



**CENTRE  
FOR  
WORKFORCE  
INTELLIGENCE**



## **Big picture challenges for health and social care**

Implications for workforce  
planning, education, training  
and development



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# Purpose of the document

The CfWI has developed a workforce planning framework that incorporates horizon scanning. A key element of this approach is to identify 'big picture challenges' – key drivers that will impact on the health and social care system. The purpose of the document is to describe the big picture challenges facing the health and

social care system in England that have implications on educating, training and developing the health workforce. As part of this work, we have also produced a set of posters that are available online at [www.cfwi.org.uk/workforce-planning-news-and-review/horizon-scanning-BPC](http://www.cfwi.org.uk/workforce-planning-news-and-review/horizon-scanning-BPC).

# Background

The Department of Health (DH) has commissioned the CfWI to identify the big picture challenges facing health, social care and public health to draw out their workforce implications. The aim of this work is to create hard-hitting reports to stimulate thinking in the sector and demonstrate the need for change. The project offers the opportunity to move away from professional silo thinking about workforce planning by looking at these overarching challenges in the context of the whole workforce.

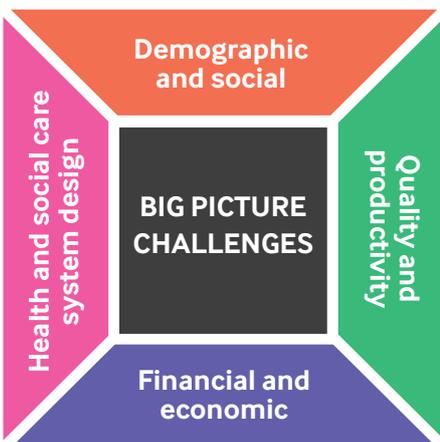
We have engaged with internal and external experts to build the list of big picture challenges that will be included in this project. These experts have provided a range of perspectives to ensure the list of big picture challenges accurately represents the

challenges faced by the health, social care and wider support system.

We have used the five domains of the Education Outcomes Framework (EOF) as a template to put forward thought-provoking questions to encourage readers to consider how Health Education England (HEE) and partners could help to address these challenges. The EOF is a set of the high-level principles and outcomes to achieve quality healthcare through education and training, and will be used by HEE and Local Education and Training Boards (LETBs) as the basis for developing the operating model for education and training, and establishing working arrangements with partners.

# Planning for the future: Big picture challenge content

Figure 1: Big picture challenge categories



The document has been structured into two key sections:

- **Section 1: Framing the big picture challenges** – this section outlines the four challenge categories and the linked challenges. The four categories are: demographic and social, health and social care system design, quality and productivity, and financial and economic. There are individual big picture challenges that sit in each category.
- **Section 2: Linking the challenges to the Education Outcomes Framework (EOF)** – this section explores the five domains of the EOF and provides information in question-and-answer format drawing out the implications the big picture challenges could have on each domain.



# Section A:

## Framing the big picture challenges

**A big picture challenge (BPC) is a fundamental challenge facing policymakers across health, social care and public health. Meeting a big picture challenge requires focused action at the highest level across the health and social care sector, politics, industry, research, etc. We have divided big picture challenges into four categories, described in detail below.**

The big picture challenges fall into four categories:

1. Demographic and social
2. Health and social care system design
3. Quality and productivity
4. Financial and economic

### 1. Demographic and social

The UK population is ageing. The over-65 population increased from 15 per cent in 1985 to 17 per cent in 2010, an increase of 1.7 million people. By 2035 it is projected that those aged 65 and over will account for 23 per cent of the total population (Office of National Statistics, 2012a). Whilst healthy life expectancy is also increasing, trends suggest that people are living a greater proportion of their lives in ill health. This means that the increasing older population could be a significant challenge for the health and social care system.

Older people are more likely to have a long-term condition, although estimates of prevalence vary. The AgeUK report *Later Life*

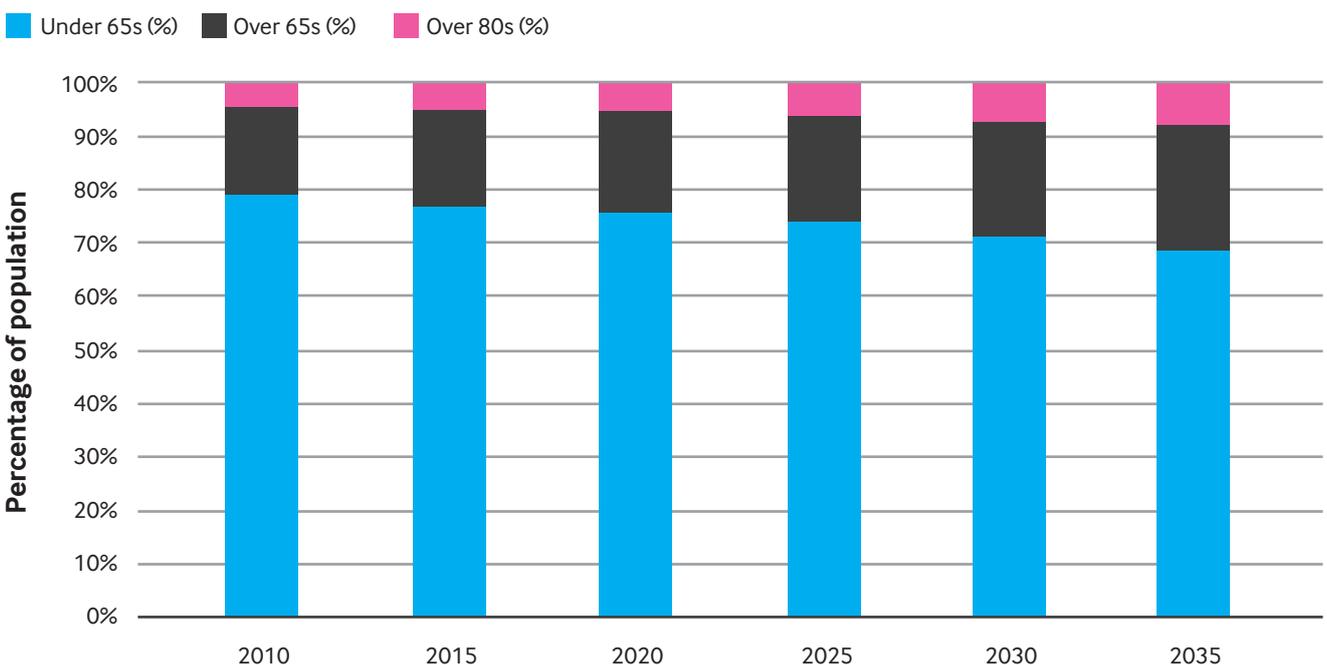
*in the United Kingdom* (AgeUK, 2012) uses data from the General Lifestyle Survey 2010 to estimate that four million people in the UK are living with a limiting, long-standing illness. This is broken down to show how prevalence increases with age. According to the data, 36 per cent of people aged 65–74 have a limiting long-standing illness, and this rises to 47 per cent of those aged 75+ and 69 per cent of people aged 85+. If nothing is done about age-related disease, the report states that the number of people with long-term conditions could rise to over six million by 2030 (AgeUK 2012). According to a report written by the Royal College of General Practitioners (RCGP), 6 out of 10 older people are living with at least one long-term condition, and most of them have two or more (The Health Foundation, 2011). Whatever the exact figures, given that people with long-term conditions account for 50 per cent of all GP appointments, 64 per cent of all outpatient attendances, and 77 per cent of all hospital bed days, the ageing population is a very significant trend (Department of Health, 2011a).

**We have identified three big picture health and social care challenges that fall into this category**

#### 1a. Planning to meet the needs of an ageing population with an ageing workforce

It is vital to understand the changing needs of the population and how the workforce will need to change to ensure services meet these needs. The challenge also touches upon other areas associated with the ageing population, such as

**Figure 2: Projected age structure of population (Office of National Statistics, 2012a)**



the fact that the workforce will also be ageing, and that the dependency ratio will decrease. This could place further financial pressure on public sector budgets and heighten the resource constraints in which the workforce operates.

### 1b. Managing changing demand resulting from an increasing prevalence of complex long-term conditions and co-morbidities

Older people are much more likely to have long-term conditions. They are also more likely to have multiple conditions which can increase the complexity of care required. Increasing obesity and unhealthy lifestyles among younger age groups could change the services people will demand as they 'store up problems for the future'. It has been projected that the number in the UK with dementia will double in the next 40 years (Alzheimer's Society, 2012) and that one out of every three people over the age of 65 will develop dementia. It is important to understand which conditions will be prevalent in the future, as this will influence the workforce required to deliver care. Multimorbidity, and the ability of the health and social care workforce and patients to balance the benefits and risks of multiple treatments and services (Guthrie, 2012), presents a challenge to the single-disease framework of most healthcare and medical education (Barnett, 2012).

### 1c. Managing changing public expectations

Public access to information about medical conditions and available services is increasing. Some are becoming empowered to make demands about the treatment they receive and how their care is delivered. They increasingly expect access to the latest technology and medical advances. Demands for 24/7 care and the improved measurement and public accountability of patient experience (The Richmond Group of Charities and The King's Fund, 2012) are examples of the changing expectations of modern services. This challenge will cover the workforce implications of an 'informed public' and the change required to manage public expectations in a resource-constrained system.

## 2. Health and social care system design

The health and social care system is undergoing a period of significant change, which aims to ensure the system is fit for purpose to deliver care to the population in the future. These system changes are designed to address some of the other big picture challenges, such as increasing demand from the ageing population, and implementation of a system which is capable of delivering high-quality and sustainable care that meets the needs of the population.

### We have identified three big picture health and social care challenges that fall into this category

#### 2a. Achieving better integration between health, social care and support organisations

One of the current aims, and challenges, is how to achieve better integration between health, social care and support

organisations. The system has been trying to integrate for decades but has yet to achieve any real progress. Integration aims to deliver a number of benefits, including being a more cost-effective way to deliver care. An increasing number of patients have complex co-morbidities, so professionals will need to work in an integrated way and across organisation boundaries to ensure that patients' needs are met and that care is delivered in a joined-up and holistic way. Despite this, however, the system is still disputing what is truly implied by 'integration' and what needs to be done to finally achieve it.

#### 2b. Shifting the focus of the system towards prevention and well-being

Shifting the focus towards prevention and well-being could help to address a number of the demographic and financial big picture challenges. By focusing on preventive services, and avoiding the development or deterioration of long-term conditions, expensive treatment and care options can be avoided in the future. This will decrease demand and free up resources for those who really need them. Shifting towards prevention will be a key challenge for a system that has always focused on treating those who are ill, rather than helping the population to stay healthy. This can significantly alter the requirements of the health and social care workforce as it will impact on the level of health need.

