England Skills and Labour Market Intelligence Assessment 2011

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DATA SOURCES

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1 Executive Summary

This is Skills for Health’s 2011 Sector Skills and Labour Market Intelligence Assessment for the health sector in England. It is one of a suite of assessments for the sector which together cover the UK and each of its countries (England, Northern Ireland, Scotland and Wales).

Our first sector skills assessment of the health sector in England, conducted in late 2009, signalled a period of significant change for the sector. Impending change was fuelled by a range of short- and longer-term drivers. It was clear that after the credit crisis, the Government was likely to explore how significant cost savings might be made in public sector expenditure, with clear impacts on the health sector. In the longer term, the demand for health provision would continue to grow through a combination of demographic changes and shifts in expectations of service quality.

Following the formation of the coalition government in May 2010, there have been a substantial number of initiatives in England, where early announcements indicate that the landscape of institutions and their roles in all ‘sub-sectors’, public, private and voluntary, are set for significant change.

During this period of rapid change, it can seem difficult to prioritise acting upon issues relating to skills mix and workforce development. However, it has never been more important to address the skills development and skills utilisation in the health sector. Failure to address issues of skills during this period of transition will undermine the sector’s ability to deliver high-quality services in England in the future.

Using a comprehensive range of primary and secondary sources and forward looking consultation activities, this assessment highlights how England’s health sector is confronted with a range of current and near-future skills needs. It highlights how the sector may wish to prepare the skills of employees further, with reference to use of technology and other innovative approaches.
Current skills demand

Health sector employers in England will need to address current skills deficiencies identified including:

- The development of ‘team working’, ‘problem solving’ and ‘communication skills’; high-quality skills in these areas will help prevent errors in patient care and provide employees with a springboard for future development.
- An increase in opportunities for those in largely routine roles (often described as 1-4 Agenda for Change pay band levels) in the health sector to undertake training and development.
- A reduction in dependence on migrant labour in the health sector.

Towards 2020: Emerging skills priorities

Our assessment also indicates that moving towards 2020; employers in England will face a growing range of skills-related priorities, including:

- Enhancement of the quality of management and leadership, particularly through excellent employee engagement and followership.
- Continued development of workforce planning capability in the sector to assist with changes to a highly complex set of services.
- Growth in the supply of those willing and able to undertake new roles at level 3 and 4 of the NHS Career Framework (Assistant Practitioner roles).
- Growth in the supply of those undertaking new roles at Level 7 of the NHS Career Framework (Advanced Practitioner roles).
- Ongoing development of new skills sets in the light of new opportunities to exploit technology, including navigator/facilitator roles.
- Ongoing willingness of healthcare professionals to deliver care in areas that require multi-disciplinary working within diverse teams.
- Growth in the skills and volume of those working in a range of non-traditional healthcare providers and community settings.
- The development of health skills for non-health specialists to assist family carers and to facilitate self-care, supported by a combination of Information Technology and human contact.

Beyond 2020: Opportunities for skills development

The health sector in England will need to look beyond the next decade to position itself for new markets and begin to monitor the skills requirements as they emerge. Skills for Health’s own monitoring activities have identified a number of early trends that may set the course for future development of the sector. The applications of genetics, new diagnostic methods and robotics all present potential opportunities for healthcare that need to be met by enhanced IT and technology-related skills.
Helping the sector meet current and future skills and employment challenges

This assessment will inform Skills for Health’s engagement with government agencies throughout England’s education and training system, and ongoing debates with employers in the sector. The aim of this will be to enable the development of greater responsiveness in the skills system.

Skills for Health also has a comprehensive range of products and services to help employers address the skills needs of the sector. Full details of these can be viewed in the Skills for Health Catalogue at www.skillsforhealth.org.uk.

We would be delighted to hear your views on any of the themes raised in this assessment. If you would like to get involved with any of our work, please contact lmi@skillsforhealth.org.uk.
2 Introduction

About Skills for Health

Skills for Health is the Sector Skills Council (SSC) for the United Kingdom’s health sector. It covers all those working in the sector, public, private and voluntary. The sector can be technically defined using the 2007 Standard Industrial Classification (SIC). A breakdown of the technical codes for the sector and SSC can be found in Chapter 12.
Appendix 1 – SIC Definitions.

How the assessment was developed

Skills for Health developed this sector skills assessment with close reference to the Common Labour Market Intelligence (LMI) Framework, established by the UK Commission for Employment and Skills (UKCES).

The assessment draws upon a range of research undertaken by Skills for Health since it was originally licensed in 2005, and a significant number of external sources, such as the Labour Force Survey and Annual Business Inquiry. The overall research agenda is guided by Skills for Health’s board and ongoing engagement with employers to determine their needs.

During 2009 and 2010, Skills for Health has undertaken a comprehensive programme of research aimed at enriching its knowledge of the skills and employment issues across the sector. Those relevant to England include:

- Tomorrow’s Workforce: Commentaries on the future of skills and employment in the UK’s health sector.
- The Hidden Workforce, Volunteers in the Health Sector in England.
- Identifying the Movement of the Workforce around the sector.
- Understanding the Contribution of Skills to Productivity in the UK Health Sector.
- Rehearsing Uncertain Futures - Scenario Planning Application and Horizon Scanning.
- Labour Market Intelligence for Counselling Professions.

The research undertaken has utilised a mix of quantitative and qualitative methodologies. These range from questionnaires, structured interviews with ‘experts’ and employers, statistical quantitative analysis of secondary data, and future-orientated research which included scenario planning and the use of technology to scan the internet for areas of development within the sector.
The research initiative of particular importance to the development of this assessment has been Rehearsing Uncertain Futures, Skills for Health’s future-orientated scenario planning and labour market intelligence initiative. Conducted throughout 2009-2010, this initiative assisted Skills for Health in identifying current and future skills priorities facing UK employers in the health sector.

A summary of each of the methodologies used in each of the research reports above is contained within Appendix 2 of the full UK Sector Skills Assessment report.

In addition, Skills for Health presented its 2009/2010 skills assessment to a number of employer audiences in England, Scotland, Wales and Northern Ireland. During these events, employers confirmed the overall trajectory of skills and employment needs that they would be confronted with in the immediate and longer-term future. These discussions have informed the Rehearsing Uncertain Futures initiative, as well as the broader 2011 sector skills assessment.

Full details of Skills for Health’s programme of work can be found on www.skillsforhealth.org.uk.

About this document

This document is a report of findings from the 2010/2011 UK sector skills assessment relating to England’s health sector only. It is one of a suite of reports for the sector which together cover the UK and each of its countries (England, Northern Ireland, Scotland and Wales).
3 Key Findings for England and its Health Sector

3.1 Introduction

This health sector skills assessment provides the basis for anticipating the future employment and skills priorities for health sector employers, and indicates that continuing to do more of the same rather than doing things differently is unsustainable and unaffordable.

The pace of change in the sector has picked up as the governments of England, Scotland, Wales and Northern Ireland seek to deal with the economic deficit and with longer-term concerns about how the workforce can raise its performance to deal with an ever-increasing demand for healthcare services.

Employers throughout the health sector in the UK and England must respond to the strategic drivers and the challenge of continuing to meet increasing demand with finite resources by improving productivity. They will also be required to demonstrate the value of new methods of delivering care in a broader range of environments.

During this period of extensive change, Skills for Health's role as a Sector Skills Council is to monitor and inform developments and to assist employers in finding the best approach to skills development and achieving the best skills mix.

This chapter summarises the key findings from this sector skills assessment. It provides a setting for understanding the skills priorities facing the sector, through a brief account of:

- The health sector in England.
- Workforce characteristics.
- Shaping the demand for healthcare in England.
- Current skills needs and training provision.
- Projection of future levels of employment in the sector.
- Current and future developments.
- Further developments.

Demand for healthcare services is arising from drivers such as demographic change and population's health seeking behaviours. Appleby et al (2010) Improving NHS Productivity, More with the same not more of the same. Developed for The Kings Fund.
It then addresses the skills priorities that will face health sector employers in the coming years, and highlights where Skills for Health will work to support employers to effectively deal with these priorities. Priorities outlined include:

- Achieving better for less.
- Addressing skills gaps and vacancies.
- Reducing dependence on migration.
- Continued development of the roles at Levels 3 and 4 of the NHS Career Framework (Assistant Practitioner roles).
- Continued development of roles at Level 7 of the NHS Career Framework (Advanced Practitioner roles).
- Continuing focus on employability and functional skills.
- The development of management, leadership and engagement.
- A focus on the skills needs of small and medium sized healthcare providers.
- Enhancing workforce-planning capability.
- Local intelligence to assist decision-making.
- Qualifications and framework development.

Skills for Health has reviewed the most recent sources of reliable available data to inform this Sector Skills Assessment. The health sector is developing at a fast pace, and where the most recent source of available data on a specific subject or region is no longer timely, this is highlighted clearly within the report. Skills for Health has made every effort to analyse and interpret the available data in the context of today’s economic, political and social environment.

3.2 Setting the context for future skills priorities

3.2.1 The health sector in England

The health sector represents one of the largest sectors of employment within England. It employs an estimated 1,529,700 workers, which accounts for approximately 7% of the whole economy. An estimated 24% are employed in the independent sector, with 76% employed in the NHS and voluntary sector. In addition to this, there are also a large number of volunteers helping to support a wide range of services, though their numbers are more difficult to quantify.

Employment within the sector grew by an estimated 24% between 1999 and 2008; this growth was supported by increased government investment in the NHS over the period. There has been a slight reduction in overall employment numbers since 2006. It is anticipated that in the short term employment across the sector will remain stable or reduce slightly, this will be a product of the need for the sector to make efficiency savings in line with the financial settlements for the NHS.
There is a very real need for employers across the sector to improve productivity and quality of services whilst delivering efficiencies, within the context of an austere economic environment. There can be no doubt that the financial settlement for the public sector will drive further debate in respect of efficiency and productivity across the sector.

### 3.2.2 Workforce characteristics

There are a wide range of paid and voluntary roles across the sector. It is estimated that there are over 300 paid roles and 111 different roles undertaken by volunteers. Females make up almost 80% of the total workforce; this presents unique challenges to employers across the sector in offering flexible working arrangements to employees.

The age profile of the health sector in England is in line with that of the sector across the UK. The sector is ‘older’ than the whole economy particularly across age banding 45-54 years. This skewed profile largely results from training times for professional staff, where many professionals do not join the sector until their mid twenties or early thirties. The opportunities for young people (16 – 21 year olds) are therefore limited to administrative and clinical support roles.

The sector is highly qualified with 60% of the workforce holding qualifications equivalent to NQF Level 4 and above, this compares to a whole economy average of 36%.

### 3.2.3 Projections of future levels of employment

Forecasts of levels of employment for the sector were produced prior to the recession. These projections predict growth for the sector in England of almost 12% over a ten-year period.

More recent intelligence and data in relation to the levels of public spending available to the health sector indicate that growth will be severely constrained over the short to medium term, perhaps with some decreases in overall levels of employment in some staff groups over the short term.

Occupations that may see a decrease include Administrative and Managerial roles as employers across the sector seek to increase productivity and efficiency whilst protecting front-line services for patients.

Analysis of the data available demonstrates that there is an opportunity for the sector and its employers to utilise retirements as a mechanism by which they can deliver transformational workforce change.
3.2.4 Current skills demand

Whilst the sector boasts a highly qualified workforce there remains a range of current skills gaps, skills shortages and occupational shortages that are highlighted as an immediate priority for the sector. These priorities are evidenced through national skills surveys, analysis of NHS vacancy data and the Migration Advisory Committee (MAC) Skilled, Shortage and Sensible shortage occupation list for the UK and Scotland.

Within the sector an estimated 22% of employers in England report that they are experiencing current skills gaps. This is higher than the percentages reported for Scotland, Wales and Northern Ireland.

The MAC list contains 35 occupations with distinct shortages, these include:

- Consultants within certain specialties.
- Pharmacists.
- Dental Practitioners.
- Specialist nurses and therapists in certain roles.

In addition to the findings above there is a need for employers to identify and address literacy and numeracy skills gaps across the sector. This action will be needed if employers want to progress individuals within the sector in order to deliver flexibility in healthcare delivery.

Addressing literacy and numeracy needs may, however, require a fundamental shift in the training patterns across the sector. Analysis of access to training across the workforce highlights an apparent inequality, with those individuals who already hold high levels of qualification (typically medical consultants or senior managers) reporting they receive more ongoing training than individuals without a high level of qualification (those in routine or support roles). If employers aspire to enhance skills utilisation across the whole workforce, they may need to examine and analyse these issues further in order to break down any barriers that currently exist.
3.2.5 What drives skills demand?

There are many drivers shaping the demand for healthcare in England.

During 2009 Skills for Health developed Rehearsing Uncertain Futures, a scenario planning initiative aimed at supporting health sector employers in planning for the workforce of the future.

This initiative involved the synthesis of several future-looking activities and the factors that emerged as driving change within the health sector are:

- The NHS Concept.
- Funding of healthcare.
- Public/private healthcare.
- Demographic changes.
- Political developments.
- Developments in bioscience, pharmaceuticals and technology.
- The choice agenda.
- Societal trends.

3.2.6 Towards 2020: emerging skills priorities

The near-future challenges for employers across the sector will be on developing a flexible and more productive workforce through more effective skills utilisation of the existing workforce. It is envisaged that the sector as a whole will increasingly be interested in:

- The development of new roles at Levels 3 and 4 of the NHS Career Framework (Assistant Practitioner roles).
- The development of roles at Level 7 of the NHS Career Framework (Advanced Practitioner roles).
- Ongoing professional development.
- The ongoing impact of ICT on roles and skills within the health sector.
- Developing capacity and capability of the volunteer workforce.
- Informal and unpaid carers.
- Self-managed care.
- Developing management and leadership.
3.2.7 Beyond 2020: opportunities for skills development

There will be potential opportunities for the sector a little further in the future, particularly through exploiting developments in bioscience, pharmaceuticals and technology, to improve services and outcomes for patients. Some of these potential developments could have significant implications on the skills utilised across the sector, with new skills sets emerging and some existing skills sets no longer being needed.

Areas of development examined include:

- The human genome and genetics.
- Innovation in diagnostics and treatment.
- Innovation in robotics and technology.

Each of these innovations are likely to shape the health sector in the long term, and provide opportunities for employers to improve services, which will in turn impact on the shape of the workforce and on skills needs.

Employers will also need to consider the cost implications of these developments, and plan training interventions to ensure smooth transitions to new ways of working.

3.3 Helping the sector meet current and future skills and employment challenges

This Sector Skills Assessment has contributed to the identification of a range of current and future skills and employment priority areas for health sector employers across England and the UK to address.

These are skills areas which Skills for Health feels employers will be increasingly focused on in the near future in order to improve productivity and flexibility within the workforce. They will inform Skills for Health’s own priorities for action and solutions for the sector. It will also enable us to report skills issues to the government to help shape the Government’s response to skills needs in the sector. They include:
These areas of skills priorities include:

- Achieving better for less.
- Addressing skills gaps and skills shortages.
- Reducing the sector’s dependence on non-EU migration.
- Continuing focus on employability and functional skills.
- Continued development of new roles at NHS Career Framework levels 3 and 4 (Assistant Practitioners).
- The development of roles at NHS Career Framework Level 7 (Advanced Practitioners).
- Dealing with the impact of ICT on roles and skills within the health sector
- The development of management and leadership, and high-quality engagement strategies.
- Skills development in small- and medium-sized healthcare providers.
- Enhancing workforce-planning capability.
- The challenge of local intelligence.
- Careers Information and Guidance for all ages.
- Health skills for non-health specialists – community, family and friends.
- Skills to enable greater ‘Self-Care’.
- Qualifications and framework development.
- Developments in far future diagnostics, treatment and technology.

These skills priorities are outlined in more detail in Chapter 10, *Helping the sector meet current and future skills and employment challenges*. 
4 The Health Sector in England

Key Features

- There are an estimated 1,529,700 people employed in the health sector in England which accounts for 79% of the total healthcare workforce in the UK.
- There is 1 healthcare employee for every 34 people resident in England.
- The health sector accounts for 7% of the country’s total employment.
- Total employment within the health sector has slightly reduced each year since 2006.
- Within England the largest percentage of growth has been seen in sub-sector 86.22 ‘specialist medical practices’.
- The independent sector accounts for 24% of the total health sector workforce in England.

4.1 Introduction


The health sector in England comprises of hospitals, medical and dental practices, ambulance transportation, complementary medicine and other human health activities. These services are delivered across a wide range of organisations within the public, private and voluntary sectors.

Throughout the UK there is no one single centre of health sector activity and the same can be said for England. Healthcare is delivered to the whole of the population with publicly funded healthcare being free at the point of care. As a result, healthcare employment is distributed throughout England and the UK, often reflecting the levels of population density in a given area. Please refer to Table 7 in the Regional Briefings which details employment and population distribution at both a regional and Local Authority level.

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2 At the time of publication the latest Northern Ireland Census was 2007 and was based upon Standard Industrial Classification (SIC) 2003. This is explained further in section 4.3 and a full descriptive of both SIC 2003 and SIC 2007 are included in the Glossary.
4.2 Size of the health sector workforce

In England the health sector employs an estimated 1,529,700 people and accounts for 79% of the total UK health sector workforce.

Within England, the health sector accounts for 7% of total employment but this proportion varies amongst the regions from 5% in London up to 8% in the North East. This shows the differing reliance on the sector in each region for employment.

Table 1: Health Employment by Country, 2008

<table>
<thead>
<tr>
<th>Country</th>
<th>Total Health Sector Employment</th>
<th>Percentage of UK Health Sector</th>
<th>Health Employment as a percentage of total economy</th>
</tr>
</thead>
<tbody>
<tr>
<td>England :</td>
<td>1,529,700</td>
<td>79</td>
<td>7</td>
</tr>
<tr>
<td>East of England</td>
<td>144,900</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>East Midlands</td>
<td>129,300</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>London</td>
<td>226,500</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>North East</td>
<td>81,900</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>North West</td>
<td>220,600</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>South East</td>
<td>240,100</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>South West</td>
<td>159,000</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>West Midlands</td>
<td>158,000</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Yorkshire and The Humber</td>
<td>169,400</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Scotland</td>
<td>227,300</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Wales</td>
<td>98,900</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Northern Ireland*</td>
<td>72,300</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>1,928,200</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

Source: ABI 2008 (SIC 2007)
Source: Northern Ireland Census of Employment 2007

In our 2009/2010 Skills and LMI report for England we detailed how the health sector had seen a growth rate of 24.2% over the period 1999 – 2008, compared to 7.3% for the whole economy. Within the regions, London and the North West saw the largest percentages of growth in the health workforce. But when comparing to the whole economy, the West Midlands saw a significant increase of 18.8% in health sector employment compared to only 1.8% in the whole economy.

Much of this growth in employment numbers occurred between 1999 and 2005; as you can see from the following chart overall employment numbers have slightly reduced since 2006.
4.3 Changes in health sub-sectors over the period 2007 - 2008

The Standard Industrial Classification (SIC) ‘Human Health’ is made up of five sub-sectors that define the activities across the health sector. In Table 2 we can see that over the period 2007 to 2008 overall numbers of employees and establishments in the sector across England have remained stable. There have, however, been some substantial variations at the sub-sector level.

The only areas of growth were within sub-sectors 86.22 ‘specialist medical practice activities’, with the number of establishments increasing by 30% and the accompanying workforce growing by 35%; and 86.90 ‘other human health activities’, with the number of establishments increasing by almost 20% but the accompanying workforce decreasing by around 2%.

With the ability to compare only two-years worth of data it is too early to draw firm conclusions regarding trends. However, this shift in sub-sector 86.22 could be indicative of the movement of services out of traditional hospital settings to more local delivery within smaller medical practices closer to home. The changes in sub-sector 86.90 could be indicative of smaller, independent health sector establishments setting up following downsizing of other businesses in the sector.
Table 2: Percentage Change in the Number of Health Establishments and Employees by Sub-Sector, 2007 - 2008

<table>
<thead>
<tr>
<th>Sub-Sector</th>
<th>2007</th>
<th>2008</th>
<th>Percentage Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employees</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>86.10 : Hospital activities</td>
<td>1,058,000</td>
<td>1,026,400</td>
<td>-3</td>
</tr>
<tr>
<td>86.21 : General medical practice activities</td>
<td>180,300</td>
<td>165,700</td>
<td>-8</td>
</tr>
<tr>
<td>86.22 : Specialist medical practice activities</td>
<td>8,300</td>
<td>11,200</td>
<td>35</td>
</tr>
<tr>
<td>86.23 : Dental practice activities</td>
<td>60,100</td>
<td>58,500</td>
<td>-3</td>
</tr>
<tr>
<td>86.90 : Other human health activities</td>
<td>223,800</td>
<td>267,900</td>
<td>20</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,530,400</td>
<td>1,529,700</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Establishments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>86.10 : Hospital activities</td>
<td>6,800</td>
<td>6,100</td>
<td>-10</td>
</tr>
<tr>
<td>86.21 : General medical practice activities</td>
<td>14,300</td>
<td>14,800</td>
<td>4</td>
</tr>
<tr>
<td>86.22 : Specialist medical practice activities</td>
<td>1,000</td>
<td>1,300</td>
<td>30</td>
</tr>
<tr>
<td>86.23 : Dental practice activities</td>
<td>9,100</td>
<td>9,500</td>
<td>4</td>
</tr>
<tr>
<td>86.90 : Other human health activities</td>
<td>13,700</td>
<td>13,500</td>
<td>-2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>44,900</td>
<td>45,200</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: ABI 2007 -2008

The growth in each sub-sector greatly influences the current and potential demand on the labour market. Demand for occupations will impact on training provision, although demand has to be planned with sufficient timing to allow for new staff to obtain qualifications or existing staff to retrain.

