to leadership and management solutions to support future growth of the economy.

Based on the latest evidence available, this report considers the specific situation in the health and social care sector to provide:

- an overview of the size and structure of the sector and the principal drivers of change over the medium term which are likely to have some bearing upon skill demand;
- an outline of current and expected patterns of skill demand in the sector;
- a description of skills supply and how this has adapted to changing patterns of skill demand;
- an analysis of mismatches between the demand for, and supply of skills, and the implications of this for the sector.

In conclusion, the report identifies the performance challenges faced by the sector and highlights the skills solutions available to address them which could enable increased levels of growth and contribute to the recovery of the UK economy.

2 The importance of the sector

The health and social care sector is fundamental to the economy, health and social fabric of the UK. It is a significant sector employing almost four million people which represents 13 per cent of all employment in the UK (Wilson and Homenidou, 2011). This makes health and social care the UK's largest sector in employment terms. Around 58 per cent are employed in the health sub-sector and the remainder in social care (see Table 2.1)¹. Perhaps of equal importance is the role the sector plays in maintaining and improving the health and quality of life of the UK workforce and the population more generally.

The sector is notable for having a very high proportion of females in the workforce (79 per cent compared to 47 per cent in the whole economy). This may also be reflected in higher rates of part time work (40 per cent in health and social care versus 28 per cent in the whole economy). Self employment is also relatively low (eight per cent versus 14 per cent in the whole economy).

Between 2000 and 2010 the sector grew at a faster rate than whole economy in terms of output (3.3 versus 1.5 per cent per annum) and employment (2.6 versus 0.4) and especially full time employment (3.7 versus -0.2). However the anticipated growth rate from 2010-20 for output (2.5 versus 2.7) and for employment (0.1 versus 0.5) is lower than expected for the economy as a whole. Table 2.1 below presents the summary output and employment data for the sector.

¹ These estimates are derived from the Working Futures database. The Labour Force Survey reports lower levels of overall employment at just over 3.8 million. The GVA figures reported here are based on the latest data recently revised by Cambridge Econometrics. The data in this report are in 2006 prices which also contributes to the difference.

Table 2.1 Key output and employment Indicators for health and social care

	Current level 2010	Growth rate: 2000 - 2010 (aagr)	Change (absolutes)	Growth: 2010 - 2020	Growth rate: 2010 - 2020 (aagr)	Change (absolutes)
Output	90,153	3.3	24,769	27.1	2.4	24,419
Employment	3,948,406	2.6	879,002	1.3	0.1	51,952
PT Employment	1,585,976	1.3	191,368	-4.5	-0.5	-71,836
FT Employment	2,030,628	3.7	619,433	9.1	0.9	184,926
Self employment	331,802	2.3	68,201	-18.4	-2.0	-61,138
Male employment	839,685	4.3	288,383	8.7	0.8	72,801
Female employment	3,108,721	2.1	590,619	-0.7	-0.1	-20,849

Source : Wilson and Homenidou (2011)

The two subsectors health and social care, are quite different in character and we briefly explore key differences below.

Healthcare and life sciences formed part of the government's initial growth review² with specific intent to remove the barriers to growth and innovation being experienced by the sector and attributed to 'an overly complex regulatory and governance environment. The NHS had a major role to play in this as the largest UK purchaser of products and services from the healthcare and life sciences sectors. The growth review also acknowledged the contribution of the NHS and the social care system in increasing health and welfare, which results in greater economic activity. One of the key recommendations was for the NHS Chief Executive to provide a report on how the adoption and diffusion of innovations can be accelerated across the NHS.

Health

The health sector represents one of the largest sectors of employment within the UK. It employs an estimated 1,928,200 workers (Skills for Health Research and LMI Team, 2011). How this is distributed across the various nations of the UK is shown in Table 2.2 below. Across the constituent nations health accounts for between 7 and 10 per cent of total

employment. In each nation health has enjoyed employment growth that has been greater than the whole economy average.

Table 2.2 Key employment indicators for the health sector

	England	Scotland	Wales	Northern Ireland
Workforce numbers	1,529,700	227,300	98,900	72,300
% total employment	7	9	8	10
Employment Growth Health	24.2 (1999-2008)	40 (1999-2008)	29.8 (1999-2008)	28.5 (1997-2007)
Employment Growth whole economy	7.3	11	10.6	21.4

Source: ABI 2008, Northern Ireland Census of Employment 2007.

An estimated 23 per cent of the health workforce is employed in the independent (or private sector) with 77 per cent employed in the public (NHS and voluntary) sector. The NHS is a significant employer with more than 1.7m people (the NHS in England is the biggest part of the system employing more than 1.4m people whilst the NHS in Scotland, Wales and Northern Ireland employ 155,312; 85,252 and 65,016 people respectively). The independent sector employs 400,400 in England, 38,300 in Scotland, 22,300 in Wales and 15,800 in Northern Ireland (Source: Labour Force Survey, 4 Quarter Average July 2009 – June 2010)

Of these, just under half are clinically qualified, including (for England), 39,409 general practitioners (GPs), 410,615 nurses, 18,450 ambulance staff and 103,912 hospital and community health service (HCHS) medical and dental staff.

According to the NHS website³ the relative size of the NHS workforce (although not formally a single employer) can be appreciated by comparison with other organisations from around the globe – only the Chinese People's Liberation Army, the Wal-Mart supermarket chain and the Indian Railways employ more people.

Social care

Approximately one in 16 UK workers is employed in the sector, equivalent to more than 1.8 million workers in total (Skills for Care and Development, 2011; includes pre-primary education in England, Scotland and Wales). Approximately 40 per cent of the workforce is in

³

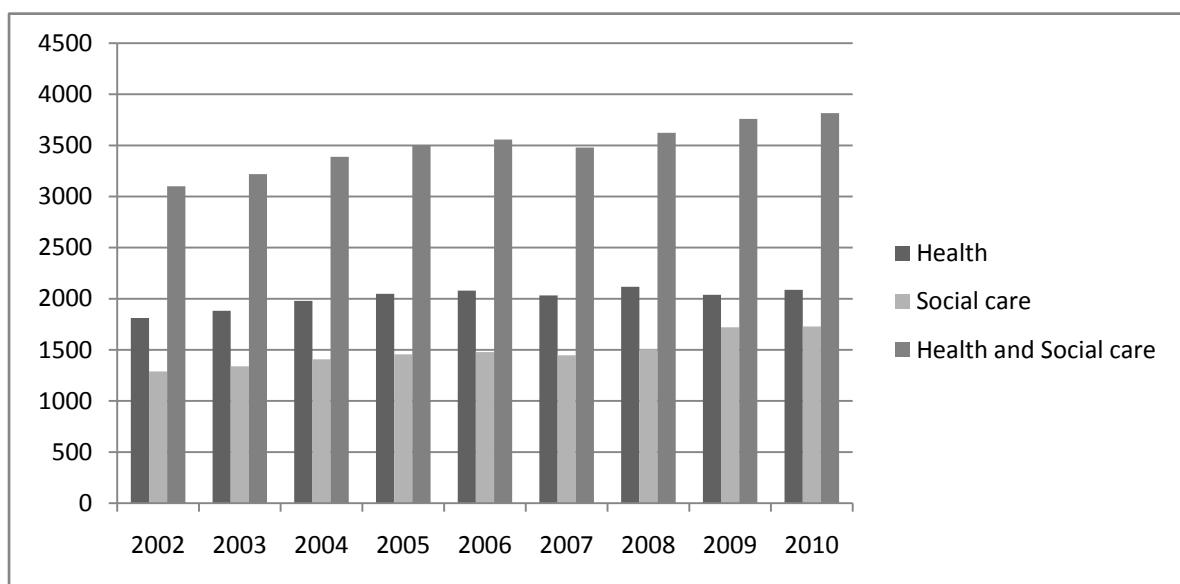
<http://www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx>

residential care, 52 per cent in non-residential services. Almost half of the workforce (47 per cent) is employed by private/commercial organisations and less than a third work for the public sector (29 per cent); more than 400,000 workers (23%) work for a charity or voluntary organisation in the sector. The number of voluntary workers in the sub sector represents more than half of all voluntary sector workers in the UK.

2.1 The changing shape of the sector

Employment in the health and social care sector stood at just over 3.8 million workers in 2010. Chart 2.1 illustrates that employment has been rising in recent years from 3.1 million in 2002, an increase of 23 per cent. Growth in employment since this time is evident in each of the sub sectors. Employment in health has risen from just over 1.8 million in 2002 to just over 2 million in 2010 (15 per cent). Respective figures for care are just less than 1.3 million in 2002 to just over 1.7 million in 2010, an increase of 23 per cent.

Chart 2.1 Employment in health and social care (000s)



Source: Labour Force Survey (2010)

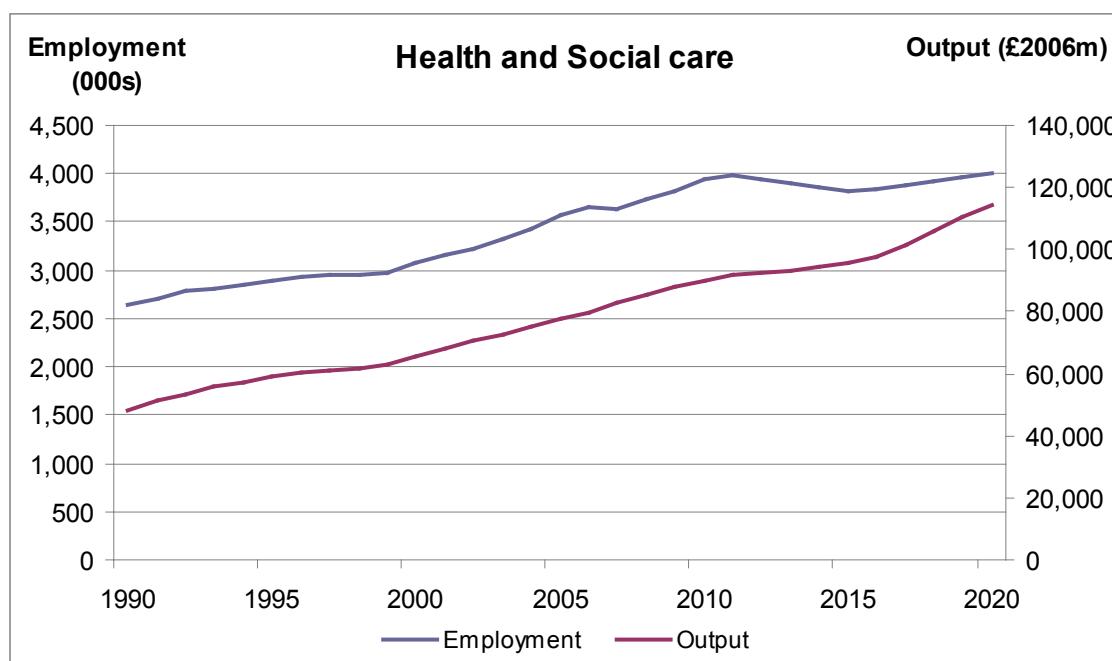
Care assistants and home carers rank second in terms of occupational size in England 2009 with 719,000 people in 2009, Nurses rank 6th with 515,000 (UKCES, 2010). There are also a number of fast growing jobs within the sector. Paramedics is the second fastest growing occupation in England with an increase of 114 per cent between 2001 and 2009, Youth and community managers have shown an increase of 62 per cent and social service managers have increased by 57 per cent over the same period.

Due to the combined effect of the sector's future social and economic significance and the anticipated need to replenish an aging workforce as it retires the sector was identified as a priority in the National Strategic Skills Audit for England (UK Commission, 2010).

Overall, it is ranked sixth among sectors for its future economic significance and first for its 'replacement labour demand' – reflecting the high volume of staff it will need to recruit in the coming years to replace its ageing workforce.

Future output growth of 2.4 per cent a year (in real terms) is projected to 2020 and assumes the continued strong demand for health and social care (Wilson and Homenidou, 2011). As Chart 2.2 indicates, there is an expectation that the pressures to restrict expenditure will result in output rising faster than employment.

Chart 2.2 Trends in employment and output in the UK 1990-2020



Source: Wilson and Homenidou (2011)

2.2 Economic significance of the sector

The economic significance of the health and social care sector is often underestimated, especially when looking at future labour productivity of the sector and projected levels of employment. The importance of health and social care lies in its contribution to all other aspects of the economy and its ability to sustain a healthy workforce.

Recent commentary on innovation in the NHS (*Innovation, Health and Wealth: accelerating adoption and diffusion in the NHS, NHSI December 2011*) suggests that the NHS contributes to the UK economy in four important ways:

- Through its services: a healthy population is more productive, and more economically active
- Innovating to improve its own productivity
- The NHS is a major customer of the life sciences industry. As such it is a consumer of innovative products and services from the life sciences industry, and by accelerating the adoption and diffusion of innovation throughout the NHS, this would support growth in the life sciences industry
- By exporting innovative ideas and expertise, it provides new business opportunities abroad for UK-based companies.

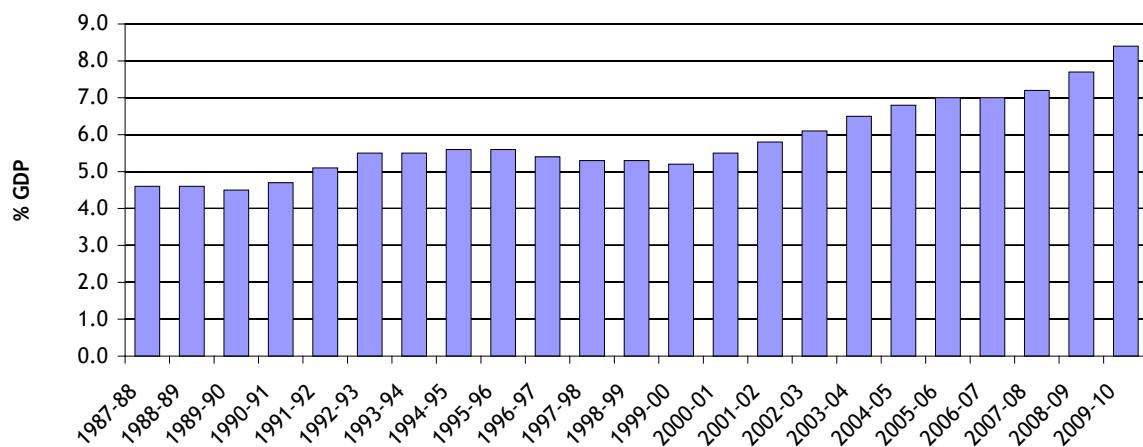
The National Strategic Skills Audit for England 2010 (UKCES, 2010) identifies a number of sectors and occupations where immediate action is needed to address high priority skills needs. Within the health sector, management and leadership skills are key to manage change and respond to and exploit future challenges. Additionally, there is a need for health professionals in a number of specialisms. The size of the sector means the magnitude of these needs is large and meeting them poses substantial challenges.

2.2.1 Expenditure

Health and social care accounts for a sizeable proportion of public sector spending. It's buying power and supply chains are therefore substantial and create significant economic benefits.

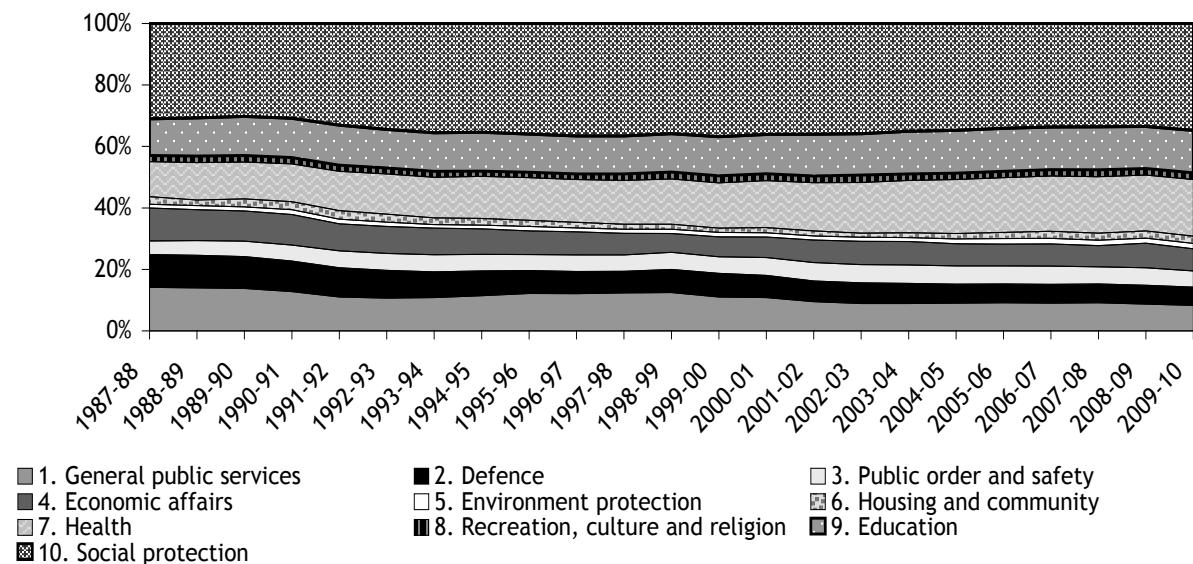
The health sector has experienced a steady increase in spend over recent years in both real terms and as a percentage of UK GDP. Public spending on health has also risen faster than most other forms of public expenditure certainly visible since the late 90s (see Chart 2.3 and 2.4).

Chart 2.3 Health expenditure as % of UK GDP



Source: *Public Sector Statistical Analyses 2011, HM Treasury*

Chart 2.4 Public expenditure as % UK GDP



Source: *Public Sector Statistical Analyses 2011, HM Treasury*

The UK's expenditure on healthcare is about the European average although a relatively high percentage of that spend is public expenditure. The increase in government expenditure on health over the period 2000-07 was higher in the UK (2.4 per cent), than other comparator nations with the exception of the Netherlands (18.9 per cent) (UK Sector Skills Assessment Full Report: Skills for Health Research and LMI Team, 2011)

The future however is likely to be much less positive in an environment of fiscal constraint. Appleby *et al.* (2010) estimate that demographic change requires annual increases to health expenditure of 1.1 per cent up to 2017, to maintain current levels of service in NHS spending to maintain current levels of quality and outputs, irrespective of any additional expenditure necessary for the adoption of new technology or changes in demand for healthcare across the population.

Skills for Care and Development report that public and private expenditure within the **social care** sector is significant at over £30 billion. UK public expenditure was more than £18bn for adult social care services 2007-08 and approximately £6.1bn for children's social care. The latter includes spending on services for looked after children of more than £2.2bn. (Skills for Care and Development 2011).

Private funding on care services accounts for an estimated third of all expenditure.

Social care is funded through local government which is set to experience a significant reduction in funding (see Table 2.3). The Local Government Association believes that local government faces a total funding shortfall in the order of £6.5bn in the next two years. The LGA estimates that local authorities with Social service responsibilities face a reduction of between -11.3 per cent to -14.3 per cent in 2011-12. A report produced by the Chartered Institute of Public Finance and Accountancy (CIPFA) for the National Society for the Prevention of Cruelty to Children (NSPCC) (CIPFA, 2011) points out that children's social care spending in England is expected to be reduced by an average of 24 per cent in 2011-12 – significantly more than the overall real-terms reduction in local government spending, and more than the average 10 percent budget reductions for most other local authority services. By comparison, adult social care spending was projected to fall in 2011-12 by less than 2 per cent.

Table 2.3 Local government settlement in England 2010-2015

2010-11	2011-12	2012-13	2013-14	2014-15
£28.5bn	£26.1bn	£24.4bn	£24.2bn	£22.9bn

Source: *Comprehensive Spending Review 2010*

The budget constraints apply across the nations of the UK; In Scotland, the draft budget for 2011-12 indicates a cut of £286.9 million in resource budgets and of £151.4 million in capital.

In Wales, the Welsh Assembly Government has published draft Budget proposals indicating a cut in overall spending of £860m in 2011-12 (and spending will be £1.8bn lower by 2014-15). The Welsh Local Government Association estimate that councils' core revenue grant funding will reduce on average by 1.4 per cent next year, 3.3 per cent in real terms. Over the three years revenue funding is set to fall by 6.7 per cent in real terms, despite indicative figures for 2012-13 and 2013-14 show small cash increases. Capital funding is set to fall by 14 per cent in 2011-12 with further cuts expected in years two and three.

The overall outlook across both health and social care is one of financial stringency which, in the face of growing demand will place considerable pressure on the sector to improve performance.

2.3 Productivity in the health and social care sector

Productivity is notoriously hard to measure in the public sector and it has been the subject of much discussion within the health and social care sector (e.g. Crosswaite *et al.* 2010, Dawson *et al.* 2005). Productivity is a measure of economic performance that is usually defined at its broadest as output per unit of input. Input refers to labour and capital, while

output is the value of goods and services produced. The ‘inputs’ and ‘outputs’ tend to be quantitative measures, such as number of workers or the cost of a specific treatment or drug.

There is debate, however, over measuring quality in relation to outputs and the impact of this on productivity (Derbyshire *et al.* 2007). In healthcare, improving quality may mean spending more time with a patient which can act to lower productivity whilst improving health outcomes.

Given the difficulty and debate in calculating productivity in the sector it is perhaps not surprising that the evidence on productivity is somewhat contradictory. For example analysis using ONS data suggests that NHS productivity fell between 1995-2008 due to increasing staff numbers. On a more positive note, Crosswaite *et al.* (2010) note that recent data (Health Service Journal, May 2009) suggests that NHS productivity has improved, with the greatest gains between 2004 and 2006. This has been attributed to stability in NHS staff numbers, a reduced dependence on agency staff, and improvements in care quality and the number of patients treated (Skills for Care, 2011).

Looking at productivity within the NHS, the main factors accounting for increases in *output* were:

- more patient treatments in hospital and community healthcare services
- an increase in general practitioner (GP) and practice nurse consultations
- a large increase in drugs prescribed by GPs
- a rise in the quality of healthcare (based on short-term survival, health gain, waiting times and patient experience) since 2001.

Increases in *inputs* was due to:

- increases in the volume of labour, especially between 2000 and 2004
- growth in the volume of goods and services, particularly in GP prescribed drugs, healthcare purchased from outside the NHS and other purchased goods and services (UKCeMGA, June 2009)

Similarly for the social care sector current output measures make no allowance for quality, nor do they take account of intensity of need which may have been increasing. Output

measures can also not readily respond to changing delivery methods of care ie if an increasing proportion of people have services provided to them at home instead of being taken into residential care. For example low cost adoption and fostering have expanded at the expense of higher cost residential care homes (Skills for Care and Development, 2011)

The Institute for Employment Studies undertook research (Jagger, 2010) which suggests that the UK is mid- range in terms of Value Added Per Employee in the care sector, with a wide range of countries performing better than the UK including the USA, Germany, Japan and France.

The overall message for the health and social care sector is difficult to determine as there is little agreement on the current trends in productivity. However it would seem that if qualitative measures are taken into account such as health outcomes, the productivity of the sector has generally judged to have been increasing. If qualitative measures are excluded then productivity has been judged to be decreasing. This might mean that the impact of current fiscal constraints could push in the opposite direction on both these measures ie quantitatively driven measures may improve as inputs decline, whereas qualitatively adjusted measures may get worse as quality is affected by financial constraints.

It is anticipated that demand for services will continue to rise and inputs will rise more slowly than in the past due to current fiscal constraints. Therefore the net effect will be to raise productivity as the gap between inputs and outputs narrows but it remains to be seen if there are lower quality outcomes occur as a result.

2.4 Performance

An LSE report into the performance of the NHS under the previous government (CEP, Election Analysis, 2010) noted that since 1997 when the percentage of GDP spent on health was 5.3 per cent, NHS spending had increased at a faster rate than at any previous period increasing by approximately 7 per cent in real terms since 2000.

This was a deliberate strategy to increase spending as a proportion of GDP to the European average. By 2010-11, healthcare expenditure was estimated to be 9.3 per cent of GDP, with the NHS accounting for approximately 18 per cent of UK public expenditure. The impact of the spend has been to increase staffing, salaries and numbers of patients treated. There has also been increases in quality and equity outcomes. Waiting times for hospital treatment and in Accident and Emergency departments have decreased substantially and vary much less by socioeconomic group than they did previously.

Bearing in mind relatively recent increases in health spending and quality outcomes, the latest OECD (2011) report on health outcomes shows many positive improvements for the UK. For example average life expectancy stands at 80.4 years in 2009 above the OECD average of 79.5 years. Mortality rates from heart disease are just below the OECD average (110 per 100,000 population versus 117) lower for stroke (42 versus 54) below the OECD average for mortality rates for all cancers (199 versus 208 per 100,000 population) although remain higher for breast cancer and prostate cancer mortality (all 2009).

The incidence of smoking in the UK is about the OECD average (21.5 per cent in the UK versus 22.1 per cent OECD average, 2009) but has shown a greater reduction of 20 per cent against an OECD average reduction of nearly 18 per cent between 1999 and 2009.

There are however also negative trends such as rising obesity rates which have risen from 14 to 23 per cent between 1990 and 2009, which is above the OECD average of 17 per cent (2009). Rates of childhood diabetes are high at 24.5 cases per 100,000 (16.9 OECD average).

2.5 Employment structure

There were approximately 141,000 establishments operating in the health and social care sector in the UK in 2010. This represents just less than six per cent of all establishments in the UK with health accounting for 2.1 per cent (55,135) and care accounting for 3.4 per cent (85,935) (UK Commission, forthcoming a). The following sub-sections elaborate on these figures using analysis from each of the SSCs covering the sector.

2.5.1 Health

Table 2.4 shows that health sector establishments account for two per cent of all establishments in England, Scotland and Wales but four per cent of all establishments in Northern Ireland. At 85 per cent the majority of all UK health sector establishments in the are located in England.⁴ This is reflects the distribution of the UK population.

Table 2.4 Health establishments by country, 2008

	Health establishments	Percentage of UK Health Establishments	Percentage of all establishments in each nation
England	45,200	85	2
Scotland	3,800	7	2
Wales	2,500	5	2

⁴

Northern Ireland*	1,700	3	4
Source: ABI 2008, Northern Ireland – Census of Employment 2007			

Over the period 2008-10 the number of health establishments increased by almost 3.5 per cent compared with a decrease of 2.6 per cent for all sectors (UK Commission, forthcoming a). Although based on a more limited time period Table 2.5 gives a sense of how employee and establishment numbers have changed in the sector for England Scotland and Wales. Specialist medical activities has reported the largest increase in establishments (and employees) and hospital activities the only decrease in establishments. Several other parts of health also reported declines in numbers of employees.