#### 2c. Delivering the personalisation agenda and providing person-centred care within financial constraints

The shift towards prevention aligns with the Government's personalisation agenda and a drive to encourage self management and self-care to shift some of the responsibility for health and social care from the state to the individual. The Government report *No Decision About me Without me* (Department of Health, 2012a) puts forward an ambition to empower patients to take more of a role in their own care, making patient choice central to decisions about treatment and care. Giving people access to appropriate information will be key to achieving this. The health and care workforce will have to be equipped to manage changing demand for service and increasing public expectations about care choices.

## 3. Quality and productivity

Providing high-quality, safe, patient-centred care is core to the success of the NHS. It is essential to ensure that all future services are planned with quality and safety at their heart, including when changes are being considered to the workforce. Treating people with compassion, dignity and respect are essential for all health and social care organisations' responsibility to provide high-quality care. Productivity refers to improvements in efficiency that lead to reduced production costs and improved outcomes. Assuring patient safety and maintaining service quality is of paramount importance in planning the future delivery of healthcare services and it is integral to the Quality Innovation, Productivity and Prevention (QIPP) programme.

In the recommendations of the Francis Inquiry on the care provided by Mid Staffordshire NHS Trust (Francis, 2010) there is

strong focus on the importance of the NHS workforce and its critical role in ensuring high-quality patient-centred care. The overall challenge will be to maintain the quality of services within the current budget commitments. It is expected that this will be further strengthened by the forthcoming Francis report (2013).

**We have identified three big picture health and social care challenges that fall into this category**

**3a. Ensuring the system delivers high-quality services within financial constraints**

The health and social care system has always aimed to deliver high-quality services, but this needs to be balanced with the resources that are available. How we deliver high-quality future care, and understanding the workforce's role in achieving this, is a key challenge. We must understand the need for investment in new technology and innovations to improve quality and productivity and allow for more time to care. We also need to ensure that funding- and outcome-based incentives are aligned to promote high-quality care and innovation, and do not encourage perverse incentives that shape behaviour.

**3b. Developing effective measures for quality of care and productivity and ensuring high-quality data is collected**

We need to measure quality of care and productivity effectively, so it is possible to demonstrate improvements in the system. For example, how do we know this way of doing it is better? This will need to include quality standards (what is 'good'), how they are measured, and how to demonstrate the value of the workforce. We will need to ensure that data is of a high quality and that it is valid and reliable.

**3c. Preparing for changes resulting from innovation and technology**

Significant changes to health and social care services, and the way the workforce operates, often result from innovation such as technological developments or scientific advancements in treatments. Anticipating what innovative changes may become operational in the future will be important for ensuring the system and the workforce are adequately prepared to take advantage of the opportunity to improve quality and productivity.

**4. Financial and economic**

The NHS is the world's largest publicly funded health service and employs more than 1.7 million people. About half of them are clinically qualified staff, including GPs, nurses, ambulance, medical and dental staff. Around 3 million people are treated in the NHS in England every week (NHS Choices, 2010).

Growth in health expenditure has far outpaced the rise in both GDP and total public expenditure. In 2011–12, spending in the NHS reached around £106 billion. In 2010, the Government published its plans to control public spending in the Comprehensive Spending Review (CSR). The Government's commitment to protect health spending was made clear in the

review. It highlighted that overall NHS spending would increase by 0.4 per cent in real terms by 2014–15. In summer 2012, the Department of Health reported that the NHS had saved £1.5 billion between 2011 and 2012 by reducing the number of managers and cutting £400 million expenditure on IT projects.

In October 2012, Health Secretary Jeremy Hunt stated that the Conservatives cannot realistically promise to protect the £110 billion of forecast spending for 2015 (The Spectator, 2012). He stated that predicting if spending in the NHS will increase in real terms is not possible due to major uncertainties in the economic outlook. This has begun to raise concerns about impacts on quality of care if spending is not increased to meet the needs of an ageing population with co-morbidities. In a recent King's Fund survey, 40 per cent of those surveyed (financial directors of hospital trusts and primary care trust (PCT) commissioners) reported that the NHS would miss its overall target of making £20 billion efficiency savings, and that patient care would deteriorate in the coming years (The King's Fund, 2012a).

**We have identified two big picture health and social care challenges that fall into this category**

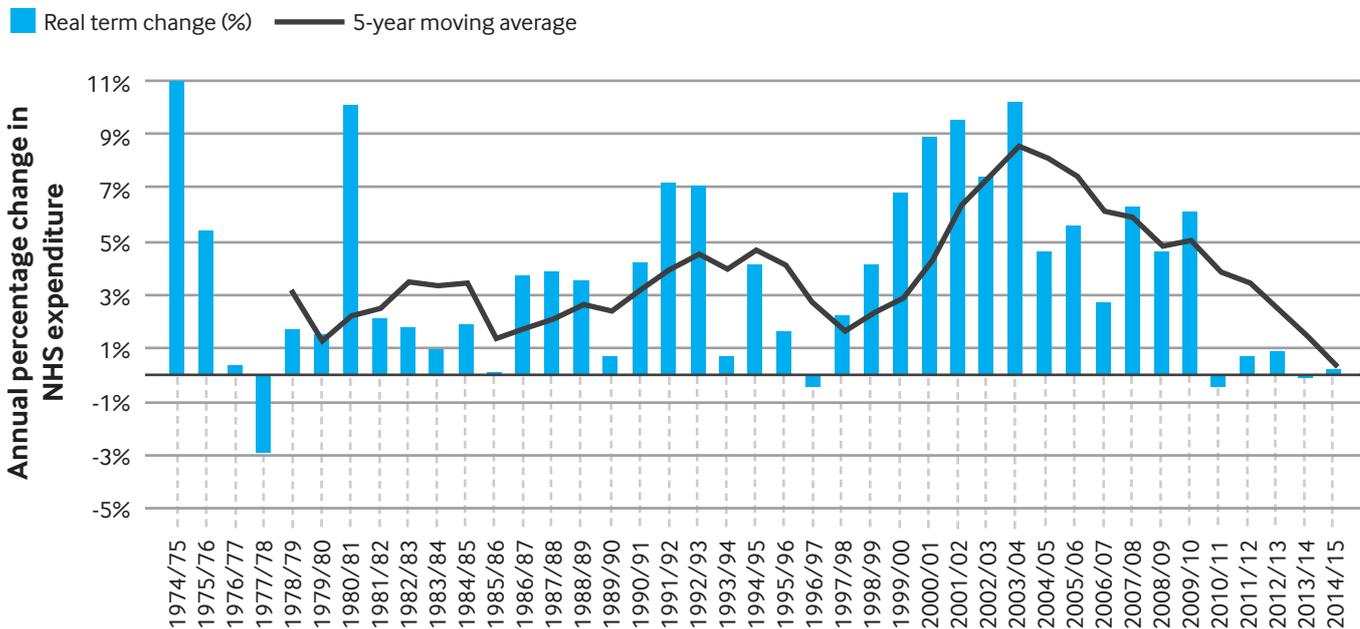
**4a. Planning service delivery given the uncertainty about level of funding in the future and how this will affect future demand for and supply of care services**

It is clear that public sector budgets will remain constrained for a number of years. This is likely to continue to affect spend on health, social care and public health for at least the next 10 years (Nuffield Trust and Institute of Fiscal Studies 2012). Looking further into the future (+10 years) there is a wider range of possible scenarios for financing the system. There is uncertainty about whether self-funding will begin to play a larger role, and about what the implications of a mixed economy provision will be. How will this change demand and for health and care services? The need to ensure the financial sustainability of providers and the workforce impact of this is also a topic that is beginning to be debated.

**4b. Uncertainty about how investment in life science, health and care will support the UK economy**

The UK currently has one of the world's strongest and most productive life science economies. In 2009, £4.4 billion was spent on pharmaceutical research and development in the UK. Medical technology and biotechnology sectors also had an annual turnover of around £18.4 billion. The Government has put measures in place to ensure that the UK remains a globally competitive environment (UK Trade and Investment, 2012). It is currently unclear how this investment in science and technology will impact on treating long-term conditions. If these investments are able to support people with long-term conditions to stay healthier for longer, there may be significant impacts on the number and types of health and care services required for the future.

**Figure 3: Annual percentage change in real terms NHS expenditure and planned expenditure in England: 1974/75 to 2014/15 (House of Commons Library, 2012)**



Fifty years ago, about 3.4 per cent of UK gross domestic product (GDP) was consumed by the NHS. If the next 50 years follow the same trajectory, by 2062 the UK could be spending nearly one-fifth of its wealth on the NHS, which would employ about one in eight of the working population (The King's Fund, 2013). A number of organisations have projected possible spending futures:

- A study by the European Commission projects that spending on public health care could rise from around 7.5 per cent in 2007, to between 7.6 per cent and 14.9 per cent by 2060
- The UK Office for Budget Responsibility's latest projections suggest spend on health care could increase from 6.8 per cent of GDP in 2016/17, to between 7.8 per cent and 16.6 per cent in 2061. If the higher scenario became reality, spending per head of population would increase from £1,745 to £9,914 (The King's Fund 2013)

**Figure 4: Big picture challenges**

Category	Challenge
Demographic and social	<ul style="list-style-type: none"> <li>■ Planning to meet the needs of an ageing population with an ageing workforce</li> <li>■ Managing changing demand resulting from an increasing prevalence of complex long-term conditions and co-morbidities</li> <li>■ Managing changing public expectations about care they receive</li> </ul>
Health and social care system design	<ul style="list-style-type: none"> <li>■ Achieving better integration between health, social care and support organisations</li> <li>■ Shifting the focus of the system towards prevention and well-being</li> <li>■ Delivering the personalisation agenda and providing person-centred care within financial constraints</li> </ul>
Quality and productivity	<ul style="list-style-type: none"> <li>■ Ensuring the system delivers high-quality services within financial constraints</li> <li>■ Developing effective measures for quality of care and productivity and ensuring high-quality data is collected</li> <li>■ Preparing for changes resulting from innovation and technology</li> </ul>
Financial and economic	<ul style="list-style-type: none"> <li>■ Planning service delivery given the uncertainty about level of funding in the future and how this will affect future demand for and supply of care services</li> <li>■ Uncertainty about how investment in life science, health and care will support the UK economy</li> </ul>

# Section B:

## Linking the challenges to the Education Outcomes Framework

The Education Outcomes Framework (EOF) and HEE’s approach to quality will link education and learning directly to improvements in patients’ outcomes. By providing a clear line of sight and improvement to patient outcomes, the EOF will help address variation in standards and ensure excellence in innovation through high-quality education and training (Health Education England, 2012a).

There are five high-level domains of the framework:

- excellent education
- competent and capable staff
- flexible workforce receptive to research and innovation
- NHS values and behaviours
- widening participation.