4.4 Number of healthcare establishments

Health sector establishments account for 2% of all establishments in the English economy and almost 85% of all health sector establishments in the UK are located in England.

This is undoubtedly due to the larger population in England, and it is also important to highlight that within each country of the UK health services are structured differently. The current structure of Primary Care Trusts (PCTs), Health/Foundation Trusts and Strategic Health Authorities (SHAs) are unique to England.

The new coalition government is proposing significant changes to the structure of the health sector in England with PCTs and SHAs to be abolished in 2012\(^3\). We would therefore anticipate some change in these numbers over the forthcoming years.

\(^3\) Department of Health (2010) Equality and Excellence: Liberating the NHS. White Paper
Table 3: Health Establishments by Country, 2008

<table>
<thead>
<tr>
<th>Country</th>
<th>Health Establishments</th>
<th>Percentage of UK Health Establishments</th>
<th>Percentage of Establishments in Whole Economy</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>45,200</td>
<td>85</td>
<td>2</td>
</tr>
<tr>
<td>Scotland</td>
<td>3,800</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Wales</td>
<td>2,500</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Northern Ireland*</td>
<td>1,700</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>UK</td>
<td>53,200</td>
<td>100</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: ABI 2008
*Source: Northern Ireland – Census of Employment 2007

Table 4 indicates that the health sector is dominated in by micro-establishments. Currently 67% of all health establishments employ 1-10 employees. This will largely consist of independent and voluntary healthcare providers.

Table 4: Size and Structure of the England Health Sector, 2007 – 2008

<table>
<thead>
<tr>
<th>Sizeband - Employees</th>
<th>2007</th>
<th>2008</th>
<th>Percentage of Growth between 2007 - 2008</th>
<th>Current Market Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 4</td>
<td>19,700</td>
<td>21,200</td>
<td>8</td>
<td>47</td>
</tr>
<tr>
<td>5 - 10</td>
<td>10,000</td>
<td>9,000</td>
<td>-10</td>
<td>20</td>
</tr>
<tr>
<td>11 - 24</td>
<td>8,200</td>
<td>8,100</td>
<td>-1</td>
<td>18</td>
</tr>
<tr>
<td>25 - 49</td>
<td>4,000</td>
<td>3,800</td>
<td>-5</td>
<td>8</td>
</tr>
<tr>
<td>50 - 99</td>
<td>1,600</td>
<td>1,600</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>100 - 199</td>
<td>700</td>
<td>700</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>200 or more</td>
<td>700</td>
<td>700</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>44,900</td>
<td>45,200</td>
<td>1</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: ABI 2008

Again, with the ability to compare only two-years worth of data it is too early to draw firm conclusions regarding trends. However, the decreases in establishments with 5-10 and 25 – 29 employees, together with the increase in establishments with 1-4 employees, may be indicative of early effects of the recession on the sector with some employers downsizing and others ceasing to trade.

It is difficult to supplement this data further by ascertaining the number of businesses registering/de-registering in the health sector as goods and services are VAT exempt with the exception of dispensing of prescriptions by a registered pharmacist which is currently zero rated. Therefore, health establishments are excluded from the data set published by the Department for Business Enterprise and Regulatory Reform.
4.5 Public and independent healthcare providers

Health services are delivered through both private and public providers, the public sector being a combination of NHS and Voluntary organisations.

Using annualised data we can estimate in England the independent sector accounts for approximately 24% of the total healthcare workforce, with the largest proportion (36%) employed in hospital activities.

It is important to note that the percentages are not definitive as employees can work in both, if not all three, sectors at any one time.

<table>
<thead>
<tr>
<th>England</th>
<th>Independent</th>
<th>Public</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Employees</td>
<td>%</td>
<td>Employees</td>
</tr>
<tr>
<td>86.10 Hospital activities</td>
<td>145,200</td>
<td>9</td>
<td>916,600</td>
</tr>
<tr>
<td>86.21/22 Medical combined</td>
<td>79,100</td>
<td>5</td>
<td>106,700</td>
</tr>
<tr>
<td>86.23 Dental practice activities</td>
<td>67,100</td>
<td>4</td>
<td>11,700</td>
</tr>
<tr>
<td>86.90 Other human health activities</td>
<td>109,000</td>
<td>7</td>
<td>246,400</td>
</tr>
<tr>
<td>Total</td>
<td>400,400</td>
<td>24</td>
<td>1,281,400</td>
</tr>
</tbody>
</table>

Source: Labour Force Survey, 4 Quarter Average Q3 2009 – Q2 2010
All number rounded to the nearest 100

4.6 Ratio of health establishments and employees in England

Table 6 shows the ratio of both health establishments and employees to the resident population. A high ratio could be indicative of easier access to services and variations in health system structures within each country. This table is subject to future debate.

The population of England is estimated at 51,809,700. This means that there is one health establishment for every 1,147 resident population and one health employee for every 34 resident population.

---

4 Definition used by the Labour Force Survey
5 Sub-sector 86.21 general medical practice activities and 86.22 Specialists medical practice activities combined for continuity in data sets
6 Population extracted Nomis – Mid-year population estimates 2009
Table 6: Ratio of Healthcare Establishments and Employees to Resident Population, 2008

<table>
<thead>
<tr>
<th>Population Estimates 2009</th>
<th>Ratio of 1 Health Establishment to every 1 Resident Population</th>
<th>Ratio of 1 Health Employee to every 1 Resident Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data</td>
<td>%</td>
<td>1,147</td>
</tr>
<tr>
<td>England</td>
<td>51,809,700</td>
<td>84</td>
</tr>
<tr>
<td>Scotland</td>
<td>5,194,000</td>
<td>8</td>
</tr>
<tr>
<td>Wales</td>
<td>2,999,300</td>
<td>5</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>1,788,900</td>
<td>3</td>
</tr>
<tr>
<td>UK</td>
<td>61,792,000</td>
<td></td>
</tr>
</tbody>
</table>

Source: ABI 2008
Northern Ireland Census of Employment 2007

This data is available at Government Office Region Level and is presented in the Skills for Health Regional Skills and Labour Market Intelligence Briefings. These briefings are available on the skills for health website and are updated annually.
5 Workforce Characteristics

Key Features

- The age profile of the health sector in England is in line with that of the sector across the UK. However, the sector is ‘older’ than the economy in general particularly across age bandings 45-54 years.
- The age profile of volunteers is typically over 45 years.
- The proportion of the workforce aged 16-24 years in the health sector is approximately half that seen in the whole economy.
- The sector is highly feminised; 80% of the workforce is female.
- The proportion of males employed in the sector is less than half that seen in the whole economy, 20% compared to 51%.
- Part-time workers account for 42% of the health workforce compared to 31% in the whole economy.
- The sector has a rich ethnic mix with 15% of the workforce being of non-white ethnicity. This is higher than the percentage working across England as a whole.
- The health sector is highly qualified with 60% of the workforce in England holding qualifications equivalent to ‘NQF level 4 and above’ compared to 36% in the whole economy.
- Nurses account for approximately 21% of the total workforce but there are over 300 different careers within the sector and 111 different roles have been identified as being undertaken by volunteers.

5.1 Introduction

The following sections outline the main characteristics of the health workforce in England in terms of age, gender, level of highest qualification held, employment patterns and roles and occupations. Differences and similarities are drawn to the whole economy in England and the health sector and whole economy of the UK.
5.2 Age profile

The health sector has an older than average age profile when compared to the whole economy. The reason for this is that many of the roles within the sector require the completion of an approved course of study. These individuals do not begin employment within the sector until they have completed formal qualifications at degree level and above. This means that there are fewer joiners to the sector aged between 16 and 24 years of age, when compared to the whole economy. Indeed many opportunities for young people aged between 16 and 21 are limited to administrative and clinical support roles.

Table 7 below shows the LFS age data for the health sector and the whole economy of England and the UK. It demonstrates that:

- The proportion of the workforce in age band 16-24 years is approximately half of the proportion of the workforce of the same age employed in the whole economy in England and the UK. This is most likely due to the time taken to qualify for specialist roles.
- The health sector employs an older workforce, particularly across age bandings 45 -54 years, when compared to the whole economy.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Health Sector</th>
<th>Whole Economy</th>
<th>Health Sector</th>
<th>Whole Economy</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24 yrs</td>
<td>6%</td>
<td>13%</td>
<td>7%</td>
<td>13%</td>
</tr>
<tr>
<td>25-34 yrs</td>
<td>20%</td>
<td>22%</td>
<td>20%</td>
<td>22%</td>
</tr>
<tr>
<td>35-44 yrs</td>
<td>27%</td>
<td>25%</td>
<td>27%</td>
<td>25%</td>
</tr>
<tr>
<td>45-54 yrs</td>
<td>28%</td>
<td>23%</td>
<td>29%</td>
<td>23%</td>
</tr>
<tr>
<td>55-64 yrs</td>
<td>16%</td>
<td>14%</td>
<td>16%</td>
<td>14%</td>
</tr>
<tr>
<td>65+ yrs</td>
<td>2%</td>
<td>3%</td>
<td>2%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Source: Labour Force Survey, 4 Quarter Average July 2009 – June 2010

In addition to the data available from the LFS data, Skills for Health have undertaken a scheme of research examining volunteers across the sector in England, Wales and Northern Ireland during 2010.

As unpaid workers, details of volunteers are rarely captured in national data collections. Our research in England\(^7\) shows that the age profile of volunteers is typically over 45 years.

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\(^7\) Skills for Health (2009), The Hidden Workforce: Volunteers in the health sector in England. Developed by the Mackinnon Partnership
5.3 Gender profile

The health sector has a greater proportion of the workforce that is female when compared to the whole economy. With 80% of the workforce being female, the health sector faces challenges that are different to other sectors. These challenges include higher numbers of workers retiring earlier, higher proportions of workers taking career breaks or returning to the sector after career breaks.

Further detailed examination of employment patterns indicates:

- The proportion of males employed in the sector is less than half that seen in the whole economy, 20% compared to 51%.
- The ratio between full-time and part-time working is 58:42 in the health sector compared to 69:31 in the whole economy.
- 42% of the workforce work part time, with the majority of these (38% of the total workforce) being female.

Table 8: Gender Profile of the Health Workforce

<table>
<thead>
<tr>
<th>England</th>
<th>Health</th>
<th>Whole Economy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data</td>
<td>%</td>
</tr>
<tr>
<td>Male Full-Time Workers</td>
<td>243,800</td>
<td>16</td>
</tr>
<tr>
<td>Male Part-Time Workers</td>
<td>66,000</td>
<td>4</td>
</tr>
<tr>
<td>Female Full-Time Workers</td>
<td>644,500</td>
<td>42</td>
</tr>
<tr>
<td>Female Part-Time Workers</td>
<td>575,300</td>
<td>38</td>
</tr>
<tr>
<td>Male</td>
<td>309,900</td>
<td>20</td>
</tr>
<tr>
<td>Female</td>
<td>1,219,800</td>
<td>80</td>
</tr>
<tr>
<td>Full-Time Workers</td>
<td>888,300</td>
<td>58</td>
</tr>
<tr>
<td>Part-Time Workers</td>
<td>641,300</td>
<td>42</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,529,700</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: ABI 2008 (SIC 2007)

Policies enabling flexible working arrangements have been at the forefront of employers’ agendas for many years in order to continue to attract and retain high-calibre employees.

These policies have succeeded in attracting females into roles that have traditionally been very male dominated. In 2008 56% of all accepted applicants to medical school were female⁸. Although not as high as the sector average, this is a significant reversal of the historic gender balance in this area of the workforce.

---

⁸ British Medical Association (2009) Equality and Diversity in UK Medical Schools
The impact of this high level of feminisation across the workforce should not be ignored and underestimated, despite shifts in the expectations of care giving across society. Large proportions of these young female doctors will at some point take maternity leave and may request more ‘family friendly’ working arrangements to allow them to balance work and family life. There is anecdotal evidence that an increasing number of female doctors in training are attracted to General Practice for this very reason.

The sector, although an early leader and adopter of flexible working practices, may therefore wish to re-examine whether or not the options available to the workforce are progressive enough to be an enabler to the progression of the careers of female medics (and indeed other staff groups) rather than a barrier.

Our research shows that there are a significantly greater proportion of female workers within the volunteer workforce as well as the paid workforce.

Examination of NHS data reveals that despite a similar gender profile as that estimated by the LFS, certain staff groups do not follow this general trend. Over 60% of qualified ambulance staff and over 50% of ambulance support staff are male, whereas only just over 10% of qualified nursing, health visiting and midwifery staff are male.

### 5.4 Ethnicity profile

There is a greater diversity of ethnicity in the health sector workforce than the whole economy. This is a pattern that is repeated across both England the UK. Compared to the other three countries of the UK the English health sector is the most ethnically diverse.

<table>
<thead>
<tr>
<th></th>
<th>England</th>
<th></th>
<th>UK</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health Sector %</td>
<td>Whole Economy %</td>
<td>Health Sector %</td>
<td>Whole Economy %</td>
</tr>
<tr>
<td>Non-white</td>
<td>15</td>
<td>10</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>White</td>
<td>85</td>
<td>90</td>
<td>87</td>
<td>91</td>
</tr>
</tbody>
</table>

Source: Labour Force Survey, 4 Quarter Average July 2009 – June 2010

The largest ‘non-white’ group within the health sector is Asian or Asian British at 7% followed by Black or Black British at 4%.

Examination of NHS data reveals that there is an under-representation of black and ethnic minority employees in ambulance services, with only 2% of qualified ambulance staff and 3% of ambulance support staff being from an ethnic minority.

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9 NHS Staff Census 2009. www.ic.nhs.uk
10 NHS Information Centre 2009 Workforce Census www.ic.nhs.uk
Further examination of ethnicity by occupation reveals that in 2008 40% of medical and dental staff working in the NHS in England were from an ethnic minority\textsuperscript{11}.

This BMA report further notes

| Of the 40 per cent (of medical and dental staff) categorised as from an ethnic minority, 28 per cent were Asian. To some extent, this reflects the historical dependence of the NHS on overseas-trained physicians. It is also a result of the strong representation of ethnic minority students in UK medical schools – in 2008, 29 per cent of students offered a place at medical school were from ethnic minority backgrounds. Challenges remain in preventing discrimination and ensuring equality of opportunity for ethnic minority students. |

While there is greater ethnic diversity in the English health sector than in the economy as a whole and high representation of ethnic minorities in medical and dental roles, some ethnic groups are currently under-represented in the UK health sector. For example, examination of NHS data\textsuperscript{12} reveals that there is an under-representation of black and ethnic minority employees in ambulance services, with only 2% of qualified ambulance staff and 3% of ambulance support staff being from an ethnic minority.

Volunteer health sector findings (from a survey conducted for the Cabinet Office in 2007 and reported in ‘Helping Out’\textsuperscript{13}) show that whilst levels of volunteering vary considerably by age and gender, overall levels of formal volunteering across all sectors do not vary significantly by ethnic origin. There are fewer volunteers of Asian origin within the UK health sector.

Individuals at particular risk of social exclusion (defined in ‘Helping Out’ as black and minority ethnic groups, those with no qualification and those who have a disability or limiting, long-term illness) also had lower levels of formal volunteering than those not at risk. These groups have been the focus of formal government volunteering policies over recent years.

While there may be a challenge for health sector employers in terms of how certain roles or activities are made more attractive to those from an ethnic minority background, the bigger challenge is, perhaps, how employers improve and maintain equality of opportunity for this section of the workforce to ensure that ethnic minorities are given a fair chance to progress within the sector and reach their full potential.

\textsuperscript{12} NHS Information Centre 2009 Workforce Census www.ic.nhs.uk
5.5 Level of highest qualification held

The health sector is broadly performing well in comparison with the rest of the economy in terms of level of qualification(s) held.

The sector is highly qualified with 60% of the English health sector holding qualifications equivalent to ‘NQF Level 4 and above’. This is slightly lower than the average across the sector in the UK (61%) but significantly higher than the workforce across all sectors of England (36%).

The health sector across England still has a challenge, however, in that it is estimated that 3% of the workforce holds no qualifications.

Table 10: Level of Highest Qualification Held in Health Sector

<table>
<thead>
<tr>
<th></th>
<th>England Health Sector</th>
<th>England Whole Economy</th>
<th>UK Health Sector</th>
<th>UK Whole Economy</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF Level 4 and above</td>
<td>60%</td>
<td>36%</td>
<td>61%</td>
<td>36%</td>
</tr>
<tr>
<td>NQF Level 3</td>
<td>11%</td>
<td>19%</td>
<td>11%</td>
<td>19%</td>
</tr>
<tr>
<td>NQF Level 2</td>
<td>12%</td>
<td>18%</td>
<td>12%</td>
<td>18%</td>
</tr>
<tr>
<td>Below NQF Level 2</td>
<td>8%</td>
<td>12%</td>
<td>8%</td>
<td>12%</td>
</tr>
<tr>
<td>Other Qualifications</td>
<td>6%</td>
<td>9%</td>
<td>6%</td>
<td>9%</td>
</tr>
<tr>
<td>No Qualifications</td>
<td>3%</td>
<td>7%</td>
<td>3%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Source: Labour Force Survey, 4 Quarter Average July 2009 – June 2010

The challenge for the sector is predominantly based around how it can increase the percentages of the workforce qualified to NQF level 2 and 3 in order to meet the challenges of creating a truly flexible and more productive workforce. This issue, including the challenges in respect of training and development, are explored further in Chapter 8.10,
5.6 Roles and occupations in the sector

The sector is naturally dominated, in terms of numbers, by clinical staff and the profile in Table 11 shows that a high proportion of the workforce is found within Associate Professional and Technical Occupations\(^\text{14}\). There are, however, a wide range of roles across the sector; NHS Careers in England\(^\text{15}\) highlight over 300 different careers within the sector including gardeners, window cleaners, and plumbers as well as doctors, nurses and ambulance staff.

A breakdown of occupations relating to the broad occupational groups can be found in the Glossary.

\(^{14}\) Associate Professional and Technical occupations include nurses, therapists and midwives etc. whilst Personal Service Occupations include nursing auxiliaries, nursery nurses etc. A breakdown of occupations relating to broad occupational groups can be found in the Glossary.

\(^{15}\) NHS Careers (2009) http://www.nhscareers.nhs.uk/ accessed 28/01/10
Table 11: Occupation Profile of the Health Workforce

<table>
<thead>
<tr>
<th></th>
<th>England Health Sector %</th>
<th>England Whole Economy %</th>
<th>UK Health Sector %</th>
<th>UK Whole Economy %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managers and Senior Officials</td>
<td>7</td>
<td>16</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td>Professional Occupations</td>
<td>16</td>
<td>14</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>Associate Professional and Technical</td>
<td>38</td>
<td>15</td>
<td>39</td>
<td>15</td>
</tr>
<tr>
<td>Administrative and Secretarial</td>
<td>15</td>
<td>11</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td>Skilled Trades Occupations</td>
<td>1</td>
<td>10</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Personal Service Occupations</td>
<td>17</td>
<td>9</td>
<td>17</td>
<td>9</td>
</tr>
<tr>
<td>Sales and Customer Service Occupations</td>
<td>&lt;1</td>
<td>7</td>
<td>&lt;1</td>
<td>7</td>
</tr>
<tr>
<td>Process Plant and Machine Operatives</td>
<td>1</td>
<td>7</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Elementary Occupations</td>
<td>4</td>
<td>11</td>
<td>5</td>
<td>11</td>
</tr>
</tbody>
</table>

Source: Labour Force Survey, 4 Quarter Average July 2009 – June 2010

Table 12 details the six largest ‘minor’ occupation groups that make up the ‘Associate Professional and Technical’ group.

Table 12: Largest Minor Occupation Groups in the Associate Professional and Technical Classification

| Total Workforce Size (England) | England | |
|-------------------------------|---------|
| Nurses                        | 356,800 |
| Therapists (not elsewhere classified) | 46,100  |
| Physiotherapists              | 34,900  |
| Midwives                      | 26,700  |
| Medical and Dental Technicians| 26,500  |
| Occupational Therapists       | 21,300  |

All figures rounded to the nearest 100

Using the labour force survey data we can estimate in England Nurses currently make up 55% of the Associate Professional and Technical workforce and 21% of the total health sector workforce.

In addition to all of the paid roles across the sector there are a great number of roles undertaken by volunteers. Volunteering England has produced a list of 111 roles for volunteers in the health sector16.

Many roles on the list are unskilled (like serving tea), or require everyday skills (like driving), some require modest training (like meeters and greeters) and a few require specialist training (like radio presenters and counsellors). Some require great personal attributes (like befriending in palliative care settings).