Table 2.5 Changes in the Health Sector by Establishments and Employees 2007 - 2008

Great Britain	2007	2008	% Variance
Employees by SIC code			
86.10 : Hospital activities	1,315,000	1,267,300	-3.6
86.21 : General medical practice activities	202,500	187,700	-7.3
86.22 : Specialist medical practice activities	9,700	12,400	27.8
86.23 : Dental practice activities	69,900	67,700	-3.1
86.90 : Other human health activities	259,200	320,700	23.7
Total	1,856,200	1,855,900	0.0
Establishments by SIC code			
86.10 : Hospital activities	7,900	7,000	-11.4
86.21 : General medical practice activities	16,300	16,800	3.1
86.22 : Specialist medical practice activities	1,000	1,500	50.0
86.23 : Dental practice activities	10,500	10,900	3.8
86.90 : Other human health activities	15,300	15,300	0.0
Total	51,200	51,500	0.6

Full Report Authors: Skills for Health Research and LMI Team based on ABI 2008 (for England, Scotland & Wales) SIC 2007 Classification

Please Note: Northern Ireland data not yet available in SIC 2007 format

Source: UK Sector Skills Assessment 2011

2.5.2 Social care

In the social care sub sector a broadly distinction is made between residential and non residential activities (SIC 87 and 88 respectively). Skills for Care and Development (2011) estimate the largest proportion of registered businesses operate in the non residential part of the sub-sector (69 per cent), see Table 2.6.

Table 2.6 Number of registered businesses in social care as at march 2009 by SIC code

SIC	Description	No.	% of 2 digit SIC	% of sub-sector
87100	Residential nursing care activities	2,565	22.9%	6.1%
87200	Residential nursing care activities for learning disabilities, mental health and substance abuse	530	4.7%	1.3%
87300	Residential care activities for the elderly and disabled	4,410	39.3%	10.4%
87900	Other residential care activities	3,705	33.1%	8.8%
87	Residential care activities	11,210	100%	26.5%
88100	Social work activities without accommodation for the elderly and disabled	4,720	16.2%	11.2%
88910	Child day care activities	9,230	31.6%	21.8%
88990	Other social work activities without accommodation n.e.c	15,275	52.3%	36.1%
88	Other social work activities without accommodation	29,225	100%	69.0%

Source: *Skills for Care and Development (UK Sector Skills Assessment for the social care, children, early years and young people's workforce, 2011), based on Inter-Departmental Business Register, ONS (as at March 2009)*

Table 2.7 shows that in Great Britain there were nearly 30,000 establishments in the residential care part of the care sub sector in 2009 compared to nearly 46,000 in non residential care (Skills for Care and Development, 2011). The data suggests that establishments providing residential services in Great Britain have declined in number with the biggest decline in residential nursing care. The table also shows that there was a significant increase across GB in residential care establishments catering for learning disabilities, mental health and substance abuse between 2007 and 2008. However caution may be required because a change in SIC classification (from SIC 2003 to 2007 occurred at this point.

Table 2.7 Residential care establishments by nation, 2007-2009

	SIC 8710 : Residential nursing care			SIC 8720 : Residential care for learning disabilities, mental health and substance abuse			SIC 8730 : Residential care for the elderly and disabled			SIC 8790 : Other residential care			
	2007	2008	2009	2007	2008	2009	2007	2008	2009	2007	2008	2009	
	Great Britain	5,166	5,455	4,435	1,329	1,931	1,880	12,345	12,580	11,960	12,560	10,896	11,200
% change		6%	-19%		45%	-3%		2%	-5%		-13%	3%	
England	4,435	4,758	3,815	1,206	1,745	1,695	10,484	10,737	10,150	11,053	9,490	9,725	
% change		7%	-20%		45%	-3%		2%	-5%		-14%	2%	
Wales	323	288	250	74	124	115	635	725	710	576	551	565	
% change		-11%	-13%		68%	-7%		14%	-2%		-4%	3%	
Scotland	408	409	370	49	62	70	1,226	1,118	1,100	931	855	910	
% change		0%	-10%		27%	13%		-9%	-2%		-8%	6%	

Source: Skills for Care and Development (UK Sector Skills Assessment for the social care, children, early years and young people's workforce, 2011), based on ABI 2007-8, IDBR 2009

A comparison of the number of establishments providing non-residential services between 2007 and 2009 (Table 2.8 below) suggests that there has not been such a common reduction in non residential care establishments with general increases in establishments providing services to the elderly and child day-care which appear to have grown over the same period.

Table 2.8 Non residential care establishments by nation, 2007-2009

Country	SIC 8810 : Social work activities without accommodation for the elderly and disabled						SIC 8899 : Other social work activities without accommodation n.e.c.			
	2007	2008	2009	2007	2008	2009	2007	2008	2009	
	Great Britain	5,054	8,314	7,870 8710	7,772	11,052	11,420	33,375	30,217	26,635
England		64.5%	-5.3% 4.8%		42.2%	3.3%		-9.5%	-11.9%	
	4,185	6,971	7,380	6,559	9,361	10,795	27,724	25,071	24,840	
Wales		66.6%	5.9%		42.7%	15.3%		-9.6% -	0.9%	
	300	476	490	361	500	625	2,021	1,873	1,795	
Scotland		58.7%	2.9%		38.5%	25.0%		-7.3% -	-4.2%	
	569	867	840	852	1,191	1,290	3,630	3,273	3,210	
	52.4%	-3.1%		39.8%	8.3%		-9.8%	-1.9%		

Source: Skills for Care and Development (UK Sector Skills Assessment for the social care, children, early years and young people's workforce, 2011), based on ABI 2007-8, IDBR 2009

2.6 Form of ownership

Health services are delivered through both independent and public providers (as shown in Table 2.9 below), the public sector being a combination of NHS and voluntary organisations. The public sector employs the majority (77 per cent) of the health sub-sector workforce. Across both the independent and public sectors nearly two thirds (63 per cent) of workers are employed in hospital activities.

Table 2.9 Healthcare employment by the independent and public sector

UK	Independent		Public		Total	
	Employment	%	Employment	%	Employment	%
86.10 Hospital activities	172,900	8	1,125,600	55	1,298,500	63
86.21/22 Medical combined	93,100	4.5	127,800	6	220,900	11
86.23 Dental practice activities	80,900	4	18,900	1	99,800	5
86.90 Other human health activities	129,900	6	309,600	15	439,500	21
Total	476,800	23	1,581,900	77	2,058,700	100

All numbers rounded to the nearest 100

Source: *Labour Force Survey, (2010)*

The number of establishments in care totals just less than 86,000 in 2010. The majority of these are found within the public sector (53 per cent) with 25 per cent in private sector and 22 per cent in the voluntary / not-for-profit sector (UK Commission, forthcoming b).

Contrary to the health sub-sector, most employment in care (74 per cent) is found within the private or independent firms (see Table 2.10). . The independent sector dominates both residential and non residential parts of the sub-sector reflecting a long term trend in within care.

Table 2.10 Social care employment by the independent and public sector

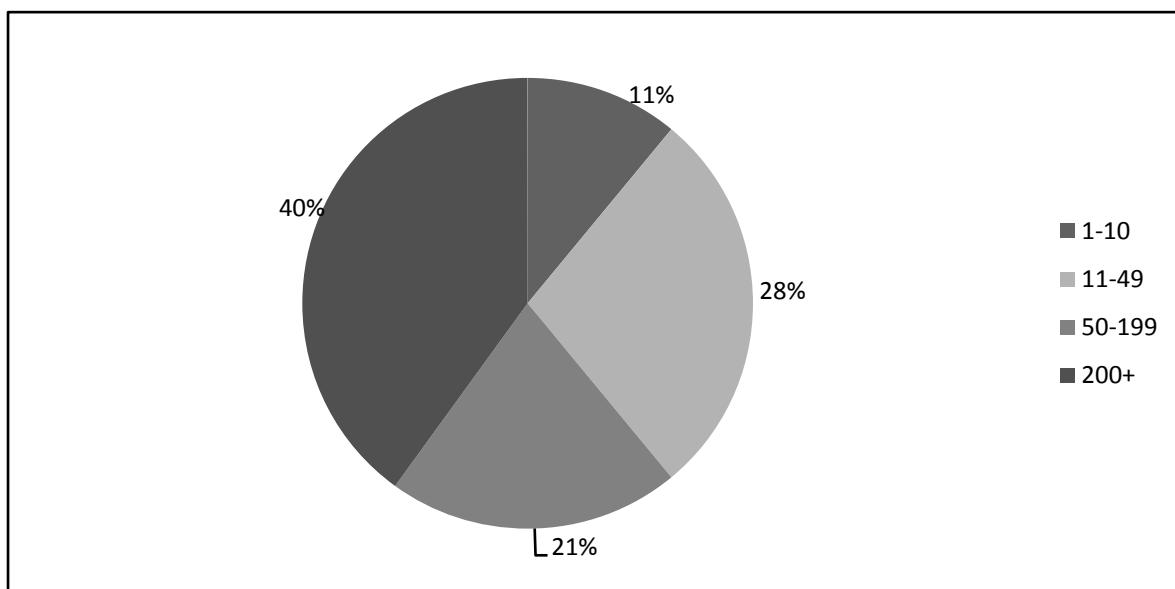
	Public	Independent	Total (000s)
87 Residential care activities	16	84	530.9
88 other social work activities without accommodation	31.8	68.1	898.9
Total	26.4	73.6	1598.2

Source: *Skills for Care and Development, 2011 based on 2009 Business Register and Employment Survey (BRES), Office of National Statistics*

2.7 Size of organisation

Chart 2.5 gives the distribution of employment by establishment size band. Compared to the average for the whole economy employment within the health and social care sector is more concentrated in large establishments. Approximately two fifths of employment in the sector is accounted for by establishments providing two hundred or more jobs compared to 32 per cent across all sectors. However, the proportion of employment provided by the smallest establishments in the sector (11 per cent) is nearly half that of the all-sector average (21 per cent). The proportion of employment represented by establishments providing 11-199 jobs is broadly similar to the whole economy average.

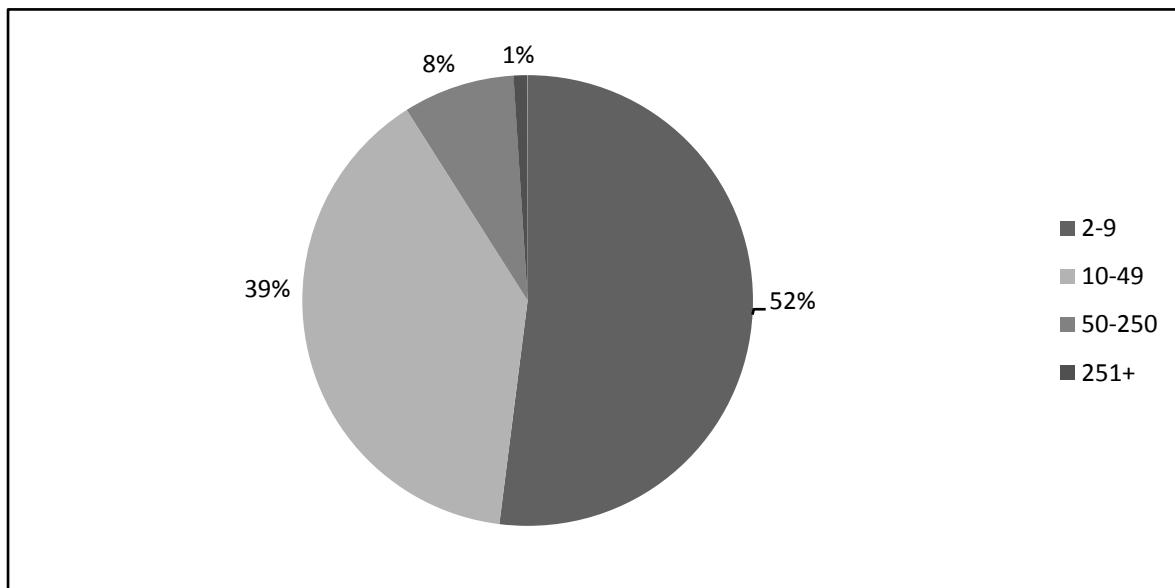
Chart 2.5 Size structure of employment in health and social care (% of employment by employer size band)



Source: UK Commission (2011) C2.7b

Considering the number of employers by size band reveals that more than half (52 per cent) of all establishments employ two to nine workers (see Chart 2.6). This is significantly less than the economy as a whole at 74 per cent. However the sector has a much greater representation of establishments sized 10-49 and 50-250 employees (39 per cent and eight per cent respectively) than average for the economy (21 per cent and four per cent). Establishments with more than 251 employees make up just one per cent of the sector which is the same as the whole economy average.

Chart 2.6 Size structure of employment in health and social care (% of establishments by employer size band)



Source: UK Commission (2011) C2.10a

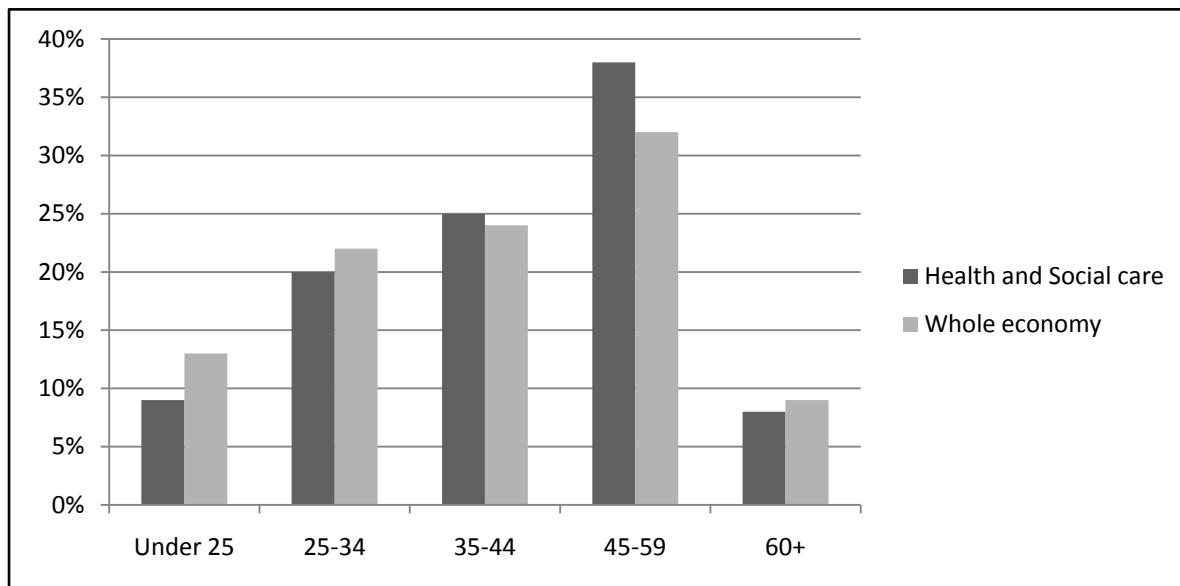
There are some differences in the two sub sectors in terms of the distribution of establishments by employer size band. Establishments providing between two and nine jobs in social care are less common than those in health (50 per cent compared to 56 per cent respectively). A greater proportion of establishments in social care (41 per cent) are represented by those providing 10-49 jobs than in health (36 per cent). The sub sectors have a similar distribution of establishments across the remaining size bands of 50-250 and 251 or more (UK Commission, forthcoming a and b)

2.8 Age structure of employment

Compared to the general working population the the health and social care sector has a higher proportion of workers aged 35-44 and 45-59 is 'older'. This older age distribution is in part due to the older age of entry of professional staff after long training programmes (see Chart 2.7).

Having a higher proportion of workers in older age groups implies that there will be a substantial need to replace workers as they leave the sector due to retirement. This replacement demand will be a significant issue in the sector and therefore emphasises the importance of recruitment and training.. The implications of relatively long training periods for many of the highly skilled roles in the sector means that action to ensure an appropriate supply of skills is critical. These issues further in sections 3.8 and 4.2.

Chart 2.7 Age structure of the health and social care workforce



Source: Labour Force Survey (2010)

2.9 Gender profile

The gender profile of employment in the health and social care sector is characterised by a high proportion of female workers. Almost four fifths (79 per cent) of the workforce are female and there is very little variation by sub sector.

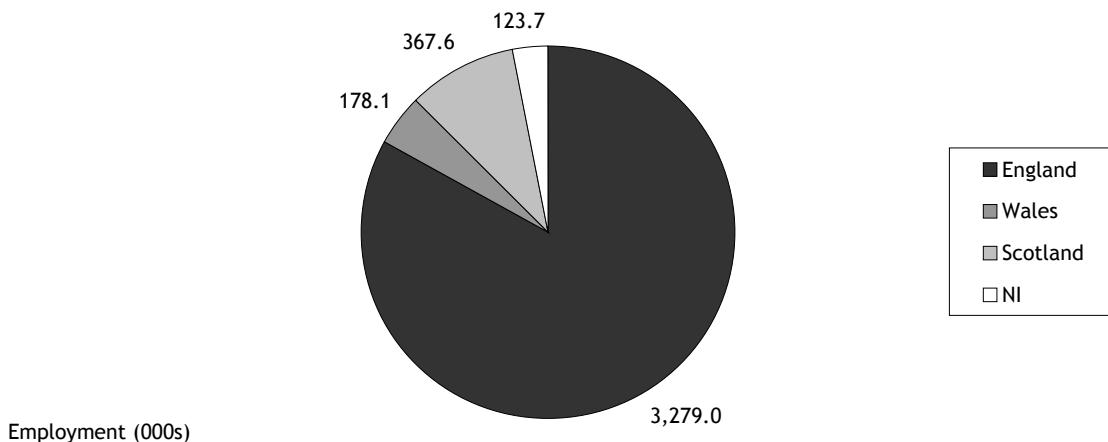
This pattern results in a higher numbers of workers retiring early, higher proportions taking career breaks and high proportions returning from career breaks (Skills for Health Research and LMI team, 2011): Skills for Health note the implications for part-time working. The ratio between full-time and part-time working is 58:42 in the health sector compared to 69:31 in the whole economy and in 2008 56 per cent of all accepted applicants to medical school were female.

By 2014, 85 per cent of the care workforce is expected to be female. Skills for Care and Development (2011) anticipate that this is likely to result in recruitment issues for the sector and refer to work by the IPPR (Roche D and Rankin, 2004) who point out that workforces relying on low skilled female labour may find it increasingly difficult to attract sufficient people into employment.

2.10 Distribution of employment by nation and region

The distribution of employment in health and social care across the UK (see Chart 2.8) shadows the distribution of the general population.

Chart 2.8 Employment by nation and region (Employment 000s)



Source: Wilson and Homenidou (2011)

Similarly, employment in the sector is distributed throughout the regions of England (see Table 2.11 below). Again this distribution is broadly reflective of population density. Skills for Care and Development (2011) point out that population growth in London, the South East and East of England is greater than for the rest of the UK and would therefore suggest a rising need for employment in these regions.

Skills for Health (UK Sector Skills Assessment 2011) highlight a recent report from the ONS (Office for National Statistics, 2010), which shows that whilst all UK countries show evidence of population ageing, the changes have not occurred evenly across the UK (or indeed in its constituent countries), and the concentration of older people varies. The lowest percentages were found in London (26 per cent) and Northern Ireland (31 per cent). The highest percentages were found in the South West of England (39 per cent) and Wales (37 per cent). Coastal and rural areas tend to have the highest percentages of population aged 50 and over, reflecting internal migration on or in preparation for retirement. This too has implications for future demand for services and therefore employment.

Table 2.11 Employment by region (000s)

	London	South East	East	South West	West Mids	East Mids	Yorks /Hum	North West	North East	Total
Health and Social care	520.4	527.9	354.4	332.7	327.6	274.2	307.9	458.6	175.4	3,279
<i>Health</i>	298.4	296.5	187.2	189.6	191.4	156.2	183.9	268.5	107.3	1,879
<i>Care</i>	221.9	231.3	167.2	143.0	136.2	118.0	124.1	190.1	68.2	1,400

Source : Wilson and Homenidou (2011)

2.11 Self employment

Self employment in the health and social care sector is much lower than average for all sectors (2.3 per versus 14 per cent respectively) (Wilson and Homenidou, 2011). The proportion of self employment is projected to fall by nearly 19 per cent by 2020 contrary to the expected trend for growth in the number of self employed in the UK as a whole. There is relatively little variance by sub sectors. Health has 2.4 per cent self employment with anticipated reductions of almost 20 per cent and care has 2.2 per cent self employment and an anticipated reduction of 17 per cent by 2020).

Skills for Care and Development (2011) note that there is a growing self employed workforce in social care of both professionally qualified and frontline carers, such as personal assistants and other community-based practitioners and independent social workers. The move to individual budgets and direct payments held by those in need of care has meant an increasing number of care employers.

2.12 International standing of the sector

2.12.1 Employment

It has already been noted that the sector provides around 13 per cent of all employment in the UK. This is relatively high in comparison to the average for the sector in Europe of 10 per cent. Only the Netherlands (16 per cent), Belgium (14 per cent), Sweden (15 per cent), Denmark (19 per cent), Norway (21 per cent) and Finland (16) have greater proportions of employment in health and social care (Eurostat, 2011)

There is indication however that jobs in health and social care have been growing across Europe. More than two million new health and social care jobs were created across Europe between 1995 and 2001 which represents 18 per cent of total job creation overall (Jagger, 2011). A greater proportion of the UK care workforce are in associate professional roles (which includes youth and community workers, housing and welfare officers) than most EU

countries (some 40 per cent more) and the UK has more personal care and related workers (twice the EU average). The UK also has a greater proportion of the workforce delivering social work without accommodation than the EU average but a smaller proportion of the workforce in residential care (Jagger, 2011).

OECD health data (using data published by OECD/Eurostat, in late 2010), gives some scope to look at nurse to population ratios for European countries and shows the UK ratios are about the EU average.

2.12.2 International market in health

The international market for healthcare is difficult to judge but what information there is suggests it is very small compared to the gross output of health services. In 2005, the UK exported an estimated \$125.7 million dollars worth of health services and imported \$107.5 million dollars worth (this is based on consumption abroad ie the travel of the service recipient) (Herman, 2009). This equates to less than one per cent of the gross output of health services. On the whole the figures suggest that international trade in health is not significant as healthcare tends to be largely consumed within the recipient's country of residence.

2.13 Conclusion

The health and social care has historically been a growing UK employer. Despite concerns that future growth will be restricted due to financial constraints, the increasing demand for services is likely to ensure that employment in the sector remains significant. Within the health subsector the NHS is hugely dominant and indeed is one of the world's largest employers. In the care subsector employment is much more dispersed with almost half of the workforce being employed by smaller, private sector organisations. Reflecting this, the care sector tends to have a larger number of smaller employers compared to the health sector.

Health and social care is seen as a priority sector by UKCES partly through its economic significance and partly because of the sizeable replacement demand (see section 4) for skills expected in the coming years.

Health and social care productivity is notoriously difficult to measure and there are contradictory findings with some commentators arguing that productivity has increased and others that it has decreased. Certainly spending on health has risen considerably since the late 1990s both in real terms and as a proportion of GDP and there have been

accompanying improvements in quality and output. As financial restraint takes effect it should act to raise productivity as employment growth is slowed and outputs continue to rise but this may be offset by declining quality.

Employment in the sector is dispersed across the four nations of the UK and within England regionally. Broadly employment reflects population density.

The workforce is older and more likely to be female than the UK workforce as a whole and this is reflected in high levels of part time working.

There has been a shift in employment structure of health in recent years with a decline in hospital activities in both the number of establishments and employees, alongside an increase in specialist medical practice activities. The employment structure of social care shows declining numbers of establishments offering residential care. This trend is set to continue with the increase in personal budgets.

Health spending in the UK (as a proportion of GDP) has been increasing relative to other countries (e.g. Europe and OECD) but again the future is uncertain regarding whether these trends will continue.

In the next section we examine some of the key challenges facing the sector in the future before looking at the implications for skills and employment.

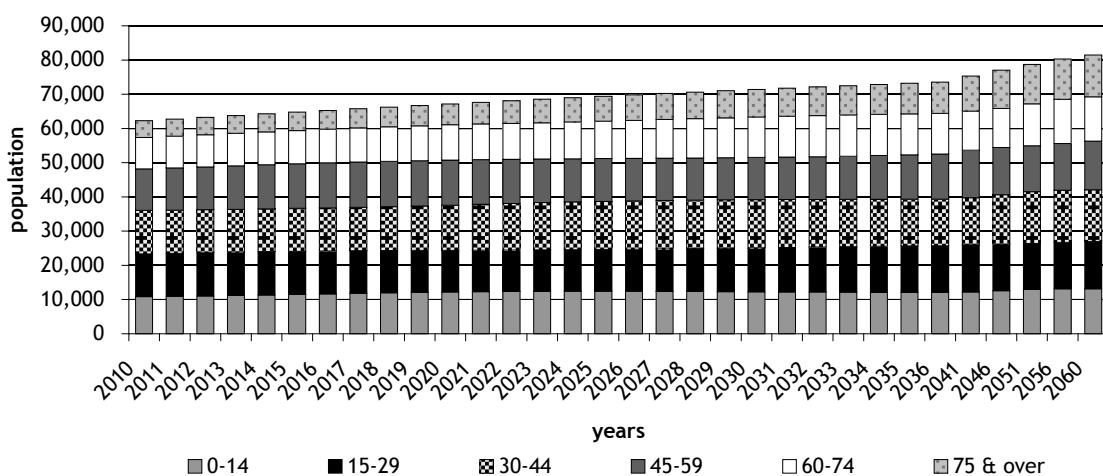
3 Key challenges facing the sector over the medium-term

A number of key challenges face the health and social care sector over the medium term whilst other issues which have been important in recent years will continue to influence the sector's performance. This section considers these challenges and their impact.

3.1 Age and population growth

Restricted budgets and the need for efficiency savings come at a time when the UK population is ageing and predicted to grow which will place additional burden on both health and social care provision. ONS population predictions expect the UK population to increase from 2010 levels of just over 62 million to almost 81.5 million by 2060 (see Chart 3.1 below).