In this section we investigate how each of the big picture challenges impacts on these five domains.

### 1. Excellent education

**Education and training are commissioned and provided to the highest standard, ensuring learners have an excellent experience and that all elements of education and training are delivered in a safe environment for patients, staff and learners.**

#### Considerations based on big picture challenges

**If more care is going to be delivered in the community, how can we ensure professionals are trained appropriately and that they are fully supported while receiving this training?**

**If more services are provided by private and third sector organisations in the future, how does this need to be reflected in training programmes?**

**Given the need for increased cross-professional working, how should this be incorporated into training programmes?**

**How do we measure the quality of education?**

**Can the productivity of training be improved?**

**How do we manage the drive for continuous improvement?**

**How is productivity affected by delivering different service models without impacting on quality?**

**How is productivity affected by delivering different service models without impacting on quality?**

**If more care is going to be delivered in the community, how can we ensure professionals are trained appropriately and that they are fully supported while receiving this training?**

*Foundation for Excellence* recommends that all foundation doctors should undertake a community placement, and the revised Foundation Programme (2012) recognises that foundation doctors need to gain experience of and demonstrate competences within community placements (Collins, 2010).

The UK Foundation Programme notes that experience in community care can be achieved in general practice, psychiatry, paediatrics and public health, and that there is scope in other specialties. Community contact may also be possible in specialties such as diabetes, endocrinology and respiratory medicine. Figure 5 outlines the top five specialties experienced in foundation year 1 (F1) and foundation year 2 (F2). As can be seen, rotations in F1 are mainly based in an acute setting. In F2, just over 40 per cent of trainees completed a general practice rotation. The number of trainees picking this specialty as a rotation has also been declining since 2009. Overall, not all foundation doctors are currently undertaking community placement. This is shown figure 5.

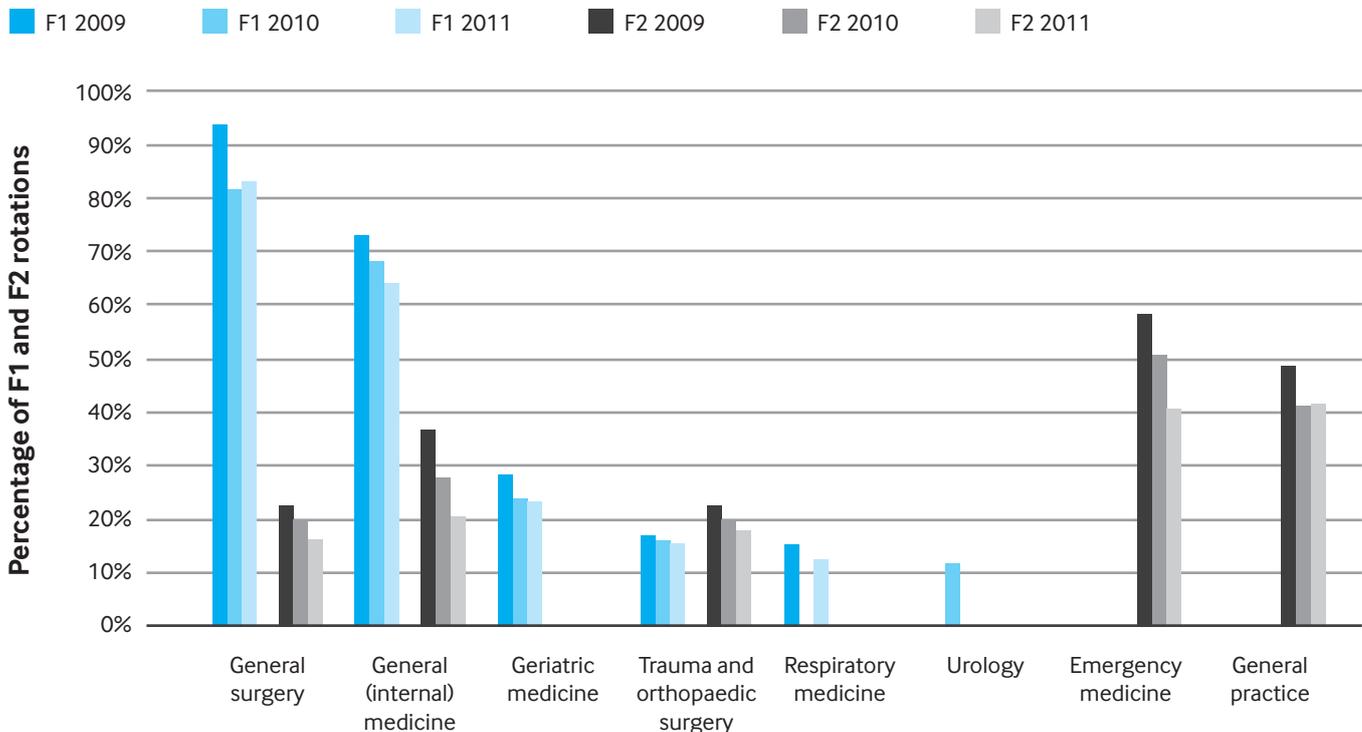
The Greenaway review is considering what changes are needed to postgraduate medical training to make sure it continues to meet the needs of patients and health services in the future. This includes looking at the balance of the workforce between specialists and generalists, options to support greater training and workforce flexibility, and how to address the tensions between obtaining training and providing a service (Shape of Training 2013).

- How can we ensure that community placements and training become a reality?
- Is it affordable to provide more placements in the community?
- Are we teaching students to work with ‘new models of care’? The GMC notes that a phased transfer of posts to community-based specialties will be needed to achieve the recommendation that all trainees undertake a community placement (Collins, 2010). Any programme of change to make this happen needs to begin immediately, as it takes 10 years to feed through into the system.

- Arrangements may need to be put in place to ensure that service delivery and productivity, both in the community and other settings, are not adversely affected by changes to training (Collins, 2010). For example, a decrease in the

numbers of junior doctors in the acute setting could result in capacity issues. Practically, how can F1s or F2s be released from trusts to do this? And what planning needs to take place to ensure that they can?

Figure 5 UK percentages of the top 5 specialties experienced in F1 and F2 rotation in 2009, 2010 and 2011 (The Foundation Programme, 2011)



**If more services are provided by private and third sector organisations in the future, how does this need to be reflected in training programmes?**

Any *Qualified Provider* and other policies suggest that the health provider market will be shaped differently in the future, with a mixture of public, private and third sector organisations. In 2010, there were more than 6,000 social enterprises delivering health and social care services for the NHS. This number is set to continue to rise, as commissioners increasingly view social enterprises as a means to meeting need and improving health inequalities (Jolob, 2010). In April 2012, Serco secured a deal worth £140 million to deliver services, including specialist nursing, community hospitals, speech and language therapy, and specialist children’s services in Suffolk (Soteriou, 2012).

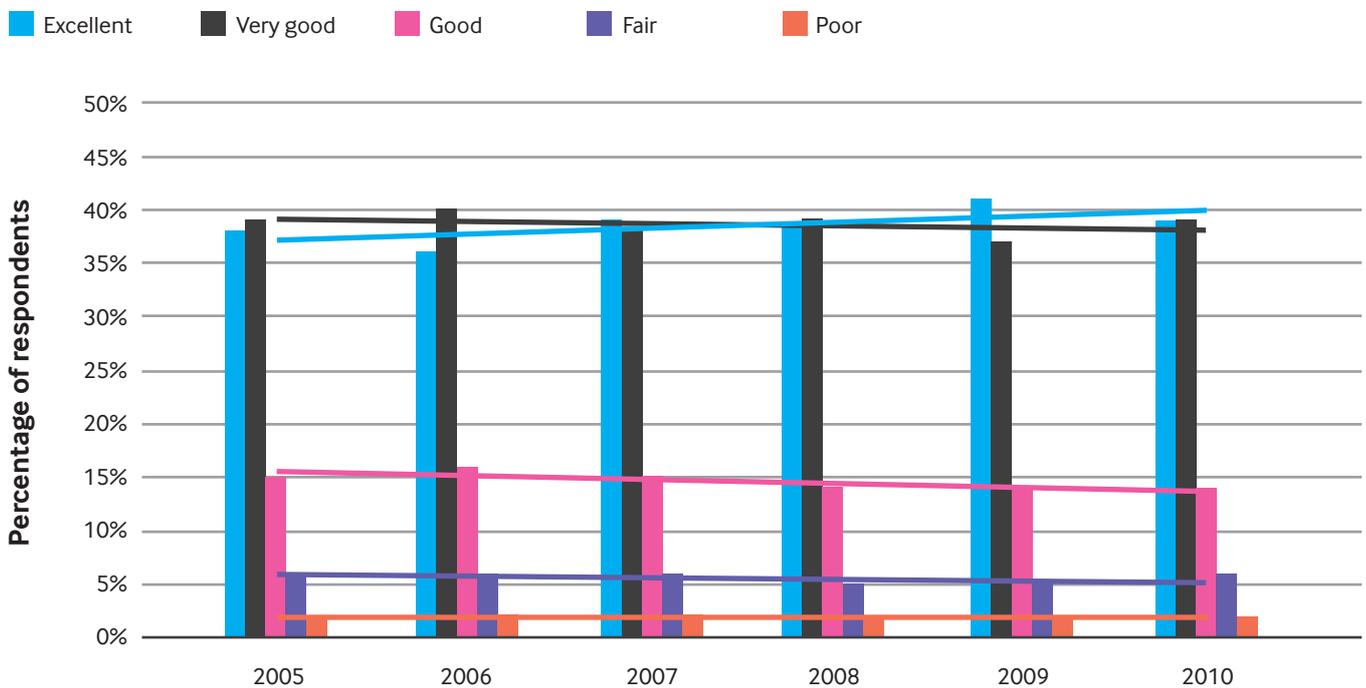
- Will it be important to reflect these changing service delivery models in training programmes to ensure that professionals are flexible and trained to work in a range of organisations, supporting the delivery of high-quality care from a mixed market economy?
- Does the workforce need different skills to work in different provider environments?
- How can we ensure that quality education is provided across these settings?

**Given the need for increased cross-professional working, how should this be incorporated into training programmes?**

A number of the big picture challenges (e.g. the ageing population, integration, financial pressures, personalisation) mean that cross-professional working is going to be key to delivering high-quality and sustainable care in the future. Professionals are expected to be able to work together to care for patients, without any formal training in how to do this effectively. Data from the NHS patient survey programme can be analysed to show patient views on how doctors and nurses work together, and how this is changing over time. Whilst the overall picture is fairly positive, Figure 6 shows that in 2010 only 78 per cent of patients questioned rated how well doctors and nurses worked together as “excellent” or “very good”. The total percentage of people responding “excellent” or “very good” to this question has remained constant since 2005.