16 Volunteering England. 111 Roles for Volunteers in Health and Social Care
http://www.volunteering.org.uk/WhatWeDo/Projects+and+initiatives/volunteeringinhealth/111+rolesforvolunteersinhealthandsocialcare
Our study examining volunteering within the health sector in England attempted to categorise these 111 roles into those:

- Requiring knowledge or skills specific to the health sector.
- Not requiring knowledge or skills particular to the health sector – but in which volunteers are likely to have patient contact.
- Not requiring knowledge or skills particular to the health sector – but in which volunteers are unlikely to have patient contact.
6 Projections of Future Levels of Health Employment in England

Key Features

- The health sector is entering a period of high uncertainty due to the recent establishment of the coalition government and policy changes, coupled with public sector funding changes. There are decisions still to be made across the public sector that could have a significant impact on the employment levels across the sector.

- According to forecasts completed in 2008, the health sector across England is predicted to grow by approximately 224,000 people between 2007 and 2017. These estimates were created prior to the economic downturn and tighter public spending and should therefore be treated with extreme caution.

- 755,000 people are predicted to retire from or leave the health sector between 2007 and 2017. This represents an opportunity for employers to reshape their workforce.

6.1 Introduction

Working Futures III 2007-2017\(^{17}\) provides a general outline of expansion and replacement demand across the sector. It is based upon historic patterns of employment across the sector and as such it suggests that there will be a large number of jobs created due to expansion, and a large number of roles that will become vacant due to retirements that will need to be filled.

The projections were formulated prior to the economic downturn and as they are based upon historic trends they are most certainly now an overstatement of growth for the sector.

6.2 Changes in the workforce by main occupation group

Working Futures III predicts that across England the health sector will grow by 224,000 people (11.8%) between 2007 and 2017. This is slightly higher than the 11.2% growth predicted for the health sector across the UK. However, the sector will need to recruit an additional 979,000 people between 2007 and 2017 to fill new jobs and replace existing workers that will retire or leave the sector.

\(^{17}\) Working Futures 2007 -2017, Institute for Employment Research, University of Warwick, December 2008
Table 13 provides an overview of the estimated expansion, replacement demand, retirements and net requirement for workers across the sector in England by occupation groups. The largest expansion in absolute numbers of workers is predicted in the Caring Personal Services Occupations, which includes nursery nurses, nursing auxiliaries etc. This group is predicted to increase by 85,000 workers, which is growth of almost 21%. The largest expansion in percentage terms is found within the Corporate Managers group at 32%.

Table 13: Changes in the Workforce across the Sector by Main Occupation Group 2007 - 2017

<table>
<thead>
<tr>
<th>Occupational Group</th>
<th>2007 000’s</th>
<th>2017 000’s</th>
<th>Projected Growth 000’s</th>
<th>Replacement Demand 000’s</th>
<th>Net Requirement* 2007-2017 000’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate/Senior Managers</td>
<td>201</td>
<td>266</td>
<td>64</td>
<td>77</td>
<td>141</td>
</tr>
<tr>
<td>Health Associate Professionals (inc. nurses, therapists, midwives etc.)</td>
<td>449</td>
<td>507</td>
<td>58</td>
<td>185</td>
<td>243</td>
</tr>
<tr>
<td>Caring Personal Services Occupations (inc. nursing auxiliaries, nursery nurses etc.)</td>
<td>479</td>
<td>564</td>
<td>85</td>
<td>195</td>
<td>280</td>
</tr>
<tr>
<td>Health Professionals (inc. medical and dental practitioners, pharmacists, psychologists etc.)</td>
<td>113</td>
<td>126</td>
<td>12</td>
<td>43</td>
<td>55</td>
</tr>
<tr>
<td>Science/Technical Professionals (inc. Chemists, Biomedical scientists, etc.)</td>
<td>32</td>
<td>43</td>
<td>10</td>
<td>10</td>
<td>21</td>
</tr>
<tr>
<td>Teaching and Research Professionals (inc. special needs teachers, primary and nursery education teachers)</td>
<td>31</td>
<td>40</td>
<td>9</td>
<td>14</td>
<td>23</td>
</tr>
<tr>
<td>Business/ Public Service Professionals (inc. social workers, accountants etc.)</td>
<td>120</td>
<td>145</td>
<td>25</td>
<td>46</td>
<td>71</td>
</tr>
<tr>
<td>Administrative Occupations (inc. admin officers, wages clerk, filing and records clerk, office assistants etc.)</td>
<td>100</td>
<td>84</td>
<td>-16</td>
<td>42</td>
<td>26</td>
</tr>
<tr>
<td>Secretarial (inc. medical secretaries, personal assistants, receptionists)</td>
<td>43</td>
<td>29</td>
<td>-14</td>
<td>20</td>
<td>6</td>
</tr>
<tr>
<td>All Other Occupations</td>
<td>325</td>
<td>315</td>
<td>-10</td>
<td>124</td>
<td>114</td>
</tr>
<tr>
<td>Total Workforce</td>
<td>1,894</td>
<td>2,118</td>
<td>224</td>
<td>755</td>
<td>979</td>
</tr>
</tbody>
</table>

Source: Working Futures III

*Net Requirement is a total of the estimated expansion of jobs + replacement demand. All figures are rounded to the nearest thousand.

As already mentioned, it is important to note that this modelling was completed prior to the start of the recent economic downturn; therefore, actual predictions for growth are now almost certainly overstated although the overall long-term trend may remain true. It is anticipated that whilst growth will return to the sector in the long term that the level of growth will not match the historic trend of the past ten years.

Reports from within the health sector show that many NHS organisations across the UK are preparing for a reduction in overall workforce numbers over the short term with much more subdued levels of growth returning to the sector in the medium term.
Within England\textsuperscript{18} there is emerging clarity in relation to planned reductions in the administrative and managerial workforce. Organisations are seeking to reduce these numbers in order to protect frontline services to patients. Within England this will be done through major structural change, which includes the abolishment of Strategic Health Authorities and Primary Care Trusts.

What the Working Futures III analysis does demonstrate, however, is that there is an opportunity for employers to utilise retirements as a mechanism by which they can deliver transformational workforce changes. However, it should be noted that although the numbers appear very high they represent an annual retirement rate of less than 4%. This, coupled with the knowledge that other types of natural wastage across the sector is very low\textsuperscript{19}, leads to the conclusion that large-scale workforce transformation programmes undertaken by employers will need to be effected through high-quality workforce planning, together with systematic change management processes, rather than relying wholly on natural wastage.

In addition to this the sector also has a number of individuals that will be leaving professional courses of study over this period; these individuals will be seeking employment within a sector that is very different to the one that existed when they embarked upon their studies. It is highly likely that in the short term the labour market for health professionals will be constrained and competition between graduates will be very high. This newly qualified workforce may have to undertake their first roles as qualified practitioners in specialties that have historically been less attractive. There also exists the potential for short-term oversupply of graduates from universities with new doctors, nurses, therapists etc. struggling to find jobs within the sector following graduation.

## 6.3 Changes in the workforce by gender and employment status

Table 14 shows the predicted changes in the workforce by gender and employment status with all figures to the nearest thousand. These figures demonstrate that over the forthcoming years the workforce will change as follows:

- An increase in percentage terms of the number of male workers (although the sector will remain highly feminised).
- A reduction in the number of females working part-time but an increase in the number of males working part-time.
- A greater general move towards full-time employment.
- The percentage of workers who are self-employed decreasing slightly.


\textsuperscript{19} Skills for Health (2009). Identifying the Movement of the Workforce around the Health Sector. Developed by MacKinnon Partnership
Table 14: Changes in the Workforce by Gender and Status 2007 – 2017

<table>
<thead>
<tr>
<th>Levels of Employment 000's</th>
<th>2007</th>
<th>2012</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full-time</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>288</td>
<td>329</td>
<td>369</td>
</tr>
<tr>
<td>Female</td>
<td>731</td>
<td>787</td>
<td>836</td>
</tr>
<tr>
<td><strong>Part-time</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>90</td>
<td>109</td>
<td>129</td>
</tr>
<tr>
<td>Female</td>
<td>650</td>
<td>650</td>
<td>640</td>
</tr>
<tr>
<td><strong>Self-employed</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>63</td>
<td>64</td>
<td>64</td>
</tr>
<tr>
<td>Female</td>
<td>72</td>
<td>76</td>
<td>79</td>
</tr>
<tr>
<td><strong>All workers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>441</td>
<td>503</td>
<td>563</td>
</tr>
<tr>
<td>Female</td>
<td>1,453</td>
<td>1,513</td>
<td>1,556</td>
</tr>
<tr>
<td>Total</td>
<td>1,894</td>
<td>2,016</td>
<td>2,118</td>
</tr>
</tbody>
</table>

Source: Working Futures III

6.4 Concluding remarks

As already mentioned, it is important to note that this modelling was completed prior to the start of the recent economic downturn; therefore, actual predictions for growth are now almost certainly overstated although the overall long-term trend may remain true. It is anticipated that whilst growth will return to the sector in the long term that the level of growth will not match the historic trend of the past ten years.

Reports from within the sector show that many NHS organisations across the UK are preparing for a reduction in overall workforce numbers over the short term, with much more subdued levels of growth returning to the sector in the medium to long term.

Across England there will be focused work to identify areas where workforce reductions can be made without impacting on patient care and the quality of frontline services. There can be no doubt that the proposed structural changes to the NHS, within the ‘Liberating the NHS White Paper’ which includes the abolishment of Strategic Health Authorities and PCTS, will reduce the overall numbers of people working in the NHS with administrative and management posts being significantly reduced.

What the Working Futures III analysis does demonstrate, however, is that there is an opportunity for employers to utilise retirements as a mechanism by which they can deliver transformational workforce changes. However, it should be noted that although the numbers appear very high they represent an annual retirement rate of less than 4%. This, coupled with the knowledge that other types of natural wastage across the sector is very low\(^20\), leads to the conclusion that large-scale workforce transformation programmes undertaken by employers will need to be effected through high-quality workforce planning, together with systematic change management processes, rather than relying wholly on natural wastage.

\(^{20}\) Skills for Health (currently unpublished). Identifying the Movement of the Workforce around the Health Sector. Developed by MacKinnon Partnership
In addition to this the sector also has a number of individuals that will be leaving professional courses of study over this period; these individuals will be seeking employment within a sector that is very different to the one that existed when they embarked upon their studies. It is highly likely that in the short term the labour market for health professionals will be constrained and competition between graduates will be very high. This newly qualified workforce may have to undertake their first roles as qualified practitioners in specialties that have historically been less attractive. There also exists the potential for short-term oversupply of graduates from universities with new doctors, nurses, therapists etc. struggling to find jobs within the sector following graduation.

Chapter 7, *Current Skills Demand*, draws on the range of data and intelligence that is available to examine the key current skills demands of the health sector.
7 Current Skills Demand

Key Features

The National Employers Skills Survey for England, 2009 shows:

- A comparatively strong picture for the health sector in respect of skills gaps, skills shortages and training.
- 22% of establishments within the England health sector report having skills gaps within their workforce.
- Employers within the health sector cite Technical and Practical skills as their main skills gaps.
- 84% of establishments within the England health sector report having provided training in the preceding 12 months.
- The workforce that are more highly qualified are more likely to have received training in the last 13 weeks.

7.1 Introduction

The need for the sector to adopt a more flexible workforce, with competences as a key vehicle to achieve this, was a central component of Skills for Health’s Sector Skills Agreement. The key messages promulgated then are just as relevant today. Indeed, the economic crisis has raised the issue of increased flexibility in the workforce to a greater level.

The strategic direction that underpins this Sector Skills Assessment is to develop an increasingly affordable and flexible workforce. Skills for Health envisage a growing role for competence-based job design in securing this strategic direction.

The sector consists of a wide range of professionals and practitioners, many of whom have undertaken lengthy academic, vocational and practical training. As such, the sector has a rich stock of qualifications, as well as some areas of skills gaps and shortages.

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21 Available at http://www.skillsforhealth.org.uk/~/media/Resource-Library/PDF/Caseforchange-Final.ashx
22 Labour Force Survey 2009/10, 4 Quarter Average (Q3 2009 – Q2 2010) estimates that 61% of the UK health sector are qualified to NQF Level 4 or above compared to 38% in the general economy
7.2 About skills and employment surveys

The National Employers Skills Survey 2009 (NESS09) for England provides robust and reliable information from employers in England on recruitment difficulties, skills deficiencies, and workforce development to help in the development of policy and influence actions to address skills issues.

Overall, the NESS 2009 survey presents a comparatively strong picture for the health sector, with some specific areas that need further work or attention.

It is important to note that the NESS 2009 survey was conducted at the very start of the recession when the full effects were arguably not felt across the whole economy and the impact on the public sector had been minimal. The results of the survey should therefore be treated with some caution as the landscape for employment and skills across the sector has changed since this time.

7.3 Skills gaps in the health sector

Skills gaps are said to exist at an establishment when the employer indicates that staff at the establishment are not fully proficient at their jobs. The number of skills gaps refers to the number of staff not fully proficient.

Table 15 shows that the percentage of health sector establishments reporting skills gaps has increased by 6% between 2007 and 2009. The percentage of establishments reporting skills gaps ranges from 18% in London through to 25% in the West Midlands compared to an average of 22% for England23.

<table>
<thead>
<tr>
<th>Region</th>
<th>% of Establishments with any skills gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2007</td>
</tr>
<tr>
<td>East of England</td>
<td>13</td>
</tr>
<tr>
<td>East Midlands</td>
<td>16</td>
</tr>
<tr>
<td>London</td>
<td>14</td>
</tr>
<tr>
<td>North East</td>
<td>22</td>
</tr>
<tr>
<td>North West</td>
<td>13</td>
</tr>
<tr>
<td>South East</td>
<td>18</td>
</tr>
<tr>
<td>South West</td>
<td>20</td>
</tr>
<tr>
<td>West Midlands</td>
<td>16</td>
</tr>
<tr>
<td>Yorkshire and The Humber</td>
<td>14</td>
</tr>
<tr>
<td>England Average</td>
<td>16</td>
</tr>
</tbody>
</table>


If the incidence of skills gaps across the sector are analysed as a percentage of total employment an estimated 120,500 people, or 8% of the sector’s workforce, have skills gaps.

**Skills that need improving**

Analysis of the 2009 National Employers Skills Survey for England also reveals the following main two skills gaps areas across the health sector:

- Technical and Practical (64%).
- Customer Handling (45%).

Chart 2 demonstrates that many of the skills that need improving are similar to those found in other sectors of the whole economy. Areas where the skills needs were greater in the health sector than the whole economy include:

- General IT Skills.
- Written Communication Skills.
- Office Admin Skills.
- IT Professional Skills.

**Chart 2: Skills that Need Improving in Organisations with Skills Gaps**

Source: NESS 2009
A comparison between the 2007 and 2009 surveys show that there has been an increase across the board in the types of skills that need improving in the health sector. This pattern is mirrored in the whole economy, with the exception of foreign language skills.

The largest increases in the health sector have been in the technical, practical or job specific skills (9% increase) followed by problem solving (8%), general IT skills (7%) and office admin skills (7%).

### Table 16: 2007 and 2009 Comparison of Skills That Need Improving

<table>
<thead>
<tr>
<th>% of All with Skills Gaps</th>
<th>2007 Health Sector</th>
<th>2007 Whole Economy</th>
<th>2009 Health Sector</th>
<th>2009 Whole Economy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical, practical or job-specific skills</td>
<td>55</td>
<td>52</td>
<td>64</td>
<td>64</td>
</tr>
<tr>
<td>Customer handling skills</td>
<td>38</td>
<td>41</td>
<td>45</td>
<td>48</td>
</tr>
<tr>
<td>Problem solving skills</td>
<td>36</td>
<td>36</td>
<td>44</td>
<td>45</td>
</tr>
<tr>
<td>Team working skills</td>
<td>37</td>
<td>35</td>
<td>41</td>
<td>43</td>
</tr>
<tr>
<td>Oral communication skills</td>
<td>35</td>
<td>36</td>
<td>39</td>
<td>42</td>
</tr>
<tr>
<td>General IT user skills</td>
<td>28</td>
<td>24</td>
<td>35</td>
<td>30</td>
</tr>
<tr>
<td>Written communication skills</td>
<td>29</td>
<td>25</td>
<td>33</td>
<td>31</td>
</tr>
<tr>
<td>Office admin skills</td>
<td>26</td>
<td>23</td>
<td>33</td>
<td>28</td>
</tr>
<tr>
<td>Management skills</td>
<td>28</td>
<td>29</td>
<td>32</td>
<td>36</td>
</tr>
<tr>
<td>IT professional skills</td>
<td>16</td>
<td>15</td>
<td>22</td>
<td>19</td>
</tr>
<tr>
<td>Literacy skills</td>
<td>18</td>
<td>17</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>Numeracy Skills</td>
<td>14</td>
<td>15</td>
<td>15</td>
<td>19</td>
</tr>
<tr>
<td>Foreign language skills</td>
<td>12</td>
<td>12</td>
<td>13</td>
<td>11</td>
</tr>
</tbody>
</table>

Source: NESS 2007 and 2009

### Causes of skills gaps

The six main identified causes of skills gaps within occupations in the health sector are lack of experience or their being recently recruited (76%), failure to train and develop staff (18%), inability of workforce to keep up with change (18%), staff lack motivation (18%), recruitment problems (10%) and high staff turnover (7%).

These percentages mirrored the whole economy picture except for:

- ‘lack of experience or their being recently recruited’ – across the whole economy this was cited as a cause by 58% (18% lower than in the health sector, and
- ‘failure to train and develop staff’ - across the whole economy this was cited as a cause by 28% of establishments (10% higher than in the health sector).
Impact of skills gaps on employers

The most cited impact of skills gaps by employers in the health sector is to increase the workload of other staff with 54% of establishments reporting this as an impact. This implies that employees who are fully proficient in their roles have to pick up tasks for colleagues that are not proficient.

Approximately a quarter of establishments believe that skills gaps in their current workforce cause difficulties in meeting quality standards. Understanding and addressing skills gaps could therefore be critical in improving quality and performance across the sector.

Interestingly, skills gaps are cited as creating difficulties introducing new working practices for 28% of establishments with skills gaps. As the sector is currently entering a significant period of change it may now be time for establishments to focus on identifying and reducing skills gaps in order to increase the likelihood of this change being successful.
Table 17: Impact of Skills Gaps on the Organisation

<table>
<thead>
<tr>
<th>Percentage of All Establishments with Skills Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Sector</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Lose business or orders to competitors</td>
</tr>
<tr>
<td>Have difficulties meeting quality standards</td>
</tr>
<tr>
<td>Increase operating costs</td>
</tr>
<tr>
<td>Have difficulties introducing new working practices</td>
</tr>
<tr>
<td>Increase workload for other staff</td>
</tr>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

Source: NESS 2009

The comparison with the whole economy demonstrates that skills gaps appear to impact on operating costs and loss of business/orders to competitors less in the health sector. This is a reflection of the structure of the sector, its high proportion of government-funded organisations that have not historically operated in a ‘competitive’ environment.

7.4 Skills shortages in the health sector

Skills shortages are defined as hard-to-fill vacancies where the causes of being unable to fill the vacancy include:

- Low numbers of applicants with the required skills.
- Lack of work experience the company demands.
- Lack of qualifications the company demands.

The reporting of vacancies, hard-to-fill vacancies and skills-shortage vacancies within the latest skills survey in England show a clear divide between the private and public sectors. There was a marked decrease in the number of vacancies in those SSCs dominated by the private sector, whilst there was only a small decrease in vacancies in those SSCs dominated by the public sector.

The following extract is taken from the 2009 UKCES Main Skills Survey Report.24

“Employers in the SSC sector largely composed of public sector employers are the most likely to report vacancies with around a quarter of these covered by Government Skills (17 per cent), Skills for Justice (26 per cent), Skills for Care and Development (24 per cent) and Lifelong Learning UK (24 per cent) reporting vacancies. This is consistent with the pattern seen in 2007 and 2005, although the incidence of vacancies has decreased slightly from previous years in the SSC sectors.

Establishments covered by the Skills for Health SSC also have higher than average levels of vacancies (20 per cent) and report the highest levels of hard-to-fill vacancies among all SSC sectors (7 per cent).”
Whilst the health sector reported the highest level of hard-to-fill vacancies among all SSCs the percentage of establishments identifying these as skill-shortage vacancies was not significantly greater than the whole economy. This suggests that there are other reasons that establishments are struggling to fill vacancies other than the skills being available in the labour market.

An indicator of where severe skills shortages currently exist within the ‘professions’ can be found in MAC Skilled, Shortage and Sensible shortage occupation list for the UK and Scotland\(^25\). Evidence for shortages across the UK health sector are gathered and submitted collaboratively by Workforce Review Team, Skills for Health\(^26\), NHS Employers and Scottish Government. The full list contains approximately 35 health-related roles where shortages are currently being experienced. The list includes medical practitioners, specialist nurses and therapists in certain roles where shortages have been identified.

It is important to note that for many of the staff groups on the list the roles that are experiencing severe shortages require very specialist levels of skills in sometimes very specific areas of health specialties, and as such overall occupation numbers across the sector within the UK may be low. The latest MAC report\(^27\) notes that:

> “Of the top ten occupations (that have made use of the shortage occupation route), the majority are concerned with healthcare and related activities.”