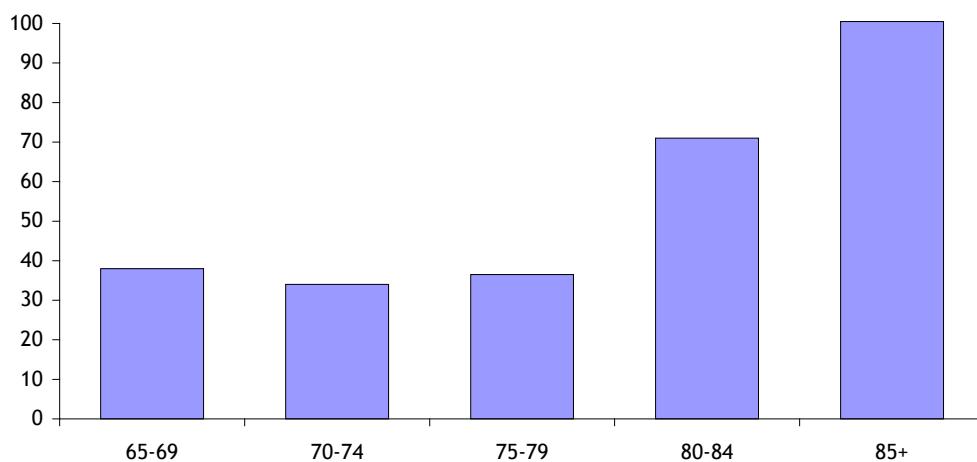
Chart 3.1 Population growth 2010-2060



Source: ONS, *National Population Projections, 2010 release*

The expected percentage growth in the number of people aged 65 or over in the UK is substantial and is greatest for those aged over 80 (see chart 3.2). In 2010 it was estimated that 10 million people in the UK were over 65 years old. Projections were for 5½ million more people over 65 by 2030 and the number to have nearly doubled to around 19 million by 2050. Within the elderly population, the number of very old people is set to grow faster. In 2010 there were estimated to be three million people aged over 80 years which is projected to nearly double by 2030 and reach eight million by 2050. An ageing population results in greater NHS costs – currently the average spend on retired households is almost double that on non retired (Cracknell, 2010).

Chart 3.2 Percentage growth in the number of older people in England 2010-2030 by age group



Source: The Report of the Commission on Funding of Care and Support based on ONS 2008 population projections

The Dilnot Commission (Dilnot, 2010) estimate that approximately three quarters of people aged 65 will need some form of care, of which half can expect care costs of up to £20,000 and a quarter can expect costs of over £100,000. The Commission also states that demand for care over the last four years has outstripped expenditure by nine per cent and that funding for care has not kept pace with more general NHS funding. Real spend on adult social care has increased by 70 per cent over the period 1994/95 to 2009/10 compared to NHS increase of almost 110 per cent).

However there is evidence that changing assessments of demand for services will make the impact of population ageing less straightforward. Skills for Care and Development, 2011 highlight information from the Audit Commission (2009) that the proportion of older people in residential care or receiving home care was declining, and around 10,000 fewer people over 65 received personal social services in 2007/08 compared to 2006/07. This was driven by increased rationing of resources with the result that councils were tending to provide more hours of care to fewer people. In Scotland the number of long-stay residents aged 65+ supported in care homes has also fallen from around 32,000 in 2002-03 to 31,000 in 2009-10. However, the Scottish Government anticipates a future increased need for care. In Wales, total home care hours provided by local authorities decreased by four per cent and based on a sample week in September 2009, 23,600 people received home care, a fall of four per cent compared to the previous year.

As part of the Comprehensive Spending Review, the UK Government announced an additional £1 billion a year for social care through the NHS, as part of an overall £2 billion a year of additional funding to support social care by 2014-15. The Scottish Government has allocated £70 million for a new change fund in 2011-12 intended to enable the redesign of services that support shifting the balance of care towards primary and community care.

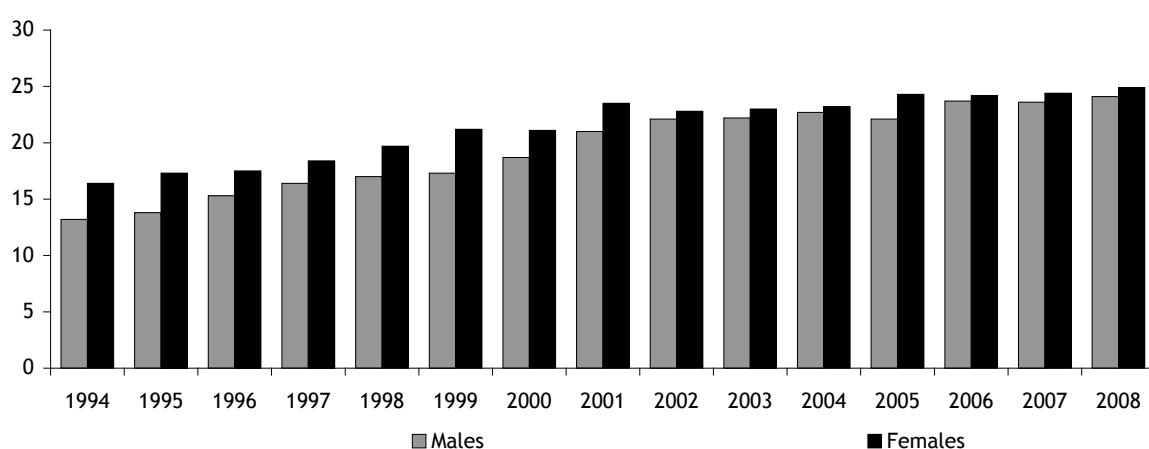
3.2 Lifestyle choices

There are a range of lifestyle choices that act to increase demand for health or social care. Trends in obesity, levels of physical activity and alcohol consumption reveal potential consequences that not only have implications for skills in the sector as overall demand for services rise, but also the nature of the skills required to provide public health preventative services and primary and secondary care.

3.2.1 Obesity

The National Obesity Observatory (http://www.noo.org.uk/NOO_about_obesity/trends) reports a significant rise in adult obesity levels in the UK. By 2050 the prevalence of obesity is predicted to affect 60 per cent of adult men, 50 per cent of adult women and 25 per cent of children (Aylott *et al.* 2007). The cost of obesity to the NHS is estimated at £5.1 billion per year and with levels of obesity rising pressure on budgets is only likely to increase (Department of Health, 2012).

Chart 3.3 Trends in adult (aged 16+ years) obesity prevalence (HSE) in England



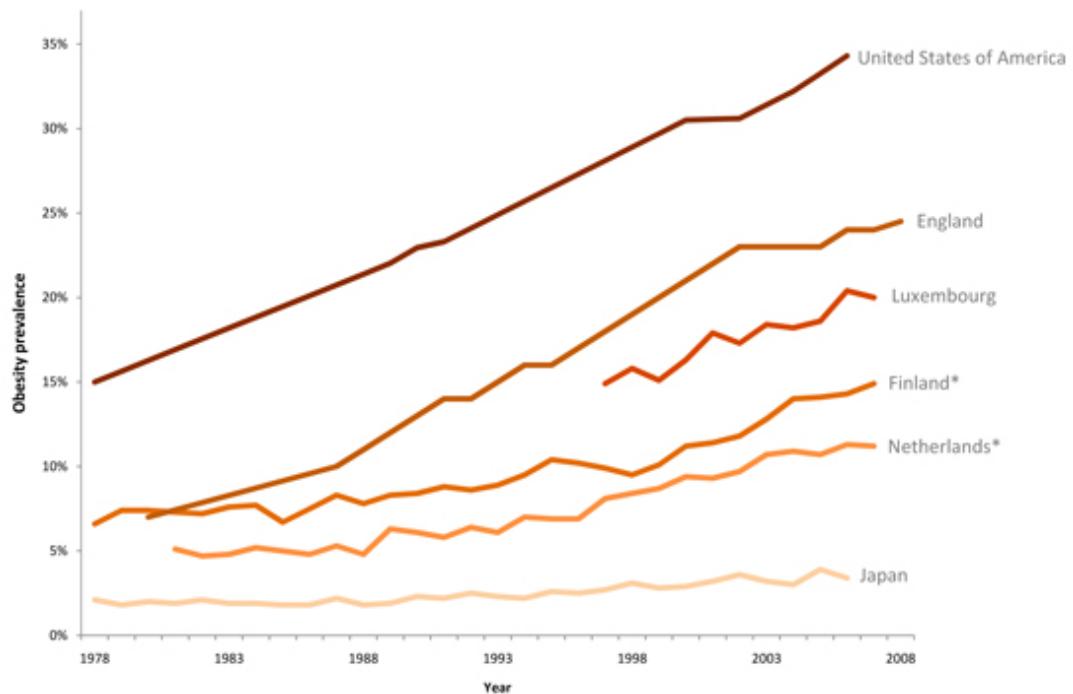
Source: National Obesity Observatory (based on data from the Health Survey for England)

Scotland has higher levels of obesity than England, and the highest in the OECD, (Scottish Government, 2011). The Scottish Government estimates that between 1995 and 2010, the

proportion of adults aged 16-64 who are classified as obese increased from 17 per cent in 1995 to 27 per cent in 2010. As for England this rise appears to have levelled off slightly. Data for Wales suggests that 22 per cent of Welsh adults are obese in 2010 (up slightly from 2004 when figures were 36 per cent overweight and 18 per cent obese). The Northern Ireland Health and Social Wellbeing Survey in 2005/06 found that 24 per cent of adults were obese. Levels had remained much the same at the 2010 survey

The UK is not alone in experiencing rising rates of obesity but has higher incidence than several other countries (see Chart 3.4 for comparisons of England with other nations):

Chart 3.4 Trends in adult prevalence of obesity* in a selection of countries



<http://www.ecosante.org/index2.php?base=OCDE&langs=ENG&langh=ENG>*Self reported data (prevalence rates for the other countries are based on measured data)

Source: National Obesity Observatory (based on data from the OECD

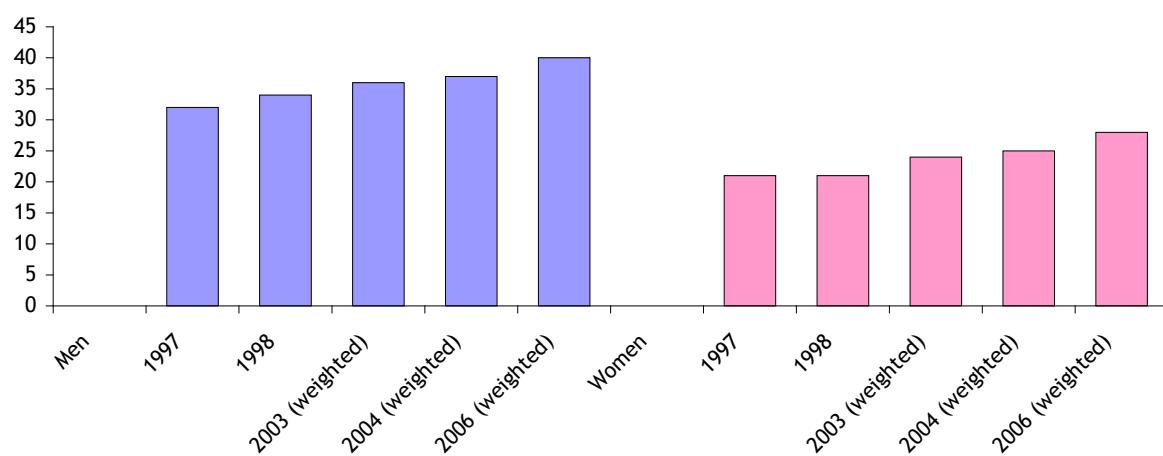
3.2.2 Physical activity

Physical activity has direct benefits for health and the proportion of adults in UK countries achieving recommended levels of activity (30 minutes five times a week) has been rising. Patterns of participation vary across the UK but it is generally males who are more active.

Chart 3.5 and the NHS information centre note that for England:

- physical activity has increased among both men and women since 1997, with 40 per cent of men and 28 per cent of women meeting recommended levels in 2006 (at least 30 minutes of at least moderate intensity activity at least 5 times a week)
 - participation is related to income for both men and women, those in the lowest income quintile are more likely to be in the low participation group than those in the highest income quintile
- Chart 3.5 Proportion of adults achieving the physical activity guidelines, by gender, 1997, 1998, 2003, 2004 and 2006 England

Chart 3.5: Proportion of adults achieving recommended physical activity levels, by gender in England



Source: Statistics on obesity, physical activity and diet: England, January 2008, <http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/obesity/statistics-on-obesity-physical-activity-and-diet-england-january-2008> based on Health Survey for England

3.2.3 Alcohol consumption

For a significant and growing number of people in England, alcohol consumption is a major cause of ill-health. More than 10 million people are now regularly drinking above the guidelines set by Government, and increasing the likelihood of ill-health or injury as a result. Hospital admissions for alcohol related conditions more than doubled in the 11 years between 1995-96 and 2006-07 from 93,459 to 207,788, although this is in the context of a general rise in admissions of about a third over the same period. Alcohol related deaths also doubled in the UK between 1991 and 2006 (NAO, 2008)

Four years ago the Department of Health estimated that alcohol misuse costs the health service approximately £2.7 billion per year. Including wider costs such as crime and disorder, social and family breakdown and sickness absence the total annual cost of alcohol

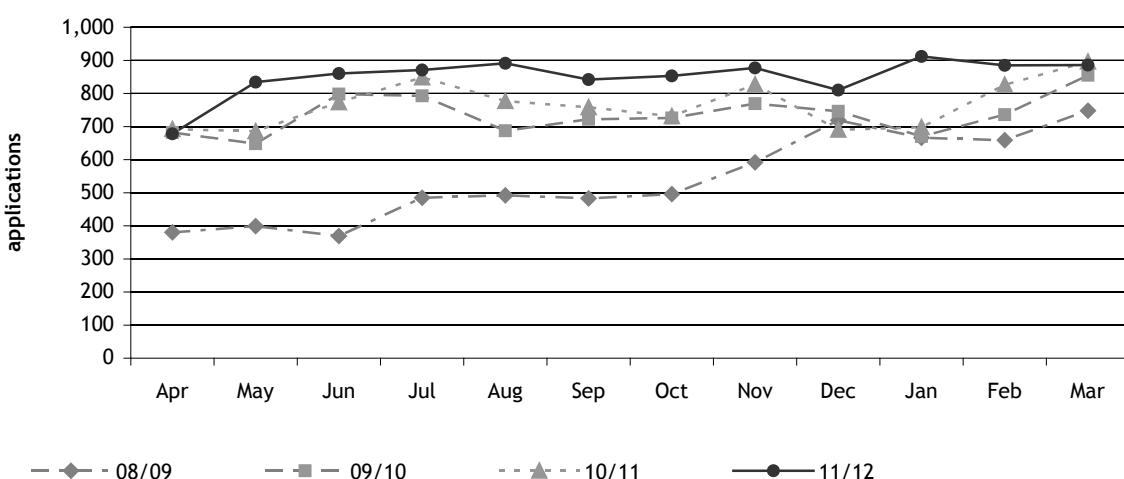
misuse to the UK economy has been calculated by the Cabinet Office at up to £25.1 billion (NAO, 2008).

3.3 Children taken into care

The number of looked after children is rising (Skills for Care and development, 2011) In 2007-2008, there were approximately 81,375 looked after children in the UK, in 2008-2009 the figure was almost 86,000. The number of children looked after increased in each of the four nations between 2008 and 2009.

There are currently record numbers of applications to take children into care (see Chart 3.6). The Children and Families Court Advisory Service (Cafcass) suggests this is due to greater awareness of the potential dangers of leaving children within damaged households.

Chart 3.6 Care demand statistics, 1998/99 – 2011/12



Source: <http://www.guardian.co.uk/news/datablog/2012/feb/09/local-child-abuse-care-statistics>,

3.4 The recession and recovery

Whilst not directly affected by the recession the health and social care sector is impacted by the Government's deficit reduction plan and the drive for efficiency in the public sector which resulted from the financial crisis.

The NHS is facing major restructuring. In brief the main proposals contained in the government's Health and Social Care Act 2012 (<http://services.parliament.uk/bills/2010-11/healthandsocialcare.html>) are to transfer responsibility for commissioning of health services for patients to GPs with the abolition of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs). There are also other governance changes which sees

the role of the Care Quality Commission strengthened and Monitor, the body that currently regulates NHS foundation trusts, turned into an economic regulator to oversee aspects of access and competition in the NHS.

A key outcome of the bill is the proposed reduction in bureaucracy and consequent reductions in management and administrative costs. The Coalition Government stated that the costs of NHS administration would be cut by a third (Programme for Government). In Equity and Excellence (Department of Health, 2010), the government states that: *Over the next four years we will reduce the NHS's management costs by more than 45 per cent.*

The Department of Health report that overall NHS spending will increase by 0.4 per cent (from £103.8 bn to £114.4bn) in real terms over the course of the Spending Review period to 2015 (see Table 3.1). This includes a 1.3 per cent increase in the resource budget, and a 17 per cent decrease in capital spending. The administration budget will be reduced by 33 per cent.

Table 3.1 Changes in NHS spending 2010 - 2015

NHS (Health)						
£ billion	baseline	2010-11	2011-12	2012-13	2013-14	2014-15
Resource DEL (1)	98.7	101.5	104.0	106.9	109.8	
Capital DEL	5.1	4.4	4.4	4.4	4.6	
Total DEL	103.8	105.9	108.4	111.4	114.4	

Source: Department of Health, http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_120676

As we have noted the health settlement also includes additional investment to support social care, rising to £2 billion per year by 2014-15, to break down the barriers between health and social care.

The increase in social care budgets have also been scrutinised because of a lack of ring-fencing within local authorities budgets which leaves the extra funding vulnerable when local authority budgets overall have been cut by 28 per cent (e.g. Phillips L, No ring-fence on councils' extra social care cash, minister confirms, 16 November 2010, Public Finance, <http://www.publicfinance.co.uk/news/2010/11/no-ring-fence-on-councils-extra-social-care-cash-minister-confirms/>)

In Scotland the draft budget increases healthcare spending from £11.2 billion in 2010/11 to £11.4 billion in 2011/12 ([Scotland's Spending Plans and Draft Budget 2011/12, the Scottish Government](#), November 2010, Edinburgh.) although it is acknowledged that this is a cut in

real terms from £11.2 billion to £11.15 billion. The Children, young people and social care budget decreases from £96.9 to £95.4m (a cut in real terms to £93.6 million).

The Welsh Government is also proposing a cut in healthcare funding real terms which the Kings Fund has estimated to be a reduction of 8.3 per cent in real terms over the next three years (e.g. The Guardian, 1 June 2011. '*King's Fund predicts 8.3 per cent cut to Welsh NHS spending*', <http://www.guardian.co.uk/healthcare-network/2011/jun/01/kings-fund-predicts-cut-welsh-nhs-spending>).

The Northern Ireland Executive has approved a combined health and social care budget which allows for an increase from £4.3 billion to £4.7 billion in 2014/15 – 8.3 per cent but which has also been noted as a real term reduction by the Kings Fund of around 2.2 per cent. Within this overall budget, social care increases from £897 million to £924 million. (Budget 2011-15, Northern Ireland Executive,

http://www.northernireland.gov.uk/revised_budget - website_version.pdf)

These reductions in budget need to be considered against increasing demand for services which we have described above. The King's Fund, 2010 (based on the Wanless review) summarised the factors and assumptions underlying funding projections. These projections suggest that irrespective of changing health or demographic patterns other factors also increase health expenditure e.g. ongoing improvements in the quality of health services, increases in pay and increasing prices paid for products such as medicines. These account for £3.5 billion, or 17 per cent of the total growth projection over the three-year period to 2013/14. An additional 25 per cent increase is accounted for by the estimated efficiency costs of making improvements in waiting times, clinical governance and capital, together with meeting higher demand for health care services arising from drivers such as demographic change and the population's anticipated health-seeking behaviours. These projections highlight the challenge facing the sector of constrained budgets alongside growing demand and other pressures.

3.5 Investment, innovation and R&D

The health and social care sectors have relatively low rates of innovation and investment compared to other sectors (see Table 3.2 below). Investment comprises investment in both physical capital and intangible assets such as software and intellectual property. It contributes to raising productivity for example via increasing the amount of capital available to workers (level and quality), and incorporating new technologies. According to research by

the LSE the UK spends less than 0.5 per cent of its GDP per annum on medical R&D (McGuire, A. et al. 2007).

Table 3.2 Sector investment as a share of total investment in £2006m CVM

Sector	2006	2007	2008	2009
Agriculture	1.9	1.8	2.1	2.0
Mining and quarrying	3.1	3.5	3.1	3.5
Manufacturing	9.2	8.9	8.4	7.9
Electricity, gas and water supply	3.7	4.5	5.1	6.3
Construction	2.3	2.1	1.7	1.4
Distribution	12.1	12.4	10.9	10.1
Hotels and restaurants	4.1	4.2	4.2	3.6
Transport and communications	15.6	14.5	15.2	16.0
Financial intermediation	5.5	5.5	5.6	4.6
Real estate, renting & business services	14.0	15.4	13.8	11.5
Public administration and defence	7.9	7.9	9.1	10.8
Education	5.3	4.9	5.6	7.2
Health and social welfare	3.3	3.2	3.7	4.5
Other services	11.9	11.2	11.5	10.5
Total	100	100	100	100

Note: Percentage shares of total investment based on current price data.

Source: UKCES (2011) B2.2 (ONS Capital Stocks, Capital Consumption and Non-Financial Balance Sheets 2010)

In response there are a number of initiatives across the sector which attempt to raise the level of innovation. The NHS recently published a report (Department of Health, 2011) which highlights the; important role played by the NHS as a customer of life science innovation; need to create value rather than cost through innovation, and; need to ensure innovation diffuses through the NHS. A number of recommendations are made by the report to that end.

There are a number of bodies which exist to further innovation across the sector, for example:

- The NHS Institute for Innovation and Improvement⁵ has worked on a range of practice and process innovations (large scale change, productive ward, High Impact Actions etc.) to support the transformation of the NHS (in England), through innovation, improvement and the adoption of best practice. The NHS Institute for

⁵ (<http://www.institute.nhs.uk/>)

Innovation and Improvement also sponsors annual Health and Social Care Awards designed to:

- Highlight and celebrate innovation and excellence across health and social care
- Recognise and encourage joint working ‘across organisations and professions, with service users and local populations’
- Similarly the Social Care Institute for Excellence (SCIE) exists to improve practice by sharing information on what works. In Scotland The Institute for Research and Innovation in Social Services (IRISS) performs a very similar role.
- Scottish Health Innovations Ltd⁶ works in partnership with NHS Scotland to protect and develop new innovations that come from healthcare professionals. SHIL was set up in 2002 by NHS Scotland and Scottish Enterprise to provide support to NHS innovation.
- The National Leadership and Innovation Agency for Healthcare (NLIAH) is part of NHS Wales and works with Trusts and Health Boards to deliver better quality and safer patient services⁷.
- The Clinical Translational Research and Innovation Centre (C-TRIC)⁸ promotes translational and clinical research, the primary objective of which is to reduce both the time to market and the costs associated with research and development of innovative health technologies, medical devices and therapeutics in Northern Ireland
- The public health Agency (Northern Ireland)⁹ supports improvement in health and social wellbeing improvement and HSC research and development

NESTA announced in November 2011¹⁰ that it was investing £1.4 million in social enterprise intermediaries including working with the [Mental Health Foundation](#), [Mental Health Media](#), [Mind](#), [Rethink](#) and the [Sainsbury Centre for Mental Health](#) in ‘Innovations in Mental Health’ working with front line workers, service users and carers to develop good ideas into effective interventions.

⁶ <http://www.shil.co.uk/About-Us/about-shil.html>

⁷ <http://www.wales.nhs.uk/sitesplus/829/home>

⁸ <http://www.c-tric.com/>

⁹ <http://www.publichealth.hscni.net/about-us>

¹⁰ (http://www.nesta.org.uk/about_us/press_office/assets/features/nesta_investments_boasts_social_venture_intermediary_market):

It is hoped that these initiatives will increase innovation activity within the NHS. However, it is important to recognise that to innovate requires skills and also implementing innovation creates the need for new and often higher skills in the workforce.

3.6 International recruitment

3.6.1 The health sector

The health sector has had a long term reliance on migrant workers to resolve skills shortages with major recruitment drives of foreign nationals at various times e.g. nurses from the Caribbean in the 1950s and from India in the 2000s. Similarly Doctors have been recruited from India, Pakistan, Bangladesh and Sri Lanka in the 1950s. By 1960, between 30 and 40 per cent of all junior doctors in the NHS were from these countries. (Snow *et al.*, 2011).

Such periods of mass recruitment have been interspersed by immigration control driven by Human Resource planning concerns for home grown staff (or other EU nationals) or by wider societal concerns over immigration. Future developments may impact on the sector's ability to source skills internationally in the future especially the cap on non EU migration (UK Skills Assessment ,2011). Currently 63 per cent of the UK's doctors qualified in the UK, 10 per cent in the EU and the remainder internationally (see Table 3.3).

Table 3.3 Doctors by world region of primary medical qualification:

PMQ World Region	No. of doctors	%	No. of GPs	%	No. of Specialists	%
EEA (excluding UK)	24,405	9.9%	3,877	6.3%	10,899	15.1%
International	66,857	27.2%	9,997	16.4%	16,920	23.4%
UK	154,740	62.9%	47,238	77.3%	44,484	61.7%
Total	246,146	100	61,112	100	72,303	100

NB: The World Region of PMQ refers to the region in which a doctor gained their initial qualification and therefore does not necessarily reflect the nationality of the doctor.

Source: GMC List of General Medical Practitioners Statistics, April 2012

Similar data for nurses are only available up to 2008 and are shown in Table 3.4 below. This shows a significant decline in new registrations from overseas nurses over the period 2004-08.

Table 3.4 Nurses and midwives by country of origin:

Country	2004	2005	2006	2007	2008
England	15,862	16,146	16,848	17,270	17,538
Scotland	2,331	2,263	2,434	2,497	2,519
Wales	812	1159	962	1,021	992
Northern Ireland	457	414	696	600	612
European Economic Area	1,033	1,193	1,753	1,484	1,872
Overseas	14,122	11,477	8,709	4,830	2,309
Total	34,617	32,652	31,402	27,702	25,842

Source: The Nursing and Midwifery Council Statistical Analysis of the Register 2008

A number of health and social care jobs are on the Migration Advisory Committee's (MAC) shortage occupation list because employers are unable to fill them from the domestic labour force.(see Table 3.5)

Table 3.5: Health and social care jobs on the Migration Advisory Committee's (MAC) shortage occupation list

Biological scientists and biochemists (2112):	<ul style="list-style-type: none"> • cardiac physiologist • clinical neurophysiologist • clinical vascular scientist • respiratory physiologist • sleep physiologist
Medical practitioners (2211):	<ul style="list-style-type: none"> • Consultants in: <ul style="list-style-type: none"> - clinical neurophysiology - emergency medicine - genito-urinary medicine - haematology - neurology - occupational medicine • Consultants in: <ul style="list-style-type: none"> - forensic psychiatry - general psychiatry - learning disabilities psychiatry - old age psychiatry • Non-consultant, non-training, medical staff posts in: <ul style="list-style-type: none"> - anaesthetics - paediatrics and general medicine specialities delivering acute - care services (intensive care medicine, general internal medicine (acute), emergency medicine, general surgery, obstetrics and gynaecology, and trauma and orthopaedic surgery) • Paediatric trainees
Social workers (2442):	<ul style="list-style-type: none"> • Social worker in children's and family services
Nurses (3211):	<ul style="list-style-type: none"> • specialist nurse working in operating theatres • operating department practitioner • specialist nurse working in neonatal intensive care units
Medical radiographers (3214):	<ul style="list-style-type: none"> • HPC-registered diagnostic radiographer • HPC-registered therapeutic radiographer • sonographer
Medical and dental technicians (3218):	<ul style="list-style-type: none"> • nuclear medicine technologist • radiotherapy technologist
Medical practitioners (2211):	<ul style="list-style-type: none"> • ALL jobs on the UK shortage occupation list • Paediatrics trainees • Staff grade and Associate Specialist (SAS) doctors in paediatrics • consultants in paediatrics

Source: MAC occupation shortlist 2011

3.6.2 Social care

One in six care assistants and home carers, currently working in the UK are not UK born and proportions in London are higher (Skills for Care, 2009). Similarly almost one in five workers in the residential care sector was not UK born possibly increasing to two out of three workers in London¹¹. Approximately three per cent of the overall Scottish social services workforce are migrant workers, although this figure may be as high as five and seven per cent within the adult residential care and care at home sector (Skills for Care (2009)).