Training together would normalise and instil the idea of cross-professional working in all care settings, and ensure that all members of the workforce are aware of what other professionals do and how to engage them. There may, however, be an issue with different skill levels when increasing cross-professional training. A report by the National Care Forum (2011) found in a staff survey that, across 34 member organisations who supplied information, the average percentage of care staff qualified to NVQ level 2 in 2011 was 65.2 per cent, an increase from 2010 at 63.9 per cent and 2009 at 61.3 per cent.

**Figure 6:** Responses over time to question 'How would you rate how well the doctors and nurses worked together?' (NHS patient survey programme, 2010)



- How can we avoid tokenism? Multidisciplinary problem-solving exercises may be more effective. For example, all the people on a trauma team (anaesthetist, specialist in emergency medicine, radiologist, nurses, and perhaps paramedics) could receive practical training on a real-life clinical situation (Soteriou, 2012).

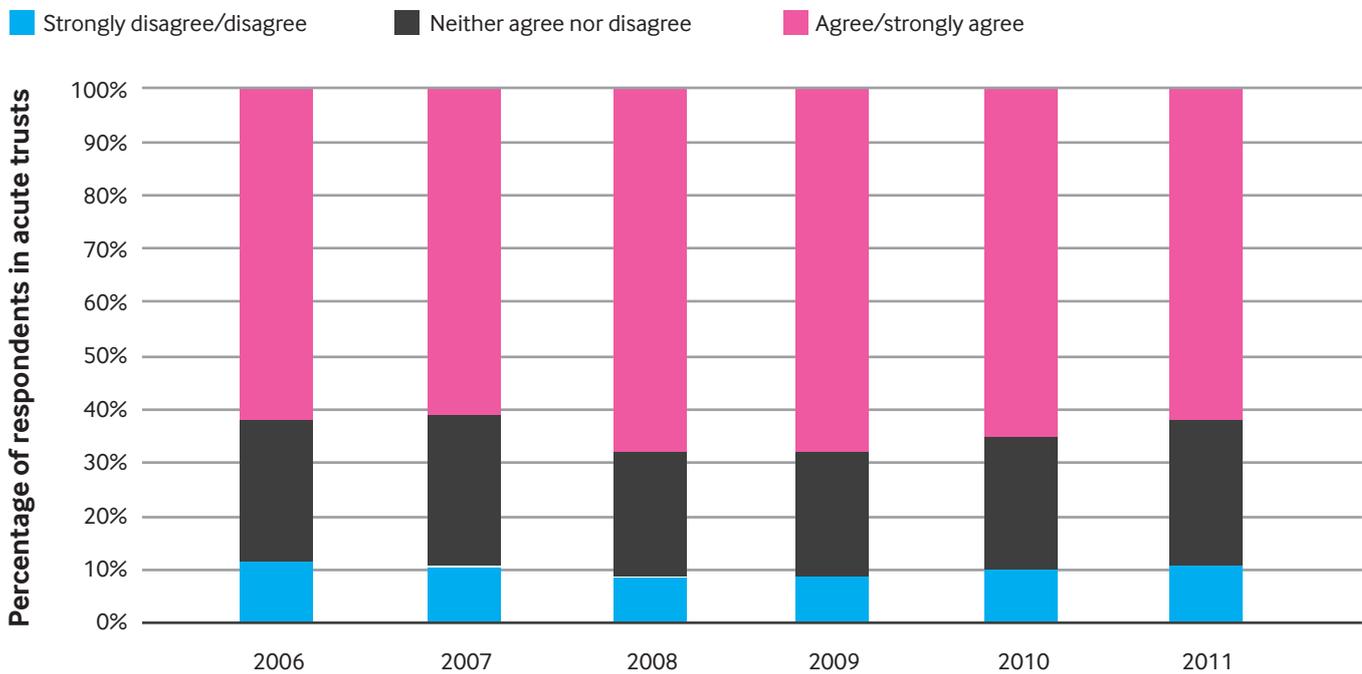
**How do we measure the quality of education?**

Ensuring a high quality of education is vitally important for producing an effective workforce, by providing them with the right skills, behaviours and training to support the delivery of care and their responsiveness to changing public needs. All residency training programmes have implemented an outcomes-based medical training competency framework, and residents regularly have their competencies assessed and signed off by consultants in order to obtain their licence (Wallenburg, 2012).

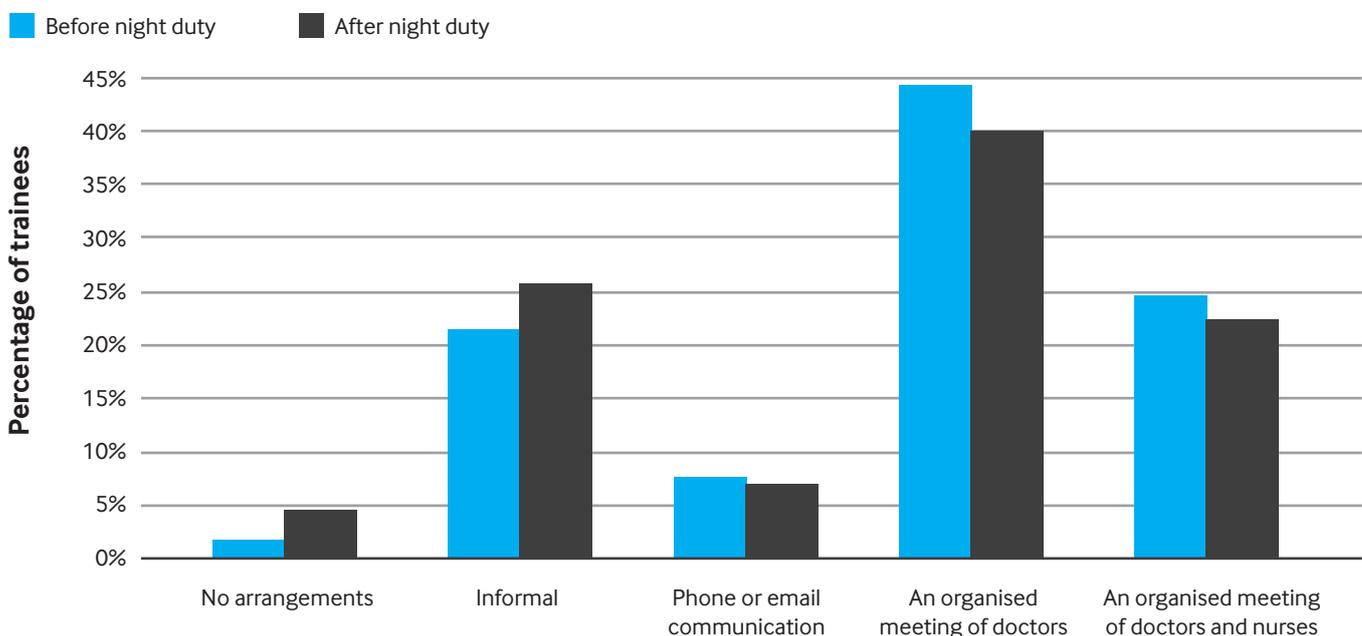
In the 2011 NHS staff survey, of those who had received some kind of training, learning or development in the past 12 months, 64 per cent felt that it had helped them to do their job better and 68 per cent felt that it helped them to stay up to date with professional requirements. Since 2008, the percentage of people who disagree or neither agree nor disagree with the statement "my training, learning and development has helped me to do my job better" has been steadily increasing (NHS Staff Survey, 2011).

The General Medical Council (GMC) national training survey in 2012 reported that overall satisfaction with training score was 80.4 per cent compared to 78.8 per cent in 2011 and to 75.97 per cent in 2006 (GMC, 2012). The GMC report on the state of medical education and practice in the UK (GMC, 2012b) found that organisations where doctors in training reported below-average satisfaction with clinical supervision also had a higher proportion of complaints. A joint survey by the Royal College of Nursing and Nursing Standard found that 81 per cent of students rated their course as either good or excellent (Nursing and Midwifery Council, 2012). The GMC (2012) highlighted a need to improve handovers. Figure 8 outlines trainees' responses to what handover arrangements were put in place before and after night duty. Fewer than 25 per cent of respondents had any organised meeting with both doctors and nurses.

**Figure 7:** Percentage of all people working in acute trusts surveyed who agree with the statement 'my training, learning and development has helped me to do my job better' (NHS Staff Survey, 2011)



**Figure 8** Handover arrangements before night duty and after night duty (General Medical Council, 2012)



Two national indicators included in the multi-professional education and training (MPET) service level agreement (SLA) 2012/13 were developed reflecting the priorities highlighted in the Francis, Temple and Collins reports (Health Education England, 2012b). The two national indicators are outlined in table 1.

- What does high quality of education look like? How do we get the public's perspective on what they think high-quality education is?
- Under the new system, who will be responsible for determining the measure of 'excellent education' and who will report on the measures?
- What are the indicators and targets? Are these outcomes focused on patient safety and experience?

**Table 1: MPET SLA indicators**

Indicator	Description
<b>Board/executive team level engagement in workforce planning, education, training and leadership of all staff</b>	<ul style="list-style-type: none"> <li>▪ provide evidence of an annual education and training plan, linked to workforce development, to meet strategic priorities</li> <li>▪ have active board/executive team engagement and educational governance in place, to review plans and education and training standards</li> <li>▪ demonstrate commitment to continuing personal and professional development (CPPD) planning evidenced by demonstrable improvements to patient care.</li> </ul>
<b>Safe trainee/student supervision</b>	<ul style="list-style-type: none"> <li>▪ meet standards for learning environment for education and training including Learning and Development Agreement (LDA), Care Quality Commission (CQC) and clinical governance standards</li> <li>▪ assure adequate levels of supervision including induction, handover, appropriate access to senior support and graded experience</li> <li>▪ meet the standards required by educational curricula set by professional, statutory and regulatory bodies (PSRB)</li> <li>▪ ensure all educational supervisors/mentors are appropriately qualified and all staff engage in supporting students/trainees.</li> </ul>

**Can the productivity of training be improved?**

'... working alone with no regular exchanges of experience for mutual improvement can no longer be considered professionally satisfactory' (Health and Social Care Policy, 2007).

**Working in a team enables the professions to solve 'complex health problems that cannot be adequately dealt**

**with by one profession alone'** (Health and Social Care Policy, 2007).

**Training practices and outcomes are varied because of local circumstances** (Wallenburg, 2012).

Table 2 shows variations across some European countries in the duration of education and training for selected health professionals.