Further evidence of vacancies across all levels of employment can be drawn from NHS data. These surveys, which happen in each of the countries of the UK, indicate that vacancies across the NHS are broadly consistent in each of the countries\(^28\). The NHS vacancy data examines posts that have been vacant for three months or more where the employer is still actively trying to recruit. They therefore show posts or professions where hard-to-fill vacancies exist; however, it is important to note that these may not always be skills-shortage vacancies. The reason for the employer experiencing difficulty filling a post may be due to other reasons such as an undesirable location, lack of career progression, or issues relating to pay and conditions.

www.ukba.homeoffice.gov.uk/aboutus/workingwithus/indbodies/mac/

\(^{26}\) As part of the process Skills for Health consulted with the devolved administrations and the independent sector.

\(^{27}\) Migration Advisory Committee (2009) Skilled, Shortage Sensible – second review of the recommended shortage occupation list for the UK and Scotland
http://www.ukba.homeoffice.gov.uk/sitecontent/documents/aboutus/workingwithus/mac/first-review-lists1/

Northern Ireland (2009) Vacancy Survey, DHPSI
On an individual staff group level, the NHS vacancy rate data appears to show that specific pressure points exist in Pharmacy, Other Physiological Sciences (7.6%) and Respiratory Physiology (6%). Within the pharmacy staff group, vacancy rates in registered pharmacists are running at approximately 5.3%. The striking issue, however, is that the vacancy rate in pre-registration pharmacy trainees is running at approximately 6%, indicating not only a severe shortage but a potential long-term issue for this staff group.

There is also survey data which examines vacancies in GP practices throughout England and Wales. These practices fall within the Independent Sector and therefore can provide a useful indication of trends for smaller employers across the sector.

The latest survey was conducted in March 2010 with over a 70% response rate from GP practices. The overall indicators show that between 2009 and 2010:

- Vacancy rates for GPs in England had increased by 0.5%, from 1.6% in 2009 to 2.1% in 2010. In Wales rates had reduced by 0.6% from 0.9% in 2009 to 0.3%.
- GP posts that had been vacant for three months or more in England had increased by 0.2%, from 0.3% in 2009 to 0.5% in 2010. In Wales the three-month vacancy rate had decreased by 1.1% from 2.2% on 2009 to 1.1% in 2010.
- Vacancy rates for practice nurses have reduced by 0.6% in England to 0.8% but have increased by 0.3% in Wales to 0.6%.
- Three-month vacancy rates for practice nurses have remained stable in Wales at 0.1% and decreased by 0.1% in England to 0.3%.
- Vacancy and three-month vacancy rates for all other practice staff have either remained stable or reduced.

It is important to put the above into context for the whole sector; skills surveys at a national level identify that skills gaps are a more significant issue for the sector than vacancies identified as hard to recruit to due to lack of skills in applicants or the labour market. In England, for example, skills gaps are estimated to affect over 120,500 staff versus 4,700 skill-shortage vacancies.

It is also important to note how difficult it can be to utilise current and historic vacancy data to make informed decisions regarding skills shortages and sensibly inform Careers Information Advice and Guidance (CIAG) activities across the sector. The workforce to fill today’s skills shortages is just completing their professional training which takes a minimum of three years. This lead-in time for a qualified workforce further adds a layer of complexity to workforce planning and CIAG across the sector.
7.5 Skills supply and training

Key to the supply of skills across any sector is high-quality training and development led by employer demand. If this is achieved there should be a greater balance between the demand and supply of skills.

NESS 2009 shows that there is a high prevalence of training across the sector. Table 18 shows that 84% of health sector establishments in England report that they have provided training for their employees in the preceding 12 months. This number has remained stable between 2007 and 2009.

Table 18: Establishments Providing Training by Region

<table>
<thead>
<tr>
<th>Region</th>
<th>% of Establishments that have provided Training (on or off the job)</th>
</tr>
</thead>
<tbody>
<tr>
<td>East of England</td>
<td>90</td>
</tr>
<tr>
<td>East Midlands</td>
<td>87</td>
</tr>
<tr>
<td>London</td>
<td>82</td>
</tr>
<tr>
<td>North East</td>
<td>90</td>
</tr>
<tr>
<td>North West</td>
<td>85</td>
</tr>
<tr>
<td>South East</td>
<td>83</td>
</tr>
<tr>
<td>South West</td>
<td>83</td>
</tr>
<tr>
<td>West Midlands</td>
<td>82</td>
</tr>
<tr>
<td>Yorkshire and the Humber</td>
<td>85</td>
</tr>
<tr>
<td><strong>England Average</strong></td>
<td><strong>84</strong></td>
</tr>
</tbody>
</table>

Source: NESS, 2009
Base: All establishments

Evidence from the UK Labour Force Survey demonstrates that members of staff that are more highly qualified are more likely to have received training in the 13 weeks prior to the survey. The implications of this are that equality of access to training and development activities across the sector does not exist.

Table 19: Percentage of the Health Sector Workforce That Have Received Training in the Last 13 Weeks Split by Qualification Level

<table>
<thead>
<tr>
<th>Qualification Level</th>
<th>England %</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF Level 4 and above</td>
<td>56</td>
</tr>
<tr>
<td>NQF Level 3</td>
<td>41</td>
</tr>
<tr>
<td>NQF Level 2</td>
<td>37</td>
</tr>
<tr>
<td>Below NQF Level 2</td>
<td>29</td>
</tr>
<tr>
<td>Other qualifications</td>
<td>33</td>
</tr>
<tr>
<td>No qualifications</td>
<td>17</td>
</tr>
</tbody>
</table>

This analysis of access to training across the workforce highlights an apparent inequality, with those individuals who already hold high levels of qualification (typically medical consultants or senior managers) reporting they receive more ongoing training than individuals without a high level of qualification (those in routine or support roles). If employers aspire to enhance skills utilisation across the whole workforce, they may need to examine and analyse these issues further in order to break down barriers.

7.6 Concluding remarks

The health sector has a rich mix of qualifications with a high incidence of training. There is heavy investment in the skills of the workforce through a range of formal qualifications, vocational-based training and development and continued professional development.

Despite this, there is a history of skills gaps within the health sector workforce which employers need to understand and address in order to maximise the potential of the current workforce and improve performance and productivity. Failure to respond effectively to these skills gaps will increasingly create a barrier to effective skills utilisation across teams and hamper the real potential of productivity gains.

Cross-sector surveys such as the National Employer Skill Survey in England highlight skills shortages as less of an issue for the health sector. Other detailed analysis, however, highlights a great number of ‘risk’ areas and skills shortages, particularly in highly specialist professional roles.

The sector has had a historic reliance upon international recruitment to fill severe shortages in the health professional occupations and it is clear that this is now lessening. It is important that the sector continues to seek solutions to severe shortages that do not rely on international recruitment, particularly considering the new policy direction of the government in capping overall migration numbers.

Analysis of access to training across the workforce highlights an apparent inequality in the access to training across the workforce, with a greater proportion of those individuals who already hold high levels of qualification reporting they have received training. If employers aspire to enhance skills utilisation across the whole workforce they may need to examine and analyse these issues further in order to break down barriers.

Chapter 8, What Drives Skills Demand?, draws on Skills for Health’s current data and intelligence, including Rehearsing Uncertain Futures scenario planning and other future-orientated research to highlight the range of drivers that impact upon the skills demand of the sector.
8 What Drives Skills Demand?

Key Features

- Identifiable public expenditure on health has increased by 45% over the period 2004/05 to 2009/10.
- After Social Protection, Health is the next highest area of spend with a planned spend per head of population of £1,896.
- England has increased health spend per head by 40% over the period 2004/05 to 2009/10.
- England spends less per head of population on health than Scotland and Wales.
- Over a quarter of the resident population are affected by or harbouring existing and future health problems.
- In respect of health policy there is an increase in emphasis on partnership working with other sectors particularly social care.
- In 2008, the average household in England spent £5.80 on health products and services. Sub-regionally this ranged from £3.60 in the North East up to £7.00 in London.
- Between 2008 and 2009 overall UK household expenditure dropped by 3%. The largest annual drop was seen in ‘Dental Services’ which experienced a 26% drop in household expenditure.

8.1 Introduction

Throughout the UK healthcare provision, and the skills of those who provide it, are being shaped by a wide range of social, economic, cultural and political forces.

The identification of the key drivers for skills demand across the sector has been done collaboratively with employers across the sector, including those in Northern Ireland, through our Rehearsing Uncertain Futures scenario-planning activities.

It is clear from the Rehearsing Uncertain Futures work, and the commentaries from a wide range of experts, that the employers within the health sector will need to think differently about how a whole range of services are offered to the population.

As a result, a range of new roles, new ways of organising work and taking full advantage of new technology will be of increasing interest to employers. These will also have meaningful consequences for the skills required of those working within the sector.

Commentaries available on the Skills for Health website www.skillsforhealth.org.uk
This chapter outlines some of the **major drivers for change** for the sector in England. A full outline of these forces and how they affect the sector's development in the UK are detailed in our UK Sector Skills Assessment summary and main report.

### 8.2 NHS concept

The NHS is a major presence in the UK health sector. How the service is organised, funded and structured has a major influence on the whole health provision within the UK. This was one of the highest ranking influencing forces on the development of health provision in the UK and in turn skills development.

The NHS is one of world’s largest employers. It is also wholly publicly funded. In many respects it is also an important ‘ideal’ and is part of the cultural landscape of the UK. Few public institutions receive the same level of support than the NHS in the UK.

When the NHS was launched in 1948 it was based on three core principles:

- That it meet the needs of everyone.
- That it be free at the point of delivery.
- That it be based on clinical need, not ability to pay.

These principles continue to guide the development of the NHS more than sixty years later. Whilst finessed throughout the years, various modernisation programs have sought to drive forward change whilst upholding these principles. Tensions do however exist within the concept of the NHS and the practicalities of health provision which help shape its development.

One of the key tensions of the NHS concept is its aim to provide a universal service within finite (publicly funded) resources whilst demand and expectations for services continue to rise. As a result there has been a growing debate on how to measure and achieve better productivity in the NHS. The debates on skills mix and workforce reconfiguration are continually pushing the development of new services.

The concept of the NHS also influences the development of private and voluntary sector provision. This influences how these sub-sectors are able to provide services and therefore employ and develop people. For instance, within England there has been a greater emphasis on private sector institutions delivering healthcare funded by the public purse through a programme of increasing patient choice. In Scotland there is a greater emphasis on the use of NHS only.
The NHS concept therefore has an important set of further consequences for change and therefore the development of employment and skills related issues:

- The NHS, because of its size, can handle change poorly, according to many commentators. Reconfiguring services and skills sets can therefore take time and pose a challenge for employers.
- Change can be stymied by the complex set of institutions that the NHS needs to relate to, each with different needs and, often, regulatory powers.
- Managers and Leaders can be confronted with a set of issues that are not easily (and sometimes never) resolvable.

The current position of the NHS concept is usefully illustrated in the current government’s deficit reduction plan. The NHS been protected from many of the cuts other public institutions have been confronted with. There remains a need however for significant efficiency savings to take account of surging demand. These efficiency savings will require better skills utilisation and development as well as management.

### 8.3 Funding/economic

Following the economic crisis and subsequent public sector deficit, the immediate focus for employers will be on achieving sustainable efficiency savings.30

The settlement for the NHS outlined in the Comprehensive Spending Review (CSR) in October 2010 confirmed the Government’s commitment to protect NHS spending over the course of the parliament. The NHS budget in England is to rise by £10 billion between 2010/11 and 2014/15. This equates to a 0.4% real terms growth over the spending period.

It will mean funding increasing to just over £114 billion by 2014/15.32 This is a more austere settlement than has historically been the case and, as set out by the previous government, 5% efficiency savings per annum have been targeted across the NHS through the Quality, Innovation, Productivity and Prevention (QIPP) programme. This requires the NHS to achieve somewhere in the region of £20bn of annual savings by 2014/15.

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30 [http://budget.treasury.gov.uk/improving_public_services.htm](http://budget.treasury.gov.uk/improving_public_services.htm)
Gainsbury S, Public Spending Cuts will be worse than predicted – Institute for Fiscal Studies. Health Service Journal 24th April 2009
Laing and Buisson Press Release, 29th October 2008
[www.laingbuisson.co.uk/Portals/1/PressReleases/Laings_Review_2008.pdf](http://www.laingbuisson.co.uk/Portals/1/PressReleases/Laings_Review_2008.pdf)
32 This includes capital (£4.6 bn) and administrative budgets (£109.8 bn) for the NHS in 2014-15.
It is clear, therefore, that whilst the settlement for the health sector can be regarded as generous, particularly in the light of very tight budgetary constraints across central government, there is still a significant challenge to the NHS in order to meet the efficiency savings whilst coping with increased demand and inflationary cost pressures. These pressures will include demand from an ageing population as well as lifestyle factors such as obesity, alcohol consumption and smoking, whilst inflationary cost pressures will include the provision of more expensive drugs or treatments that improve outcomes for patients.

Chart 4 details identifiable public expenditure on health in England from 2004-05 and includes the planned spend in 2009-10. Health expenditure in 2004-05 was £67.8bn with a planned spend of £98.3bn in 2009-10, an increase over the period of 45%.

**Chart 4: Identifiable Public Expenditure on Health 2004-05 – 2009-10**

Source: www.hm-treasury.gov.uk
As Chart 5 illustrates England, with the exception of 2006-07, has remained fairly consistent with its increases year on year, normally between 8 and 9%. The drop to 5% in 2006-07 reflects a period of change when there were targeted efficiency savings on the NHS to reduce budget deficits and achieve monthly run rate balance.

Chart 5: England Health Budget Percentage Change Year on Year

Source: www.hm-treasury.gov.uk

Chart 6 details the planned spend by service for England in 2009-10. After Social Protection (income support, tax credits, unemployment benefits, pension etc), Health is the next largest area of spend. Compared to each of the other countries in the UK, England does not spend the most per head on any of the sub functions listed below.

Chart 6: Planned Public Expenditure per Head of Population by Service 2009

Source: www.hm-treasury.gov.uk

Key
1 = General Public Services  
2 = Defence  
3 = Public Order and safety  
4 = Economic affairs  
5 = Environment Protection  
6 = Housing and community amenities  
7 = Health  
8 = Recreation, culture and religion  
9 = Education  
10 = Social protection

Source: www.hm-treasury.gov.uk
Chart 7 illustrates that England plans to spend one of the lesser amounts on health per head in 2009/10. From the start of the period in 2004/05, England has increased health spend per head from £1,353 to £1,896 (40%) and in-between the period 2008/09 and 2009/10 funding has increased from £1,748 to £1,896. At 8%, this is the largest annual increase of any of the UK countries.

Recent publications have highlighted that Scotland spends more on health than any of the four countries but is yet to realise the benefits. However, as Chart 7 illustrates, Wales too spends more than England and Northern Ireland. The lack of quantifiable impact on health after continual investment is often referred to as the ‘Scottish effect’ and is said to be present in both North Wales and the North East of England. This effect demonstrates the complex interactions between health outcomes and other societal factors.

**Chart 7: Planned Health Spend per Head of Population, 2009/10**

<table>
<thead>
<tr>
<th>Region</th>
<th>Spend (2009/10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N Ireland</td>
<td>£1,881</td>
</tr>
<tr>
<td>England</td>
<td>£1,896</td>
</tr>
<tr>
<td>Wales</td>
<td>£1,956</td>
</tr>
<tr>
<td>Scotland</td>
<td>£2,066</td>
</tr>
</tbody>
</table>

Source: www hm-treasury.gov.uk

Table 20 suggests that using current health-profiling models the allocation of funding is not directly linked to the health of the resident population. Using the latest intelligence, Northern Ireland has 21% of its population affected with existing problems compared to 14% in England and plans to spend slightly less per head.

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33 Health profile models are drawn from CACI’s Health and Consumer profiles. A full explanation of the profiles can be found in Section 8.4.2, *A snapshot of current and future patterns of health and wellbeing.*
Current research undertaken by the TUC\(^\text{34}\) raises the issues that the areas that need it most will feel the anticipated cuts in public funding the hardest.

It is important to recognise that there are many societal and environmental factors that impact upon the health and wellbeing of the population. For this reason government spend on other areas of welfare and social protection can have a very real and positive benefit to the health of the population. Research\(^\text{35}\) indicates that one such area is housing support and investment in this area can potentially improve health outcomes and reduce health inequalities. Well insulated, energy efficient homes can help to combat:

- Cardiovascular disease - cold weather increases blood pressure and thus increases the risk of heart attacks and strokes.
- Respiratory illness – being cold impairs lung function and can trigger a range of respiratory diseases. Dampness in cold houses can also cause asthma and respiratory infections.
- Mobility issues and falls - symptoms of arthritis become worse in cold or damp houses, strength and dexterity also decrease in the cold increasing the risk of injury and falls.
- Mental and social health issues – damp, cold housing is associated with an increase in mental health problems and social isolation.

\(^{34}\) http://www.tuc.org.uk/economy/tuc-18463-f0.cfm
\(^{35}\) http://www.tuc.org.uk/economy/tuc-18467-f0.pdf

\(^{35}\) www.dhcarenetworks.org.uk/_library/Resources/ICN/ICN_advice/HousingSupport.pdf
8.4 Old age/demographics

8.4.1 Lifestyle

Lifestyle risk factors, such as alcohol consumption and increasing levels of obesity, are a key concern. It is estimated that currently 8.2 million people in England are drinking above the low-risk or sensible level and 1.1 million people are dependent on alcohol. The consequences for a whole range of areas are significant.

Obesity is also a key factor in determining future health needs with an estimated 1 in 4 adults reported obese. Without intervention it is estimated that, by 2050, 9 in 10 will be overweight/obese.

8.4.2 A snapshot of current and future patterns of health and wellbeing

The general trends in health and health provision are played out very differently throughout the regions and sub-regions of England. There are a range of organisations seeking to understand the variances in health and wellbeing throughout England and the UK, including Public Health Observatories, as well as local healthcare providers.

CACI’s health and consumer ACORN profiles (A Classification of Residential Neighbourhoods) is one commercially available source of data profiling the demand of healthcare in the UK. This profile provides us with a snapshot of current and possible future health requirements.

Health ACORN classifies households into four main health groups. These are:

- Existing problems – Where the levels of illness are above average. The proportion of people with angina is 60% higher than average, the proportion who have suffered a heart attack is 45% above average. The incidence of diabetes, high blood pressure and high cholesterol are also above average, and this is the only group where this is the case.
- Future problems – The areas classified as harbouring future problems do not generally have high incidence of existing illnesses. Exceptions to this are depression, asthma and migraine.
- Possible future concerns – These are areas with lower levels of smoking, obesity and average or slightly below average incidence of illness.
- Healthy – The healthy areas tend to have a younger demographic and the proportions of people with high blood pressure, angina, diabetes and high cholesterol are lower than average. This group are likely to take more exercise and less likely to be smokers or overweight.

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38 These draw extensively from official sources of intelligence, such as the annual population survey, 2001 Census, consumer surveys and expenditure data. These sources enable models of healthcare and consumer demand to be developed on a local, regional and country basis.
These four main groups are refined into a further twenty-five health types, which provide more explanation of household composition, work position, lifestyle and diet. Examples include:

- Older couples, traditional diets, cardiac issues.
- Disadvantaged elderly, poor diet, chronic health.
- Poor single-parent families with lifestyle-related illnesses.

The largest health groups in England are ‘healthy’ and ‘possible future concerns’. The latter are often households whose position and wealth are relatively comfortable, but whose lifestyle choices, such as through alcohol consumption, may be leading them towards encountering future health issues.

There are of course less favourable groups such as ‘existing problems’ and ‘future problems’. Over a quarter of the population fall into these categories. Table 21 outlines the health profile of England compared to the UK.

<table>
<thead>
<tr>
<th>Health Group</th>
<th>England Data</th>
<th>England %</th>
<th>UK Data</th>
<th>UK %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing Problems</td>
<td>7,011,380</td>
<td>14</td>
<td>9,270,098</td>
<td>15</td>
</tr>
<tr>
<td>Future Problems</td>
<td>6,231,293</td>
<td>12</td>
<td>7,582,290</td>
<td>12</td>
</tr>
<tr>
<td>Possible Future Concerns</td>
<td>18,174,048</td>
<td>35</td>
<td>21,297,772</td>
<td>34</td>
</tr>
<tr>
<td>Healthy</td>
<td>19,987,231</td>
<td>38</td>
<td>23,153,555</td>
<td>37</td>
</tr>
<tr>
<td>Unclassified</td>
<td>479,950</td>
<td>1</td>
<td>557,817</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>51,883,902</td>
<td></td>
<td>61,861,532</td>
<td></td>
</tr>
</tbody>
</table>

Source: CACI Health ACORN 2010

Of the six health types that make up the health group ‘healthy’, four are slightly overrepresented in England. The largest health type is ‘affluent towns and villages with excellent health and diet’ accounting for 11.4% of the country’s population and having a presence slightly higher than the UK average.