3.7 Strategic role of management skills

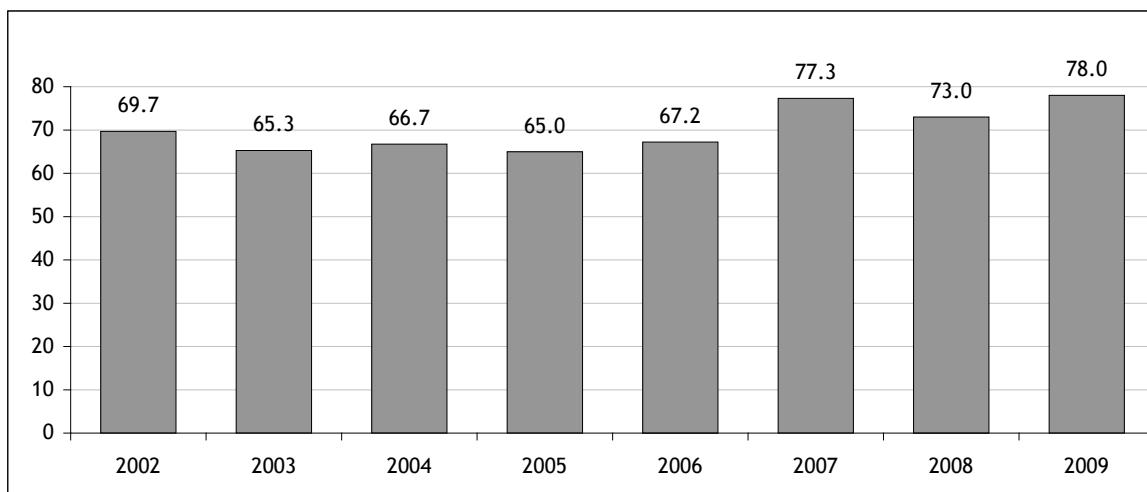
A recent report published by the LSE (Dorgan *et al.* 2011) highlights the importance of good quality management practices in hospitals in the UK, US, Canada, Sweden, Germany, France and Italy. The paper found that management practices were related to the quality of patient care and productivity outcomes. Better management was positively associated with levels of competition, the proportion of clinically qualified managers, levels of autonomy, and size of hospital. Private and not for profit hospitals were better managed overall than public hospitals. The researchers concluded that the UK delivers particularly strong hospital management especially considering its level of health expenditure. UK hospital management practice scores are slightly lower than for the US, similar to Sweden and higher than Germany, Canada, Italy and France.

The impact of management practice on outcomes is marked. In the UK a one point increase in management practice quality is associated with a 6.5 per cent reduction in the risk of death within 30 days of heart attack, a 33 per cent increase in income per bed and a 20 per cent increase in the likelihood that the hospital achieves above average patient satisfaction.

These findings need to be considered within the context of the current standard of management and leadership within the sector. This is difficult to ascertain but qualification levels can be used as a proxy. Exploration of available data shows that the proportion of managers qualified to level 4 or more has been rising steadily within the Skills for Health footprint (see Chart 3.8).

¹¹ N.B. the LFS sample size was small so Skills for Care urge caution

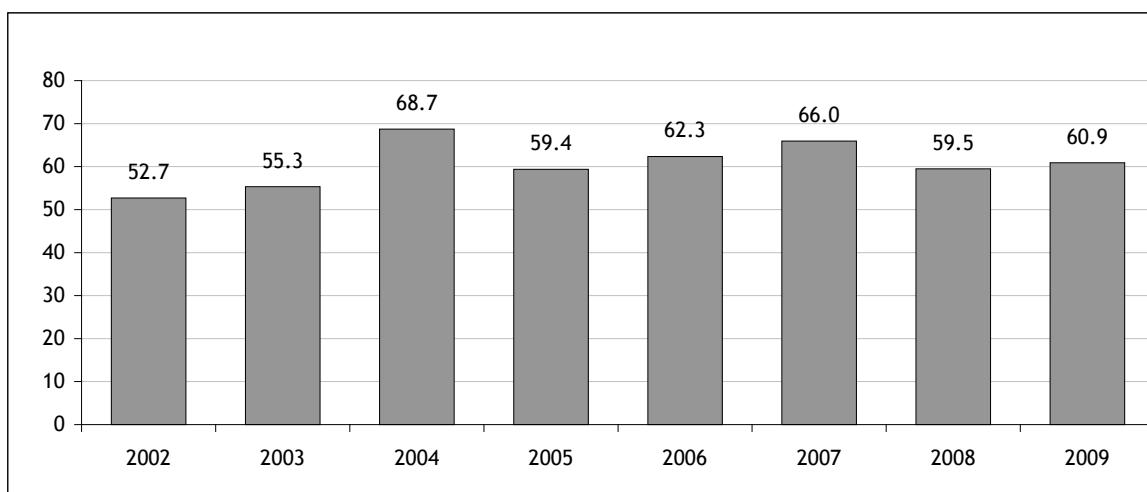
Chart 3.8 Percentage of managers and senior officials (19-59/64), qualified to NQF level 4 or more in Skills for Health



Source: UKCES (2011)

The same data sources for Skills for Care and Development show that the proportion of managers qualified to NQF level 4 or above has remained relatively stable in recent years at around 60 per cent (see Chart 3.9). These are relatively high levels compared to other sectors but nonetheless suggest that some 40 per cent of social care managers are not qualified to the level recommended as a minimum for managers (UKCES, 2010).

Chart 3.9 Percentage of managers and senior officials (19-59/64), qualified to level 4 or more (NQF level) in Skills for Care and Development



Source: UKCES (2011)

Given the evidence supporting an association between management capability and organisational performance (both financial and quality outcomes), the challenge for the sector is to raise capability in managing change and financial stringency.

3.8 Conclusion

The health and social care sector faces major challenges of demand for its services brought about by demographic and social change including population growth, the ageing population, lifestyle choices that are injurious to the health of the wider population and declining social cohesion affecting demand for some social care services.

Limited growth in budgets will place particular strains across public aspects of the sector in this context and it is expected that administrative and managerial workforces will significantly reduce.

The challenge facing the sector is to respond to these pressures and to capture the opportunities provided by innovation. As a result there are a raft of initiatives which aim to increase the use of ICT and to improve innovation.

Historically the sector has had high reliance on immigrant labour to deal with skills shortages and this remains a potential issue as the government seeks to reduce migration flows into the UK.

Evidence shows (*Dorgan et al. 2011*) that management and leadership skills are an important contributor to both quality and financial performance and that private sector organisations out-perform those in the public sector which suggests that there is further opportunity for improvement.

Section 4 considers the implications of these various drivers of change for employment and skills demand.

4 Employment and skill demand in the sector

The last chapter examined some of the key challenges facing the sector. In this chapter we look in more detail at other factors affecting the demand for skills in the years ahead and the implications for the demand for skills.

We have already seen that the sector is a significant employer. and that growth in employment has been much higher than the whole economy average in the period since 2000. However the future is more uncertain due to opposing pressures. On the one hand financial restraint is widespread across the sector and may inhibit future growth. Whilst on the other hand, increasing demand for both health and social care from a growing and ageing population, will act to stimulate employment growth. In the period to 2020 expected employment growth is less than that for the whole economy. Nevertheless, even a small percentage growth in employment for a large sector will mean a large volume of skill needs.

4.1 Factors affecting the demand for skill

The National Strategic Skills Audit (UKCES 2010) provides a common framework to identify the drivers of change that will impact on the in the UK in the future. The drivers indicate the nature and direction of travel and provide a broad analysis to help reveal the implications for jobs and skills. These drivers are interdependent and their dynamic interplay means they may mitigate or reinforce each other.

In discussing the key developments in the sector, the previous chapter alluded to some of the drivers. This section uses the framework to draw out the implications of these drivers for the demand for skills in the digital and creative sector in more detail.

The framework uses the following structure:

- Regulation and multi-level governance
- Demographic and population change
- Environmental change
- Economics and globalisation
- Technological change
- Changing values and identities

- Changing consumer demand

4.1.1 Policy, regulation and legislation

Government policy, regulation and legislation (locally, regionally, nationally and internationally) have implications for the sector's demand for skills:

Skills for Health state that policy shifts, such as increased emphasis on patient experience and control, the delivery of care closer to home, a continued emphasis on public health, greater integration across sectors and improved productivity will all have effects.

Similarly, Skills for Care and Development highlight changes to national policy, regulation and registration such as direct payments, self directed support and the personalisation of services.

National regulation is a key determinant of training activity and required skills levels in social care (UKCES, 2010). The social care sector has used regulation as one mechanism through which to raise overall levels of skills (Rogers *et al.*, 2002 in UKCES 2010).

The Government's plans for reforming the social care sector are laid out in Caring for our future: reforming care and support, (Department for Health, 2012a). This is concerned with giving people a personal budget entitlement, improving the quality of information on care and support and piloting the use of direct payments. A number of implications for skills flow from this:

- SfC&D and Skills for health are to work together to produce a code of conduct and recommend minimum training standards for adult social care workers and healthcare support workers;
- The number of apprentices in the Care sector are to double to 100,000 over the next five years, with clear progression routes to Higher Level Apprenticeships as an additional route for Care managers;
- Care ambassadors scheme to be developed to promote a positive image of the sector, making links with schools, colleges and sector employers;
- Setting up a Leadership Forum to explore how best to support registered managers and to ensure that provision offers regular mentoring and supervision;

- Chief Social Worker and principal social workers to be appointed following the Munro Review of child protection. The chief social worker will act as an advisor to Government on adult and social work issues and principal social workers will be responsible for quality -assuring the safety of practice

4.1.2 Demographic change

As we have seen in section 3 demographic changes (especially a growing and ageing population), the lifestyles choices of the population, innovations in health and social care provision, and the rising incidence of long term health conditions will challenge scale and form of health care provision.

Similarly demographic trends indicate that demand for social care services is likely to increase. It is predicted that from 2006 to 2020, the number of staff working with older people will need to rise by over 25 per cent, to meet demographic changes (*Skills for Jobs: Today and Tomorrow: The National Strategic Skills Audit for England 2010*, UKCES, 2010).

The challenge across the health and social care sector is that the level and sources of investment that would fund any expansion are also unclear. Although service demand is expected to rise, public expenditure constraint in the coming years may limit employment growth (UKCES 2010 quotes Brinkley 2009b, Hogarth *et al.*, 2010; Cogent *et al.*, 2009). Traditionally both the health and social care sectors have been heavily reliant on migrant labour (see Section 3.6) to balance demand and it remains to be seen if the government's restrictions on migrant labour will negatively impact the sector.

4.1.3 Globalisation

In many ways the health and social care sectors have been protected from the impact of globalisation as the sector is public sector dominated (especially health) and internationalisation of provision has been relatively low (Section 2.6). However the wider effects of globalisation do have an impact especially the implications of the financial downturn on public finances. Current attempts to reduce the financial deficit have led to cost pressures across the sector (which although relatively protected from the worst of spending cuts) has led to financial concerns (see Section 3.4).

As we have seen in section 3.8 international recruitment is high which brings the need for English language skills. The Department for Health for example has announced that it will introduce new powers so that all doctors coming to work in England from other nations can be checked for their language skills (Department of Health, 2011a). In the care sector there

have been some good practice examples of improving language skills for international workers (e.g. Cunnah, 2007).

4.1.4 Technological change

Innovation and new technology has enormous application in the sector both in terms of how services are delivered but also in terms of available treatments and their potential impact on length and quality of life. Technology has the potential to both save money but also increase costs across the sector. Health care economists estimate that 40–50 per cent of annual cost increases can be traced to new technologies or the intensified use of old ones (Callahan, 2008). Advances in technology have enabled a better understanding of the human genome which has created benefits for the prediction and treatment of health conditions. Such advances need to be supported with relevant skills for their benefits to be realised. However, there is also evidence that higher skilled jobs including legal work and interpretation of health care tests, for example in radiology, are being transferred overseas on grounds of cost effectiveness (UKCES, 2010).

Research into the Impact of e-Health and Assistive Technologies on Healthcare, suggested that e-Health, assistive technologies, telemedicine, and telecare will play a very large part in making healthcare more accessible, improving as well as improving the availability of specialist expertise (TeHIP, 2005).

Similarly innovation and technology are likely to play an increasingly important role in social care. These technologies include assistance devices linked to response teams via a person's telephone, such as community alarm services, detectors or monitors of fire, gas or falls. They also embrace a range of technologies from low-level to high-tech devices and broadly cluster into:

- supportive technologies helping individuals perform tasks that they may find difficult (for example, video entry systems, and medication reminder units);
- responsive technologies to help individuals manage risks and raise alarms (for example, unburned gas detectors and panic buttons/pendants);
- preventative technologies to help prevent dangerous situations (for example, falls predictors, monitors for assessing physiological symptoms, room occupancy monitors).

The benefits of such technologies have been found to include increased choice, safety, independence and sense of control, improved quality of life, maintenance of independent living and reduced accidents and falls in the home (Beech and Roberts 2008). Technological advances may potentially increase the demand for non-residential care.

4.1.5 Consumer demand

Across the sector there are growing patient and customer expectations which fuels client demand.

There are also a number of implications of changing consumer demand:

- jobs are becoming more complex due to the changing nature of health social care delivery and the greater integration between social care and health;
- there are relatively high rates of agency staff who do not always reflect community diversity;
- increased focus on commissioning, procurement and negotiation skills;
- increased demand for working in interdisciplinary and inter-professional areas (which includes leadership and management).

4.1.6 Changing values and identities

It is increasingly anticipated that older people will want independent care at home, with evidence suggesting this demand could increase by one-third by 2020 (HMT/BERR, 2008 in UKCES 2010). It has also been noted in the UK and other countries that it is challenging to recruit to care roles from native populations. Later sections will examine the extent of recruitment difficulties and skills shortages. Greater labour market participation of women and changes to family structures such as the growth of single parent families and single person households means that there are also increased demands for care services.

This suggests that the drivers identified by UKCES at a UK-wide, all sector level have resonance in the sector although at present environmental issues are underplayed.

4.2 Changing patterns of skill demand

Employment in the health and social care sector is projected to grow by 1.3 per cent between 2010 and 2020 (Table 4.1). This is slower than reported growth for the sector in the previous decade (2.6 per cent, see Table 2.1). It is also below the projected total employment growth across all sectors of 5.1 per cent (Wilson and Homenidou, 2011).

Two occupations dominate the sector to 2020. It is anticipated employment will rise by over nine per cent (126,000 jobs) among caring, leisure and other service occupations. This compares to almost 12 per cent for the whole economy for the same occupation. Employment growth of over eight per cent is expected for professional occupations (104,000 jobs) compared to 15 per cent on average for the same occupation across all sectors.

Besides professionals, employment in other higher occupational groups (managers, directors and senior officials, and associate professional and technical occupations) are expected to increase over the period 2010 to 2020. Respective increases of 10.5 per cent and 8.8 per cent are forecast. These increases are consistent with the drivers of skills demand and the key challenges facing the sector discussed above but are less than the average growth forecast across all sectors of 18 per cent for managers and 14 per cent for associate professionals.

Demand for administrative and secretarial workers, and skills trades occupations, is expected to decrease between 2010 and 2020 by just over 30 per cent (153,000) jobs compared to 11 per cent for all sectors. Skilled trades occupations in the sector are expected to decrease by almost one third by 2020 (18,000 jobs) compared to an average of seven per cent for the occupation across the whole economy.

Table 4.1 Changing pattern of skill demand

Health and Social Care:	2010	2015	2020	2010	2015	2020	2010-2020 Change (000s)	2010-2020 Change (%)
Employment Growth	Numbers (000s)			% shares				
Managers, directors and senior officials	184	188	203	4.7	4.9	5.1	19	10.5
Professional occupations	1,247	1,260	1,351	31.6	33.0	33.8	104	8.3
Associate professional and technical	414	419	451	10.5	11.0	11.3	37	8.8
Administrative and secretarial	497	406	344	12.6	10.6	8.6	-154	-30.9
Skilled trades occupations	55	41	37	1.4	1.1	0.9	-18	-32.8
Caring, leisure and other service	1340	1,341	1,466	33.9	35.2	36.6	126	9.4
Sales and customer service	55	50	50	1.4	1.3	1.2	-5	-9.3
Process, plant and machine operatives	25	19	18	0.6	0.5	0.4	-7	-28.5
Elementary occupations	131	90	82	3.3	2.4	2.0	-49	-37.6
All occupations	3,948	3,813	4,000	100.0	100.0	100.0	52	1.3

Source: Wilson and Homenidou (2011)

4.2.1 Sub-sector variation

Most of the growth in employment in the health and social care sector is expected to be driven by the care sub-sector. Employment in care is projected to increase by 4.9 per cent which is practically the same as expected growth in the whole economy (5.1 per cent). Countering this is a forecast decrease of 1.3 per cent in total health employment (see Tables 4.2 and 4.3).

The net change in employment is projected to be much greater in the care sub-sector than in the health sub-sector. The bulk of the increases in total employment will be among the higher level occupational groups and, unsurprisingly caring occupations. Administrative and secretarial, skilled trades, sales and customer service, and process, plant and machine operative occupations are expected to contract.

Table 4.2 Changing pattern of skill demand - health sub sector

Health Employment Growth	2010	2015	2020	2010	2015	2020	2010-2020	Change (000s)	Change (%)
	Numbers (000s)			% shares					
Managers, directors and senior officials	109	109	116	4.8	5.0	5.2	7	6.3	
Professional occupations	730	729	771	32.1	33.5	34.3	41	5.6	
Associate professional and technical	242	242	256	10.6	11.1	11.4	14	5.8	
Administrative and secretarial	285	232	194	12.5	10.7	8.6	-91	-32.0	
Skilled trades occupations	32	23	19	1.4	1.1	0.9	-12	-38.9	
Caring, leisure and other service	759	753	813	33.3	34.6	36.2	53	7.0	
Sales and customer service	32	29	28	1.4	1.3	1.3	-4	-11.3	
Process, plant and machine operatives	14	10	8	0.6	0.4	0.3	-6	-42.9	
Elementary occupations	73	49	42	3.2	2.2	1.9	-31	-42.7	
All occupations	2,277	2,175	2,247	100.0	100.0	100.0	-29	-1.3	

Source : Wilson and Homenidou (2011)

Table 4.3 Changing pattern of skill demand - care sub sector

Care	2010	2015	2020	2010	2015	2020	2010-2020	
	Employment Growth			Numbers (000s)			% shares	Change (000s)
Managers, directors and senior officials	75	78	87	4.5	4.8	5.0	12	16.6
Professional occupations	517	531	580	30.9	32.4	33.1	63	12.2
Associate professional and technical	172	177	194	10.3	10.8	11.1	23	13.2
Administrative and secretarial	212	174	150	12.7	10.6	8.5	-62	-29.4
Skilled trades occupations	23	18	17	1.4	1.1	1.0	-6	-24.3
Caring, leisure and other service	581	588	653	34.8	35.9	37.3	72	12.4
Sales and customer service	23	21	22	1.4	1.3	1.2	-2	-6.6
Process, plant and machine operatives	11	10	10	0.7	0.6	0.6	-1	-10.9
Elementary occupations	57	41	40	3.4	2.5	2.3	-18	-31.0
All occupations	1,672	1,638	1,753	100.0	100.0	100.0	81	4.9

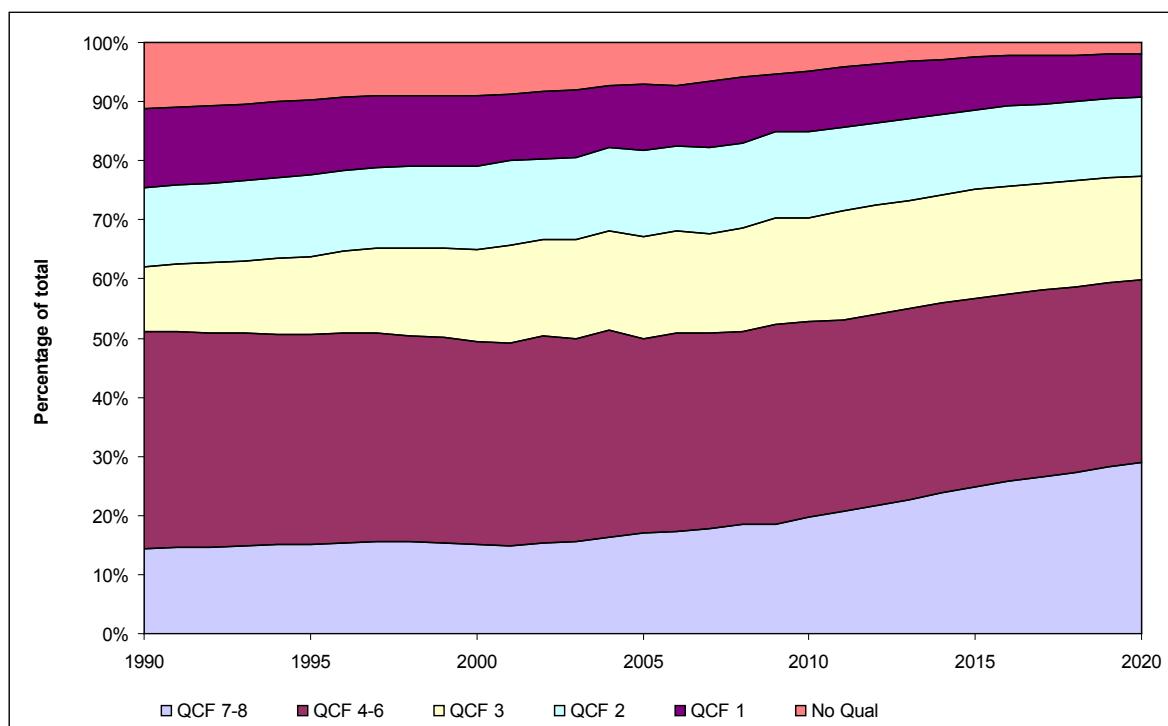
Source : Wilson and Homenidou (2011)

4.2.2 Qualification levels

The demand for skilled and highly qualified labour is predicted to rise over the next decade in a sector that is already more highly qualified than the UK workforce as a whole. Chart 4.1 shows the projected changes in employment by qualification level in the health and social care sector and Chart 4.2 illustrates the profile for the UK. In 2020 39 per cent of the workforce is projected to be qualified at first degree level or above, compared to 27 per cent in 2010. This compares to 24 per cent in 2010 and 33 per cent in 2020 for the whole economy. This indicates the sector is relatively well qualified at present and that it is expected to improve upon this by 2020.

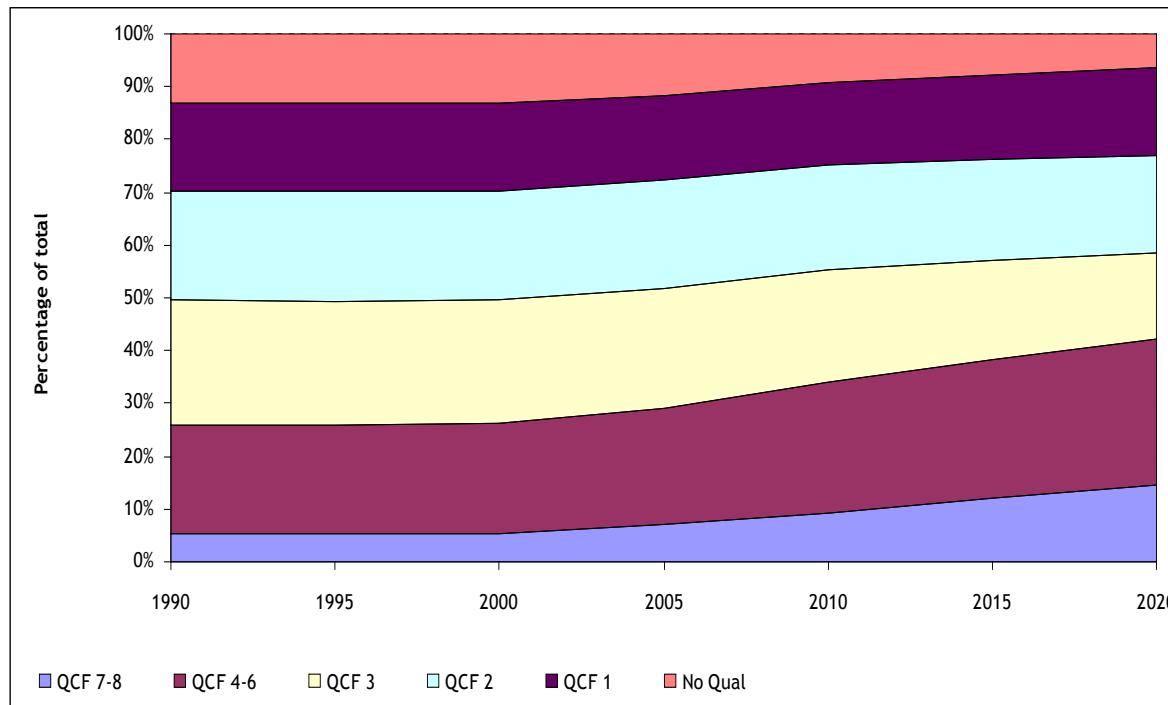
There are projected to be increases in the numbers of health and social care workers qualified at higher education below first degree level (QCF 4), and in the number of those with GCSEs (A-C) (QCF 2). Decreases are expected in foundation degrees (QCF 5) and those with level 1 (QCF 1) or no qualifications.

Chart 4.1 Qualification levels of employment: Health And Social Care



Source: Wilson and Homenidou (2011)

Chart 4.2 Qualification levels of employment: all sectors



Source : Wilson and Homenidou (2011)

Tables 4.4 and 4.5 show the projected employment changes by qualification separately for the two sub-sectors. There is a close relationship between Tables 4.5/4.6 and 4.2/4.3. The expected percentage change in the number of jobs requiring qualifications at first degree or above (QCF 6+) between 2010 and 2020 is greater in the care sub-sector than in health. However, due to the different employment levels in each sub-sector these changes translate into an additional 257,000 jobs requiring qualification at degree level or above in health and 234,000 in care. The percentage share of jobs that required qualifications at QCF 6 and above were very similar across the two sub-sectors in 2010 and are expected to be similar to each other in 2020.