**Table 2: Duration of education and training for selected health professions in selected countries (Matrix Insight, 2012).**

	Minimum duration: Physicians (years)		Minimum duration: Other health professionals (years)			
	General	Specialist	Nurses	Midwives	Dentists	Pharmacists
<b>Austria</b>	9	12		4.5	6	4.5
<b>Belgium</b>	9-10	9-13	3	4	5	5
<b>Croatia</b>	11	12	2-5	2-5	5-6	5
<b>Czech Republic</b>	6	11	3-5	3	5	5
<b>Denmark</b>	11	11.5-15	3.5		5	5
<b>Finland</b>	9	11-12	3.5	4.5	5	5
<b>France</b>	8.5	10-12	3	4	5	6
<b>Germany</b>	10.5-11.5	11.5-13.5	3	3	5	4
<b>Greece</b>	9	10-13	4	4	5	5
<b>Iceland</b>	7	11.5	4	6	6	5
<b>Italy</b>	9	10-12	3		5	4
<b>Latvia</b>	6	9	3-4	3-4	5	5
<b>Lithuania</b>	7	10-12	3.5-4	3.5-4	6	5
<b>Portugal</b>	10.5	11.5-13.5	4		5	5
<b>Spain</b>	9	9-11	4	6	5	5
<b>Sweden</b>	12	12	3		5	5
<b>United Kingdom</b>	8-9	8-13	3-4	3	5	4

- What methods can improve the productivity of training and how is this built into education commissions?
- How do we provide more multi-professional training environments?
- How do we monitor and measure productivity and value from investment in education and training?
- How do we make sure that employers have the right incentives to invest in training and continuous professional development?
- Who is rethinking how we deliver training? How is innovation accounted for in the training of the health workforce?
- Who is looking at future technologies that will affect the productivity of training, such as simulation (simulation laboratory)?
- If planning the workforce across care pathways is seen as more productive, is training going to be provided across pathways?

#### How do we manage the drive for continuous improvement?

Quality education and training is needed to ensure the development of the health and care workforce and thereby enable continuous improvements to service delivery and outcomes for patients. Simulation, for example, offers an important route to safer care for patients, but is underutilised. In radiotherapy, for example, Virtual Environments for Radiotherapy Training was introduced to help students develop clinical skills and to reduce student attrition. It has been found to have very positive effects on the student experience, but is only used in around half of UK radiotherapy centres (James, 2012). A report from the Yorkshire and Humber Postgraduate Deanery (2012) found that patient groups are shocked to learn that doctors frequently perform procedures for the first time on real patients.

According to the Department of Health (2012) report, *Liberating the NHS: Developing the Healthcare Workforce*, local education and training boards (LETBs) will be key in promoting and ensuring the integration of innovation and leading practice in both training and service delivery.

- What is the process to agree a new curriculum due to innovations in medical treatment and technology? How long does this take, and how can we ensure that this is completed in a timely fashion?

- Will geographical variations in the quality of education and training become more apparent as LETBs work with clinical commissioning groups (CCGs) and other organisations?
- How are we equipped to deal with the constant flux of innovation in health and embed changes into education and training?
- What is affordable education?
- Will a move toward more skill standardisation affect the number of people able to provide more innovative care?

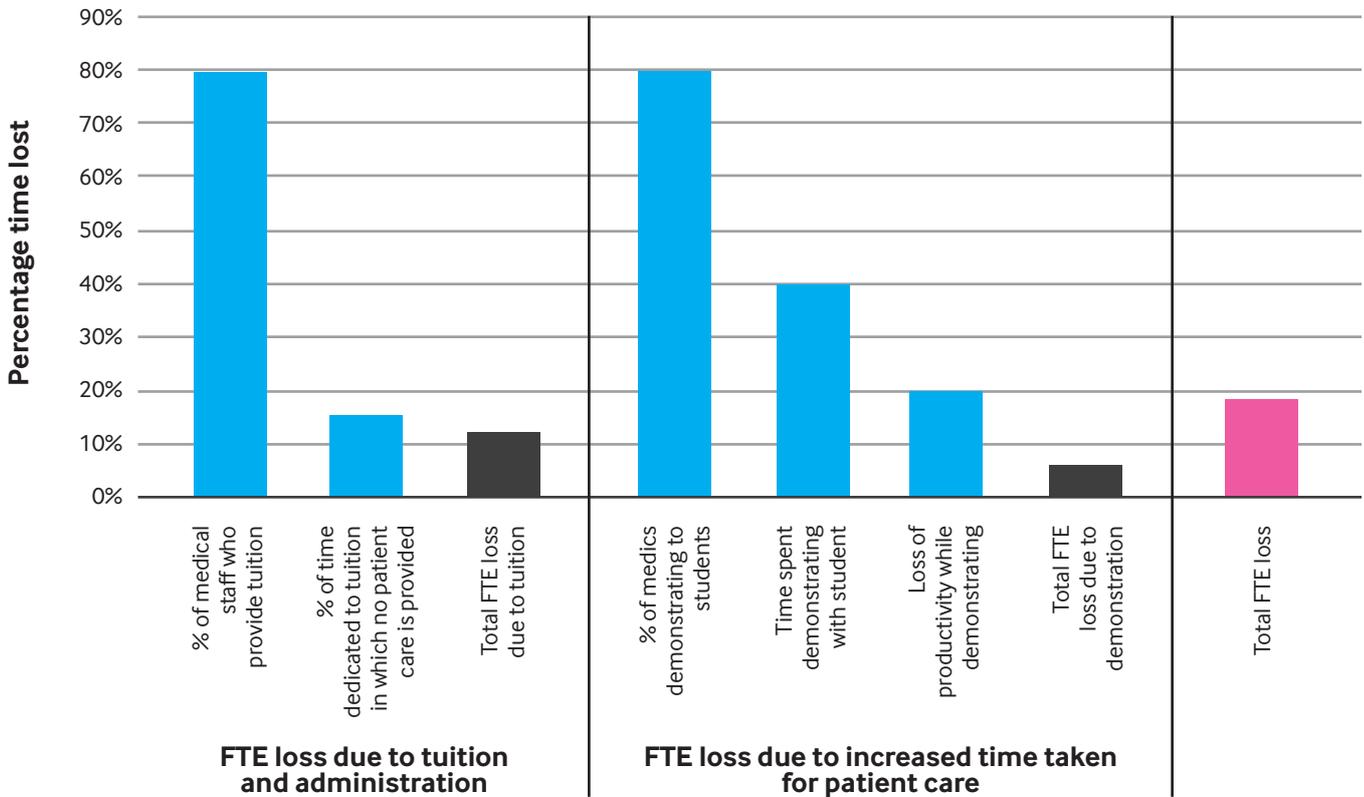
#### How is productivity affected by delivering different service models (e.g. consultant-present service) without impacting on quality?

A series of analyses commissioned by NHS London found that teaching environments are less productive than non-teaching environments and that there were productivity losses due to education activities in teaching hospitals. Teaching hospital productivity loss attributed to providing education activities was 18 per cent (NHS London, 2008). Figure 9 highlights the productivity losses.

- If we are leaning towards providing a more consultant-present service, how will this impact on workforce productivity?
- 'It takes longer to do everything because we try to provide more quality' – Professor Tony Mundy (Dunne, 2002).

The Quality, Innovation, Productivity and Prevention programme (QIPP) is a national Department of Health strategy involving all NHS staff, patients, clinicians and the voluntary sector. The programme aims to ensure that each pound spent on NHS care is used to bring maximum benefit and quality of care to patients; improving the quality and delivery of NHS care while reducing costs. The target is to deliver £20bn efficiency savings by 2014/15 which will be reinvested to support the front line (QIPP website). The NHS delivered £5.8 billion QIPP savings during 2011/12 (Department of Health 2012e).

**Figure 9: Productivity loss due to education activities in teaching hospitals (NHS London, 2008)**



## 2. Competent and capable staff

There are sufficient numbers of health staff educated and trained, aligned to service and changing care needs, to ensure that people are cared for by staff who are properly inducted, trained and qualified, who have the required knowledge and skills to do the jobs the service needs, whilst working effectively in a team.

How can we ensure the health and social care system has effective leadership at all levels?

With the focus on prevention, how can we ensure the workforce has a broad range of knowledge and skills about public health?

### Considerations based on big picture challenges

How do we ensure security of supply?

How do we ensure a good and affordable skills mix for the workforce?

If the trends around the ageing population and increase in prevalence of long-term conditions and co-morbidities are correct, what skills does the workforce need to care for the population effectively?

What skills are needed to deliver personalised care effectively?

How can the knowledge of the ageing workforce be leveraged and passed on to trainees / junior staff?

### How do we ensure security of supply?

Many social and demographic factors are changing and will affect future demand for health and social care services. Given the long training pathways, how do we ensure that we have the right numbers of health and social care workers in the future? Every year the Migration Advisory Committee (MAC) makes recommendations to the Home Office about professions that will be on the shortage occupation list. There are 12 specialties that have been on the list for more than 4 years. Table 3 lists them.

**Table 3: Professions/specialties in health and social care on the MAC shortage occupation list for over 4 years (Centre for Workforce Intelligence, 2011)**

Professions/specialties	
<ul style="list-style-type: none"> <li>■ Consultants within:                             <ul style="list-style-type: none"> <li>□ forensic psychiatry</li> <li>□ general psychiatry</li> <li>□ learning disabilities psychiatry</li> <li>□ old age psychiatry</li> </ul> </li> <li>■ specialist nurse working in operating theatres</li> <li>■ operating department practitioner</li> </ul>	<ul style="list-style-type: none"> <li>■ Consultants within:                             <ul style="list-style-type: none"> <li>□ genitourinary medicine</li> <li>□ haematology</li> <li>□ neurology</li> <li>□ occupational medicine</li> </ul> </li> <li>■ HPC-registered diagnostic radiographer</li> <li>■ HPC-registered therapeutic radiographer and sonographer</li> </ul>

Over the last decade, there has been remarkable growth in both the health and social care workforces, as shown in Figure 10. For instance, the NHS workforce grew from 1.16 million to 1.35 million between 2002 and 2011. However, in the same period, the adult social care workforce grew from 929,000 to just over 1.85 million. Not only is the adult social care workforce now larger than

the NHS, but it has grown at a faster rate as demand for services has increased. The adult social care workforce is set to increase from 1.85 million in 2011 to 3.1 million by 2025: a 68 per cent increase (Skills for Care, 2012), and over three times higher than what it was in 2002.

A CfWI report, *Shape of the medical workforce: Starting the debate on the future consultant workforce*, states that unless action is taken to alter the current trajectories, there could be more fully trained hospital doctors than the current projected demand suggests will be required. This would mean an increase of over 60 per cent in the fully trained hospital doctor headcount by 2020, and an estimated £6 billion spend on total consultant salary costs. This equates to an increase of about £2.2 billion on the 2010 figure, if all eligible doctors become consultants (CfWI, 2012).

- How do we get a clearer view of future demand to inform workforce planning?
- Who is assessing demand for health services for the next 20 years?
- What composition of the health workforce is affordable to meet the future demand for services?
- How can we encourage more young people to join the professions? How can we retain them?