The health groups and types of concern to the country are:

- Existing Problems – ‘disadvantaged neighbourhoods with poor diet and severe health issues’ account for 3.9% of England’s population but with a presence slightly lower than the UK average.
- Future Problems – ‘deprived multi-ethnic estates, smokers and overweight’ - slightly higher than the UK average but, to keep in some context, only account for 4% of the country’s population.
- Possible Future Concerns – ‘affluent professionals, high alcohol consumption, dining out’ account for 8.5% of the country’s population and are again slightly higher than the UK average.
**Geographical profile of health groups in England**

Fig. 1 below details the Local Authority areas categorised by its dominant health group. The map itself serves to illustrate the complexity of health economies throughout England. It also highlights how skills and employment need to be shaped locally in order to best meet the needs of these populations.

The areas which predominately are healthy are shaded in purple; these are located in the rural north and southern borders of England. Existing problems, shaded red, are in the North East, North West and Yorkshire and The Humber regions. Further detail and analysis are available in the Skills for Health Regional LMI Briefings.

Further illustrations are available in Appendix 3, which details Local Authorities where for each health group the proportion of the resident population exceeds the UK average.

**Fig 1: Dominant Health Group by Local Authority 2010**

Source: CACI Health ACORN, 2010
8.4.3 Health inequalities

Aligned to consumer expectations is the issue of health inequalities. While over the last 10 years there have been improvements in terms of both life expectancy and infant mortality, the gap between the most disadvantaged groups and areas and the rest of the population has remained\(^{39}\).

Government sees the health sector, and the services it provides, as a key component of tackling health inequalities, although it is recognised that inequalities arise from a complex interaction of many factors including other societal factors. For this reason government spend on other areas of welfare and social protection can have a very real and positive benefit to the health of the population. Section 8.3, Funding/economic, has already highlighted the importance of housing support in improving health outcomes for the populations.

8.4.4 Ageing population and the growth of long-term conditions

A recent report from the ONS\(^{40}\) 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.

These figures show that in 2008 people aged 50 and over made up at least 25% of the population in each part of the UK. The lowest percentages were found in London (26%) and Northern Ireland (31%). The highest percentages were found in the South West of England (39%) and Wales (37%).

Coastal and rural areas had the highest percentages of population aged 50 and over, except within Northern Ireland. These higher percentages reflect the known patterns of internal migration related to people of retirement age within the UK moving to such areas over a period of many years.

The ONS reports that one of the most striking features of UK population ageing is the increasing numbers in the oldest age groups. Although much smaller in volume compared to younger age groups, they are noted as being important because this is where most growth is projected to take place in the future. There is also concern that the extension of life may mean more ‘unhealthy years’ for many individuals within the UK. These older people will have a potentially disproportional effect on demand across the sector.

\(^{39}\) Tackling Health Inequalities 10 years on. Department of Health 2008
\(^{40}\) Office for National Statistics (2010) Regional Trends 42, Ageing Across the UK.
Population projections from the Office for National Statistics\textsuperscript{41}, published November 2009, show that the population in England is expected to grow by 9 million people between 2008 and 2033. Growth in absolute numbers is expected in the majority of the age groups but the population aged over 60 will grow at a faster rate than those under 60 years of age.

Chart 8 shows age groups as a proportion of the total population of the country. These clearly show that there is anticipated to be significant shifts in the proportion of the population of England aged 60 years and over and decreases in the proportion of the population aged under 60.

**Chart 8: Population Changes by Detailed Age Bands as a Proportion of the Total Population 2008 – 2033**

Source: Office for National Statistics

\textsuperscript{41} www.statistics.gov.uk/StatBase/Product.asp?vlnk=8519
There has been an increase in the prevalence of long-term conditions due to the demographic and lifestyle risk factors described above. There is a projected increase in the prevalence of long-term conditions, due to the demographic and lifestyle risk factors as described above. An estimated 15.4 million people in England are living with a long-term condition and this is set to rise by 23% over the next 25 years\(^{42}\).

### 8.4.5 An ageing workforce

Predicted changes in the population of the country have a double impact on the health sector. Demographic pressures of an ageing population will increase demand for health services, whilst a potentially dwindling labour pool will mean that employers may struggle to supply the labour and skills needed to deliver the services the population needs.

### 8.4.6 Internal migration

Research shows that people migrate for four main reasons: work, family, change of lifestyle and the cost of living. Migration affects, amongst many things:

- The labour market.
- Demand on health.
- The age profile of the resident population.

Chart 9 shows the interregional migration movements for the UK year ending December 2009. The data demonstrates that the South East has seen the greatest number of internal migrants with London being the region that has experienced the greatest outward migration.

**Chart 9: Interregional Migration Movements**

![Chart 9: Interregional Migration Movements](chart9.png)

Source: www.statistics.gov.uk

8.5 Politics

The Government’s White Paper – Equity and excellence: Liberating the NHS, was published on the 12th July 2010. The paper outlines the Coalition’s proposal for radical reform in the English NHS and has been published as the one document which outlines the Government’s long-term plan for the NHS over the next five years.

The Government’s intention is to create an NHS which is much more responsive to patients, and achieves better outcomes, with increased autonomy and clear accountability at every level. Patients will be at the heart of everything the NHS does, clinical outcomes will replace process-driven targets and health professionals will be empowered.

The key policy areas that are currently being developed are:

- Mental Health Strategy
- Drug Strategy
- Autism
- Dementia
- Public Health
- End of Life
- Carers.

Implications for skills development

Whilst the White paper does not offer any specific individual Health Policy commitments it does signal some key Health Policy areas and suggests focus, review or strengthening in those areas. These ‘flags’ allow a prediction of the White Paper’s implication for skills development:

- **Public Involvement**
  The aim to involve patients in all aspects of their care will mean healthcare providers will have to have the skills to deal with this.

- **Workforce planning and commissioning – move to GP consortia**
  The GP consortia will need to have the skills to commission services and education.

- **Broader range of service providers**
  The move to localised planning and delivery of services and increased support for innovation and social enterprise means that a wider range of organisations may potentially become the providers of services. They will need to ensure their workforce is equipped with the skills to deliver high-quality, safe and effective care. Now is a key time to strengthen our links with the voluntary, independent and social enterprise sector.

- **Greater Focus on Improved Health Outcomes**
  The NHS will focus on outcomes, moving away from top-down targets. The ‘NHS Outcomes Framework’ sets national outcome goals focusing on clinical effectiveness and patient safety. This will be supported by quality standards developed by NICE.
- **Role and functions of key new infrastructure organisations**
  This White paper offers Skills for Health an opportunity to influence policy as it is being developed and to engage with some emerging key players in the future of health service provision. Skills for Health are actively engaging with a range of the key stakeholders mentioned in the paper and this ongoing dialogue is essential to maintain our influencing role, maintain and grow our position as experts and also to explore new opportunities for partnership working.

- **Closer engagement between health and social care**
  There is a growing relationship with Skills for Care through existing work programmes and potential for us explore other opportunities and position ourselves in relation to our sister SSC, to work more closely in other areas as we move towards a greater integration of services and growing function in the Department of Health, for Social Care and Health to be considered and reformed alongside each other.

### 8.5.1 Policy developments in the workforce

The strategic direction for the NHS healthcare workforce in England is set out in *‘High Quality Workforce’* (Department of Health 2008), the workforce report that was published as part of the NHS Next Stage Review.

The report emphasises the fact that healthcare is delivered by a team which consists of not only clinicians (defined as those groups of staff who provide clinical care for patients) but all staff groups in health, as well as the increase in emphasis on partnership working with other sectors, e.g. social care.

There is an expectation that all clinicians will take on a new professionalism of not only being a Practitioner, but also a Partner and a Leader in order to contribute to the vision outlined in the main review. Work on developing the three core roles will be led by the appropriate professional regulator in conjunction with patients, the public, employers, educators and professional bodies.

Common themes that arise from the report include the need to ensure that training and career pathways are fit for purpose in line with the new vision. Detailed plans are set out for most of the professional groups with greatest emphasis on the medics and nursing.

Finally, the report recognises that ongoing skills development for the NHS workforce is key and that this will enable staff to move within a career framework and become better equipped to work within a changing health service. Key to this is the importance of Continuing Professional Development (CPD).
8.6 Technology

Historically the sector has benefited from continued development in bioscience, pharmaceuticals and technological innovation. Such innovations can occur rapidly and have far-reaching consequences for health provision and the skills of the workforce.

In some cases, traditional forms of healthcare practice have become redundant within a relatively short period of time. There are indications that the UK’s Pharmaceutical and Bio-science industries are themselves encountering a period of significant change and the government is backing collaboration between these sectors and all parts of the UK’s health sector.

8.7 Choice

It is widely acknowledged that consumer expectations of the level of service they receive have risen. New generations are much more demanding and possibly better informed about healthcare issues. In some cases, there is growing awareness of their statutory entitlements. The role of the NHS is also culturally significant to those within the UK and many are committed to its core values and its role as a universal healthcare provider.

Rising consumer expectations mean that patients expect to have a greater degree of control with respect to their chosen treatments, place of treatment and time of treatment. This agenda is driven in part by government policy but also by the wide range of information available to patients through public health initiatives, pharmacies and information from other sources such as the internet.

43 Compass bitter pill to swallow www.compassonline.org.uk/publications/
44 Life Sciences Blueprint A statement from the Office for Life Sciences July 2009 http://www.dius.gov.uk/innovation/business_support/~/media/publications/O/ols-blueprint
8.8 Societal

This driver encompasses a wide range of broad trends within society which will act on and with the development of the health sector. This driver seeks to identify how people relate to groups of common interest and how these groups relate to wider society and other communities of interest. These include:

- Patient self-reliance and responsibility are key. Will society be content to continue to provide healthcare to those who openly take risks with their own health such as smoking or poor diet?
- To what extent will communities be exclusive in the sense that they become tribal and look after their own rather than working with other communities collectively? Could this, in combination with localism, create many systems that do not wish to work with one another?
- There are a range of complex issues around public health that will have implications for the future health provision; for example increasing levels of migration, tourism, air travel etc. lead to a growing potential for the spread of an increasing array of communicable diseases and fears for increased risk of pandemics.

This driver is of particular relevance as the coalition government is seeking to develop the relationship between individuals, communities and the state. The developments may have particular relevance for those working within the voluntary sector. However it will also have an important influence on publicly funded health provision, which will need to be more responsive to a greater diversity of community needs.

8.9 Public/private

Much of the debate around the drivers for change focuses on the important areas of policy development. However, there are also a range of developments in terms of how people consume health products and services as privately paying individuals; this can be from paying for toothpaste and dental bills to taking out private healthcare insurance.

In 2008, across the UK, the average household expenditure on main commodities and services was £471 a week\(^45\). The average weekly expenditure on health across the UK was £5.10 making health the lowest priority of spending; the highest category was transport\(^46\).

\(^{45}\) Household spending is analysed according to an internationally agreed classification system, the Classification of Individual Consumption by Purpose or COICOP.

Chart 10 shows the average weekly spend on health in each of the English regions, the average spend across England was slightly higher than the UK average at £5.80 per week. The average spend in London (£7.00) is approximately twice that seen in the North East (£3.60).

**Chart 10: Average Household Expenditure on Health in the English Regions**

![Chart 10: Average Household Expenditure on Health in the English Regions](image)

Source: Consumer Spending, Q2 2009 ONS

Charts 11 and 12 illustrate the average UK household expenditure on health from 1998 up to 2009. From 2007 we can see the beginning of a slowing down in the rate of increase in spend and from 2008 the first actual decrease from since 1998.

**Chart 11: Household final consumption expenditure - Health**

![Chart 11: Household final consumption expenditure - Health](image)

Source: Consumer Spending, Q2 2009 ONS
The percentage change year on year shows a slowing down in growth from 2007 but 2009 has seen the first reduction in household expenditure.

**Chart 12: Percentage change, year on year in UK households’ expenditure on Health**

These charts clearly show that there was an overall real decrease in UK household consumption expenditure on health in 2009. Overall expenditure dropped by 3.4%.

Table 22 shows detailed analyses of the health spend by the component parts. Household expenditure is made up of the following:

- Pharmaceutical goods – medicinal preparations, drugs, medicines, serums, vaccines, vitamins and other oral products.
- Other medical products – clinical thermometers, plasters, bandages, dressings, syringes, body supports and non-oral contraception.
- Therapeutic equipment – spectacles, contact lenses, hearing aids, artificial eyes and limbs, orthopaedic footwear, supports, wheelchairs, invalid carriages, special beds, other devices.
- Out-patient medical services – consultations with doctors, specialists and orthodontists.
- Dental Services – Services of dentists, hygienists and other dental facilities.
- Paramedical services – Private Nurses, midwives, acupuncturists, aromatherapists, reflexologists.
- Hospital Services are all in-patient hospital services, including medical care and meals and accommodation charges.
Table 22: Analysis of UK Household Expenditure on Health Services and Products

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<th></th>
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<td>Other medical products</td>
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<td>Therapeutic appliances and equipment</td>
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<td>2,830</td>
<td>2,805</td>
<td>4.9</td>
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</tr>
<tr>
<td><strong>Out-patient services:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical services</td>
<td>1,079</td>
<td>1,022</td>
<td>981</td>
<td>837</td>
<td>-22.4</td>
<td>-14.7</td>
</tr>
<tr>
<td>Dental services</td>
<td>1,367</td>
<td>2,055</td>
<td>1,746</td>
<td>1,301</td>
<td>-4.8</td>
<td>-25.5</td>
</tr>
<tr>
<td>Paramedical services</td>
<td>538</td>
<td>498</td>
<td>484</td>
<td>535</td>
<td>-0.6</td>
<td>10.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,984</td>
<td>3,575</td>
<td>3,211</td>
<td>2,673</td>
<td>-10.4</td>
<td>-16.8</td>
</tr>
<tr>
<td>Hospital services</td>
<td>2,627</td>
<td>2,712</td>
<td>2,793</td>
<td>2,924</td>
<td>11.3</td>
<td>4.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>12,760</td>
<td>13,775</td>
<td>13,893</td>
<td>13,420</td>
<td>5.2</td>
<td>-3.4</td>
</tr>
</tbody>
</table>

Source: ONS, Consumer Trends Q2 2009

Whilst spend on many areas saw a decrease over 2008 – 2009 the household expenditure on ‘Other medical products’ continued to increase. The data between 2006 and 2009 appears to indicate a continued upward trajectory in this category, this may be indicative of consumers taking more responsibility for self treatment using over the counter medication armed with the wealth of knowledge available to them through public health, the advice of pharmacists and information from other sources such as the internet.

The largest annual drop was seen in ‘Dental Services’, which experienced a 26% drop in household expenditure. The reasons for this are unclear but as dental services (even NHS provided services) are not free to all it may be that constrained household budgets have resulted in individuals perhaps waiting longer between dental visits.
8.10 Towards 2020: Emerging Skills Priorities

**Key findings**

Skills for Health was able to use the insights derived from the scenario planning exercise to explore with colleagues the implications of the drivers and plausible futures on future employment and skills. These insights assisted Skills for Health in refining further analysis of potential developments in the sector. The priorities in this section focus on those developments likely to have an impact on skills as we approach 2020. These include:

- The development of new roles at Levels 3 and 4 of the NHS Career Framework
- The development of roles at Level 7 of the NHS Career Framework
- Ongoing professional development
- The ongoing impact of ICT on roles and skills within the health sector
- Developing capacity and capability of the volunteer workforce
- Informal and unpaid carers
- Self-managed care
- Developing Management and Leadership

8.11 Introduction

The scenario development workshops (phase 2 of Rehearsing Uncertain Futures) produced a set of eight factors that were agreed as having a high impact with a wide range of possible consequences for skills demand, as well as three potential scenarios of how the UK health sector will look in the year 2020.

This understanding of the drivers shaping skills demand assisted Skills for Health’s thinking about possible future skills needs for the sector. Three application workshops were run with employers and stakeholders to think about emerging skill sets and changes to occupations by 2020.

Skills for Health developed the output from these application sessions using additional desk research and consultation, to ensure that relevant sector trends were taken into account when considering future skills priorities.

The current and near future skills priorities that emerged from this stage and further research include:

- Changing skill sets and emerging health roles
- More effective use of information technology

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47 Skills for Health Working Paper (forthcoming) Rehearsing Uncertain Futures; New Skillsets, roles and occupations
Developing capacity and capability of the volunteer workforce
Informal and unpaid carers
Self-managed care
Developing management and leadership

This chapter addresses these skills priorities, looking at what employers in the UK health sector will need to focus on (and in some instances, are already focusing on), in the near future, to ensure the presence of a productive, flexible workforce in the year 2020. Further explanations of these priorities and emerging examples of new roles and practices are contained within the UK Sector Skills Assessment full report.

8.12 Development of roles at Levels 3 and 4 of the NHS Career Framework

The future orientated work by Skills for Health, and subsequent research has identified a range of changes to roles at or around levels 3 and 4 of the NHS Career Framework. This framework was developed to enable skills escalation and helps develop new roles to meet patient need, and are driven by a range of factors.

The development of these roles provides an important opportunity for employers to adjust the skills mix of the teams which they are working with and meet the increasing demand for health provision within tightening budgets.

Skills for Health have developed the following definition of the Assistant Practitioner role as:

“The Assistant Practitioner role developed is at Level 4 of the Career Framework. An Assistant Practitioner is defined as a worker who competently delivers health and social care to and for people. They have a required level of knowledge and skill beyond that of the traditional healthcare assistant or support worker. The Assistant Practitioner would be able to deliver elements of health and social care and undertake clinical work in domains that have previously only been within the remit of registered professionals The Assistant Practitioner may transcend professional boundaries. They are accountable to themselves, their employer, and, more importantly, the people they serve.”

The diagram below illustrates how an Assistant Practitioner may work in relation to other roles and professions typically found within a healthcare setting. This is a flexible approach to role development i.e. the competences required for different services by different employers can be drawn from different mixes of professions based on the needs of the patients within that pathway.

**Fig 2: The domain of the Assistant Practitioner**

Recent analysis commissioned by Skills for Health\(^{49}\) indicates that there has been a raft of activity to develop new roles at NHS Career Framework Levels 3 and 4 with a particular emphasis at Level 4. Many of these posts are labelled as Health Care Assistants (normally at Level 3) or more often Assistant Practitioners (Level 4). This activity is taking place throughout the UK.

The move towards more Assistant Practitioners is also more attractive and potentially more pressing in the light of the decision that nursing should become a graduate entry profession\(^{50}\). The Royal College of Nursing’s policy discussion paper on Assistant Practitioners notes that:

> “...developing roles at the assistant practitioner level is extremely important in terms of bringing people into the registered nursing profession, and maintaining a wide entry gate to an all-graduate pre-registration nurse education programme.”\(^{51}\)

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\(^{49}\) Skills for Health expert paper (forthcoming) The Role of the Assistant Practitioner. Developed by Dr Linda Miller, Institute for Employment Studies


The response from employers to these developments is generally positive as evidenced in the Assistant Practitioner Scoping Report52 commissioned by Skills for Health. This states:

"...the overwhelming response we have had from all regions is very positive about the introduction of Assistant Practitioners."

The Assistant Practitioner role is one that continues to grow in popularity across all countries of the UK and development of these roles has been employer led. Quantifying the potential for widespread development of this role across the UK requires further analysis at a national and regional level.

Whilst there has been widespread instances of these roles being developed there are a number of institutional factors which continue to affect these changes. These include:

- The debate about the nature of the role, in particular around how ‘assistive’ or ‘autonomous’ these roles are able to be
- How they are developed and accepted by others particularly in relation to the healthcare professions

There remain a range of factors that may affect the successful development of this role include:

- The need to address numeracy and literacy skills amongst those who might be considered candidates for the role
- The numbers of staff ready, motivated and able to progress their careers in this way
- The appropriate opportunities for training and development to progress into these roles and beyond53

Whilst there will inevitably be challenges as these roles develop and become more refined - the drivers for change point to an increase in their demand. Overall, this approach is likely to be more cost effective and could generate significant productivity improvements in terms of public investment in education and training.

53 Skills for Health expert paper (forthcoming) The Role of the Assistant Practitioner. Developed by Dr Linda Milier, Institute for Employment Studies
8.13 Development of roles at level seven of the NHS Career Framework

Another key innovation in extending knowledge and practice is the development of roles at level seven of the NHS Career Framework. These are also often referred to as Advanced Practitioners.

These roles seek to extend the existing professional knowledge and skills of the ‘registered’ clinical workforce. Successful development into Advanced Practitioner roles will enable this section of the non-medical workforce to undertake tasks that have traditionally been the sole responsibility of doctors.

People undertaking development into advanced practitioner roles will already be highly skilled and qualified (typically qualified to S/NVQ level 4 or equivalent and above) and development is usually through a Masters level programme.

An independent evaluation of the introduction of Advanced Practitioners in one area of the UK notes the following reasons for introducing Advanced Practitioners:

- Ensuring better access to services
- Improving activity and service delivery
- Addressing governance and compliance issues
- Increasing workforce productivity
- Enhancing patient experience

The evaluation report further notes:

“The findings from the case studies and the wider work on impact which has run through the evaluation clearly show that the Advanced Practitioner roles are having a positive impact on patient care and service delivery in their trusts.”

More recent work by Skills for Health with a single NHS Trust has demonstrated the impact that advanced practitioner roles can have. The introduction of Advanced Practitioners into the orthopaedic assessment service reduced referrals to secondary care from 100% to 30%. The impact on patients meant that 70% of them were treated in community locations, closer to home with improved patient experience and satisfaction.