Demand for individuals with no qualifications is projected to fall by over 60 percent in both the health and social care subsectors. Similarly, jobs requiring qualifications at QCF 1 (GCSEs below grade C) are forecast to decline by around two fifths in each sub-sector. These figures emphasise the continued importance of obtaining qualifications in order to secure better employment prospects in health and social care.

Table 4.4 Changing pattern of skill demand by qualification level, health

Qualification categories	Industry Employment, 1990 to 2020, by Qualification Level					2010-2020
	Health					Change
Percentage Shares	1990	2000	2010	2015	2020	% change
QCF8 Doctorate	0.7	0.9	1.8	2.4	3.0	63.7
QCF7 Other higher degree	6.5	5.9	8.6	10.7	12.9	48.0
QCF6 First degree	6.6	10.6	17.1	20.5	23.4	34.8
QCF5 Foundation degree; Nursing; Teaching	25.3	19.6	15.4	13.5	11.1	-28.8
QCF4 HE below degree level	4.3	3.1	3.3	3.5	3.7	9.1
QCF3 A level & equivalent	11.0	17.6	20.4	20.4	19.3	-6.7
QCF2 GCSE(A-C) & equivalent	16.3	17.2	17.5	18.2	18.9	6.7
QCF1 GCSE(below grade C) & equivalent	18.2	15.2	10.9	8.5	6.2	-44.3
No Qualification	11.1	9.9	4.9	2.3	1.6	-68.0
Total	100.0	100.0	100.0	100.0	100.0	-1.3

Source : Wilson and Homenidou (2011)

Table 4.5 Changing pattern of skill demand by qualification level, care

Qualification categories	Industry Employment, 1990 to 2020, by Qualification Level					2010-2020 Change % change
	1990	2000	2010	2015	2020	
Percentage Shares						
QCF8 Doctorate	0.2	0.7	1.6	2.2	2.8	85.7
QCF7 Other higher degree	4.6	5.4	8.2	10.4	12.6	60.5
QCF6 First degree	3.7	9.4	16.5	20.1	23.1	46.5
QCF5 Foundation degree; Nursing; Teaching	27.7	19.6	15.2	13.2	10.9	-24.9
QCF4 HE below degree level	3.2	2.9	3.4	3.7	4.0	24.1
QCF3 A level & equivalent	7.4	17.8	20.9	20.6	19.2	-3.9
QCF2 GCSE(A-C) & equivalent	18.0	17.8	17.9	18.5	19.1	12.3
QCF1 GCSE(below grade C) & equivalent	21.9	16.1	11.3	8.8	6.6	-39.1
No Qualification	13.2	10.3	5.1	2.4	1.8	-62.7
Total	100.0	100.0	100.0	100.0	100.0	4.9

Source : Wilson and Homenidou (2011)

A review of skills needs in the health sub-sector and identified a number of emerging priorities (Skills for Health, 2010). Amongst these are some of the challenges we have noted, such as achieving better for less, reducing the sector's dependence on non-EU migration, dealing with the impact of ICT on roles and skills within the health sector, the development of management and leadership skills and developments in diagnostics, treatment and technology. There are also current issues to resolve such as addressing skills gaps and skills shortages, continuing to focus on employability and functional skills, continued development of new roles, and enhancing workforce-planning capability.

Sector information from the University of Warwick (NGRF – LMI Future Trends, 2011) predicts that advances in medical treatment and technology is expected to influence the kinds of roles needed in the future. Employers will be seeking to keep costs down and maximise productivity. This is likely to fuel the development of flexible new roles requiring softer, employability skills in negotiating and facilitating change.

Skills for Care (2010) has identified a number of areas where new qualifications are needed:

- a new level 5 qualification aimed at LDSS practitioners to replace the current Children's Care, Learning and Development qualifications for England;

- New National Occupational Standards such as nutrition and food safety, assistive technology, integrated working, the common assessment framework and ICT skills as well as how to work more effectively with the Third Sector;
- Adaption of relevant skill sets to the personalisation of services such as the Diplomas in Leadership and Management for Care services (LMC);
- Specialist qualifications and units in response to the growing incidence of dementia, sensory services, nutrition and diabetes. Leadership and management skills are in growing demand due to budgetary constraints facing the sector and the need to effect transformational change. A particular example is the need for managerial skills in commissioning, procurement contracting and management of tendered services as these are likely to be more common over time.

The increasing incidence of service users directly employing care workers may lead to greater flexibility from the care workforce and the formation of new roles and opportunities. Care sector workers may start to provide a ‘portfolio’ or sample of experience, education, accomplishments and skill sets to present to service users who may choose an active role in procuring their services.

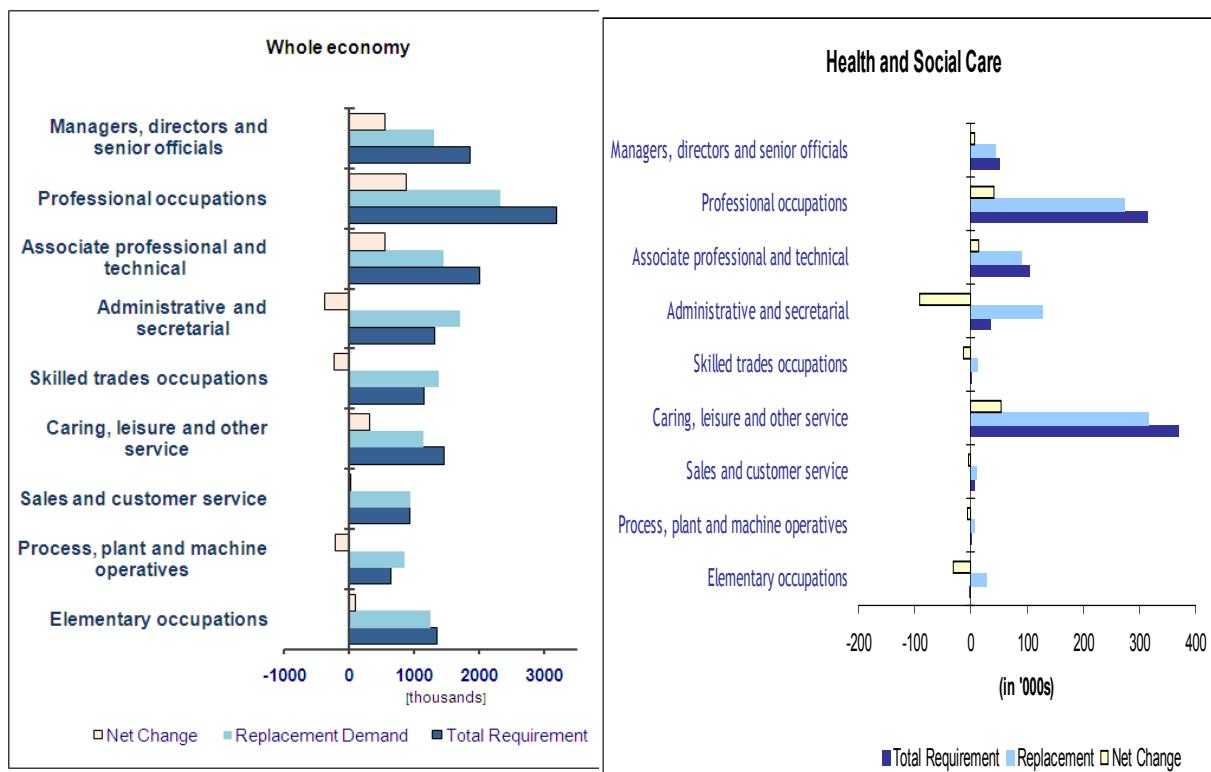
Growth in the care sector is fuelled in part by demand for adult social care services as the population of the elderly people increases, and as more elderly people live alone due to social changes. It is anticipated that this will have most effect on personal assistants and others roles providing self directed care (anticipated increase from 8-29 per cent of the workforce between 2006 to 2025). Other care roles such as social workers, occupational therapists, nurses etc. are also likely to increase especially nurses in residential settings. It is expected that the recession and restrictions on government spending will result in slowed job growth in the early years, particularly within children and young people’s services (the University of Warwick, 2011). This contrasts with other data sources which suggest that the proportion of those receiving publicly-funded care has declined because of higher qualification criteria being imposed by local authorities (see Section 3.1, Skills for Care and Development 2011, citing Audit Commission 2009). This suggests that there may be a widening gap of unmet demand.

4.3 Replacement demands

In addition to the net expansion and contraction of the workforce due to changing demand there is also the need to replace workers that vacate their jobs, primarily due to retirement. Replacement demands can be of such magnitude that even in sectors where employment is

forecast to contract (negative net growth) there remains a need to recruit staff. The pattern of replacement demand in the sector compared to that for the UK is evident from Chart

Chart 4.3 Replacement demand in health and social care 2010-20



Source: Wilson and Homenidou (2011)

For the health and social care sector replacement demand is anticipated to be around 1.62m jobs over the period to 2020 (see Table 4.6), equivalent to 41 per cent of the sector's total employment in 2010. This compares to 40 per cent for whole economy. Combining replacement demand with expected net employment change gives a total requirement to fill just less than 1.7m jobs in the sector by 2020.

As one might expect, the two largest occupations in the sector (professionals and caring, leisure and other services) report the greatest volumes of replacement demand; 485,000 and 570,000 jobs respectively. This is equivalent to 39 per cent of the 2010 employment in professional occupations and 43 per cent in caring roles; both equal to the whole economy average for these occupations. Replacement demand as a proportion of employment in 2010 is anticipated to be highest in administrative and secretarial occupations (46 per cent) and lowest in sales occupations (36 per cent).

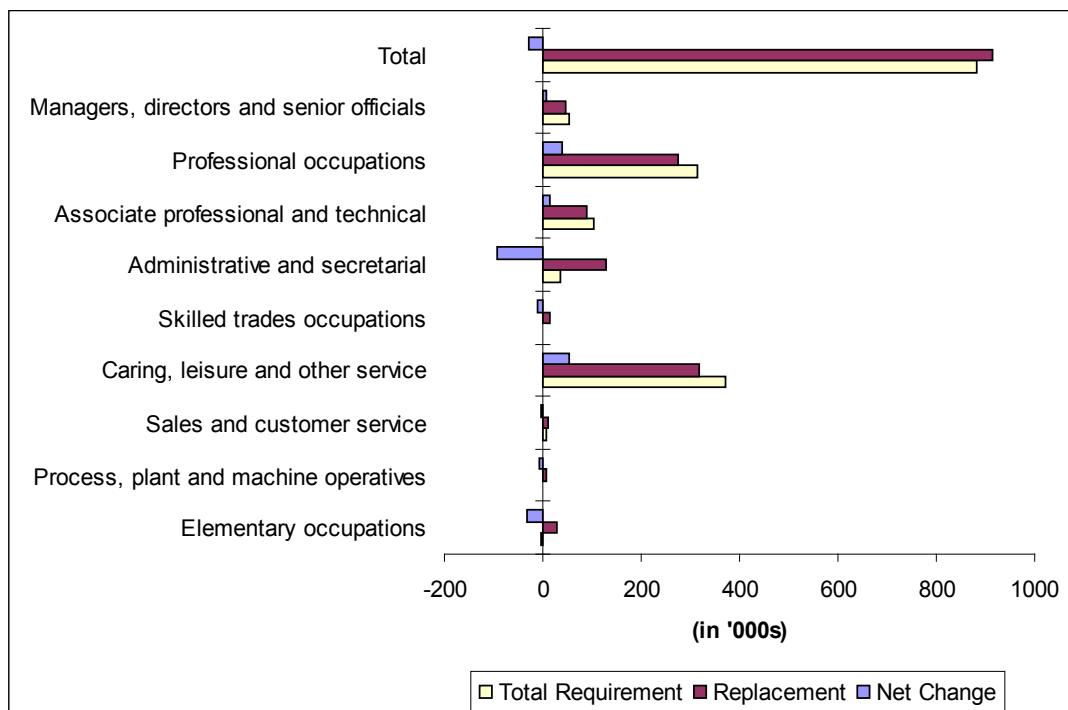
Table 4.6: Total requirement for employment in health and social care (2010-20)

000s	Net Change	Replacement Demand	Total Requirement
Managers, directors and senior officials	19	79	99
Professional occupations	104	485	589
Associate professional and technical	37	156	193
Administrative and secretarial	-154	229	75
Skilled trades occupations	-18	22	4
Caring, leisure and other service	125	570	695
Sales and customer service	-5	20	14
Process, plant and machine operatives	-7	11	4
Elementary occupations	-49	51	2
Total	52	1,623	1,675

Source: Wilson and Homenidou (2011)

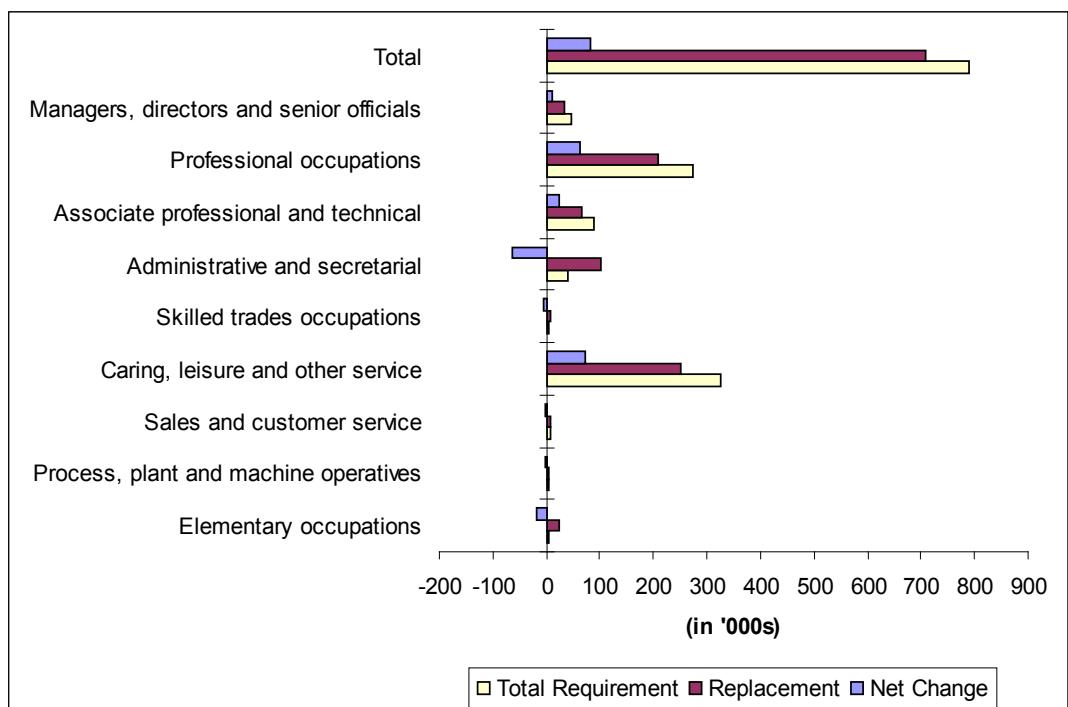
A breakdown by subsector (charts 4.4 and 4.5) shows that both health and social care have very similar demand profiles in terms of demand for caring, leisure and other service and professional occupations. Administrative and secretarial occupations are set to reduce significantly, alongside a slight decline in elementary occupations.

Chart 4.4 Replacement demand in health (2010-20)



Source : Wilson and Homenidou (2011)

Chart 4.5 Replacement demand in social care (2010-20)



Source : Wilson and Homenidou (2011)

4.4 Conclusion

The key drivers of change in the health and social care sector have a variety of implications for skills demand. Demographic change is anticipated as being a major driver of changing skill demands but this will conflict with public expenditure constraint brought the Government's plans to reduce the deficit. Public spending constraints are likely to bring increasing demand for some services as the consequences of financial hardship begin to bite. New forms of technology such as assistive technologies will change how care is delivered and may help to ameliorate the impact of the challenges facing the sector. Other issues will stoke demand for high level technology specific skills in the sector such as advanced in medical technology e.g. genomics.

Employment projections for the sector as a whole indicate that there will be growing need for high level skills. It is expected that there will be 160,000 more managers, professionals, and associate professional occupations between 2010 and 2020. This represents an increase of between eight and ten per cent on the 2010 employment level in these occupations. When considering qualification levels, the projected growth in high skill levels is even greater – there will be a need for 490,000 more people qualified at first degree level or above by 2020.

In addition to meeting this expansion demand as the sector grows, there will also be the need to meet replacement demands as individuals leave the sector. These replacement demands are projected to be greater than the expansion demands for all roles. As a result, there is a total requirement for high level occupational groups of just over 880,000 between 2010 and 2020.

Therefore a key concern for the sector is whether the supply of skills be sufficient to meet these growing and changing demands. In the next chapter we examine the sources of supply and in Chapter 6 look at any current or potential mismatches between supply and demand.

5 Skills supply

The supply of skills comes from two sources: the investments that individuals make in their initial education and training before they enter the labour market, any individual investment in continuing professional development whilst in work and the investments that employers make in developing the skills of their workforce. Obviously there are links between the two and the State is also involved in funding initial education and training and supporting workforce development. In examining the supply of skills to the health and social care sector we distinguish between individual, initial investment and employer investment.

5.1 The supply infrastructure

Table 5.1 outlines the main qualification levels within the health and social care sector.

Table 5.1 Main health and social care qualifications – levels and descriptions

Qualification and level	Description / examples
QCF - Entry, Levels 1, 2 and 3	Basic, key skills
QCF – Levels 2 and 3	Certificate, Award and Diploma in Health and Social Care, Various specialisations; qualification to assistant nursing, dental nurses, children care, support services; Intermediate Apprenticeships, Advanced Apprenticeships, GCSE in Health and Social Care, NVQ/SVQ Level 2
QCF – Levels 3 – 5	Advanced Apprenticeships, Foundation degrees, NVQ Level 3 and 4, Scottish Skills For Health: HNC (Level 4), HND (Level 5); Scottish Social Services Council: SVQ Level 3 and 4
QCF – Level 6	Degree level qualifications: e.g. BA in Nursing, mandatory for fully registered nurses
QCF – Level 7 and 8	Higher degree and doctorate
Vocational Related Qualifications (VRQ)	Vocational qualifications, which can be provided at any QCF level
Other	Qualifications and training programmes aimed at progression into management and supervisory roles; Qualifications from professional institutions, often linked to an existing course, for example in the accreditation of degree courses

Source: Adapted from Skills for Health, Skills for Care and UKCES

The NHS offers a wealth of career opportunities many of which require qualifications at degree level (QCF 6) or above. As such Higher Education Institutions, (HEIs) are a major source of skills for the sector. The NHS careers website gives details of 114 different potential career paths (<http://www.nhscareers.nhs.uk/atoz.shtml>) with details of the entry

qualifications needed and the training programmes required. The care sector also offers a range of different occupations requiring different levels of prior education or expertise:

- Social workers are required to have a Degree in Social Work (Diploma level qualifications will still exist but have been phased out for new entry and have to be registered with the General Social Care Council (England); the Care Council for Wales; the Northern Ireland Social Care Council or Scottish Social Services Council and adhere to a professional code of practice
- Occupational therapists require a degree in occupational therapy.
- Qualification requirements for Community support and outreach workers qualifications vary from no formal qualifications to NVQ levels 2 or 3 (Skills for care http://careerpathways.skillsforcare.org.uk/what_is/comm/comm_mentalsupport.html)
- Care workers often require no formal qualifications but there has been an increase of workers qualified to level 2 or 3
- Youth workers require a degree level qualification or diploma (but the diploma is being phased out)

For many professional qualifications the NHS operate workforce planning processes to attempt to ensure that supply meets demand. With changes taking place within the NHS there are new structures for workforce planning, education and training of the health workforce ([Department](#) of Health, 2012b). There are two central bodies involved in functioning of the new system – Health Education England (HEE) and the Local Education and Training Boards (LETBs).

- HEE will provide leadership and oversight on strategic planning and development of the health and public health workforce, and allocate education and training resources. It will be responsible for functions such as medical trainee recruitment.
- The LETBs will be the vehicle for providers and professionals to work with HEE to improve the quality of education and training outcomes to meet the needs of service providers, patients and the public.

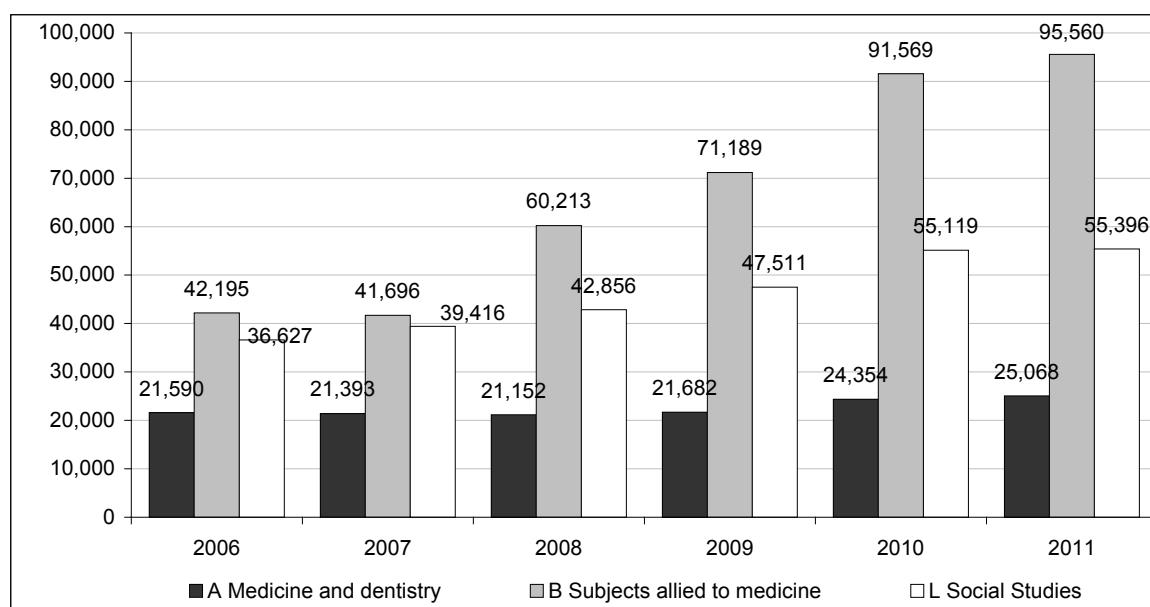
The Department of Health will continue to set the regulatory, policy and legal framework and to set performance outcomes. It will hold the HEE Board to account for delivery of its strategic objectives.

5.2 Trends in skill supply: individuals

5.2.1 Higher education

Higher Education Institutions (HEIs) are one of the main suppliers of professionals to the health and social care sector. There has been an increase in the number of students applying for medical degrees, subjects allied to medicine and social studies, which has slowed slightly in the last few years (see Chart 5.1).

Chart 5.1 Students applying to health and social care courses 2006/2011

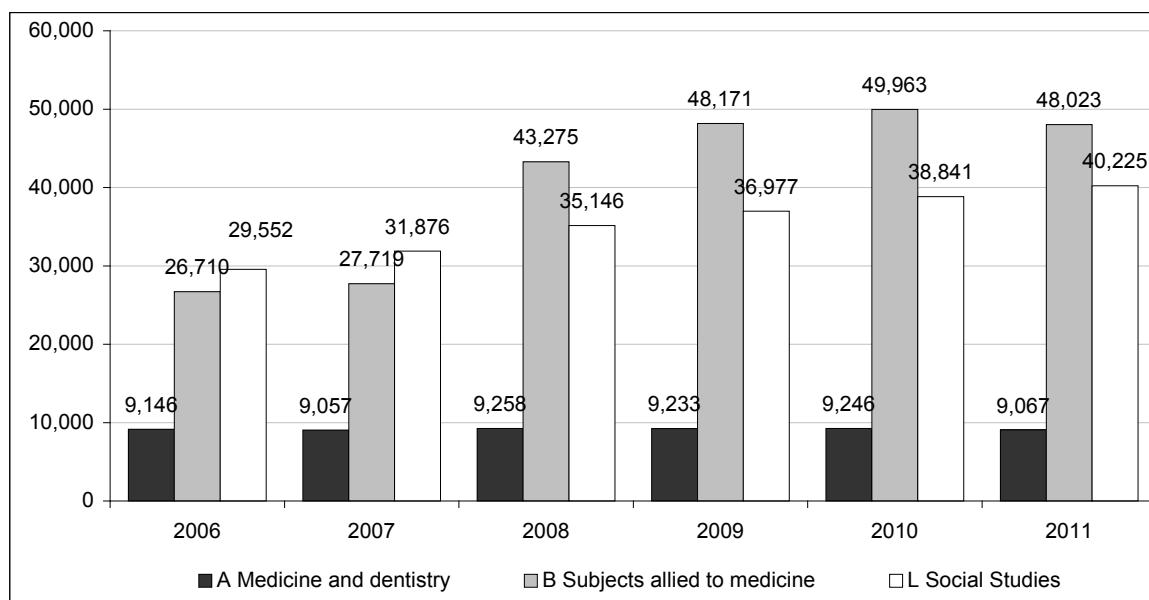


Source: UCAS (2011)

Chart 5.2 shows the number of students accepting offers to study HE courses in medicine and dentistry, subjects allied to medicine¹² and social studies. These figures show that medicine acceptances has been level across the period, subjects allied to medicine have been increasing but declined slightly in 2011 and social studies have continued to rise. There is a considerable gender imbalance in students studying courses related to the sector with 82 per cent being female (UCAS, 2011)..

There have, however, been concerns that budgetary restraint across the UK may lead to a reduction in some areas such as nurse student numbers. For example NHS London is cutting the number studying adult nursing each year from 2,000 to 1,580 (Clover, 2011).

¹² Subjects allied to medicine are: Anatomy, Physiology and Pathology; Pharmacology, Toxicology, and Pharmacy; Complementary medicine; Nutrition; Ophthalmics; Aural and Oral Sciences; Nursing; Medical Technology, and; Others in subjects allied to medicine.

Chart 5.2 Students acceptances to health and social care courses 2006/2011

Source: UCAS (2011)

Latest figures (see Table 5.1) show some decline (2.7 per cent for medicine and dentistry and 11.7 per cent for social studies) against an all subject average reduction of seven per cent – subjects allied to medicine have shown a minor increase.