**Figure 10: Comparison of Adult Social Care and NHS Hospital and Community Health Services (HCHS) workforces, England, 2002-2011 (Skills for Care, 2003, 2008 & 2012; HSC IC, 2012)**

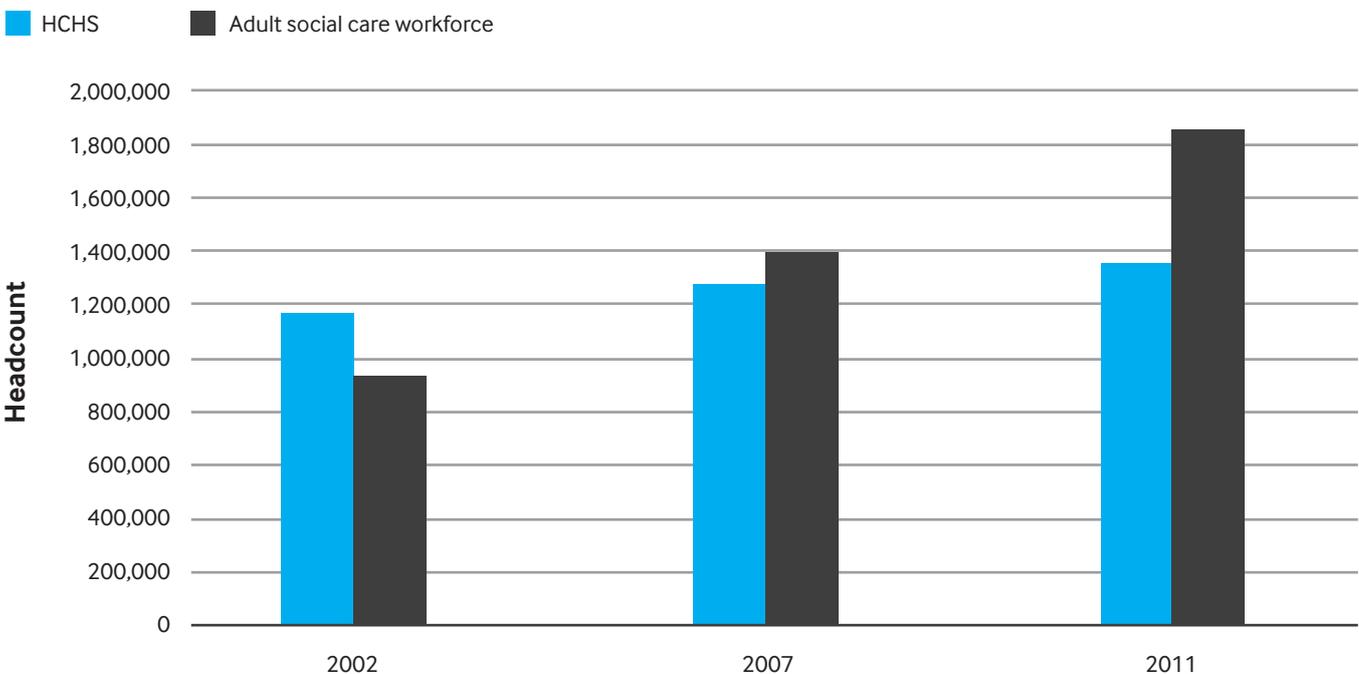
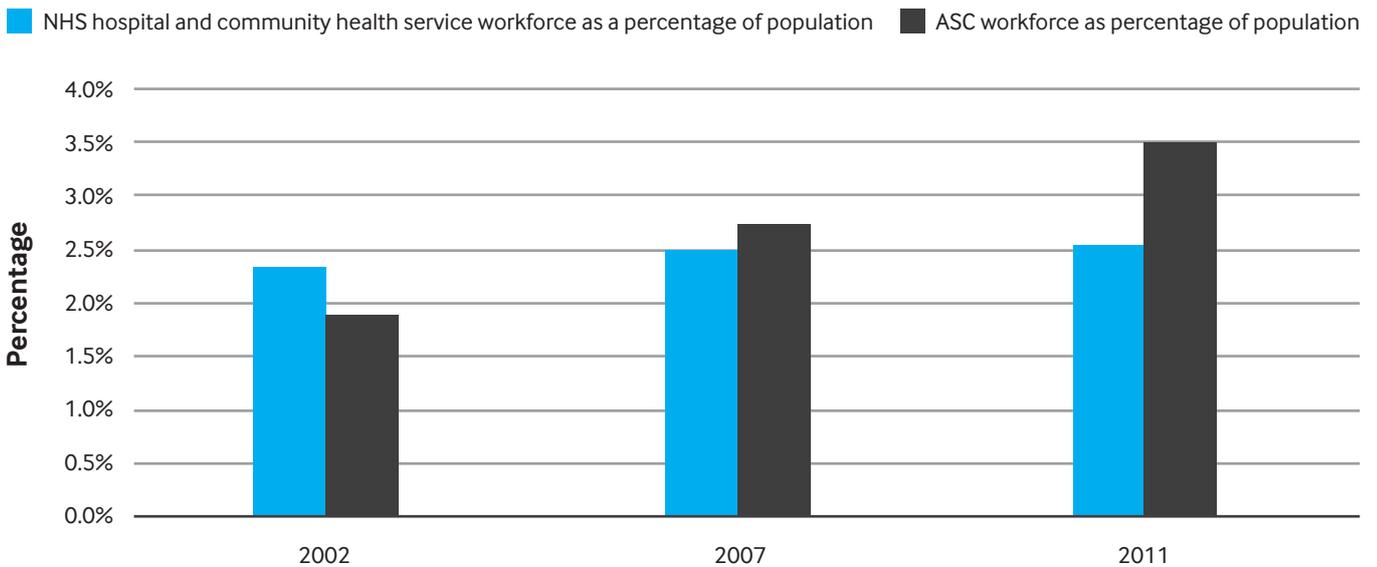


Figure 11 shows how the health and social care workforce increased from 2002 to 2011 as a percentage of the total population of England. The increase was greatest in adult social care; in 2011 3.48 per cent of the population worked in this area, compared to 1.87 per cent in 2002. Does this increase in

workforce reflect an increase in demand for these services resulting from the ageing population and increase in prevalence of complex long-term conditions and co-morbidities? How is this trend going to play out in the future, and what are the implications for workforce supply?

**Figure 11: NHS HCHS and adult social care (ASC) workforce as percentage of total population (Skills for Care 2003, 2008 & 2012; HSC IC 2012; ONS 2002, 2007, 2011)**

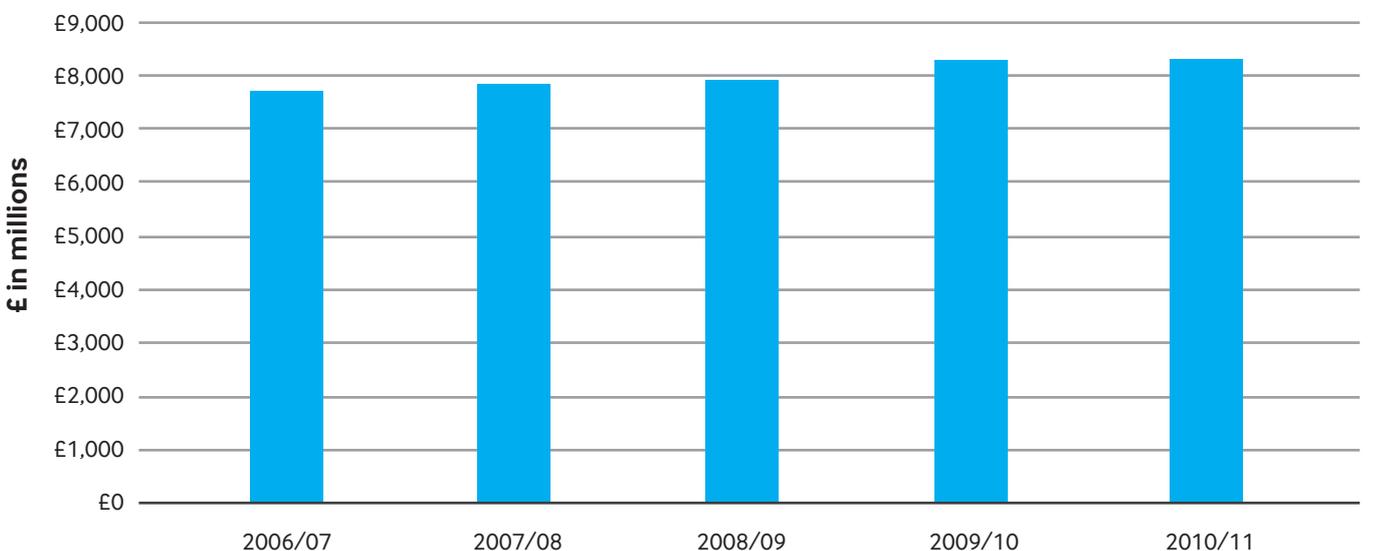


**How do we ensure a good and affordable skills mix for the workforce?**

Approximately 30 per cent of people in the UK use some form of local-authority-funded social care in the last year of life, and there is some evidence across all age groups that higher social care costs at the end of life tend to be associated with lower inpatient

costs. As the initial gatekeepers – and under the 2012 Health and Social Care Act the commissioners – of care, general practitioners will be crucial in managing future care. Figure 12 shows that recent investment in general practice in England has remained relatively constant since 2009, with a 0.6 per cent increase from 2010/11 to 2011/12 (The NHS Information Centre for Health and Social Care, 2011b).