Employers are likely to continue to focus on the development of a range of advanced practitioner roles in order to better enable more flexible team working across a wider clinical team and to enhance the quality of care delivered within the finite resources available.

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**Continual Professional Development**

Employers will seek to enhance their workforce through maximising opportunities for skills acquisition and enhancement through professional development. This appears particularly pressing, given that an estimated 60% of the workforce that will work in the sector in 2018 are already working in the sector today.

There will be opportunities for employees across the sector to acquire skills within their current role as well as skills that traditionally fall outside of their professional boundaries. It is most likely that this will be facilitated through re-targeting the resources available to support Continuing Professional Development (CPD). The exact number of employees that could benefit from this form of CPD rather than the more ‘traditional’ form of CPD over the next five years cannot be estimated with any accuracy at this stage however the potential to improve skills utilisation across the sector is great.

**8.14 The ongoing impact of ICT on roles and skills within the health sector**

As mentioned in Chapter 8, What Drives Skills Demand?, the developments of information technology, bio-tech and pharmaceuticals are highlighted as significant drivers for change in the health sector. Their importance has grown given the recent emphasis on achieving greater efficiencies.

There is huge potential for ICT to reshape the way that services are delivered across the health sector. All roles, wherever they are based will over the next ten years be affected by the ongoing saturation of the health sector by ICT. The effect of the ongoing impact of ICT includes:

- Many roles will have to understand how to operate basic ICT systems in order to do their jobs. This implies increased levels in many of the related ‘functional’ and key skills.
- Data handling skills with respect to Issues of confidentiality and security will grow in importance. There is likely to be debate within the sector about what roles should be using and processing patient information.
- A range of potential developments for health professionals and clinicians. With ICT developments bringing remote diagnostics or even surgery within ever closer 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.
The development of ‘navigator’ skills and roles in the health sector

The expansion of information technologies will provide new opportunities for health professionals through support of clinical decision making. Healthcare professionals will increasingly need to be skilled ‘knowledge managers and navigators’. They will also need to support patients in this navigation of service-related information technology.

The Rehearsing Uncertain Futures work highlighted the Personal Health Navigator role which may be of interest to employers in the future. Part advocate, part information organiser and broker, the participants described a care co-ordinator role. The role could act as an enabler assisting clients, especially vulnerable people, to navigate their way through the increasingly joined up systems of health, social care, education and housing.

Enhanced Collaboration with Bio-technology and Pharmaceutical Industries

The health sector, with its vast knowledge base, is in a unique position to collaborate with global bio-technology and pharmaceutical companies in the development of future generations of medical treatments. This is particularly important, as innovations will become more incremental and will require ongoing feedback beyond their initial development. Current government policy is seeking to encourage greater collaborative working between the ‘upstream’ sectors of pharmaceuticals/bio-tech and the ‘downstream’ user sector of health.

It will be critical to put the right skills in place to enable the health sector to relate better to these sectors.
8.15 Developing Capacity and Capability of the Volunteer Workforce

The provision of healthcare is not confined to ‘conventional outlets’ such as hospitals and clinics. There are a range of alternative forms of provision which are increasing in popularity amongst policy makers and employers. There is currently a wide range of health related services provided in the voluntary sector.

In order to develop the capacity and capability of the local community to deliver health services there are a wide range of policy responses available to organisations. Empowering individuals, through volunteering and social enterprise, to shape and develop their local health services will continue to grow in emphasis.

Whilst many of those involved in this ‘non-conventional’ form of delivery may have a healthcare or related background there are significant implications for skills development in respect of the successful implementation and management of volunteers and volunteer programmes.

The volunteer workforce

There are an estimated 300,000 people volunteering in the NHS in England, however, estimating the number of volunteers in the voluntary and community health sectors outside the NHS continue to be problematic.

Recent research commissioned by Skills for Health highlighted a wide range of roles undertaken by volunteers across the sector, over 110 have been identified. The research attempts to categorise these roles into those that are wholly unskilled, require everyday skills, require modest training, and require specialist training. Some roles require very high levels of interpersonal skills and personal attributes (such as befriending in palliative care settings).

Volunteering can provide significant opportunities to break the circle of joblessness, poverty and ill-health in some of the most deprived sections of the community. It could promote greater social and ethnic diversity as well as promoting social inclusion and capacity building in local communities.

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58 There are an estimated 9,000 health and social care volunteers in voluntary and community organisations in Northern Ireland. Skills for Health (Unpublished) The Hidden Workforce, The role of health and social care volunteers in Northern Ireland.
For the full potential of the volunteer workforce to be realised, there will need to be access to training and support for skills development of people in these roles across the sector. This is also particularly important as volunteering can act as a stepping stone into paid employment within the sector. Investment in the skills of volunteers can therefore have wider benefits in improving employability and soft skills of the labour market.

The management of volunteers

Recent research identified how the management of volunteers is a particular skills need for organisations across the sector. This is particularly important when existing services are being refocused and volunteers are being asked to change working practices.

The management of volunteers has many of the facets of managing paid employees, but with the added complexity of managing the volunteer’s often very personal motivations. Formal qualifications are available for those responsible for managing volunteers across all countries of the UK. Greater use of these qualifications and dedicated volunteer managers may be one area of growth for the sector over the short term.

Mainstreaming volunteer programmes

Another particular business-related challenge for the community and voluntary sector is in the mainstreaming of successful volunteer programmes beyond the initial project stage when initial funding has ended. This is of particular importance in the current economic conditions.\textsuperscript{60} The skills that may be required by individuals include evaluation and influencing skills.

Informal & Unpaid Carers

Carers provide unpaid care and support to ill, frail or disabled friends or family members\textsuperscript{61}. There are vast numbers of carers across the UK, estimated to save the government billions of pounds in NHS treatment.

There is perhaps a more proactive role for the sector to play in respect of supporting carers. By making a relatively small investment in the skills of the unpaid carers the sector could ensure that high quality care at home is delivered and sustained. This investment could save the sector significant sums in respect of avoiding acute periods of ill health and thereby avoiding hospital admissions. These individuals are very likely to require tailored skill sets delivered in a suitable individualised context.


\textsuperscript{61}Carer’s UK (2009) Who are Carers? http://www.carersuk.org/Aboutus/Whoarecarers
Self-Managed Care

There is a growing body of evidence to suggest that supporting people to self-manage can improve outcomes for service users as well as contributing to capacity across the sector. This support can be enabled through the existing workforce but also through better use of self-diagnostic and other supportive technology.

There are two important dimensions to self-managed care. Firstly, supporting people to self manage will require a shift in the skills, attitudes and behaviours of the workforce itself. Skills for Health working with Skills for Care has already undertaken steps to identify this shift through our programme of work on the ‘Common Core Principles to support Self Care’.

Secondly, service users and their carers will need to be supported to develop the necessary skills. Some support for this already exists through programmes such as the ‘Expert Patient Programme’ in England and Wales. There is also potential in the future, through the piloting of personal health budgets in England, for service users to become employers in their own right. This will result in the need for these people to be equipped with appropriate knowledge and skills.

The Rehearsing Uncertain Futures work highlighted how technology could continue to enhance more effective self care and assist those with long term conditions to avoid hospital admissions. The scenario workshops highlighted the ‘remote diagnostic technician’ role as one of interest to employers in future. The role would involve monitoring banks of telemetry and is based upon the concept of a new system that sees homes and individuals connected to a central monitoring system. Such a role could also be responsible for allocating visits by district nurses on the basis of the outputs of the monitoring.

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64 For England See http://www.expertpatients.co.uk/. For Wales see http://www.expwpwales.org/
Developing management and leadership

It is a staple of media reporting to decry the level and competence of management and leadership in the UK’s health sector particularly in the NHS. Reforming governments appear to be frustrated with the pace of change in the NHS in all nations. Poor management and leadership are often cited as slowing the pace of reform.

However, according to recent employer skills surveys in England skills gaps in relation to management are no greater in the health sector than those in other sectors of the economy. Around 28% of organisations with skills gaps across the sector in England. This particular survey is conducted with managers and senior officials who have a particular responsibility for issues around skills and employment. It is therefore possible that these may not understand the detail of the issue particularly amongst those dealing with delivery at a local level. It is therefore feasible that the extent to which management and leadership is a skills issue might be underestimated.

Graeme Martin writing in a recent Skills for Health commentary highlights several indicators unique to the NHS that signal improvements in management and leadership practice are required. These include;

- A large-scale survey of 9000 staff in the NHS in England (IPSOS/Mori, 2008) provides some evidence to suggest that staff within the NHS experience a lack of effective management. It reported low agreement with the statements ‘I understand my role and where it fits in’, ‘I feel fairly treated with pay, benefits and staff facilities’ and ‘senior managers are involved with our work’. The research concluded that staff did not feel they helped to provide high quality patient care to any significant extent, and that these last three factors were important causes of this problem.

In October 2009 the Care Quality Commission surveyed almost 290,000 employees in England, asking for their views of working in the NHS (fifty-five percent responded). The survey concluded:

- over 90% of NHS employees reported working in teams but only 40% reported their teams to be effective
- only 45% of all staff felt that healthcare professionals and managers worked well together; only a quarter of staff felt their managers involved them in important decisions and only a third felt that managers involved staff in important decisions
- on organisational engagement with their Trusts, only a third of staff were satisfied with the extent to which their Trust valued their work, half believed their Trust communicated aims clearly, and only 44% felt their Trusts were committed to helping staff achieve work-life balance.

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65 Skills for Health (2009), Skills for Health (2009), Health Care Providers and Skills Development, Relevant Findings from the 2007 National Employer Skills Survey for England and The Alliance of Sector Skills Councils (currently unpublished), Health Scottish Sector profile 2008
66 Martin Greame (2009) Do we need a leadership 2.0 in health care? Tomorrows workforce, commentaries on the future of skills and employment in the UKs health sector
67 For full results please see http://www.cqc.org.uk/aboutcqc/howwedoit/engagingwithproviders/nhsstaffsurveys/staffsurvey2009.cfm
Management and leadership in a complex environment

The development of management and leadership are intimately linked with the nature of the health service in the UK, particularly the role of the NHS which is a major contributor to health care provision as well as the skills for those involved. The NHS itself is a highly complex system with many conflicting demands.

This complexity is iterated in a recent study by the NHS confederation, who highlight the comment of a chief executive who arrived from the private sector:

“...rather than being given the scope to help lead the reform of the NHS, chief executives were treated as little more than conduits for the policies of the centre. The interviews illustrate how undermined and demoralized many of them came to feel.”

This complexity in the environment often makes leaders in the health sector dealing with an increasing range of intractable problems which Kellerman refers to as ‘wicked’.

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Improving performance through better employee engagement and ‘distributed’ leadership

There are a range of systemic issues that make the issue of management and leadership in much of the NHS more challenging. However, the NHS remains a valued part of the UK’s infrastructure. In addition, when international comparisons are made, the NHS continues to be relatively cost effective. It is also clear that in most comparable societies, political concerns are a feature and challenge of management and leadership.

This has led many commentators to explore the potential benefits of improving employee engagement. This more holistic approach, taking into account engagement, may unlock the potential for higher quality management and leadership in the sector.

Many commentators have sought to formulate how better engagement with all levels of employees combined with authentic messages about the limitations of what they are seeking to achieve are valuable and can help employee understand the pressures and circumstances that managers and leaders are attempting to work within.

These last points resonate with a model widely proposed in the public sector. Kellerman\textsuperscript{71} has described a staff typology he refers to as ‘responsible followership’, based on level of engagement.

These typologies are:

- **Isolates** – Isolates are completely detached, scarcely aware of what is going on around them and do not care about leaders or respond to them. However, by being passive they provide tacit support to status quo
- **Bystanders** - Bystanders disengage from the organization, watching from the sidelines almost as an observer. They go along passively but they offer little active support
- **Participants** - Participants care about the organization and try to make an impact. If they agree with the leader they will support them. If they disagree, they will oppose them.
- **Activists** - Activists feel more strongly about their organizations and leaders and act accordingly. When supportive, they are eager, energetic, and engaged.
- **Diehards** - Diehards are passionate about an idea a person or both and will give all for them. When they consider something worthy, they becomes dedicated.

\textsuperscript{71} Kellerman ibid.
According to this model, the most desirable category of followership are the Activists and therefore the challenge of leadership will be to instil this form of followership in their employees reinforced by high quality and ‘authentic’ engagement. The challenge for the sector is in part therefore to develop strategies that engender followership through authentic leadership.

**The arrival of ‘new’ entrepreneurship**

Recent government intentions have been to enable consortia of general practitioners a greater role in the commissioning of health care. The hope is for these arrangements to bring a new sense of entrepreneurship into healthcare provision. It is also hoped that the changes will enable healthcare provision to be connected more closely with the local communities.

Management and leadership will continue to be key issues confronting the sector in light of radical proposals by government and the ongoing increase in debate around delivering better quality healthcare using increasingly limited resources. Those leading within the NHS will need to become more accustomed to a new plurality of healthcare providers with a diverse range of backgrounds.

**Management and leadership in the Independent Sector**

Overall, there is less debate around the quality of management and leadership in the independent/private sector than in the NHS. General surveys on management suggest again that on the whole, skills deficits in management are no greater than the rest of the economy.

Skills for Health will be undertaking further research assessing the skills issues within the independent sector during 2010/2011, and will explore management and leadership as a key theme.

**Business development skills for small and medium sized enterprises**

The role of smaller enterprises in providing health care has grown throughout the UK over the past decade. Available intelligence indicates a high degree of confidence amongst smaller providers in their health provision competences.

There are indications that SME’s in the private sector indicate that they would like appropriate support for business related activities, such as marketing or business development.

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72 National Employer Skill Surveys in England, Scotland, Northern Ireland and Wales.
73 Skills for Health (forthcoming) An exploration of Skills Needs with SME Independent Providers of Health Care in Scotland
Supporting Workforce Development Strategies

The NHS across the UK operates as a planned workforce economy. As a result, workforce planners will need to place the reform of the healthcare system at the centre of their deliberations. They will also need to work closely with those who commission services and to link the design of the workforce to patient pathways.

In order to ensure that any programmes of workforce transformation or skills change undertaken by employers across the sector are coherent with each other, it will be necessary for all employers to develop clear Workforce Development Strategies. These strategies may be focused externally as well as internally.

Internally focused strategies cannot be restricted to merely addressing the suggested workforce development programmes themselves. To illustrate this point, the development of significant numbers of Assistant Practitioners is dependent on having sufficient applicants from people occupying posts, such as Healthcare Assistants, who are already developed up to S/NVQ Level 3 or equivalent.

Evidence currently available from a variety of studies suggests that there would be a need for significant development of large numbers of people to S/NVQ Level 3 or equivalent. This would have to begin with functional skills such as literacy and numeracy. Recruitment strategies would need to attract more people into pre-employment and 'starter jobs' that are ready, willing and able to be developed, to the point where they are then employable as Trainee Assistant Practitioners.

In addition to internal strategies, many employers may also look externally to neighbouring organisations to ensure that there is coherence in workforce development strategies across a local geographic area. This may be necessary in order to ensure that any significant shifts in the models of health service delivery and the structure of the workforce do not destabilise the utilisation of existing skills or adversely impact upon the capacity of organisations to continue to support education and training activities in the future.

Concluding Remarks

This chapter has outlined the priority areas relating to skills development that employers in the health sector are likely to be already focusing on, or will be focused on in the near future, before 2020. These areas were informed by the application sessions of the Rehearsing Uncertain Futures initiative and refined by subsequent research and analysis. They provide an indication of where resources will be invested by employers in order to develop a more productive, flexible workforce and to continue to improve the quality of health care in the UK.

In summary, the roles of assistant practitioner and advanced practitioner are gaining currency within the sector. The introduction of these roles will help those in specialist professional occupations to focus more on their specific areas of expertise, driving high quality outcomes and greater efficiencies in the system.
There will be little overall growth in levels of employment in the health sector in the near future. Hence, employers will need to focus on effectively utilising and developing the skills of their existing employees. They will need to create teams with the right skill mix to deliver high quality health care. It is likely that the ‘soft skills’ of team working, communication skills and problem solving (already identified as current skills needs) will become even more pressing for the sector in the future.

Information Technology will provide a range of opportunities for the sector to greatly enhance its productivity through improved information exchange, management and access. Staff will need to develop the appropriate skills to ensure that new technology is accepted and utilised effectively.

Another key area for skills development will be the management of the volunteer workforce. Specific skills will need to be developed to ensure that this unpaid workforce is managed effectively, and that successful volunteer programmes are mainstreamed smoothly.

The health sector will also play an increasingly important role in supporting informal and unpaid carers in the community, to help reduce admission to acute care and increase service capacity.

There will be a stronger focus in the sector on helping patients to better manage their own health and illness. This will require a new set of skills to enable staff to empower and educate patients to monitor their own symptoms and take more responsibility for the treatment of their own illness.

A high level of management and leadership skills will be required in order to facilitate the anticipated changes required by health care employers. Given the emphasis being placed on working more flexibly and productively, an important facet of the management skill set will be around employee engagement.

Next, Chapter 9, Beyond 2020: Opportunities for Skills Development, looks at the outcomes from the next stage of Rehearsing Uncertain Futures – the horizon scanning stage – which identified potential opportunities for skill development beyond 2020.
9 Beyond 2020: Opportunities for Skills Development

Key Features

Skills for Health’s scenario-planning and horizon-scanning activities have highlighted a range of longer-term developments which may impact upon the skills and workforce development issues of the workforce beyond 2020. These include:

- Developments in exploiting the human genome and genetics.
- Innovation in diagnostics and treatments.
- Innovations in robotics and supporting technologies.

9.1 Introduction

So far, this assessment has outlined the current skills needs within the health sector, the drivers toward future skills demand, and the current and near-future skills priorities for the health sector.

This chapter provides a more long-term look at factors that are likely to drive opportunities for employers to develop their workforce beyond the year 2020. These factors emerged from the horizon scanning element of Skills for Health’s Rehearsing Uncertain Futures initiative and the use of our horizon-scanning technology. The emerging themes that appear of significance to the sector include:

- The human genome and genetics.
- Innovation in diagnostics and treatment.
- Innovation in robotics and technology.

This chapter is also intended to provide a high-level overview of the factors that are likely to drive opportunities for skills development beyond 2020, rather than an exhaustive mapping of all potential future opportunities. Examples are provided of some long-term developments that are likely to impact on skills demand and shape the workforce. These examples give an indication to employers of the possible ways the health sector could be shaped in the long term and of how the workforce will need to develop to support these changes.
9.2 The human genome and genetics

While the human genome has been mapped, our understanding of the building block of human life is still developing. The identification of genes thought to cause life-limiting conditions is continuing to evolve. What is clear is that at some point in the future, there will come a time when we can manipulate a variety of genes to eradicate common, yet devastating, life-limiting genetic conditions such as cystic fibrosis.

The technology needed for progressing gene therapy is rapidly advancing and gene therapy has the potential to radically transform the skills needs of the sector, from reliance upon skills to assist patients in managing and treating their conditions, to the development of skills relating to the correction of ‘defective’ genes in order to prevent serious illness and life-limiting conditions.

The progression of gene therapy across the world has been slowed by fears of safety and the need to understand the long-term effects of changing the genes of individuals. Recent successes have been reported in respect of treating inherited blood disorders. However, long-term evaluation is needed in order to assess and understand any long-term side effects of the treatment.

9.3 Innovation in diagnostics and treatment

The technology for faster and more accurate diagnosis and more effective treatment is constantly evolving. Together with this evolution consumer expectations are also rapidly changing, with an increased expectation of ‘no waiting’ and immediate feedback from tests. Currently this is not always possible, with some specialist testing taking weeks or even months to report.

Recent developments in diagnostic testing include the development of a one-hour TB test (versus the current 8-week timescale). The potential benefit here is that such swift diagnosis will mean quicker treatment and a significant reduction in the risk of passing infection on to others.

New forms of diagnostic testing are also being developed with the potential for new techniques to replace traditional techniques such as x-rays. One such new technique is Raman Spectroscopy, which measures the intensity and wavelength of light from molecules to identify diseased tissue. The technique has the potential to identify bone disease, high cholesterol, cancer and even early tooth decay, giving results within a few seconds. It also has the potential to identify the difference between benign or malignant tumours, perhaps avoiding the need for biopsy procedures for many individuals in the future.
The growth of ‘home testing’ and ‘home monitoring’ over recent years will no doubt continue over the foreseeable future. The next set of large-scale developments in these areas are already being trialled and include:

- Pills fitted with microchips that send a signal to another microchip implanted in the patient’s shoulder when they are taken. If the patient misses a dose the microchip will send a text message to the patient’s mobile phone. The additional cost of this technology is as low as one penny per pill; however, the health and financial benefits of greater compliance from patients in managing their conditions and avoiding acute illness and hospital admissions could be great.

- The use of an insulin pump to treat diabetes which provides a constant low dose of insulin to the diabetic rather than regular injections. This means that blood sugar levels can be better controlled and the pump will adjust the levels of insulin administered in line with when the patient eats, thereby mimicking the natural insulin response in non-diabetics. Pumps are currently only used by around 2% of diabetics in the UK but the finer control that they provide over regulating blood sugar levels means that wider use could reduce the large number of diabetes-related complications such as heart attacks, strokes and amputations in the UK.