Table 5.1 Total applications subject group April 2012

Subject Group	2011	2012	Change	Change (%)
Group A Medicine & Dentistry	96,440	93,858	-2,582	-2.70%
Group B Subjects allied to Medicine	353,439	355,430	1,991	0.60%
Group L Social Studies	233,917	206,504	-27,413	-11.70%
Total	2,739,606	2,539,430	-200,176	-7.30%

Source: UCAS (2012)

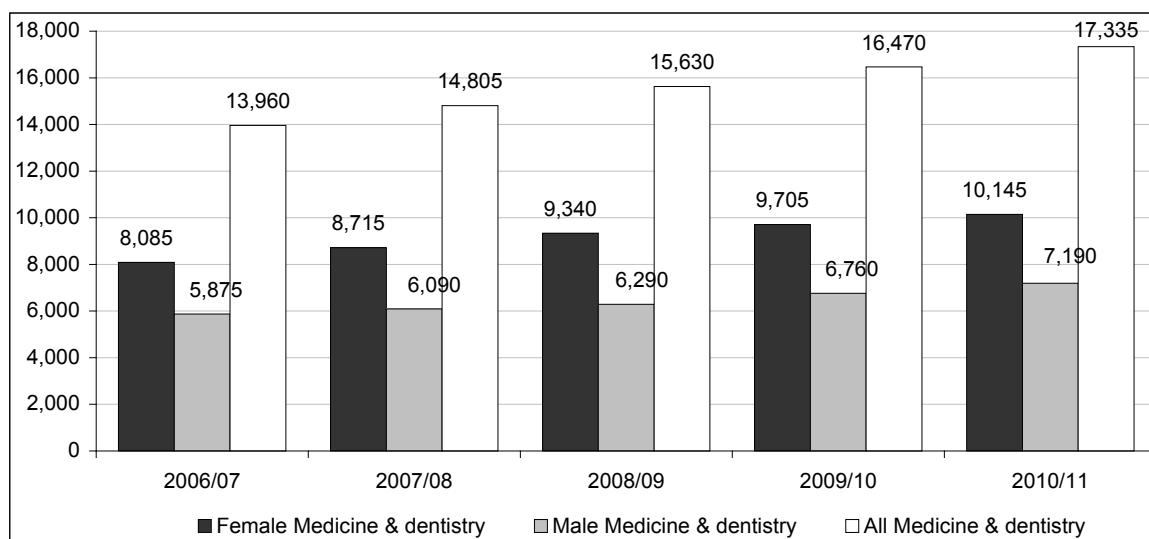
Having considered the inputs into the HE system it is now useful to look at the health and social care graduates and postgraduates it has produced.

The number of medicine and dentistry qualifications have been increasing in recent years (Chart 5.3). There is also a durable gender imbalance with females accounting for 58 per cent of qualifications awarded between 2006/07 and in 2010/11. Given the number of acceptances to study medicine and dentistry is relatively stable it may be difficult to maintain the recent increases in qualification attainment in these subjects. This is concerning given the growing demand (expansion and replacement) reported in section 4 for high skilled jobs especially in professional medical occupations.

Turning to subjects allied to medicine (Chart 5.4), numbers of attainments have been relatively stable over the last four years. The proportion of attainments by females has declined slightly since 2006/7 from 83 per cent to 80 per cent. Whilst applications and acceptances for these subjects have increased substantially, although there are indications that these may be beginning to plateau or perhaps decline, it does not seem to have converted to an increase in qualification attainment. Again this is concerning given the expected pattern of future demand for skills.

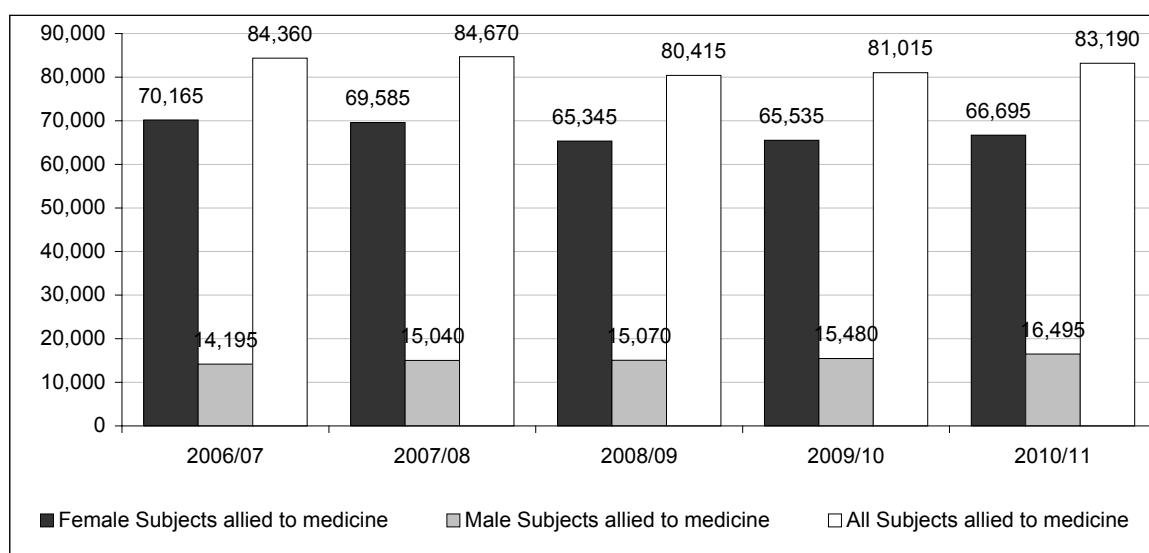
The number of social studies qualifications has increased (Chart 5.5) whilst the dominance of women has been relatively stable at 63/64 per cent over the period.

Chart 5.3 Medicine and dentistry qualifications attained in UK HEIs, 2006/7 to 2010/11



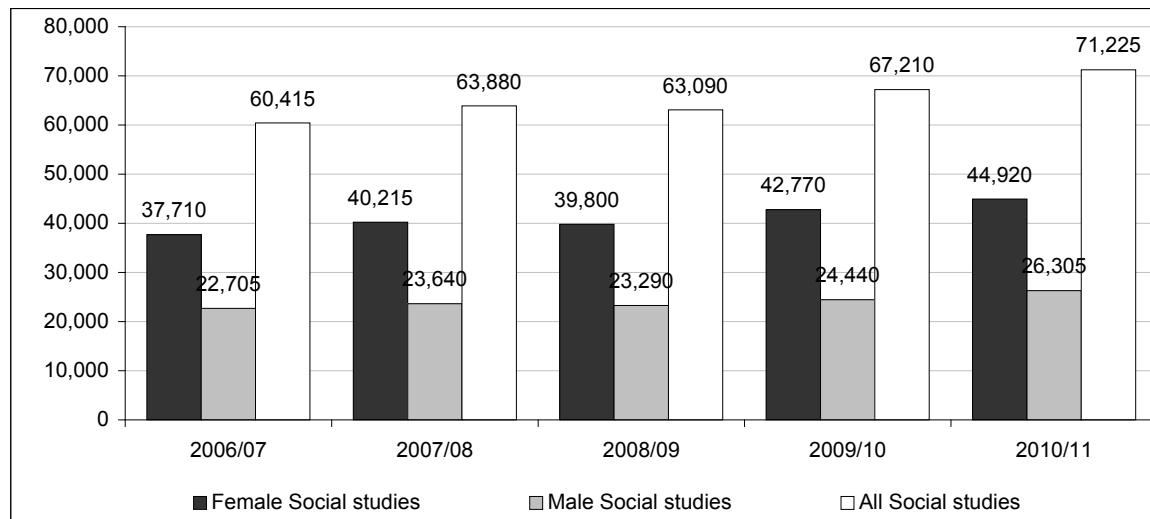
Source: HESA 2012

Chart 5.4 Subjects allied to medicine qualifications attained in UK HEIs, 2006/7 to 2010/11



Source: HESA 2012

Chart 5.5 Social studies qualifications attained in UK HEIs, 2006/7 to 2010/11



Source: HESA 2012

Given the pattern of applications and acceptances to study courses relevant to the sector

5.2.2 Apprenticeships

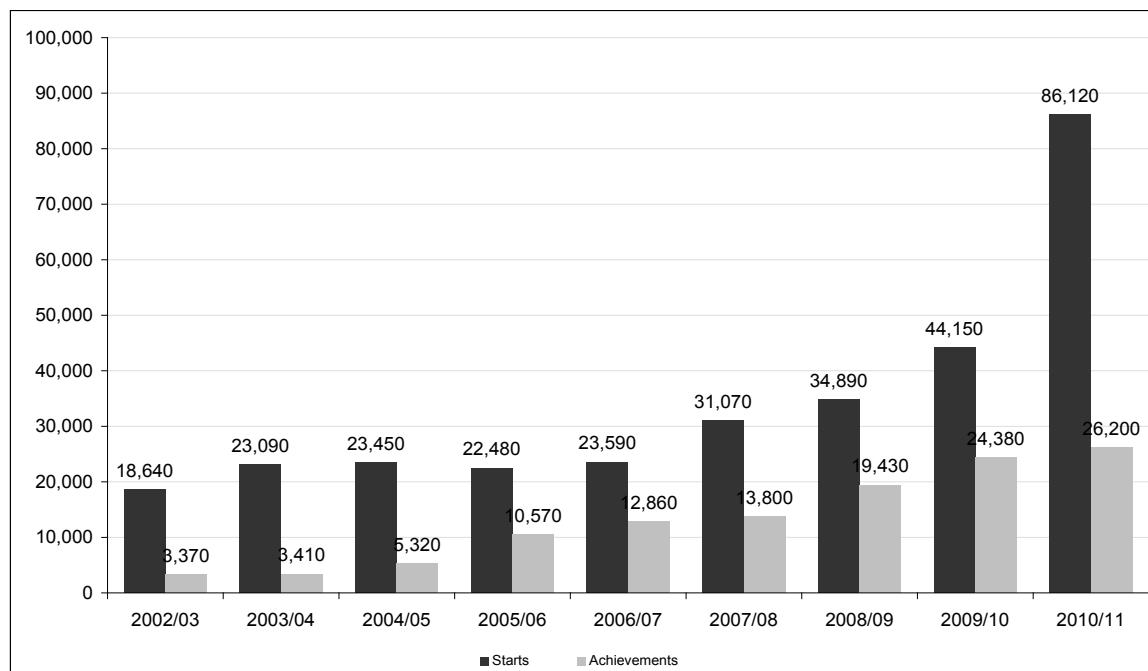
There is an increasing focus in the UK's vocational education and training system on apprenticeships, particularly as a source of supply of intermediate technical skills. The level of uptake of apprenticeships across the sector has grown considerably (see Table 5.2 and Chart 5.1). These show nearly a fourfold (382 per cent) increase in apprenticeship start numbers between 2002 and 2011 with particular expansion in advanced apprenticeships. This growth exceeds that for all sectors (172 per cent) by some margin. The growth in older people starting apprenticeships has been especially marked. The data shows nearly a doubling in starts for all apprenticeships between 2009/10 and 2010/11 although the number of achievements shows only a modest increase to date.

Table 5.2 Health, public services and care apprenticeship starts by level and age in England (2002/03 to 2010/11)

Intermediate Apprenticeships									
	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11
<19	6,690	8,470	9,850	8,820	8,890	9,150	10,670	13,670	12,190
19-24	5,770	7,210	6,060	5,860	6,250	6,500	6,770	9,840	14,940
25+	-	-	10	10	30	1,780	2,990	3,880	20,520
Total	12,460	15,680	15,920	14,680	15,170	17,440	20,440	27,390	47,650
Advanced Apprenticeships									
	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11
<19	1,790	2,030	2,530	2,580	2,700	2,680	3,210	3,870	4,880
19-24	4,400	5,380	5,000	5,200	5,700	6,460	5,490	7,990	13,150
25+	-	-	10	20	20	4,490	5,750	4,900	24,300
Total	6,190	7,410	7,530	7,790	8,420	13,630	14,450	16,760	42,320
All Apprenticeships									
	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11
<19	8,480	10,490	12,380	11,390	11,590	11,830	13,880	17,540	17,060
19-24	10,170	12,600	11,050	11,060	11,950	12,960	12,260	17,830	28,090
25+	-	-	10	30	50	6,270	8,750	8,780	44,820
Total	18,640	23,090	23,450	22,480	23,590	31,070	34,890	44,150	89,970

Source: ONS (2012)

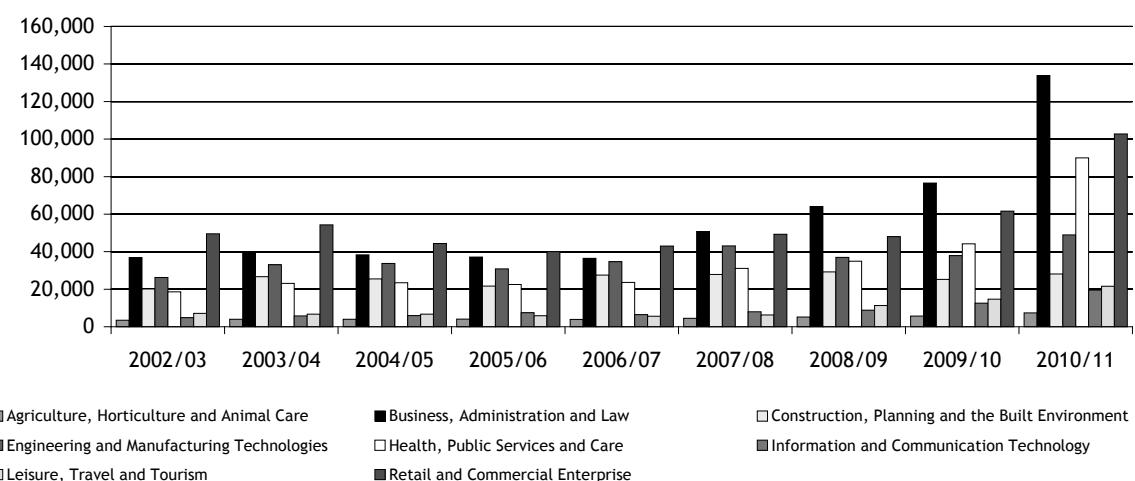
Chart 5.6 Apprenticeship starts and completions in health and social care in England (2002 - 2010)



Source: ONS (2012)

This growth is not limited to apprenticeships in health and social care (see Chart 5.7) and starts across a number of sectors have been increasingly significantly. The National Apprenticeship Service (NAS, 2010) believes that the increase is due to a range of factors, including: more young people taking up apprenticeships during the recession, a greater awareness of apprenticeships as an effective route to gaining employment and qualifications at the same time and more employers realising the real benefits that Apprenticeships can bring. Apprenticeships became available for those aged over 25 years in 2009 which has provided more and more people with opportunities for employment and training.

Chart 5.7 Apprenticeship programme starts by sector subject area (2002/03 to 2010/11)



Source: ONS (2012)

Notes: Statistical First Release using Work-based learning (WBL) – 2007/08 and earlier years (W13 final), 2008/09 (E13 final), 2009/10 (E13 final 2010/11 (ER13 final), 2011/12 (R06 final).

5.3 Employer investment in skills

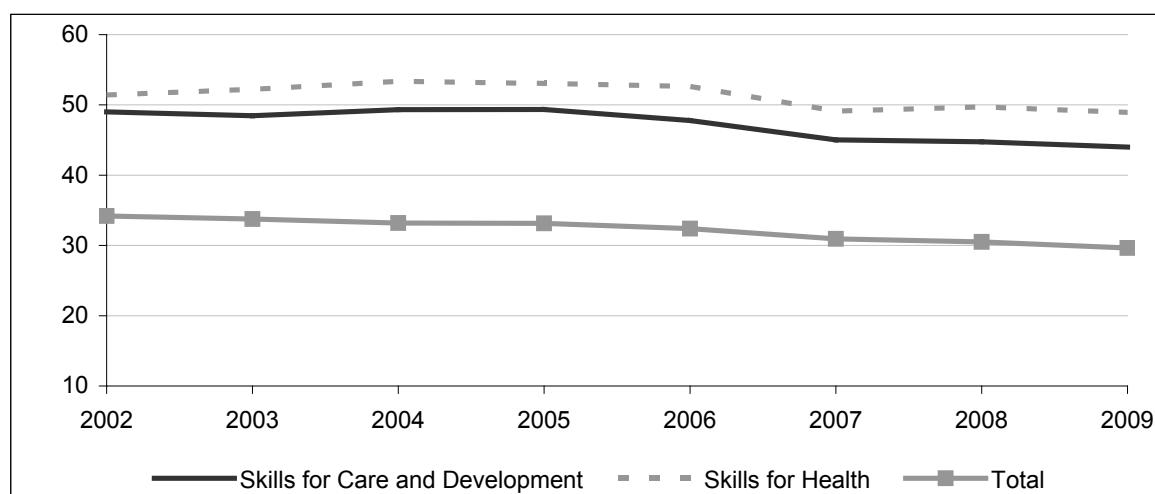
Investment in training and development in the health and social care sector is relatively high. Table 5.3 shows that more than 43 per cent of the sector's workforce received training in the previous 13 week compared to more than 25 per cent on average for all sectors. All occupations in the sector are more likely to have recently received training than the average for their counterparts in other sectors. Differences were particularly marked for managers (44 versus 23 per cent), professionals (59 versus 40 per cent) and associate professionals (52 versus 35 per cent). However, it is noticeable that the proportion of people aged under 25 receiving training is well below the all-sector average.

Table 5.3 Number of employees in receipt of work-related training over the past 13 weeks

Occupation (SOC Major Groups)	Health and Social Care		Whole economy	
	Number	% of workforce	Number	% of workforce
All	1,659,724	43.5	7,352,628	25.5
Managers, directors and senior officials	143,655	43.5	1,008,425	22.6
Professional occupations	277,182	59.3	1,588,563	39.5
Associate professional and technical	546,223	52.1	1,505,022	35.3
Administrative and secretarial	110,315	25.3	670,009	21.1
Skilled trades occupations	14,056	28.1	476,943	15.6
Caring, leisure and other service	518,668	41.4	927,704	36.5
Sales and customer service	7,497	32.9	416,531	19.4
Process, plant and machine operatives	4,616	22.2	288,954	15.2
Elementary occupations	37,512	20.5	470,477	14.5
Women	1,301,198	43.34	3,868,241	28.9
Men	358,785	44.30	3,484,387	22.6
People aged under 25	147,968	8.92	1,091,698	29.5

Source: Labour Force Survey, 2010

Although the incidence of work-related training in the H&SC sector is greater than in the workforce as a whole, the incidence has been falling in recent years as it has across all sectors. Chart 5.8 shows the recent trend in the proportion of employees who had received work-related training over the past 13 weeks. The proportion of employees in receipt of training in the social care sector fell from 49 per cent in 2002 to 44 per cent in 2009 and in the health sector from 51 per cent to 44 per cent. The proportion of employees in receipt of training across all sectors (total) fell from 34 per cent to 30 per cent over this period.

Chart 5.8 Percentage of employees in receipt of work-related training over the past 13 weeks

Source: Labour Force Survey, UKCES Almanac

The UK Commission's UK Employers Skills Survey 2011 (Davies et al., 2012) reports that over 80 per cent of employers in the health and social care sector provided training to their employees in the past 12 months. The average for all employers in UK is 59 per cent (see Table 5.4).

The average number of days of training per trainee was between 8 and 8.4 days in health and social care but slightly more, 8.9 days, across all sectors. This suggests that although many more employers train their employees, the investment per person is about the same (or slightly less) than for the whole economy.

Current involvement with apprenticeships is slightly above the level in the economy as a whole, although the proportion of employers who do not currently offer apprenticeships but plan to offer them in the future was slightly less than it was across all sectors, at six per cent compared with eight per cent across all sectors. The recruitment of young people straight from school is about the same as for the whole economy, although the proportion of employers who have recruited young employees straight from college or higher education is higher than the average across all sectors.

Table 5.4 Employer investment in skills

	Health	Social Care	Whole economy
% of employers training	86	84	59
% average number of training days (per trainee)	8	8.4	8.9
Average expenditure on training per employee (UK ESS)		£1,550	£1,775
Average expenditure on training per trainee (UKESS)		£2,325	£3,275
% of employers who have any staff undertaking Apprenticeships at their site [^]	7		5
% of employers who currently offer Apprenticeships at their site [^]	5		4
% of employers who plan to offer Apprenticeships in the future [^]	6		8
% of employers who have recruited someone 16- 18 from school (UK ESS)	10.0		9.7
% of employers who have recruited someone 17- 24 from college/FE/university/HE (UK ESS)	18.0		12.2

Source: Davies et al. (2012) except [^] (Shury et al., 2011)

Base for training: All establishments (87572, unweighted)

Base for expenditure: All trainers completing the Investment in Training Survey (11,117 unweighted)

Base for recruiting from school/college/HE: All establishments (86,069 unweighted, not asked in Scotland)

Health and social care employers generally express a similar level of barriers to training, such as expense or time away from work to the whole economy. The exception is a slightly more employers (16 per cent (11 per cent health and 19 per cent in care) versus 10 per cent in whole economy state that no money is available for training (Davies et al., 2012).

5.4 Migrant labour supply

Up until now, this chapter has just looked at domestic supply of skills. One other source of supply is to bring in skill from abroad in the form of migrant labour. As we have seen in section 3 there is a heavy reliance on migrant flows of labour into key parts of the sector.

5.4.1 Health

Evidence published by the Migration Advisory Council suggests that parts of the sector rely fairly heavily on immigrant labour (MAC 2010). MAC's analysis of Labour Force Survey data on the share of workers who were born overseas shows that in 2008 18 per cent of health professionals and 18 per cent of associate health professionals were non-UK born, compared to the average figure of 13 per cent. Health professionals were the occupational group with the 2nd highest share of non-UK born workers. This was an increase of 3 percentage points from 2002.

Nurses too have been actively recruited from other countries over many years and this route has been significant in the past. In the period between the late 1990s to 2005/6, the UK, (particularly England) actively recruited nurses from a range of countries. As we noted in section 3.6 there has been a substantial decline in nurses from overseas coming to work in the UK.

Approximately 63 per cent of medical staff in the sector are UK qualified with the remainder being a mix of EEA and non-EEA qualified practitioners (NHS, 2011). The data suggests that for many grades there has been a steady increase in the proportions of non-UK qualified medical staff. Similar data for GPs shows that the proportion of GPs who obtained their primary medical qualification in the EEA and elsewhere between 2000 and 2010 has increased from 19 to 23 per cent (NHS 2011).

The proportions of non-UK qualified personnel varies considerably by role (Table 5.4. Two thirds or more of associate specialist, staff grade, and senior house officer staff qualified

outside of the UK (see Table 5.5) Chart 5.10 illustrates the that dependence over time on non-UK qualified staff in associate specialist and staff grade is broadly stable but that for senior house officer roles dependence has risen fast.

Table 5.5 Hospital and community health services (HCHS): Medical staff by country of qualification (England, September 2011)

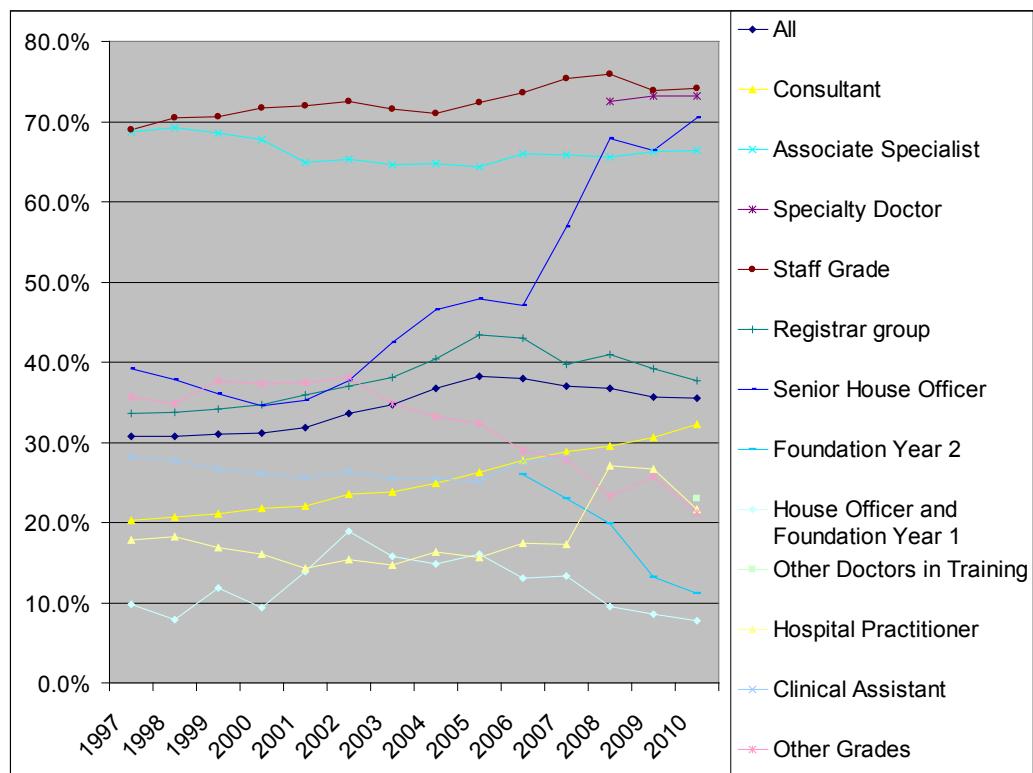
Countries of Qualification	United Kingdom	Rest of EEA	Elsewhere	All
All staff	65,415	6,738	28,107	101,705
Consultant (including Director of Public Health)	25,530	2,729	9,827	38,341
Associate Specialist	1,184	239	2,130	3,572
Staff Grade ¹	225	81	497	808
Registrar Group	24,548	2,510	10,891	38,386
Senior House Officer	316	146	577	1,059
Foundation Year 2	5,324	179	432	6,043
House Officer & Foundation Programme Year 1	5,381	124	209	6,225
Hospital Practitioner/ Clinical Assistant	1,409	82	271	1,782
Other Staff	226	13	55	313

1 A staff grade doctor is a non training, non consultant post under the supervision of a consultant (Thinking of taking a staff grade post? (Published 29 November 1997):BMJ 1997;315:S2-7120

Source: Reproduced from the NHS Information Centre NHS staff 1997-2007 (Medical and Dental) statistics (Slowther et al., 2009)

<http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-1997--2007-medical-and-dental> (accessed 4th February 2008)

Chart 5.9 Hospital and community health services (HCHS): Relative proportion of non UK qualified medical staff country 1997-2010



Source: Reproduced from the NHS Information Centre NHS staff 1997-2010, September each year, (Medical and Dental) statistics (Slowther et al., 2009)

5.4.2 Social care

Workers born outside the UK made up 11 per cent of the UK care sector workforce in 2008-09, with about one in twelve workers having been born outside the EEA (or an estimated 132,000 workers) (Skills for Care and Development, 2011). This is noticeably less than the 37 per cent of UK medical staff who are non-UK qualified.

Over the last four quarters, one in six of the care assistants and home carers, including higher qualified and more experienced senior care workers, currently working in the sector was not born in the UK. Skills for Care and Development believe this proportion could be higher in London where competition for skilled labour remains strong.