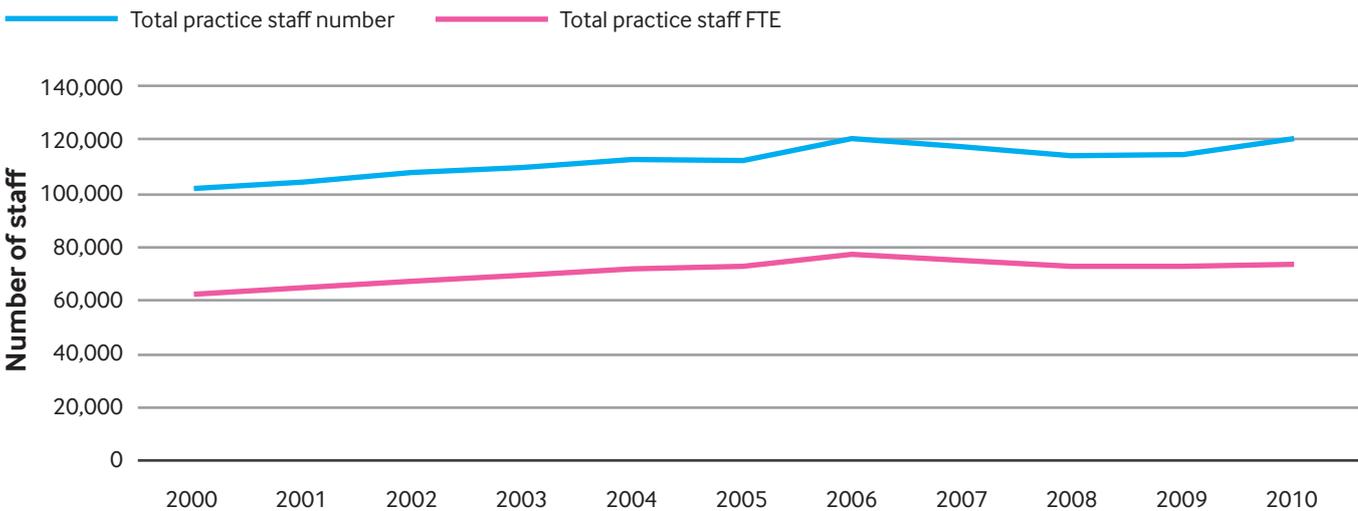
**Figure 12: Investment in General Practice in England from 2006/07 to 2010/11 (HSCIC, 2011b)**



However, while GP headcount has increased, the number of full-time equivalents (FTEs) decreased by 842 (2.3 per cent) from 2009 to 2010, although there have been significant overall increases since 2000 (The NHS Information Centre for Health and Social Care, 2011b). There were 13,167 FTE practice nurses in 2010, a decrease of 3.1 per cent since 2009 with an increase of 22.9 per cent since 2000. The total FTE of practice staff has decreased slightly since 2007 as can be seen in figure 13.

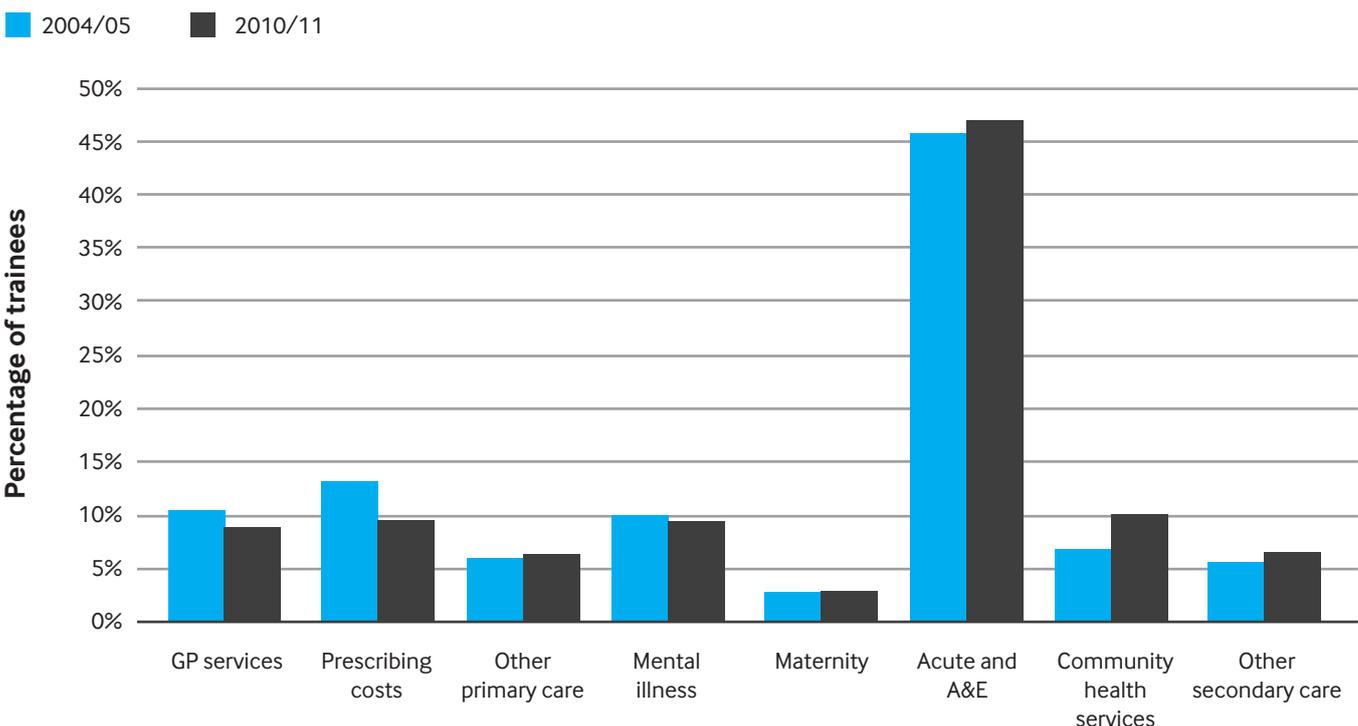
- Will the system produce not only the right numbers but also the right balance of numbers in general practice in future?
- The CfWI published concern about the potential shortage of general practitioners in its report "A strategic review of the future healthcare workforce: informing medical and dental student intakes" (CfWI 2012a). This issue is being explored further in the GP review project.

Figure 13: Total number of practice staff vs. total FTE of practice staff (The NHS Information Centre for Health and Social Care, 2011b)



Looking at the NHS accounts from 2010–11 and previous years shows that the percentage investment in primary and secondary care has remained largely constant.

Figure 14 NHS spend by area 2004–05 and 2010–11 (National Audit Office, 2006 and 2011)

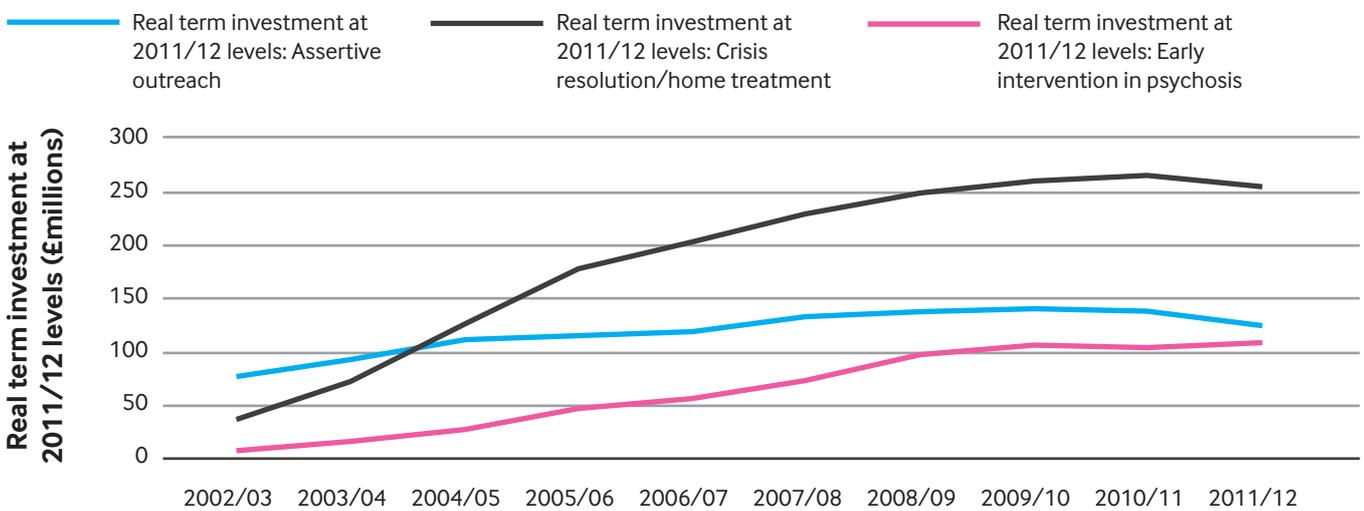


In 2004–05, 7 per cent of the total primary and secondary care commissioned was spent on community health services. This increased to 10 per cent in 2010–11, although there was a decrease in percentage spend on GP services. However, figure 14 shows that the majority of care commissioned is acute and A&E based, and this has not changed in the last six years. If there is an ambition to deliver more care in the community in the future, does this ratio of investment need to change to ensure the workforce has the correct skill mix?

- Where do community staff need to be located to avoid locality shortages?"

The adult mental health workforce provides an example of how changes to skill mix can occur quickly. In 2002–03, the main priority of investment for adult mental health was in assertive outreach. However, by 2011–12, investment in outreach significantly decreased compared to crisis resolution and home treatment, which had become the main priority of investment (DH, 2012b). Over the last decade, as Figure 15 explains, adult mental health services have therefore become much more focused on care in the community, as opposed to more assertive and interventionist approaches. The example below demonstrates that changes to skill mix can be possible in a short timeframe.

Figure 15: Priority areas of investment in adult mental health in England, 2002/03 to 2011/12 (DH, 2012b)



- What proportion of staff need to be community based in the future to meet the need for care delivered in this setting? What needs to happen to enable this shift to take place?
- What levels of skills at bands 1-4 and care assistant level are needed in the future? What are the expectations for skill mix at bands 1-4, given pay levels?
- Do healthcare professionals need different skills to work in the community? Will they need more training to give them confidence in independent working, and increased risk assessment skills?

**If the trends around the ageing population and increase in prevalence of long-term conditions and co-morbidities are correct, what skills does the workforce need to care for the population effectively?**

The workforce will need core generalist skills to manage the multiple conditions and co-morbidities of older people and ensure that care considers a person’s holistic needs. They will also need to work together effectively as a team and ensure that care is delivered in a coordinated manner, and that boundaries between organisations and professions are invisible to the patient. By 2030, it is projected that there will be an 81 per cent increase in obese adults, 47 per cent increase in adults with diabetes and a 72 per cent increase in over 65s with dementia (Universities UK, 2012).