Developments such as those outlined in this section will not necessarily have a big impact on the types of skills utilised across the sector, they will, however, improve patient outcomes, aid productivity and help to reduce or control demand across the sector.

9.4 Innovation in robotics and technology

The use of Robotics within surgical procedures has been widespread for many years across the health sector. It is likely, however, that such technology will continue to develop in order to make surgery less invasive for patients and therefore improving patient experience and recovery times.

In more recent times robots have been used in new and emerging ways in order to improve efficiency and quality within hospitals. These emerging uses include:

- Robots used in Forth Valley Royal Hospital Scotland to assist in ‘domestic duties’ - collecting dirty laundry and delivering clean laundry. The robots have their own designated ‘clean’ or ‘dirty’ duties. This has the potential to dramatically reduce cross contamination and infection across the hospital.

- Robots used in pharmacy settings in Forth Valley Royal Hospital and Swindon to improve the dispensing and stock control of drugs within the hospital.
An Emerging Example:

Managers at the Forth Valley Royal hospital estimate that a £400,000 automated pharmacy has saved £700,000 off the hospital's drug bill. Efficiencies experienced include:

- More effective use of staff time on wards.
- Reduction in dispensing errors.
- A paperless system allowing real time feedback concerning what stage each prescription is at.
- Reduction in the amount of stock having to be held by the hospital.

Looking towards the future, it is evident that this is an area attracting interest globally. Toyota has invested and created ‘Partner Robots’ which are aimed at supporting people’s everyday life. They see a major role for these very agile robots in both domestic duties and nursing and healthcare in the next ten years.

Further developments within the wider technology field, including increased ways that we can connect with workplaces and the reliability of these connections mean that there may be a time when a surgeon does not have to physically be in the same hospital as the surgical robot to control it. This can be done remotely with the support of the usual on-site wider operating theatre teams.

Finally, there has been some recent success in robots performing procedures on ‘tissue’ without the control of a surgeon. The robots are programmed to ‘see’ using ultrasound technology. Their use on biopsy tissue in trials has so far achieved a 95% success rate. It could therefore be envisaged that, if the technology can be further refined, very routine operations could be performed by such robots sometime over the next twenty to thirty years.

All of these developments have significant cost implications for the sector in respect of investing in new technology when it becomes available, however, given the current reliance of the sector on human capital the potential to supplement the workforce with robotic technology to improve the patient experience, increase productivity and drive up quality is great.

If the sector looks to adopt and implement such radical robotics technology there could be significant implications on the skills needs of the workforce that would need to be planned and managed. Some sections of the workforce will require additional training and development in order to fully utilise the technology available, whilst other skills that they are currently utilising may no longer be required.

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74 Hospital robots cut hospital pharmacy bill. BBC News http://www.bbc.co.uk/news/uk-scotland-tayside-central-11552610
9.5 Concluding remarks

As can be seen from this chapter, early signs exist today of factors that are likely to shape the health sector and its workforce in the long term, beyond the year 2020. A look at these factors and at how they might play out in the future indicates that there are opportunities for employers to avail of developments in science and technology to improve health services. Taking advantage of opportunities will have a direct impact on the workforce in terms of the development of relevant roles and skills.

Summary of opportunities for skills development beyond 2020

Developments in gene therapy may lead to a shift in balance from the treatment of illness to greater prevention of long-term conditions. This will have a significant impact on the skills required in the health workforce.

Innovation in diagnostics and treatment should result in faster clinical diagnoses and may empower patients to self-diagnose. The outcome of this will be improved patient outcomes and increased workforce capacity. There will be direct skills implications for employers, in that new skills will be required to implement and/or administer new methods of diagnoses and treatment.

Innovation in robotics and technology will lead to less invasive surgery, as well as the automatic completion of routine tasks. Again, these developments should improve patient outcomes and experience of health services, and should provide professionals with more capacity to carry out more expert, less routine tasks. They will require the development of skills around the use and maintenance of robotics and other advanced technologies in the workplace.

The key drivers behind the adoption of new technologies and scientific processes are likely to be the improvement of the quality of health services, as well as the achievement of efficiency savings. Employers may also identify new technologies that can help specifically to address existing skills gaps and skills shortages.

Furthermore, the introduction of new techniques and technologies could enable the sharing of skills across country borders and the creation of international centres of excellence. In this way, technology could help to create a truly global health sector in respect of skills. Within the UK, the sharing of best practice and learning around the adoption of new technologies could enable significant efficiencies to be realised across the sector.

The sector presents opportunities for smaller technology solution providers, as the appetite for NHS-wide solutions has waned due to previous high-profile difficulties in implementing ‘one size fits all’ solutions across a diverse range of employers.
Potential challenges associated with these opportunities

The focus on improved productivity and quality will undoubtedly force employers across the sector to take a long-term view of the way in which technologies are adopted and implemented. However, a challenge for the sector will be around whether organisations will be willing to risk large investments in cutting-edge technologies for the sake of potential long-term benefit during times of economic uncertainty.

In addition, employers will need to recognise the way in which rapidly advancing technology can impact upon the skills needs of the workforce and plan training interventions in such a way as to enable the new technology to seamlessly transform quality and productivity across the sector.

Lastly, sharing best practice between employers regarding technological developments may be easier within Scotland, Northern Ireland, and Wales, where a more collaborative and partnership approach to operating health systems is seen. The greater emphasis on an ‘internal market’ within England and encouragement of competition between providers may present a barrier toward shared learning.
10 Helping the sector meet current and future skills and employment challenges

Key features

The areas of current and future skills and employment priorities facing health sector employers and Skills for Health include:

- Achieving better for less.
- Reducing the sector’s reliance on non-EU migration.
- Continuing focus on employability and functional skills.
- Continued development of new roles at NHS Career Framework levels 3 and 4.
- The development of roles at NHS Career Framework Level 7.
- Dealing with the impact of ICT on roles and skills within the health sector.
- The development of management and leadership, and high-quality engagement strategies.
- Skills development in small- and medium-sized healthcare providers.
- Enhancing workforce-planning capability.
- The challenge of local intelligence.
- Information and guidance for all ages.
- Health skills for non-health specialists, including the community, family and friends.
- Skills to enable greater ‘Self-Care’.
- Qualifications and framework development.
- Developments in far-future diagnostics, treatment and technology.

10.1 Introduction

This Sector Skills Assessment has contributed to the identification of a range of current and future skills and employment priority areas for employers in the sector, across Wales and the UK, to address.

These areas, summarised in this chapter, will inform Skills for Health’s own priorities for action and solutions for the sector. They will also enable us to report skills issues to the government to help shape the Government’s response to skills needs in the sector.
10.2 Overarching priority – achieving better for less

The most immediate concern across the UK health sector is, and will continue to be, the unremitting search for finding better ways of delivering services which cost less and surpass previous performance.

With over 70% of expenditure being accounted for by employment costs, the need to develop high-quality teams and equip the workforce with the right skills will be a central concern for healthcare employers.

Skills for Health highlights a range of best practice and support in this field to enable employers to make the necessary changes required to working practices. This will continue to be developed and updated to maintain high-quality advice and guidance to those seeking to make transformations to their services. Skills for Health’s experience includes:

- Development of transferable models.
- Transforming Community Services.
- Modernising Scientific Careers.
- The development of National Transferable Roles.
- Whole organisation redesign processes.
- The development and use of web based tools and support.
- Patient pathways/workforce reengineering.

10.3 Addressing skills gaps and shortages

The health sector performs relatively well in comparison to the whole economy in terms of skills and qualifications. Employers in the UK’s health sector are faced with a variety of skills gaps and shortages, and will continue to be faced with these in the near future.

A central component of the Skills for Health’s Sector Skills Agreement is the development of a more flexible workforce, using competences as a key vehicle toward achieving this. Coupled with the impact of the current economic environment, this focus has placed the need for a more affordable, flexible workforce at the heart of this assessment.

Skills for Health envisages a growing role for competence-based job design in achieving a more flexible workforce. This approach will also allow employers to examine their current skills gaps and work towards more effective skills utilisation of the existing workforce.

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75 Available at http://www.skillsforhealth.org.uk/~/media/Resource-Library/PDF/Caseforchange-Final.ashx
10.4 Reducing dependence on non-EU migration

Historically there has been reliance across the sector on international recruitment in order to fill skills-shortage vacancies and to create additional capacity within the sector. The need for this was created by the increased investment across the sector and the time lag for professionals to complete training.

More recently this heavy reliance on international recruitment has subsided, however, there are currently 35 occupations within the healthcare sector that are on the MAC Skilled Shortage and Sensible list. Whilst there is consultation on the future development of this list, particularly under current policy around establishing a cap on immigration, this is an important indicator of the scale of dependency that the sector has on migration to fulfil its demand for employment and skills needs.

Important developments may impact upon the sector's ability to source skills internationally in the future. These include:

- The proposed cap on migration. This cap seeks to reduce significantly the people arriving into the UK under tier 1 and 2 during the course of the current parliament.
- The longer-term development of the UK in relation to the world’s leading economies does not mean that it will necessarily be a destination of choice for many foreign workers in the future.

Reducing this dependency further will result in the need to 'up-skill' and 're-skill' individuals, where necessary, to fill roles. However, there are a wide range of possibilities to re-think teams and team working through conducting workforce redesign, allowing the sector to deliver better services using new mixes of skills and people.

In addition, further in the future beyond 2020, technological innovations will enable countries to develop centres of excellence that can be exported to other countries throughout the world. An immigration system that allows the right expertise to develop this capacity will be essential.

Skills for Health will continue to monitor the signals for such developments in the sector. The sector will need to start now to rehearse and develop how it wishes to compete in the future global health market through developing areas of expertise to offer services and attract the talent it needs to do so. This will need to be developed in tandem with future immigration policy.
10.5 Continuing focus on employability and functional skills

There are broad indications that the development of employability and functional skills will continue to be a priority for the sector. In simple terms, many of those in routine jobs are currently less likely to receive opportunities to develop their skills.

High-quality provision of these skills in the sector will assist in the supply of appropriate candidates for those seeking to become Assistant Practitioners if they wish. At the same time, developing these skills will enable all those in the sector to enhance their jobs wherever their ambitions might be.

These are exciting developments comprising new areas of intelligence that will feed into our future understanding of the extent of demand for these skills in the sector, and how they are being applied in practice. To support this, Skills for Health has developed a Literacy and Numeracy Initial Assessment Tool, allowing individuals to assess their current level of literacy and numeracy, identify areas for development, and plan their future learning. Taken alongside the development of the Skills Passport, the tool has the potential to provide a closer view of how these skills are being developed across the sector.

10.6 Continued development of new roles at NHS Careers Framework levels 3 and 4

Our analysis indicates a growing demand amongst employers for a range of Assistant Practitioner roles. These flexible roles, often considered to be working at around band 4, offer a range of opportunities for re-configuration of teams. There is already substantial evidence that such roles are already being developed within the health sector throughout the UK.

Skills for Health’s own ‘National Transferable Roles’ initiative offers a framework that health employers can use to develop a wide range of roles. It also acts as a potential reservoir of best practice that can be referred to by employers.

The sector will need to continue to refine how Assistant Practitioner roles are developed, putting patient safety and flexible working at the heart of this development.

10.7 The development of roles at NHS Career Framework Level 7

Skills for Health has gathered substantial anecdotal evidence that indicates that Advanced Practitioner roles will continue to have relevance in the health sector. At present, it is reasonable to assume that employers will wish to continue the development of these types of roles. Skills for Health will continue to monitor the progress of this development to assist in the development of best practice.

10.8 Dealing with the impact of ICT on roles and skills within the health sector

There is huge potential for ICT to reshape the way that services are delivered across the health sector. All roles, wherever they are based, will over the next ten years be affected by the ongoing impact of ICT on the health sector.

The effect of ICT includes:

- Many roles will have to understand how to operate basic ICT systems in order to do their jobs. This implies increased levels in many of the related ‘functional’ and key skills.
- Data-handling skills with respect to issues of confidentiality and security will grow in importance. There is likely to be debate within the sector about which roles should be using and processing patient information.
- A range of potential developments for health professionals and clinicians. With ICT developments bringing remote diagnostics, or even surgery, within ever closer 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.
10.9 The development of management and leadership, and high-quality engagement strategies

There is a widespread perception that the sector suffers from low levels of skills in management and leadership. Our analysis supports this, indicating a range of systemic factors that can make it difficult to deliver high-quality management and leadership in the health sector, particularly in the context of the NHS. This can also explain the inconclusive impact of a considerable range of high-performing working practices pursued by employers in the sector.

Whilst management and leadership education remains a core skills development need, the sector will also need to explore how it can address the issue of improving engagement with staff to enable the step change required.

The challenge of high-quality management and leadership will be an ongoing feature of the health sector skills development landscape, increasing further as new initiatives are fed into the sector.

10.10 Skills development in small- and medium-sized healthcare providers

The role of smaller private enterprises in providing healthcare has grown throughout the UK in recent years. Early research suggests that employers in this part of the sector are confident about their ability to deliver particular health interventions. Many staff have studied to at least a degree level, will have continual professional development provided by their professional body and in recent times have been regulated to a greater degree.

A recurring area of skills development for the small, private enterprises relates to business-related skills. Owners of these organisations have a strong desire to improve and drive forward their business, but it appears that, for a significant number, this desire is not supported by learning opportunities that are easily accessible and tailored to their needs.

10.11 Enhancing workforce planning capability

The sector has further developed its workforce-planning capability, drawing on Skills for Health’s support. However, more is required in the ever-increasing complexity of the sector and the pace of change demanded by policy makers. The sector will need to continue, therefore, to develop its expertise.

Skills for Health will build on its track record of providing capability-building exercises in this area. It will continue to offer this important service to employers.
10.12 The challenge of local intelligence

The assessment has also demonstrated how employers and providers will be placing more emphasis on the local needs of the population. There is a strong need for a greater degree of localised intelligence to support the development of local service solutions. Skills for Health will provide guidance to employers wishing to explore this area further and it has already begun to extend its intelligence activities to encompass intelligence that takes account of local needs.

10.13 Careers Information and Guidance for all ages

The demand for high-quality, dispassionate information, advice and guidance will only grow as the sector undergoes a series of reforms over the next 5 to 10 years. Those starting their careers will need advice on occupations within the sector. Those within the sector already will require information about future opportunities in the health sector and in related sectors.

10.14 Health skills for non-health specialists – community, friends and relatives

The delivery of healthcare away from traditional outlets into the community has been called for by the Government for some time, and is linked to achieving greater local responsiveness and choice as well as to helping deal with increasing demand for provision. This drive has been given further impetus by the coalition Government’s desire to create a larger role for communities through its ‘big society’ initiatives.

10.15 Skills to enable greater ‘Self-Care’

Self-care skills are also a growing area of development and the health sector will need to ensure individuals are coached, mentored and provided with accessible information to enable them to provide care for themselves.

10.16 Qualifications and framework development

The attainment of qualifications is one important indicator of skills levels in the sector. As a result, there remains a strong requirement for the ongoing development of qualifications and educational frameworks.

As the SSC for health across the four UK countries, we are responsible for working with employers and Awarding Organisations to develop health-related, competence-based qualifications for health occupations for the Qualifications and Credit Framework (QCF) and Scottish Vocational Qualifications (SVQ).
10.17 Beyond 2020

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 opportunities may change the skills needs of the health sector further into the future, and are offered here for consideration. Skills for Health will undertake monitoring of these and other trends in the sector as they arise, and further details will soon be available on the Skills for Health website. By their speculative nature, these are not intended as definitive opportunities. Instead, they provide a kernel of insight into emerging long-term health sector trends and related skills issues.

The human genome and genetics

Following the mapping of the human genome, scientists are now focusing on how genetic conditions can be prevented. Once the ethical debates have been settled, the long-term promise of genetic therapy will mean a wide range of skills needed to assist in the treatment of conditions and correction of genetic dysfunctions.

Diagnostics and treatment

The technology for faster and more accurate diagnosis and more effective treatment is rapidly evolving. Consumer expectations are also rapidly changing with an increased expectation of immediate feedback from tests. The following are examples of innovation in these areas:

- The one-hour TB test (versus the current 8 week timescale).
- Raman Spectroscopy, which has the potential to identify bone disease, high cholesterol, cancer and even early tooth decay, giving results within a few seconds.
- The growth of ‘home testing’ and ‘home monitoring’ technologies which, if managed correctly, will help to deliver higher quality healthcare within a restrained budget.

These developments will continue to shape the skills of those working within the sector and the teams that they work within. Likely consequences include an increase 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 in the health sector will continue to proliferate in both the near and longer term. There is evidence that they can assist with many of the mundane tasks, such as delivering the post or accurately dispensing drugs, and in some of the more complex areas of surgery. Early signs indicate that the use of robots in these areas is likely to improve outcomes for patients.

All of these developments have significant cost implications for the sector in respect of investing in new technology when it becomes available. As robots become more common the shape of teams that use them, and the skills they require to use them, will develop, as will the market for healthcare and healthcare interventions.
11 Conclusion

The health sector in England and the UK is being transformed by a combination of short- and long-term drivers for change. In the short term, the government is seeking to deal with the UK’s budget deficit in the light of the financial crisis of 2008. In the longer term, the demand for health provision continues to grow as a result of a range of factors including aging populations and ever-increasing expectations. The overriding concern of many within the sector is, therefore, how better healthcare can be delivered for less.

The establishment of the coalition government in 2010 has led to the announcement of a wide range of initiatives in England designed to reform the health sector and which place improved performance and local accountability at their centre. These initiatives are being introduced at some speed, which adds further uncertainty to the already complex situation employers are finding themselves in.

Around 70% of total spend in the health sector is on employment-related issues. It is therefore the largest single area for development. The challenge of continuing to develop skills and achieve the right skills mix within teams throughout the sector has rarely been more important.

There is clearly a need for employers and policy makers to think strategically about how they wish to address the wide range of current and future skills needs identified in this report.

The skills challenges identified in this assessment will be shaped by local and regional contexts, as well as by the policies of the devolved administrations. Specific intelligence is also available for Scotland, Wales and Northern Ireland in a suite of national Labour Market Intelligence and Skills Assessments available on the Skills for Health website www.skillsforhealth.org.uk.

Skills for Health will continue to support employers across the UK health sector to identify, understand and meet the skills challenges facing them in the short-term and long-term. Skills for Health has a track record of providing assistance to employers regarding their service development needs. Examples of such activity can also be found on Skills for Health’s website www.skillsforhealth.org.uk.

Skills for Health is an independent authority on skills and employment issues for the health sector. Our work is ongoing and we welcome the involvement of employers and stakeholders on all aspects of our research work. As part of this ongoing work, Skills for Health will be actively developing the insights contained within these assessment reports throughout 2011 via a series of consultations with employers and sector stakeholders. If you want to get involved or provide feedback please contact us on lmi@skillsforhealth.org.uk.
12 Appendix 1 – SIC Definitions

Standard Industrial Classifications (SIC)

In all technical analysis of the health sector, historic publications from Skills for Health have defined the sector (Skills for Health footprint) as:

85.1 Human Health Activities – comprised of:

- 85.11 – Hospital activities both public sector hospital activities including NHS Trusts (85.11/1), private sector hospital activities (85.11/2) and medical nursing home activities (85.11/3)
- 85.12 – Medical practice activities
- 85.13 – Dental practice activities
- 85.14 – Other human health activities

This definition utilised 2003 Standard Industrial Classification (SIC 2003). In recent years the SIC classifications have been updated in an attempt to better represent the sectors working across the whole economy.

This updating of classifications means that the Skills for Health footprint is now defined as:

86 Human Health Activities – comprises of:

- 86.1 – Hospital activities including Hospital activities (86.10/1) and Medical nursing home activities (86.10/2)
- 86.2 – Medical and dental practice activities including General medical practice activities (86.21), Specialist medical practice activities (86.22) and Dental practice activities (86.23)
- 86.9 – Other human health activities

All secondary data source utilised by the LMI and research team are now available in SIC 2007 however this reclassification has created some notable differences in the baseline data.
Baseline Variations

If we examine data for England, Scotland and Wales from the Annual Business Inquiry\(^7\) 2008 by the Skills for Health Footprint as defined by both SIC 2003 and SIC 2007 there is an overall variation of 185,300 employees.

The table below summarises these variations by each country:

<table>
<thead>
<tr>
<th></th>
<th>SIC 2003 85.1</th>
<th>SIC 2007 86</th>
<th>Variation</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>1,684,000</td>
<td>1,529,700</td>
<td>-154,300</td>
</tr>
<tr>
<td>Scotland</td>
<td>244,400</td>
<td>227,300</td>
<td>-17,100</td>
</tr>
<tr>
<td>Wales</td>
<td>112,800</td>
<td>98,900</td>
<td>-13,900</td>
</tr>
<tr>
<td>Total</td>
<td>2,041,200</td>
<td>1,855,900</td>
<td>-185,300</td>
</tr>
</tbody>
</table>

* Numbers rounded to the nearest hundred

The reasons for these variations were examined in more detail and the following should be noted.