Almost one in five workers in the residential care sector was not born in the UK whilst in London, the proportion of residential care workers born in the UK could be less than a third (Skills for Care do however urge caution on this statistic due to low LFS sample size). Proportions vary considerably across the various nations of the UK, for example a recent survey by Skills for Care and Development suggests that approximately three per cent of the overall Scottish social services workforce are migrant workers, although Skills for Care and

Development state that this figure may be as high as five or even seven per cent within the adult residential care and care at home sector.

Research by IES (Jagger, 2011), suggests UK reliance upon migrant workers is less than for some other EU states but greater for residential care services than for France, Italy and Germany.

Concern has been expressed that a heavy reliance on migrant labour may leave some parts of the sector and in some areas of the UK vulnerable should migration be restricted through government intervention and that this will result in wider skills shortages than currently experienced (London was judged to be especially vulnerable) (Skills for Care and Development, 2011). This has the potential to impact upon the availability and the effectiveness of service delivery. Skills for Care and Development expressed particular concern about the impact of restrictions upon recruitment of social workers from outside the EEA in terms of child protection and family support.

5.5 Conclusion

The health and social care sector has a large number of roles requiring high level qualifications and there has been a tendency to raise skill requirements over the years as various jobs have moved from diploma- based qualifications to degree- based (social work, nursing, youth work). As such higher education is a major provider of skills for the sector.

The attainment of qualifications related to the sector have either been broadly constant or increasing. However, acceptances have steadied and in some areas shown slight decline. This raises concerns within the sector that the quantity of graduates may not be sufficient to meet the growing demand for professional and technical skills outlined in Chapter 4.

The sector has traditionally employed high levels of migrant workers and dependence on these is high especially in some highly skilled roles. Reliance on nurses from overseas has decline though.

There are also growing numbers of apprenticeships in the sector although slightly fewer health and social care employers who do not currently offer them plan to do so in the future which might suggest that any growth might be limited. As a consequence of high qualification demands of certain roles the health and social care population as a whole are highly qualified.

Once qualified and employed health and social care workers are more likely to receive training than workers in the rest of the economy in all occupational groups, similarly employers are more likely to provide training. Higher than average levels of training are reported among managerial, professional and associate professional occupations. Barriers to training experienced by health and care sector employers are similar to those noted across the whole economy, except for care sector employers being more likely than other employers to state that no money is available for training. With future pressure on budgets, health employers may find it difficult to sustain current levels of training.

In the next section we look at the evidence on skills mismatch and see whether the skills supply system is able to meet the current level of demand.

6 Skill mismatches

6.1 Defining skill mismatches

Previous evidence has demonstrated that mismatches between the demand for, and supply of skills, can be damaging for organisational performance (Garrett *et al.*, 2010). To some extent, skill mismatches will result from ongoing processes of technical and organisational changes within firms, and shifts in the pattern of demand in external markets. To some degree these will be transitional mismatches as the demand side ie employers, begins to fully articulate its skill requirements and the supply side responds accordingly. But there are also likely to be structural mismatches where the demand for, and supply of, skills remain out of kilter despite the market signalling what skills are required.

As there is no direct measure of mismatches between the demand for, and supply of, skills, at the sectoral level inferences about the balance between the two are typically made through hard-to-fill vacancies (HtFVs) and those that are hard to fill as a result of a lack of skills, experience or relevant qualifications (skill-shortages, SSVs) in the external labour market. Surveys also capture information about problems employers experience with any lack of proficiency in their jobs (i.e. skill gaps). Finally, skill deficiencies can also be inferred from data on earnings, as employers can respond to a skill shortage by offering higher wages.

6.2 Evidence of employer reported skill deficiencies

The UK Commission's UK Employer Skills Survey (Davies *et al.*, 2011) provides an opportunity to gauge the current state of recruitment problems and skills deficiencies at a time of lower demand than has been the case over much of the previous two decades. As such this section draws heavily on the survey.

The survey reports the extent of vacancies, hard-to-fill vacancies, skill shortage vacancies and skill gaps at the level of companies (these terms are defined below).

Hard-to-fill vacancies are vacancies which are proving difficult to fill, as defined by the establishment.

Skill-shortage Vacancies (SSVs) are vacancies which are proving difficult to fill due to the establishment not being able to find applicants with the appropriate skills, qualifications or experience.

Skills gaps are where an employee is not fully proficient – i.e. is not able to do their job to the required level.

The survey provides comparable and representative results for the whole UK, sectors and separate nations as well as for the sector and can easily reveal whether the skills issues are more severe in the sector than elsewhere (see Table 6.1). The evidence suggests that despite rising demand for skills, supply is broadly in line with the UK average. For 2011, almost 28,000 vacancies were reported for the health sub sector and almost 37,500 for the care sub sector, which corresponds to almost 14 and 25 vacancies per 1000 employees respectively. Health is below the total economy average and social care is slightly above it. If measured as a percentage of establishments however, then health and social care has a higher proportion of establishments with at least one vacancy (18 per cent compared to 12 per cent all economy average).

In terms of vacancies which are proving difficult to fill, only 19 per cent and 16 per cent of the health and care vacancies respectively were reported as hard to fill, compared to the corresponding share of 23 per cent in the total economy. Similarly skill shortage vacancies are below the whole economy average on almost all indicators. As a proportion of all vacancies SSVs represent 12 per cent in health and nine per cent in social care versus 16 per cent for the whole economy.

Table 6.1 Skill deficiencies

	UK	Health	Care
Vacancies			
per 1,000 employees	23.1	13.9	24.9
as a % of employees	2	1.4	2.5
% of establishments with at least one vacancy	12	18	
Total	635,900	27,811	37,494
Hard to fill vacancies (HtFVs)			
per 1,000 employees	5.2	2.6	3.9
as a % of vacancies	23	19.9	15.9
% of establishments with at least one HTFV	4	3.1	4.4
Total	143,550	5,281	5,924
Skills Shortage Vacancies			
per 1,000 employees	3.8	1.7	2.2
as % of all vacancies	16	12.5	8.9
% of establishment with at least one SSV	3	2.7	3.0
Total	103,450	3,330	3,335
Skill Gaps			
per 1,000 employees	54.1	50.9	52.1
as % of employees	5	5.1	5.2
% of establishments reporting a skill gap	13	19	17
Total	1,489,500	101,986	78,458

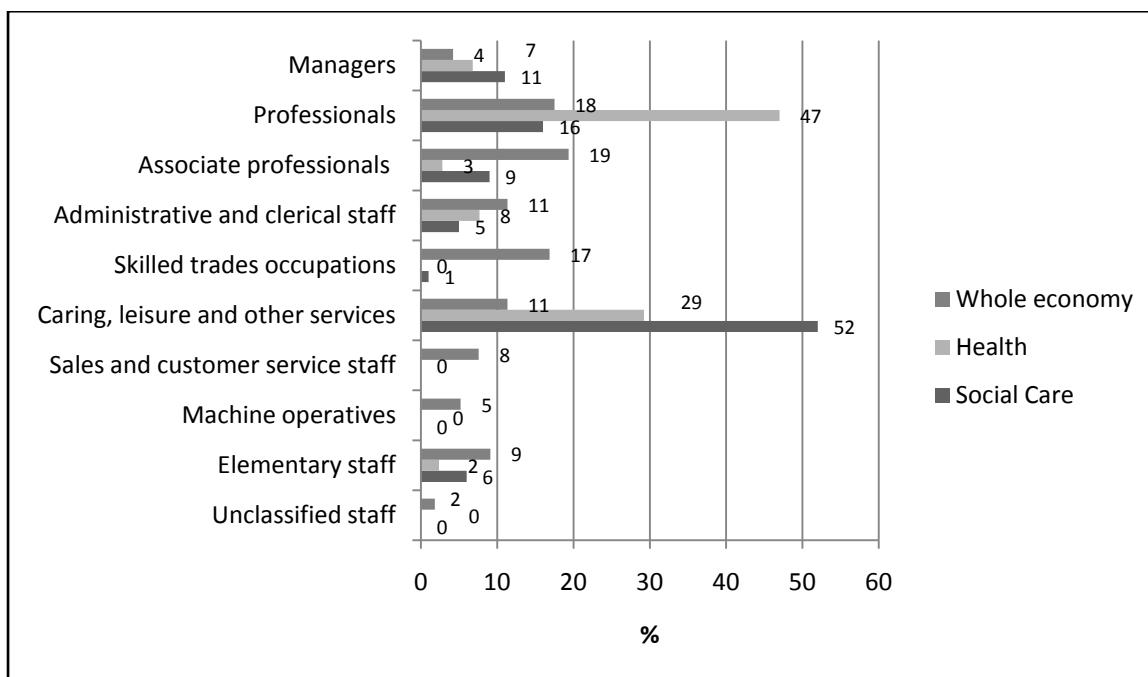
Various bases: All establishments; Vacancies as a % of employees based on all employment; Hard-to-fill vacancies as a % of vacancies based on all vacancies; SSVs as a % of vacancies based on all vacancies; Skills gaps as a % of employees based on all employment.

Notes: Numbers rounded to nearest 50

Considering the distribution SSVs as a proportion of all skill shortage vacancies in the sector provides a further level of understanding (Chart 6.1). Skills shortages are concentrated in the two largest occupations in the sector; professionals and caring, leisure and other service roles. SSVs in caring roles represent more than two fifths of all SSVs in the care sub-sector and professionals represent nearly half of all SSVs in health. The concentration of SSVs in these occupations may not be surprising but it is concerning given each occupation only represents around one third of employment in each sub-sector (section 4). So it is evident that SSVs are disproportionately concentrated in occupations which are central to the sector.

In the economy as a whole management SSVs make-up a small proportion (4 per cent) of total SSVs and the same can be said for health and social care. However, the proportions in each sub-sector are nearly double and three times (7 per cent and 11 per cent) that of the all-sector average for managers.

Chart 6.1 Occupational distribution of skill shortage vacancies in health and social care

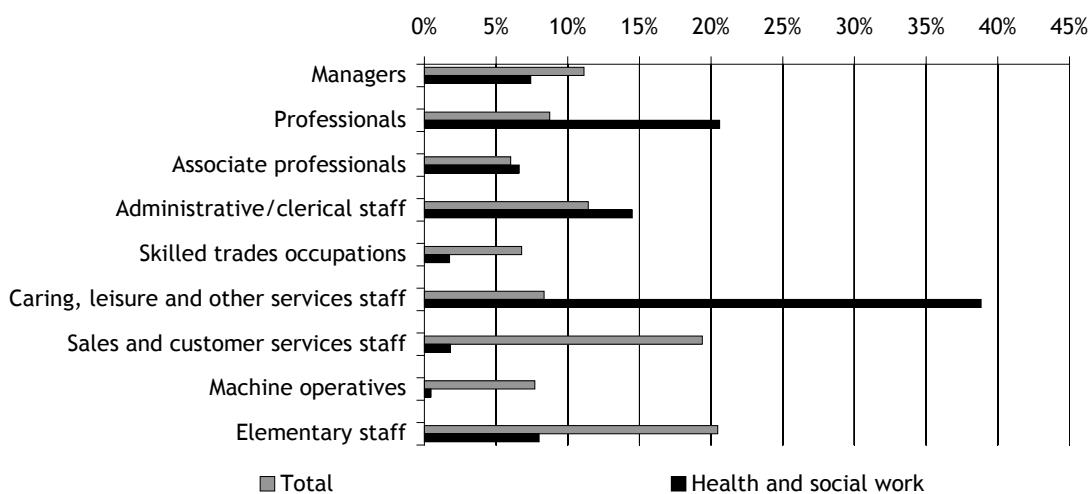


Base: All skill shortage vacancies

Source: Davies et al., (2012)

Turning to the issue of skills gaps, the proportion of employees that are reported as not being fully proficient in their role (i.e. having skills gap) by employers is in health and social care sub-sectors is line with the UK average at five per cent. The proportion of establishments reporting skills gaps among their staff is higher in both sub-sectors than the average but this is explained by the much smaller of proportion of small establishments in the sector highlighted in section 2.

Skill gaps are most common among caring staff and professional occupations in health and social care sector. Skill gaps are also slightly more common amongst administrative and secretarial occupations than they are in the economy as a whole (Chart 6.2). This profile broadly reflects the key skill needs in the sector.

Chart 6.2 Occupational Distribution of Skill Gaps in H&SC

Base: All Skill gaps

Source: Davies *et al.* (2012)

Skills for Care and Development (2011) identify a range of current skills gaps, skills shortages and occupational shortages that are an immediate priority for the sector. They estimate 22 per cent of employers in England currently report skills gaps. This is higher than the percentages reported for other parts of the UK.

UK NHS vacancy data examines posts that have been vacant for three months or more and the employer is still actively trying to recruit. Skills for Health indicate from this evidence that vacancies in the sector are broadly consistent in each of the nations. The data also shows that specific difficulties exist in Other Physiological Sciences (eight per cent of employment) and Respiratory Physiology (six per cent). Vacancy rates for registered pharmacists are running at approximately five per cent and at six per cent for pre-registration pharmacy trainees which may be indicative of a potential long term shortage.

6.3 Causes, impacts and remedies

The UK Commission's UK Employer Skills Survey (Davies et al. (2012) provides a wealth of information about the causes and implications of skill shortages and gaps. In general, the main cause of skill shortage vacancies was a low number of applicants with the required skills, reported by 24 per cent of H&SC employers, compared to 40 per cent of employers across all sectors. Poor terms and conditions were cited by 23 per cent of H&SC employers compared to 13 per cent in the economy as a whole). Job characteristics were also more commonly mentioned by H&SC employers eg the job entails shift work or unsociable hours mentioned by 16 per cent (compared to 9 per cent in the economy as a whole), and a remote location or poor public transport was highlighted by 12 per cent (compared to 6 per cent in the economy as a whole).

6.3.1 Skills shortage vacancies

Table 6.2 shows that there were a range of skills that employers found difficult to obtain from applicants when attempting to fill vacancies, and these differed between the two sub-sectors. Job-specific skills were those most commonly found difficult to obtain, with 77 per cent of health employers and 54 per cent of care employers reporting difficulties obtaining these skills (67 per cent across all sectors). Technical and practical skills were reported to be difficult to obtain by 37 per cent of health employers and 39 per cent of care employers, below the proportion across all sectors of 48 per cent.

Just under half of care employers found it difficult to obtain planning and organisation skills and customer handling skills slightly above the proportions across all employers, and the proportion of care employers who reported difficulties obtaining written communication skills was also above the average, at 46 per cent of care employers compared to 35 per cent of all employers. Team working was raised by 42 per cent of care employers compared to 34 per cent of employers across the wider economy.

On the whole the percentage of health employers reporting each type of skill as lacking was less than the average for all sectors. These include technical skills (37 per cent versus 48 per cent across all sectors), planning and organising skills (29 per cent versus 43 per cent across all sectors) problem solving skills (23 per cent, compared to 40 per cent across all sectors) written communication skills (19 per cent, compared to 35 per cent), literacy skills (13 per cent, compared to 29 per cent), advanced IT/software skills (39 per cent, compared to 23 per cent), numeracy skills (6 per cent, compared to 28 per cent).

Table 6.2 Skills found difficult to obtain

	Health %	Social care %	Whole economy %
Job specific skills	77	54	67
Technical or practical skills	37	39	48
Planning and Organisation skills	29	49	43
Customer handling skills	28	49	43
Oral communication skills	23	44	40
Problem solving skills	23	42	40
Strategic Management skills	23	32	31
Basic computer literacy / using IT	22	26	17
Team working skills	22	42	34
Advanced IT or software skills	21	17	23
Office admin skills	20	16	20
Written communication skills	19	46	35
Foreign language skills	16	17	16
Literacy skills	13	34	29
Numeracy skills	6	22	28
Personal attributes e.g. motivation, work ethos, common sense, initiative, reliability, commitment, punctuality, flexibility)	5	1	3
Don't know	2	2	3
No particular skills difficulties	2	9	4
Other	1	0	1
Experience/lack of product knowledge	0	6	2
Oral Welsh language skills	0	3	1
Written Welsh language skills	0	1	1

Source: Davies et al. (2012)

Base: All establishments with skill shortage vacancies

6.3.2 Implications of skills shortages vacancies

The main impact of skill shortages was to increase the workload of other workers. This was mentioned by 76 per cent of health and 77 per cent of care employers compared with an average of 83 per cent of all employers in the UK. Having difficulties meeting customer services objectives was mentioned by about a third of both health and social care employers (36 per cent health and 33 per cent care compared to 45 per cent across all sectors). Skills shortages also caused significant numbers of employers to report; increased operating costs (41 per cent health and 34 per cent care, 39 per cent across all sectors); difficulties meeting quality standards (34 per cent both sub sectors which is the same as for all sectors) and; difficulties introducing new working practices (31 per cent health, 34 per cent care and 32 per cent all sectors).

In a sector such as health and social care these impacts can be significant, particularly where standards of care are concerned. Also of relevance given the degree of change facing the sector is the difficulty introducing new working practices.

6.3.3 Remedies for skills shortages

The main responses to experiencing skill shortages were to increase advertising or recruitment spend 44 per cent health, 45 per cent care compared to 39 per cent all sectors) or to use new recruitment methods or channels, (26 per cent of health employers compared with 22 per cent of care employers and 30 per cent of all employers).

6.3.4 Skills gaps

A skills gap exists where an employee is not fully proficient in their role. Skill gaps were seen to result primarily from staff being new to their role (health 37 per cent; care 50 per cent) or only partially trained (health 40 per cent; care 50 per cent) (see Table 6.3). This compares to 47 and 46 per cent respectively for the whole economy. Skills gaps were also seen to result from staff not receiving the appropriate training, cited by 37 per cent of health employers and 23 per cent of care employers, compared with 23 per cent of all employers. So this appears to be a particular issue in health.

Table 6.3 Causes of skills gaps

	Health		Care	
	Number	%	Number	%
They are new to the role	37,470	37	38,871	50
Their training is currently only partially completed	41,148	40	39,571	50
Staff lack motivation	36,164	35	24,959	32
They have been on training but their performance has not improved sufficiently	21,869	21	23,560	30
The introduction of new working practices	24,861	24	21,241	27
They have not received the appropriate training	37,994	37	17,685	23
Unable to recruit staff with the required skills	28,631	28	13,885	18
The introduction of new technology	18,904	19	10,777	14
The development of new products and service	14,539	14	11,397	15
Problems retaining staff	11,296	11	7,624	10
Lack of other skills e.g. communication, interpersonal	1,499	1	1,282	2
Lack of aptitude to do job/reached maximum potential	369	*	805	1
Non-work related problems e.g. health or personal problems	144	*	1,605	2
Language barrier - English not first language	1,346	1	237	*
Staff are too old to carry out the work required	80	*	279	*
Other	854	1	837	1
No particular cause	392	*	135	*
Don't know	23,741	23	14,330	18
<i>Weighted base</i>	101,986		78,458	
<i>Unweighted base</i>	11,053		9,654	

Base: All establishments with skills gaps

Notes: Percentages are based on all skills gaps followed up rather than all establishments with skills gaps. Figures therefore show the proportion of skills gaps in each sector caused by each stated reason.

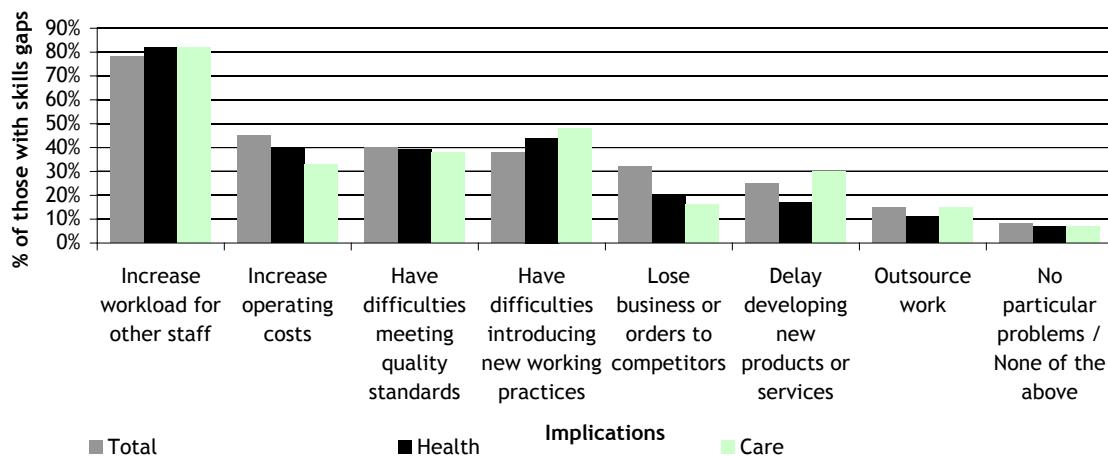
The skills most commonly cited as needing improvement were team Working skills, reported by 47 per cent of health and social care employers compared to 38 per cent of all employers. Other skills which health and social care employers were more likely than other employers to report needing improving were strategic management skills, and written communication skills.

6.3.5 Implications of skills gaps

Skills gaps were having a major impact on performance in 11 per cent of health and social care establishments, compared to 15 per cent across all sectors. The main implications of skills gaps can be found in chart 6.6. The most frequently cited implications are common across the two sub-sectors and also follow the same pattern as that for all sectors. Increased workload for other staff, increased operating costs, and difficulty in meeting quality standards.. However a particular issue for health and care employers is difficulties

introducing new working practices (44 and 48 per cent compared to 38 per cent of all firms). As with the impact of SSVs, problems introducing new working patterns and difficulties meeting quality standards are particularly concerning given the nature of the sector and the changes it faces. Not surprisingly given the make-up of the sector, employers are less likely to mention more commercial issues such as increasing operating costs or losing business orders to competitors.

Chart 6.3 The Implications of skills gaps



Base: All with skills gaps that have impact on establishment performance

Source: Davies et al. (2012) Table 78

The potential impact of skills deficiencies is also discussed in the National Strategic Skills Audit (UKCES, 2010). Evidence suggests that the health and social care workforce are broadly well qualified. However over 40 per cent of managerial occupations within the health and social care sector lack the NQF level 4 qualifications deemed appropriate for their role (UKCES, 2010). Section 3.7 highlighted the importance of management capability in the sector especially in the context of the challenges and change it faces.

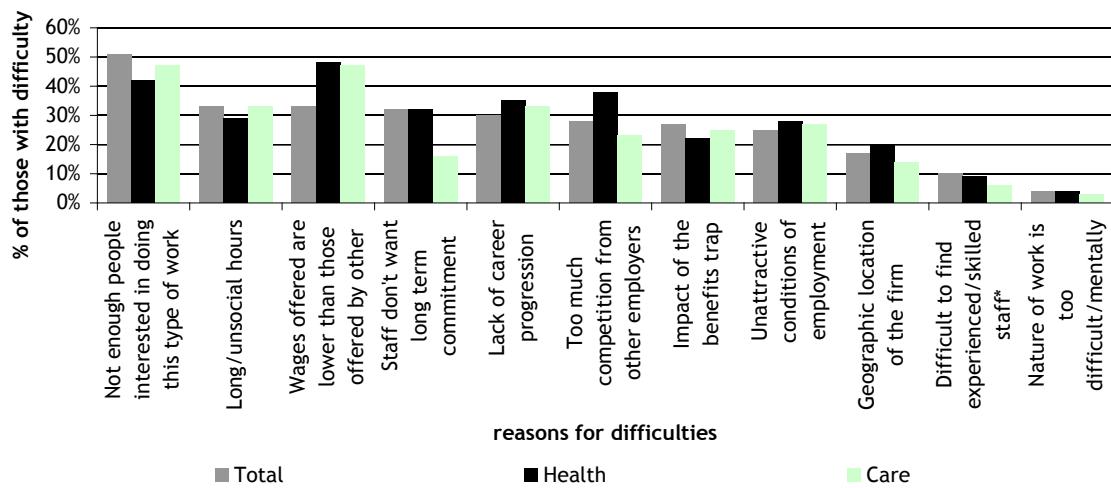
6.3.6 Remedies for skills gaps

The actions that were taken to improve the proficiency or skills of staff with skills gaps were broadly in line with those across all sectors – most commonly increasing training activity/spend or increasing or expanding trainee programmes, more supervision of staff, more staff appraisals/performance reviews, implementation of mentoring or a buddy scheme, and re-allocating work. Care employers were more likely than those in health to undertake a range of actions particularly more staff appraisals and reallocating work.

6.3.7 Retention difficulties

The UK Employer Skills Survey enables us to explore why employers were experiencing retention difficulties. Chart 6.3 below shows that employers in both health and social care were more likely to feel that wages, lack of career progression and unattractive conditions of employment were a reason for low retention.

Chart 6.4 Main reasons why it is difficult to retain staff (prompted unless *)



Base: All establishments in England, NI, Wales that find it difficult to retain staff

Source: Davies et al. (2012) Table 10

6.3.8 Remedies for effective retention

In exploring what employers had done to retain staff, health employers were more likely to have used training (31 per cent health, 23 per cent care compared to 25 per cent for all employers). Care employers were more likely to have changed the job specification by giving tasks to others (11 per cent care, 9 per cent all employers, 4 per cent health) and care employers were more likely to have sought to change the work environment than average (10 per cent care, 4 per cent for both health and all employers). Both health and care employers were more likely to have introduced ways of improving job enrichment (18 per cent care, 12 per cent health and 9 per cent all employers).

6.4 Use of Skills

In addition to considering the prevalence of skills shortages and gaps, a further perspective on the extent of any mismatch between skills demand and supply is provided by comparing the qualifications an individual has and the qualifications required to get the job they occupy.

Green (2010) distinguishes between over-qualified, over-skilled and real over qualified individuals as follows:

- Over qualified individuals have achieved a higher qualification level than is required to get their job
- Over-skilled individuals report they do not have enough opportunity to use the knowledge and skills they have or have very little opportunity to use their past experience, skills or abilities in their jobs
- Real over-qualified are both over-qualified and over-skilled.

A snapshot of the extent of skills mismatch for health and social is provided in Table 6.4. Compared to the UK average, mismatch is far less of an issue in the health and social care sector than in other sectors, with ten per cent of employees reported as being over-qualified and over-skilled 17 per cent in the economy as a whole.

Table 6.4 Skills mismatch in health and social care in 2006.

% of employees	Over-qualified	Over-skilled	Real Over-qualified	Base survey number
Whole Economy	38.9	32.7	16.8	7613
Health, Social Work	28.6	25.3	10.4	1160

Source: Green (2010)

Information on the trend in skills mismatch in the sector is given in Table 6.5. Between 1992 and 2006, over-qualification has remained unchanged in the sector over this period contrary to the average for the UK which has increase five percentage since 2001 to 35 per cent.

Table 6.5 skills mismatch in health and social care 1992-2006

% of employees	1992	1997	2001	2006
Health & Social Work	Over-qualified %	26.8	29.9	28.9
	Over-skilled %		26.4	25.5
	Real Over-qualified %		10.5	10.8

Source: Green (2010)

More recent findings from the UK Commission's UK Employer Skills Survey are that the proportion of establishments reporting over-qualified and over skilled staff is higher than the UK average for care (54 per cent versus 49 per cent). Care is similar to the average for the proportion of employees considered to be over-qualified or over skilled (17 per cent in the sub-sector versus 16 per cent in the UK). For health over-qualification or being over-skilled is less prevalent with 45 per cent of establishments and 11 per cent of employees affected (Davies et al., 2012).

Whilst rates of over-qualification or over skilling are not high compared to the all-sector average it is clear that employers in the sector are utilising their staff to their full potential. A number of tools and process can be used to manage the staff and utilise their skills in the workplace.

The UK Commission's UK Employer Skills Survey reports the prevalence of four high performance working practices in the two sub-sectors (Table 6.6). There are some substantial differences between health and social care and the UK average. Both sub sectors have a more formal approach to identifying talent which may help in achieving lower rates of under utilisation. Discretion and access to flexible working is much lower in health than care and the UK average.

Table 6.6 High performance working in health and social care

% of establishments answering yes	Health	Social Care	UK
Formally documented process are in place to identify high potential or talented individuals	20	28	14
Individuals have variety in their work	51	59	55
Individuals have discretion over how they do their work	42	53	52
Individuals have access to flexible working	27	42	44

Source: Davies et al. (2012)

Base: All establishments in module one and Scotland

Investors in People is a business improvement tool focusing on the use of people. Reflecting the more formal approach to identifying talent reveal above it is perhaps not surprising that high proportions of the sector's establishments are IiP accredited, relative to the average for all sectors in the UK (27 per cent versus 16 per cent). Nevertheless, this still means a large proportion of the business in the sector are not accredited and may be missing out on the benefits of a more focused approach to managing their people (Davies et al., 2012)

6.5 Wages

Another potential indicator of mismatch between demand and supply for skills is earnings as if skills are in short supply / high demand then wages can rise. Table 6.7 provides a comparison of average annual wage levels for full-time employees in the health and social care sector compared with the economy as a whole and suggests that although average wages were lower in 2010, they were increasing at a faster rate.

Table 6.7 Gross annual pay (£) for full-time employee jobs in health and social care: UK, 2010

Description	Median	Annual Change (%)	Mean	Annual Change (%)
All Employees	25,882	0.3	32,204	1.0
Health and Social Care	18,466	2.8	23,373	4.2

Note: Based on SIC 2007

Source: *Annual Survey of Hours and Earnings, Table 16.7a*

However, the average figure for the sector hides substantial differences by sub-sector with average earnings in care being much lower than health and experiencing negative growth (ASHE, 2011). Occupations in some parts of the sector do better or worse than the average for the same occupation across all sectors. For example hospital managers tend to earn more than the average for all managers in the UK whereas residential and day care managers earn less. Health professionals earn considerably more than the all-professional average (see Table 6.8).

Table 6.8 Occupations in health and social care: UK, 2010

Description	Median	Annual Change (%)	Mean	Annual Change (%)
Whole Economy	25,882	0.3	32,204	1
All Managers and senior officials	38,000	1.3	51,210	2.6
Health And Social Services Managers	37,071	5.0	41,064	8.4
Hospital and health service managers	42,860	2.8	51,113	12.9
Pharmacy managers	41,265	4.5	41,948	6.4
Healthcare practice managers	28,436	9.1	31,749	7.9
Social services managers	38,643	8.8	38,918	1.4
Residential and day care managers	30,037	3.5	31,545	1.4
All Professional occupations	36,528	0.7	41,764	0.9
Health professionals	62,611	3.1	74,074	3.7
All Associate professional and technical occupations	29,375	0.5	32,626	-0.7
Health and social welfare associate professionals	28,470	1.8	29,203	2.8
Health Associate Professionals	30,245	1.9	30,561	3.2
Nurses	30,056	2.1	30,385	2.9
Midwives	34,664	1.7	34,484	0.8
Paramedics	37,341	2.2	38,139	3.2
Medical radiographers	35,883	-2.9	36,380	0.6
Chiropodists	32,434	12.5	32,377	7.6
Pharmaceutical dispensers	16,255	3.7	18,452	6.4
Medical and dental technicians	27,295	3.0	28,933	1.1
Therapists	29,611	-1.9	30,983	2.0
Youth and community workers	23,816	1.2	24,378	0.9
Caring personal service occupations	16,703	2.2	17,087	1.9
Nursing auxiliaries and assistants	18,125	2.2	18,388	1.3
Ambulance staff (excluding paramedics)	23,150	6.0	24,391	-0.7
Dental nurses	16,288	0.7	16,428	-2.9
Houseparents and residential wardens	20,173	2.5	20,622	-0.8
Care assistants and home carers	16,448	1.5	16,967	1.6

Note: Based on SIC 2007

Source: Annual Survey of Hours and Earnings, Table 14.8a

Managers and senior officials have seen a greater overall percentage increase in mean salary of 2.6 percent, whereas associate professional and technical occupations have seen a slight decrease in mean salary in 2010 (-0.7 percent overall).

6.6 Conclusion

The labour market in health and social care appears to be operating effectively in that despite increasing demand, supply is broadly meeting needs with overall vacancy levels at or below the national average. However, this picture hides pockets of greater skills mismatches among managers, professionals and caring staff occupations. Skills gaps are also greatest for professional and caring staff. Overall, the health and social sector have fewer over qualified staff than the economy as a whole, although recent evidence indicates that over qualification may be slightly more of a problem in care.

The implications of skills shortages or gaps is to; increase the workload of others which can contribute to staff turnover and thereby a loss of the skills; create difficulty introducing new working practices and meeting quality standards and; increase costs which have long term consequences for a sector under financial and quality pressures. Given the challenges the sector is facing these impacts are concerning.

Organisations respond by attempting to improve the job itself through job enrichment, changing the work environment, changing the job specification. They are also likely to use training and development as a retention tool. Given that respondents attribute problems to working conditions (ie low wages, long hours, and poor career progression) it would seem that the solutions being adopted do not actually tackle these issues. It is difficult to tell if this is a misplacement of effort or an attempt to offset some of the negative attributes of the job by increasing the intrinsic attractiveness of the job itself. Wages can also be increased by employers to attract individuals with the required skills and average pay in the sector did rise in 2010 but remains lower than the average for all sectors.

In the next chapter we pull together all the evidence on the skills challenges facing the sector and examine the potential solutions

7 Conclusions

7.1 The sector today and tomorrow

Health and social care is a sector that is of great significance to the UK's economic and social wellbeing. It is both a vital sector in its own right as a major employer geographically distributed across the UK and through its significant share of GDP. Health and social care is also a major contributor to UK productivity through its role in keeping the wider workforce healthy and productive.

The health and social care sector is one of the largest sectors of employment across the UK and one that has seen growth above that for the whole economy over the last decade. It is notable that employment is spread across all nations of the UK and across all English regions, in broad proportion to population density. Within the health sector, the NHS is a major employer of some 1.7 million people which places the service as one of the largest employers worldwide. Unsurprisingly, given the importance of the NHS, public sector employers dominate in the health subsector, whereas in social care the employment profile is more mixed.

Health and social care has both some of the largest occupations in England (care assistants and nurses) and some of the fastest growing (paramedics, youth and community managers, social services managers).

The size of the sector is reflected in high volumes (if not necessarily high proportions) of skills shortage vacancies in managers, professionals and caring occupations. There are also high priority skills needs in management and leadership skills in the health sector and health professionals.

In the UK Commission's National Strategic Skills Audit for England, health and social care was identified as a sector of economic importance. Significant replacement demand is anticipated in the coming years where sector employers recruit to replace its ageing workforce. It was also one of the sectors featured in the government's Growth Review.

Demand for health and social care has risen steadily and has been stimulated in part by some key demographic changes such as a growing and ageing population and changes in lifestyle choices that affect health. Technological innovation has also transformed what is possible and is continuing to shape skills demand in the sector. Public expenditure on health and social care has steadily increased over the last decade both as a percentage of GDP and relative to other parts of the public sector in response to these pressures. The likelihood

is that future spending will be much more constrained which will make rising to the health and care challenges of demographic change more difficult. In addition the sector is facing major efficiency savings, which emphasises the key role management capabilities play in meeting these challenges.

Evaluation of the outcomes of previous spending has resulted in mixed conclusions. Across the health sector, the increased spend has been associated with improved quality outputs with reductions in waiting times, increased life expectancy and reduced mortality rates across a range of diseases. Measurement of and trends in productivity in the sector is much debated with some commentators arguing that productivity in health has improved over the past decade or so, and some arguing that it has decreased. Factors shown to improve productivity include increases in patient throughput, increases in drug prescriptions, and overall improved quality of care. Factors acting to decrease productivity include increases in the volume of labour and the growth in the volume of goods and services consumed. Similar arguments apply to the social care sector with difficulties in accounting for shifts in quality or the changing profile of services.

7.2 The performance challenge

Responding to such rising demands with constrained resources means that a continuation of past approaches is not an option. Below is a summation of some key challenges faced by the health and social care sector.

The first key challenge is to do more with less (or at best the same) resource. Shifts in demography and lifestyle are of major significance to the sector. Chief amongst these are a growing and ageing population with a doubling of the numbers of those over 65 by 2050 and proportionally greater increases in those over 80. Demography and lifestyle factors place increasing demand on services for both health and social care. There are major concerns that current care provision is already inadequate and likely to need a major overhaul.

There are a range of lifestyle related issues that are of particular challenge to the health sector; rising levels of obesity and increased alcohol consumption for example. Activity levels are rising but remain insufficient with large proportions of the population well below recommended levels. All these have a long term negative effect on public health.

Within the social care sector increasing numbers of looked after children (and increased referrals to social services) place greater demand on constrained services. Although NHS and social care budgets have not been cut the settlement is a considerable reduction

compared to previous growth patterns and requires major efficiency savings to be made across the sector. The impact of this has started to be felt through job reductions.

To address the challenge of budgetary constraint there is considerable interest in innovation to drive efficiency, improve quality and transform services. A wide range of initiatives are in place across the sector to incentivise innovation and the uptake of new technology.

The second key challenge is to reduce the reliance on immigrant labour in some parts of the sector. Traditionally the health sector has relied upon immigrant labour with significant proportions of doctors and nurses coming from EU and non-EU countries. The same is true of some social care occupations (residential care workers, care assistants and home carers), particularly in the London area. There are concerns that government attempts to restrict immigration into the UK will cause skills supply problems across the sector.

The third key challenge is to raise the capability of management skills and leadership qualities to respond to pressures in the sector and improve the quality of care offered. Management and leadership skills are seen as a high priority skills needs in the sector and there is evidence that management capability is associated with both financial and quality outcomes. There will be a need for greater investment in training, developing and supporting managers and leaders.

The Fourth key challenge is to resolve acute skills shortages vacancies and gaps in key occupations, particularly professionals and caring roles. IN health these include pharmacy, other physiological science and respiratory physiology roles. There is a high turnover rate in social care, skills shortages in caring staff, professional and manager roles and skills gaps amongst caring staff and professionals too. The impact of these issues is to raise the workload of others which is unsustainable in the long term), create difficulties in meeting customer service and other quality standards and limit the ability to react to change effectively.

In the next section we discuss the potential solutions that employers can adopt or become involved with to drive up the skills and performance of the sector's workforce. The challenges and potential solutions are summarised in Table 7.1.

Table 7.1 Meeting the challenges facing the health and social care sector

Challenge	Solution
Doing more with less	Changing working practices and reconfiguring roles to maximise efficiency Encouraging innovation and using the opportunities for developing new ways of working offered by new technology. Raising engagement to maximise productivity, retention and minimise absence
Reducing the reliance on immigrant labour	Raising engagement to maximise productivity, retention and minimise absence Develop new routes into the sector to maximise recruitment and retention
Raise the capability of management and leadership	In-house training and more continuous professional development (cpd)
Resolve skills shortages and gaps	Develop new routes into the sector to maximise recruitment and retention Raising engagement to maximise productivity, retention and minimise absence

7.3 Growth through skills

In this section we briefly review each of the solutions outlined in Table 7.1 in turn and, where available, point to examples of where policy bodies or employers have developed appropriate initiatives.

7.3.1 Changing working practices and roles

There are anticipated demands in the health sector for particular skills eg new roles at advanced and assistant practitioner, workforce planning capability, adapting to ICT and new diagnostics, treatments and technology.

As Skills for Health points out (2011) the development of new roles is likely to have an increasing impact on skills as we approach 2020. These developments include:

- The development of new roles at levels three to four of the NHS Career Framework. This will include roles commonly referred to as Assistant Practitioners, with a wide range of roles being developed throughout the sector.
- The development of roles at level seven of the NHS Career Framework. This will include roles often referred to as Advanced Practitioners.

Skills for Health highlight their ‘National Transferable Roles’ initiative which offers a framework that health employers can use to develop a wide range of roles and provides a reservoir of best practice that can be referred to by employers.

Introducing Advanced Nurse Practitioners in Glasgow

NHS Rehabilitation and Assessment Services are facing increasing demand for example as the number of elderly patients increases and the proportion of these with long-term conditions grows. There needs to be a clear plan how to deliver medical care using different skills and mix of staff. One way of meeting this changing skill need is for nursing staff to develop into areas of Advanced Practice. A more flexible workforce including Advanced Nurse Practitioners could release professional capacity to make services more streamlined.

NHS Greater Glasgow and Clyde Health Board decided to test the Advanced Nurse Practitioner role in care of the elderly, on a busy rehabilitation ward where medical cover was usually provided on a rotation basis without a permanent ward based junior doctor. The health board worked with a range of stakeholders including Skills for Health and higher education institutions. They identified three levels of practitioner encompassing progression from Level 5 to Level 7 of the Career Framework (CF). This project scoped the skill requirements of an expert practitioner working autonomously at CF Level 7. Using Skills for Health’s Career Framework and Competences assessment tools, the service selected competences and produced a job description.

For this pilot, the Advanced Nurse Practitioner role had a clinical focus, although it is sufficiently flexible to allow greater emphasis in other areas such as educator, research or practice development – as appropriate to the service need. The post holder completed a Higher Education clinical assessment module as part of his work based learning, to upskill for the role. Once in post, the Advanced Nurse Practitioner was able to address a wide range of areas.

There have been a number of benefits including:

- Improved continuity of care with patients seen more quickly in a rehabilitation ward.
- Staff able to work at the top of their level, improving productivity.
- Greater opportunities for nurses to progress along career framework and raises profile of rehabilitation nursing and support multi disciplinary ways of working

“The project has given solid evidence of the benefits this type of role has to offer improved patient care, more flexible ways of delivering services and greater opportunities for nurses to progress along the career framework. The Advanced Nurse Practitioner role provides an ideal way for nurses to retain a balance of hands-on practice and combine it with skills in prescribing, leadership and education.”

Elaine Burt, Head of Nursing Rehabilitation & Assessment Directorate, NHS Greater Glasgow and Clyde

Source *Skills for Health*

Skills for Care and Development also highlight the need to manage and develop new roles to create user responsive care. Roles and skills are also expected to change as the boundaries between health care and social care begin to merge and there will be a continuing move to more integrated patterns of working.

Developing new care roles to reduce emergency hospital admissions

Normally, over 75 per cent of 999 calls to the ambulance service result in admission to an emergency department tying up resources and creating trauma for patients. Skills for Care has worked with a number of employers to develop a competence framework for emergency, urgent and unscheduled care to skill up practitioners and devise a role and learning programme for Emergency Care Practitioners (ECPs)

ECPs can attend with rapid response vehicles to assess and treat at the scene, staff clinical support desks to advise on clinical decision making, support primary care staff in home visits or out of hours cover, or work in minor injury units.

As a result the introduction of ECPs has reduced emergency admissions: Data from one NHS trust shows almost a third of patients avoided transfer to an emergency department when treated by an ECP at the scene. Almost a half of elderly patients suffering a fall and seen by an ECP did not need to be admitted.

There are also costs benefits to trusts as the cost of ECP attendance to a 999 call is much less than sending an ambulance in response.

There are benefits for patients and staff too:

- Patient satisfaction is higher; as generally patients prefer to be treated close to or in their own homes.

- For staff the new competencies provide the opportunity to develop new skills and expertise and provide career progression.

"The effect of using emergency care practitioners has been phenomenal. In some areas of the Trust, up to 90% of 999 cases are discharged without needing further emergency care. Emergency departments are the lynchpin of an acute trust, so reducing the pressure on a unit in this way has a major beneficial impact on the whole hospital."

Consultant Emergency Care Practitioner Mark Ainsworth-Smith, South Central Ambulance Service NHS Trust

Source: Skills for Health

7.3.2 Develop new routes into the sector to maximise recruitment and retention

Skills for Care and Development (2011) note the HR challenge facing care providers and suggest that this needs to be tackled in many ways including opening new routes into the sector through new qualifications and new workers. Routes include apprenticeships and diplomas and other learning programmes. In the social care sector, new qualifications are likely to result in up-skilling, for example a Level 5 to replace current children's care, learning and development qualifications.

Using Foundation Degrees to improve the level of care

In Norfolk and Suffolk a rising elderly population led to increasing pressure on community nursing services to deliver routine care such as dietary monitoring, support for those with diabetes, wound dressing and other routine procedures. At the same time care staff were not qualified to carry out these procedures which is frustrating for staff and patients. The situation was unsatisfactory for both time pressured community nurses and care staff whose capabilities were being underutilised. Carers lacked a progression route other than into management and retention was low.

It was felt that professional development opportunities would provide a structured pathway for career progression and thus help care homes recruit and retain the volumes of staff needed to meet future demand. Care homes identified that learning would need to be either fully work based or based on blended learning to reduce absence from the workplace and resolve potential travel difficulties.

A partnership between Skills for Health, Foundation Degree Froward, University Campus Suffolk and MOVE Lifelong Learning Network devised a new Foundation Degree to enable care staff to become qualified to offer basic care through a blend of work-based and theoretical learning and by providing credit accumulation and transfer to ensure long term viability and validity.

It was anticipated that there would be benefits for care homes in improved staff retention, greater efficiency and potential savings and reduced turnover of staff. Patients would experience more timely treatment and greater continuity of care. There would also be benefits to the wider health sector eg through reduced pressure on the scarce resources of community nurses, and through reduced hospital admissions because of a lack of capacity in care homes to provide appropriate care.

Source : Skills for Health

7.3.3 Encouraging innovation and using the opportunities for developing new ways of working offered by new technology.

There is huge potential for ICT to reshape the way that services are delivered across the health sector. All roles, are likely to be affected by the ongoing impact of ICT on across the sector.

Skills for health highlight some of the impacts expected of ICT includes:

- how to operate basic ICT systems will affect all jobs.
- the sensitivity of data-handling will require skills of confidentiality and data security. This may affect which roles should be using and processing patient information.
- ICT will impact on health professionals and clinicians with developments in remote diagnostics and surgery within reach.

The challenge for the sector is how well it embraces the technology already available to maximise productivity and efficiency whilst ensuring that the workforce is ready for implementation of the technology

Skills for Health's horizon-scanning activities have identified a number of longer-term opportunities for the UK health sector that are likely to be driven by technological and scientific innovations. These include:

- the Human Genome and Genetics requiring a wide range of skills needed to assist in the treating of conditions and correction of genetic dysfunctions.
- Diagnostics and Treatment will benefit from faster and more accurate diagnosis and more effective treatments and could increasingly be undertaken at home. Likely consequences include an increase both in the volume of patient data that needs to be managed, and in the speed of patient treatment.
- Robotics and Technology The use of robots can help with many mundane tasks, and in some more complex areas of surgery.

7.3.4 Raising employee engagement to maximise productivity, retention and minimise absence

Skills for care and development (2011) highlight the importance of raising the profile of the sector to counter any negative image of the sector as low paid, low skilled or low valued work. Work is ongoing to raise the profile through branding and promoting positive images of care. There is suggestion of a long term campaign to focus on the recruitment of new workers which will emphasise the benefits of working in the sector.

The Department of Health has published frameworks for staff engagement which highlight the importance of teamworking, management and leadership capability (*A Framework for Staff Engagement: An introduction to staff engagement in the NHS and guidance on starting staff engagement policy,*

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114439.\)](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114439.)

Improved employee relations at Sandwell Mental Health and Social Care NHS Foundation Trust

Sandwell Mental Health and Social Care NHS Foundation Trust (Sandwell MH & SC NHS FT) employs just over 1000 staff. It is the major provider of mental health and hospital-based learning disability services including adult, older adult, CAMHS, substance misuse services, and provides specialist learning disabilities services. The trust also provides services to people who live outside of Sandwell in neighbouring Boroughs and specialist mental health services to people from the wider Black Country and parts of Birmingham.

The trust had a traditional consultative framework with monthly, management-led, meetings with staff side, chaired by the chief executive. In 2006/07 in response to the 'Shared

Governance and Staff Involvement' agenda the need to empower staff was jointly recognised with staff engagement and involvement being 'managed by staff for staff' and consequently a staff forum was set up chaired by the staff side and with directors and other managers invited to attend for specific issues.

As the forum has evolved staff involvement has been embedded into the trusts operation and ongoing development including:

- staff sit on the interview panels for new executive directors
- improved communication links have been created
- the development of a staff side business plan to support the trust's business plan
- staff side managing the annual staff survey

The development of partnership working has been judged to have improved employee relations and helped the management of change, with staff feeling both informed and supported. Staff representatives are now felt to be embedded in the change process, rather than responding to it. It has also increased the confidence of management in working closely with staff representatives and sharing sensitive information with them.

Social Partnership Forum:

<http://www.socialpartnershipforum.org/casestudies/Priority4/Pages/ImprovedemployeerelationsatSandwellMentalHealthandSocialCareNHSFoundationTrust.aspx>

7.3.5 The development of management and leadership capability

Skills for health (2011) identify that there is a widespread perception that the sector suffers from low levels of skills in management and leadership which they suggest has negatively impacted on the effects of high performance working practices in the sector. Skills for care suggest that management and leadership education and continuing professional development remains a core skills development need, but should be considered alongside improving staff engagement to help make the step change required.

Case Study: Improving management and leadership in Social Care

The National Skills Academy for Social Care is working to raise the quality of management and leadership and training provision.

The NSA is a membership organisation of more than 1000 employers which offers leadership training to:

- **Recent graduates** through a National Management Trainee Scheme which seeks to attract people into the sector and develop future leaders.
- **Front-line leaders** which focuses on how the values and behaviours of leadership at the front line are crucial to excellent care delivery.
- **Senior managers of the future** An Aspiring Leaders programme focuses on leadership within the commercial reality of day-to-day operations.
- **New Directors** working with the Association of Directors of Adult Social Services (ADASS) to run a programme to support senior managers when they're newly promoted to lead local authority adult social services.

The Academy also aims to raise the quality of provision by offering quality marks for organisations and individuals:

- **Centres of Excellence** are training providers who demonstrate exemplary commitment to meeting the needs of learners, compliance with the social model of care, and understanding and measuring impact of provision on lives of service users.
- **Recognised Providers** demonstrate a professional approach to education and training in adult social care.
- **Endorsed Practitioners** are 'sole-trader' training providers who demonstrate a professional approach to education and training in adult social care.

MacIntyre is a national charity that provides learning, support and care for more than 1000 children and adults with learning disabilities. It found that managers in care were often lacking key management and leadership skills and also lacking confidence in the role, as a result many front line managers were unhappy in their role and leaving. The charity worked with National Skills Academy for Social Care on a programme for those working or leading at the social care front line to develop the language and values of leadership and peer learning

The Academy developed a suite of courses to engage social care employers and front line managers working in the sector. The programme looked at four areas:

- How I work with myself

- How I work with others
- How I work with my company
- How I work with people who use services

Macintyre found the programme helped managers manage their role better and gave them the confidence to cope effectively with the tougher more personal aspects of the role. Feedback from attendees has been very positive generating high levels of enthusiasm, learning new things and helping attendees think about themselves and their roles differently.

Source: National Skills Academy for Care

7.4 The Benefits of Skills

As outlined throughout this paper, investing in skill development can bring a range of benefits to individuals, employers as well as wider economic and societal gains (Garrett et al., 2010).

There is also considerable evidence that health and social care employers who invest in their workforce experience positive effects. Development of the workforce has been associated with better quality outcomes for patients and service users. Better quality management in the health sector has been associated with better financial outcomes, lower patient mortality rates, a 33 per cent increase in income per bed and a 20 per cent increase in the likelihood that the hospital achieves above average patient satisfaction (see section 3.7, Dorgan et al. 2011).. The response of the sector to the challenges facing it in the future will be critical in terms of its ability to deliver services within cost constraints whilst ensuring the best possible outcomes for patients and service users.

In the Social Care sector, better performing Care homes have been shown to have higher proportions of staff with relevant qualifications including managerial and supervisory staff, senior care workers and care workers; greater proportions of workers with higher level qualifications, including care workers at level 3 and managers with professional and managerial qualifications and; more experienced staff on hand (Eborall, 2011).

Generally the possession and acquisition of skills and qualifications is directly associated with an individual's employment and earnings prospects. The UK Commission's review, in particular, outlined the economic return to higher level academic qualifications (i.e. Bachelor degrees and above) and also apprenticeships. There are significant wage premiums attached to gaining an apprenticeship, from an individual's point of view and employers recoup any costs they incur in providing apprenticeships in a short space of time.

There are a range of business benefits that investment in training can bring employers. Evidence across a number of sectors suggests that employers who invest in training are more likely to survive than those who don't (Collier, et al., 2007). This relationship also holds true in the health and social care sector.

The business benefits of training in the sector go beyond survival. Organisations that are willing and able to innovate will reap rewards through better financial performance, staff satisfaction and retention. Garrett et al. (2010) conclude that 'the investments employers make in workforce training raises productivity and firm performance across a range of measures and that the productivity benefits of training available to employers are two to five times greater than the wage benefits received by employees.'

The sector is suffering from pockets of key skill shortages, even in the current slack labour market, which are impacting on colleagues and the ability to adapt to change. Also although reported skill gaps and skills shortage vacancies are relatively low, where they do occur they tend to be among managers and professionals or among key caring staff where the core capability of the organisation and its ability to meet future challenges often lies.

There are also wider benefits to consider. Generally the evidence suggests that higher levels of workforce training are associated with stronger economic prosperity. Garrett et al. (2010) comment that 'the potential economic gain from raising skill levels is huge'.

There are wider societal benefits too from greater use of digital technology (for example in the education, health and care sectors) and creativity underpins large parts of the country's cultural infrastructure, which in turn support other sectors. Learning can also help to create a stronger and more stable society and contribute to individual well-being.

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UKCES
Renaissance House
Adwick Park
Wath upon Dearne
South Yorkshire
S63 5NB
T +44 (0)1709 774 800
F +44 (0)1709 774 801

UKCES
28-30 Grosvenor Gardens
London
SW1W 0TT
T +44 (0)20 7881 8900
F +44 (0)20 7881 8999

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