The SIC 2003 classification included Nursing Home Activities (excluding homes for the aged) SIC 85.113 within Hospital Activities. This has always been an area where we have known there to be significant overlap with Skills for Care and Development in respect of responsibility for the workforce. However, it has never been possible to disaggregate this section of the workforce within the data that we hold.

The SIC 2007 classification now splits this sub classification into Medical Nursing Home Activities under the direct supervision of medical doctors (which falls within the Skills for Health footprint) and several other sub-classifications which now clearly fall within the footprint of Skills for Care and Development.

The net result of this split is that it appears that our overall workforce numbers across the health sector have reduced by the numbers as outlined above.

Implications for Research and LMI

The main implication of this change in classification is that it means that medium and longer-term historical comparisons are no longer possible. We are able to take data from 2007 onwards but any comparisons with data prior to this date will require the provision of suitable caveats in respect of the change in classifications and the known variations in data.

\(^{7}\) Northern Ireland data sourced from Census of Employment and released biannually.
## 13 Appendix 2 – Health and Consumer Profiles

### 13.1 Health Profile, England 2010

#### Health ACORN Group Profile

<table>
<thead>
<tr>
<th>Profile</th>
<th>Data as % of England</th>
<th>Data as % for UK</th>
<th>Avg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing Problems</td>
<td>7,011,380</td>
<td>13.5</td>
<td>15.0</td>
</tr>
<tr>
<td>Future Problems</td>
<td>6,231,293</td>
<td>12.0</td>
<td>12.3</td>
</tr>
<tr>
<td>Possible Future Concerns</td>
<td>18,174,048</td>
<td>35.0</td>
<td>34.4</td>
</tr>
<tr>
<td>Healthy</td>
<td>19,987,231</td>
<td>38.5</td>
<td>37.4</td>
</tr>
<tr>
<td>Unclassified</td>
<td>479,950</td>
<td>0.9</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Total Population:</strong></td>
<td><strong>51,883,902</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

#### Health ACORN Type Profile

<table>
<thead>
<tr>
<th>Profile</th>
<th>Data as % of England</th>
<th>Avg</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Older couples, traditional diets, cardiac issues</td>
<td>219,905</td>
<td>0.4</td>
</tr>
<tr>
<td>2 Disadvantaged elderly, poor diet, chronic health</td>
<td>156,922</td>
<td>0.3</td>
</tr>
<tr>
<td>3 Vulnerable disadvantaged, smokers with high levels of obesity</td>
<td>311,720</td>
<td>0.6</td>
</tr>
<tr>
<td>4 Post industrial pensioners with long term illness</td>
<td>862,760</td>
<td>1.7</td>
</tr>
<tr>
<td>5 Deprived neighbourhoods with poor diet, smokers</td>
<td>894,048</td>
<td>1.7</td>
</tr>
<tr>
<td>6 Elderly with associated health issues</td>
<td>1,380,553</td>
<td>2.7</td>
</tr>
<tr>
<td>7 Home owning pensioners, traditional diets</td>
<td>1,148,333</td>
<td>2.2</td>
</tr>
<tr>
<td>8 Disadvantaged neighbourhoods with poor diet &amp; severe health issues</td>
<td>2,037,139</td>
<td>3.9</td>
</tr>
<tr>
<td>9 Poor single parent families with lifestyle related illnesses</td>
<td>391,734</td>
<td>0.8</td>
</tr>
<tr>
<td>10 Multi-ethnic, high smoking, high fast food consumption</td>
<td>985,521</td>
<td>1.9</td>
</tr>
<tr>
<td>11 Urban estates with sedentary lifestyle &amp; low fruit &amp; veg consumption</td>
<td>1,363,583</td>
<td>2.6</td>
</tr>
<tr>
<td>12 Deprived multi-ethnic estates, smokers and overweight</td>
<td>2,065,554</td>
<td>4.0</td>
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<tr>
<td>13 Disadvantaged multi-ethnic younger adults, high levels of smoking</td>
<td>1,424,901</td>
<td>2.7</td>
</tr>
<tr>
<td>14 Less affluent neighbourhoods, high fast food, sedentary lifestyles</td>
<td>2,517,605</td>
<td>4.9</td>
</tr>
<tr>
<td>15 Affluent healthy pensioners dining out</td>
<td>1,949,400</td>
<td>3.8</td>
</tr>
<tr>
<td>16 Home owning older couples, high levels of fat &amp; confectionery</td>
<td>3,864,176</td>
<td>7.4</td>
</tr>
<tr>
<td>17 Affluent professionals, high alcohol consumption, dining out</td>
<td>4,392,290</td>
<td>8.5</td>
</tr>
<tr>
<td>18 Low income families with some smokers</td>
<td>3,245,729</td>
<td>6.3</td>
</tr>
<tr>
<td>19 Affluent families with some dietary concerns</td>
<td>2,204,848</td>
<td>4.2</td>
</tr>
<tr>
<td>20 Young mobile population with good health and diet</td>
<td>2,221,478</td>
<td>4.3</td>
</tr>
<tr>
<td>21 Younger affluent, healthy professionals</td>
<td>2,574,932</td>
<td>5.0</td>
</tr>
<tr>
<td>22 Students and young professionals, living well</td>
<td>1,012,032</td>
<td>2.0</td>
</tr>
<tr>
<td>23 Towns and villages with average health and diet</td>
<td>4,218,155</td>
<td>8.1</td>
</tr>
<tr>
<td>24 Mixed communities with better than average health</td>
<td>4,030,570</td>
<td>7.8</td>
</tr>
<tr>
<td>25 Affluent towns and villages with excellent health and diet</td>
<td>5,930,064</td>
<td>11.4</td>
</tr>
<tr>
<td>Unclassified</td>
<td>479,950</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Total Population:</strong></td>
<td><strong>51,883,902</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Source: CACI 2010
### 13.2 Consumer Profile, England 2010

#### ACORN Category Profile

<table>
<thead>
<tr>
<th>Profile</th>
<th>UK</th>
<th>Data as % of England</th>
<th>Data as % for UK</th>
<th>Index Avg = 100</th>
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<tbody>
<tr>
<td>Wealthy Achievers</td>
<td>12,736,929</td>
<td>24.5</td>
<td>25.3</td>
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<tr>
<td>Urban Prosperity</td>
<td>6,313,985</td>
<td>12.2</td>
<td>11.8</td>
<td><strong>103</strong></td>
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<tr>
<td>Comfortably Off</td>
<td>14,924,793</td>
<td>28.8</td>
<td>27.3</td>
<td><strong>105</strong></td>
</tr>
<tr>
<td>Moderate Means</td>
<td>7,357,750</td>
<td>14.2</td>
<td>13.9</td>
<td><strong>102</strong></td>
</tr>
<tr>
<td>Hard Pressed</td>
<td>10,082,575</td>
<td>19.4</td>
<td>20.9</td>
<td><strong>93</strong></td>
</tr>
<tr>
<td>Unclassified</td>
<td>467,870</td>
<td>0.9</td>
<td>0.9</td>
<td><strong>102</strong></td>
</tr>
<tr>
<td><strong>Total Population</strong></td>
<td>51,883,902</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Source:** CACI 2010

#### ACORN Group Profile

<table>
<thead>
<tr>
<th>Profile</th>
<th>UK</th>
<th>Data as % of England</th>
<th>Data as % for UK</th>
<th>Index Avg = 100</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Wealthy Executives</td>
<td>4,549,131</td>
<td>8.8</td>
<td>8.6</td>
<td><strong>102</strong></td>
</tr>
<tr>
<td>B Affluent Greys</td>
<td>3,925,166</td>
<td>7.6</td>
<td>7.9</td>
<td><strong>96</strong></td>
</tr>
<tr>
<td>C Flourishing Families</td>
<td>4,262,632</td>
<td>8.2</td>
<td>8.8</td>
<td><strong>93</strong></td>
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<tr>
<td>D Prosperous Professionals</td>
<td>1,071,220</td>
<td>2.1</td>
<td>2.1</td>
<td><strong>100</strong></td>
</tr>
<tr>
<td>E Educated Urbanites</td>
<td>3,244,372</td>
<td>6.3</td>
<td>5.9</td>
<td><strong>105</strong></td>
</tr>
<tr>
<td>F Aspiring Singles</td>
<td>1,998,393</td>
<td>3.9</td>
<td>3.8</td>
<td><strong>101</strong></td>
</tr>
<tr>
<td>G Starting Out</td>
<td>1,965,614</td>
<td>3.8</td>
<td>3.5</td>
<td><strong>106</strong></td>
</tr>
<tr>
<td>H Secure Families</td>
<td>8,083,199</td>
<td>15.6</td>
<td>14.9</td>
<td><strong>104</strong></td>
</tr>
<tr>
<td>I Settled Suburbia</td>
<td>3,234,665</td>
<td>6.2</td>
<td>5.8</td>
<td><strong>107</strong></td>
</tr>
<tr>
<td>J Prudent Pensioners</td>
<td>1,641,315</td>
<td>3.2</td>
<td>3.0</td>
<td><strong>105</strong></td>
</tr>
<tr>
<td>K Asian Communities</td>
<td>908,534</td>
<td>1.8</td>
<td>1.5</td>
<td><strong>118</strong></td>
</tr>
<tr>
<td>L Post Industrial Families</td>
<td>2,443,965</td>
<td>4.7</td>
<td>4.6</td>
<td><strong>101</strong></td>
</tr>
<tr>
<td>M Blue Collar Roots</td>
<td>4,005,251</td>
<td>7.7</td>
<td>7.7</td>
<td><strong>100</strong></td>
</tr>
<tr>
<td>N Struggling Families</td>
<td>6,306,297</td>
<td>12.2</td>
<td>13.0</td>
<td><strong>93</strong></td>
</tr>
<tr>
<td>O Burdened Singles</td>
<td>1,906,995</td>
<td>3.7</td>
<td>4.2</td>
<td><strong>87</strong></td>
</tr>
<tr>
<td>P High Rise Hardship</td>
<td>629,512</td>
<td>1.2</td>
<td>1.6</td>
<td><strong>75</strong></td>
</tr>
<tr>
<td>Q Inner City Adversity</td>
<td>1,239,771</td>
<td>2.4</td>
<td>2.0</td>
<td><strong>118</strong></td>
</tr>
<tr>
<td>Unclassified</td>
<td>467,870</td>
<td>0.9</td>
<td>0.9</td>
<td><strong>102</strong></td>
</tr>
<tr>
<td><strong>Total Population</strong></td>
<td>51,883,902</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Source:** CACI 2010
14 Appendix 3 – Comparisons to the UK Health Profile

14.1 Existing Problems

The following map illustrates where the percentage of the resident population with ‘existing problems’ at Local Authority Level exceeds the UK average of 15%. The highest proportions of population are found in Knowsley and Barnsley with 40% and 39% respectively of the resident population compared to less than 2% in Rutland and Bracknell Forest.

Merthyr Tydfill with 65% has the highest percentage of its resident population affected with ‘existing problems’ in the UK.

Existing problems – where the levels of illness are above average. The proportion of people with angina is 60% higher than average, the proportion who have suffered a heart attack is 45% above average. The incidence of diabetes, high blood pressure and high cholesterol are also above average, and this is the only group where this is the case.
14.2 Future Problems

The following map illustrates where the percentage of the resident population with ‘future problems’ at Local Authority Level exceeds the UK average of 12%.

The highest proportions of population are found in London with four of the London Boroughs having the highest proportions; Newham (38%), Southwark (45%), Hackney (47%) and Tower Hamlets (50%) compared to less than 2% in Richmond upon Thames and Wokingham.

Tower Hamlets with 50% has the highest percentage of its resident population affected with ‘future problems’ in the UK.

Future problems – The areas classified as harbouring future problems do not generally have high incidence of existing illnesses. Exceptions to this are depression, asthma and migraine.
### 14.3 Possible Future Concerns

The following map illustrates where the percentage of the resident population categorised as ‘possible future concerns’ at Local Authority Level exceeds the UK average of 34%.

The highest proportions of population categorised as ‘possible future concerns’ are found in Wokingham and Windsor and Maidenhead with 71% and 63% respectively compared to just 10% in Tower Hamlets and City of Kingston upon Hull.

Wokingham with 71% has the highest percentage of its resident population affected with ‘possible future concerns’ in the UK.

Possible future concerns – These are areas with lower levels of smoking, obesity and average or slightly below average incidence of illness.
14.4 Healthy

The following map illustrates where the percentage of the resident population classified as ‘healthy’ at Local Authority Level exceed the UK average of 37%.

The highest proportions of healthy population are found in City of London and Ealing with 70% and 62% respectively compared to only 17% in Newham and 18% in Liverpool.

The Isles of Scilly with 100% followed by the Orkney Islands has the highest percentage of its resident population classified ‘healthy’ in the UK.

Healthy – The healthy areas tend to have a younger demographic and the proportions of people with high blood pressure, angina, diabetes and high cholesterol are lower than average. This group are likely to take more exercise and less likely to be smokers or overweight.
## 15 Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ABI</strong></td>
<td>The Annual Business Inquiry is a business survey which collects both employment and financial information.</td>
</tr>
<tr>
<td><strong>ACORN</strong></td>
<td>A Classification of Residential Neighbourhoods. A geodemographic classification using census and other data to classify postcodes into neighbourhood categories. The classification has been developed by the marketing-data firm CACI.</td>
</tr>
<tr>
<td><strong>CIAG</strong></td>
<td>Careers Information Advice and Guidance</td>
</tr>
<tr>
<td><strong>CPD</strong></td>
<td>Continual Professional Development</td>
</tr>
<tr>
<td><strong>CSR</strong></td>
<td>Comprehensive Spending Review</td>
</tr>
<tr>
<td><strong>Footprint</strong></td>
<td>All organisations in the health sector Standard Industrial Classifications (SIC) Human Health Activities. In analysing data for the Skills for Health footprint SIC codes are used. The most recent SIC codes that have been developed are SIC 2007. The codes relevant to the Skills for Health Footprint are SIC code 86 – Human Health Activities which is comprised of the following areas:</td>
</tr>
<tr>
<td></td>
<td>- SIC 86.101 – Hospital activities</td>
</tr>
<tr>
<td></td>
<td>- SIC 86.210 – General medical practice activities</td>
</tr>
<tr>
<td></td>
<td>- SIC 86.220 – Specialist medical practice activities</td>
</tr>
<tr>
<td></td>
<td>- SIC 86.230 – Dental practice activities</td>
</tr>
<tr>
<td></td>
<td>- SIC 86.900 – Other human health activities</td>
</tr>
<tr>
<td><strong>GOR</strong></td>
<td>The nine Government Office Regions are the primary statistical subdivisions of England.</td>
</tr>
<tr>
<td><strong>Great Britain</strong></td>
<td>Refers to the whole of England, Scotland and Wales including offshore islands. It does not include Northern Ireland, the Channel Islands or the Isle of Man.</td>
</tr>
<tr>
<td><strong>ICT</strong></td>
<td>Information and Communication Technology</td>
</tr>
<tr>
<td><strong>LFS</strong></td>
<td>The Labour Force Survey (LFS) is a quarterly sample survey of households living at private addresses in the UK.</td>
</tr>
<tr>
<td><strong>LMI</strong></td>
<td>Labour Market Intelligence</td>
</tr>
<tr>
<td><strong>MAC</strong></td>
<td>Migration Advisory Committee</td>
</tr>
</tbody>
</table>
NESS  National Employers Skills Survey
NQF  National Qualifications Framework
OAs  Output Areas (OAs) are based on postcodes as at Census Day. The minimum OA size is 40 resident households and 100 resident persons but the recommended size was rather larger at 125 households. In total there are 165,665 OAs in England
PCTs  Primary Care Trusts
QCF  Qualifications and Credit Framework
QUIPP  Quality Innovation Productivity and Prevention
SHAs  Strategic Health Authorities
SIC  The United Kingdom Standard Industrial Classification of Economic Activities (SIC) is used to classify business establishments and other standard units by the type of economic activity in which they are. For further information please visit www.statistics.gov.uk/statbase/Product.asp?vlnk=14012

Skills Gaps  Skills gaps are said to exist in an establishment when the employer indicates that staff at the establishment are not fully proficient in their jobs.

Skills Shortages
Skills Shortages are said to exist when the employer indicates that they cannot recruit sufficiently-skilled workers to meet their demand.

SOC  The Standard Occupational Classification allows easy comparison of UK wide, cross sector data. The ‘Major Group’ titles are each subdivided into ‘Unit Groups’ containing occupation titles that are more relevant to employers. Examples of the ‘Unit Groups’ underpinning each ‘Major Group’ is contained in the table below.

<table>
<thead>
<tr>
<th>Code commencing with:</th>
<th>Major Group</th>
<th>Example of Unit Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Managers and Senior Officials</td>
<td>1181 Hospital and health service manager 1183 Healthcare Practice Managers</td>
</tr>
<tr>
<td>2</td>
<td>Professional Occupations</td>
<td>2211 Medical practitioners 2215 Dental practitioners</td>
</tr>
<tr>
<td>3</td>
<td>Associate Professional and Technical Occupations</td>
<td>3211 Nurses, 3212 Midwives, 3213 Paramedics</td>
</tr>
<tr>
<td>4</td>
<td>Administrative and Secretarial Occupations</td>
<td>4211 Medical secretaries</td>
</tr>
<tr>
<td>5</td>
<td>Skilled Trades Occupations</td>
<td>5434 Chefs, cooks</td>
</tr>
<tr>
<td>6</td>
<td>Personal Service Occupations</td>
<td>6111 Nursing, auxiliaries and assistants 6112 Ambulance staff (excl Paramedics)</td>
</tr>
<tr>
<td>7</td>
<td>Sales and Customer Service Occupations</td>
<td>7212 Customer care occupations</td>
</tr>
<tr>
<td>8</td>
<td>Process, Plant and Machine Operatives</td>
<td>8138 Routine laboratory testers</td>
</tr>
<tr>
<td>9</td>
<td>Elementary Occupations</td>
<td>9221 Hospital porters</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>SSC</td>
<td>Sector Skills Council</td>
<td></td>
</tr>
<tr>
<td>SVQ</td>
<td>Scottish Vocational Qualifications</td>
<td></td>
</tr>
<tr>
<td>UK</td>
<td>The United Kingdom is the nation state consisting of England, Scotland, Wales and Northern Ireland.</td>
<td></td>
</tr>
<tr>
<td>UKCES</td>
<td>UK Commission for Employment and Skills</td>
<td></td>
</tr>
</tbody>
</table>
16 Data Sources

British Medical Association
The British Medical Association is the professional medical association and trade union for doctors and medical students
www.bma.org.uk

Cabinet Office
The Cabinet Office coordinates policy and strategy across government departments
www.cabinetoffice.gov.uk

CACI
CACI offer an unrivalled range of marketing solutions and information systems to local and central government and to businesses from most industry sectors.
www.caci.co.uk

Department of Health
www.dh.gov.uk

DH Care Networks
The contents of this website are under review, following the formation of a new HM Government
www.dhcarenetworks.org.uk

DHSSPNI
Department for Health, Social Services and Public Safety in Northern Ireland
www.dhsspni.org.uk

HM Treasury
www.hm-treasury.gov.uk

ISD Scotland
Information Services Division (ISD) is Scotland's national organisation for health information, statistics and IT services.
www.isdscotland.org

Laing & Buisson
Independent provider of authoritative data, statistics, analysis and market intelligence on the UK health, community care and childcare sectors.
www.laingbuisson.co.uk

NHS Careers
The information service for careers in the NHS in England
www.nhscareers.nhs.uk

NHS Information Centre
England's central, authoritative source of health and social care information
www.ic.nhs.uk
NOMIS
Official labour market statistics
www.nomisweb.co.uk

Northern Ireland Census of Employment
Department of Enterprise, Trade and Investment, Statistics Research Branch
www.detini.gov.uk

Office for National Statistics
The Office for National Statistics (ONS) is the UK Government's main survey organisation and its main producer of official statistics.
www.statistics.gov.uk

Skills for Health
The Sector Skills Council for the UK health sector
www.skillsforhealth.org.uk

Statswales
Detailed official data on Wales
statswales.wales.gov.uk

Trade Union Congress - TUC
The national trade union centre in the UK, representing the vast majority of organized workers
www.tuc.org.uk

Working Futures 2007 - 2017
Working Futures 2007-2017 is the latest in a long series of projections produced by IER in collaboration with Cambridge Econometrics (CE). It focuses upon the future patterns of demand for skills as measured by occupation. The results covered the National (UK) picture, as well as detailed sectoral and spatial results.
www2.warwick.ac.uk

UK Border Agency
The UK Border Agency is responsible for securing the UK border and controlling migration in the UK.
www.ukba.homeoffice.gov.uk

UKCES
UK Commission for Employment and Skills
www.ukces.org.uk

UK National Statistics Publication Hub
Data on economy, population and society at national and local level

Labour Force Survey
The Labour Force Survey (LFS) is a quarterly sample survey of households living at private addresses in the UK. 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.
Living Costs and Food Survey
Comprehensive overview of all aspects of household expenditure and income for the calendar year 2008 derived from the Living Costs and Food Survey (LCF) of around 6,000 households in the UK.

Volunteering England
Volunteering England works to promote volunteering as a powerful force for change, both for those who volunteer and for the wider community.
www.volunteering.org.uk