Table 4: Ten things you need to know about long term conditions (Department of Health, 2011c)

Ten things you need to know about long term conditions (Department of Health, 2011c)	
1.	<b>Around 15 million people in England, or almost one in three of the population, have a long term condition. This number has fallen in recent years: as people become better able and supported to manage their condition, some no longer report having one.</b>
2.	<b>Half of people aged over 60 in England have a long term condition.</b>
3.	<b>While the number of people in England with a long term condition is likely to remain relatively steady, the number of people with comorbidities is expected to rise by a third in the next ten years.</b>
4.	<b>People with long term conditions are the most frequent users of healthcare services. Those with long term conditions account for 29 percent of the population, but use 50 percent of all GP appointments and 70 percent of all inpatient bed days.</b>
5.	<b>It is estimated that the treatment and care of those with long term conditions accounts for 70 percent of the primary and acute care budget in England. This means around one third of the population account for over two thirds of the spend.</b>
6.	<b>7.1 million people have clinically identified hypertension. It is estimated that the same number again have unidentified hypertension, meaning that over a quarter of the population has the condition.</b>
7.	<b>Common mental health problems affect about one in seven of the adult population, with severe mental health problems affecting one in a hundred.</b>
8.	<b>The proportion of people with a limiting long term condition in work is a third lower than those who don't.</b>
9.	<b>Long term conditions fall more heavily on the poorest in society: compared to social class I, people in social class V have 60 percent higher prevalence of long term conditions and 60 percent higher severity of conditions.</b>
10.	<b>Around 170,000 people die prematurely in England each year in total, with main causes being cancers and circulatory diseases. And those with long term conditions are likely to have a lower quality of life.</b>

Ensuring staff have the right skills will be crucial in future, given the increasing complexity of care expected. This is true of social care, where increased case complexity will impact directly on both the staffing levels required and on the increasingly specialist skills, training and support that care staff need. The Care Quality Commission (CQC) State of Care report 2011/12 assessed the outcome of supporting workers (outcome 14 in the CQC). The indicator specifically assessed health and social care organisations' ability to:

- ensure that staff are properly supported to provide care and treatment to people who use services
- ensure that staff are properly trained, supervised and appraised
- enable staff to acquire further skills and qualifications that are relevant to the work they undertake.

At present, a number of services across the social care sector are not able to support staff with proper training, supervision, appraisals and development opportunities in line with the national standards. Of those CQC inspected in 2011–12, 76 per cent of nursing homes, 84 per cent of residential care homes and 85 per cent of domiciliary care agencies met the relevant standard (2,283, 4,944 and 1,721 inspections respectively) (CQC, 2012b).

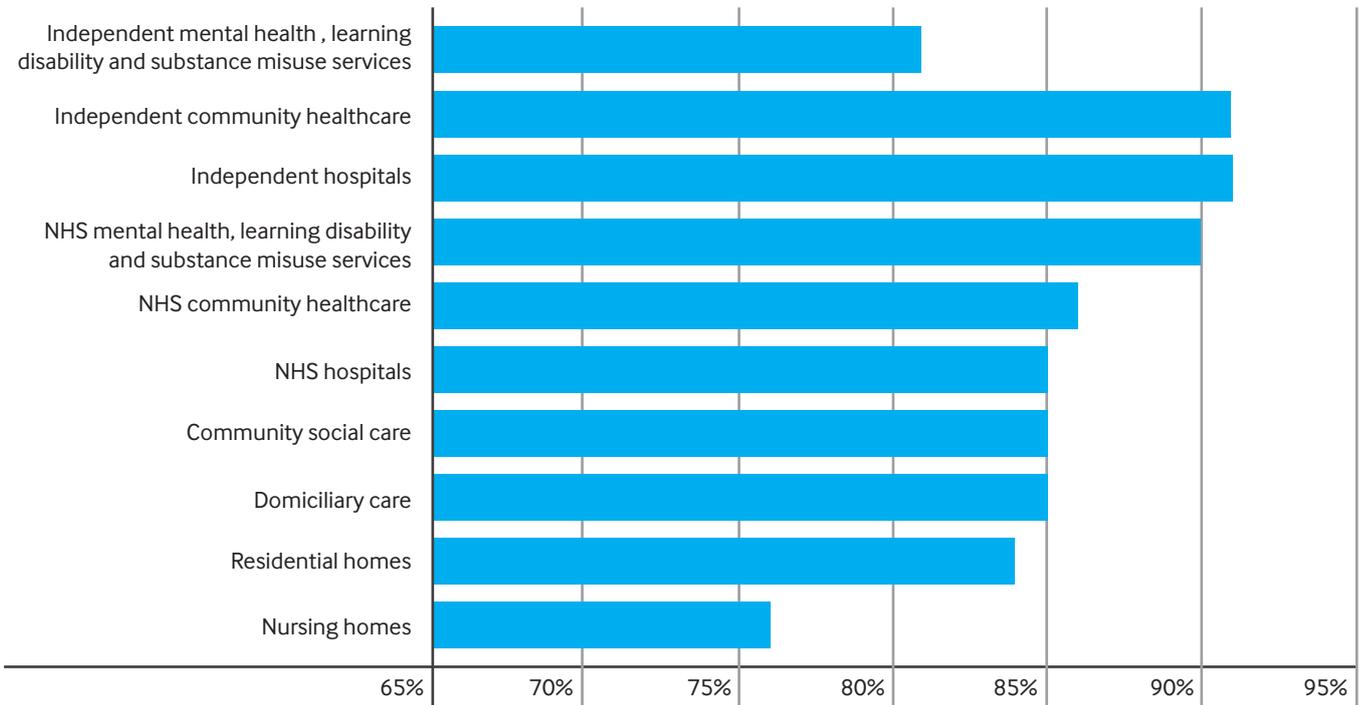
The growing importance of considering individual needs is reflected in the NHS Future Forum report (NHS Future Forum, 2012), which recommends that new patient experience measures should be developed to evaluate patients' experiences across whole journeys of care.

Recent research into dementia also reveals some remarkable results which have some important implications for patient experience.

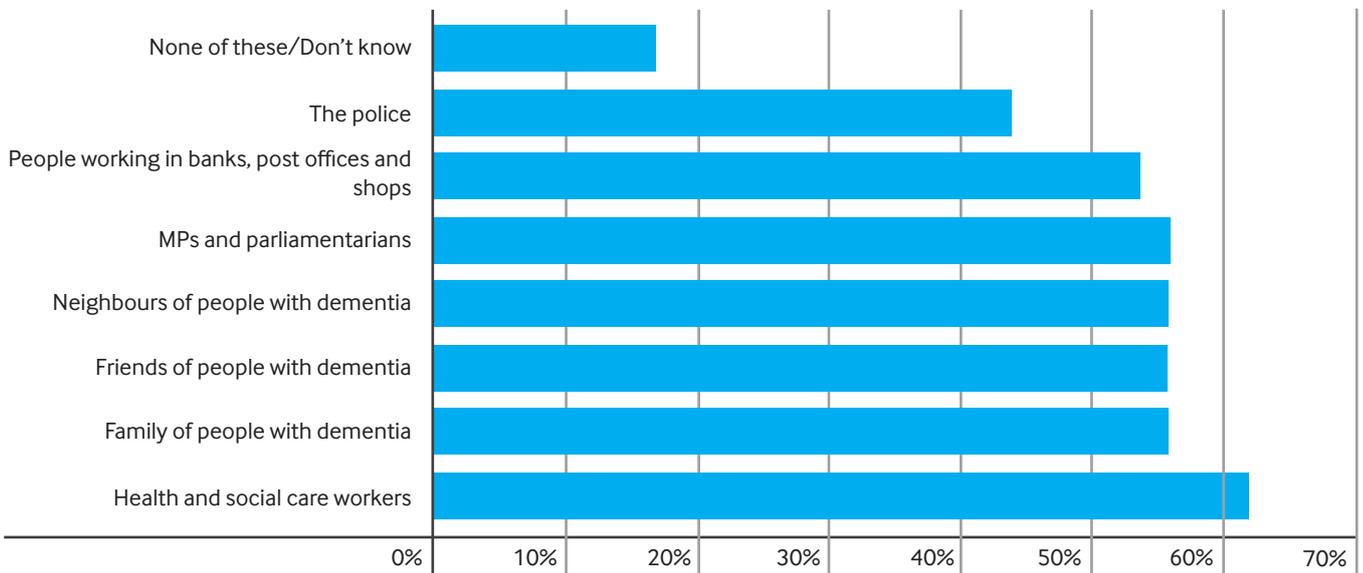
There are 800,000 people living with dementia in the UK and over the next 30 years the number of people with dementia is expected to double (HM Government, 2012). About a third of all people with dementia live in care homes, while around a quarter of older people on acute wards in hospitals are estimated to have dementia, much of it undiagnosed (CQC, 2012). Dementia is therefore a challenge of which society will become increasingly aware.

Moreover, not only is dementia a growing problem, but also one that appears not to be well understood. A 2012 study by the Alzheimer's Society found that British society is not geared towards dealing with people with dementia, with 75 per cent of respondents agreeing with that statement and 67 per cent reporting that they do not feel part of the community (Alzheimer's Society, 2012). The same study found that 62 per cent of respondents felt that health and social care workers needed to improve their understanding of dementia.

**Figure 16:** Percentage of care services that met outcome 14 on supporting staff, 2012 (CQC, 2012b)



**Figure 17:** Which groups according to the general public need to improve their understanding of dementia? (Alzheimer's Society, 2012)



- Should generalism be a characteristic of a service, department or team, rather than of an individual? What is the ideal balance?

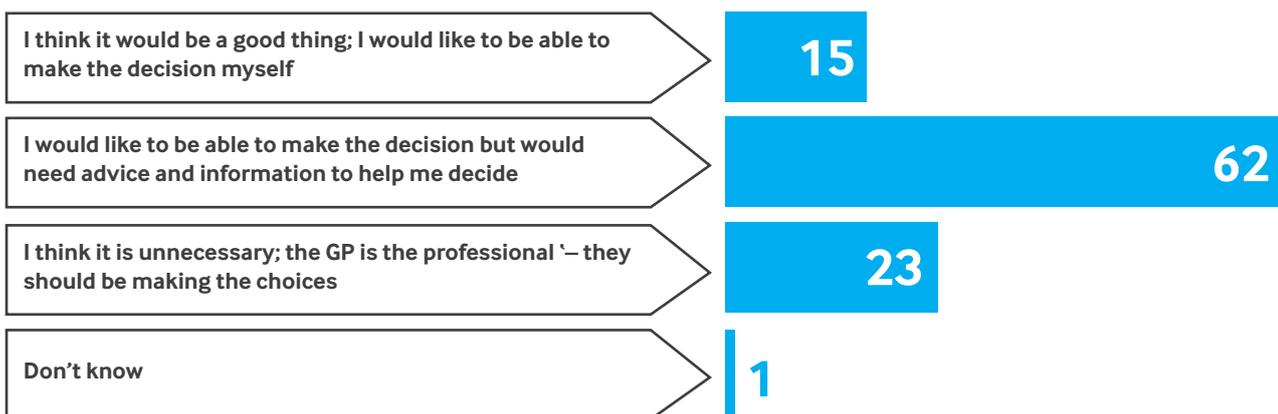
**Those adopting a generalist approach to the provision of care will need to recognise the limitations of their skills and experience and know when and where to enlist the most appropriate help, support and advice from colleagues – working across inter-professional boundaries and recognising the interdependency of professional skills.** (Collins, 2010).

- What additional skills are needed to support a generalist approach? What softer skills does the workforce require to care for this population? For example, understanding issues such as isolation and how to address them.
- How can we ensure the workforce understands the role of other professions and draws on their skills appropriately?

**What skills are needed to deliver personalised care effectively?**

If patients take a more active role in decisions about their care, professionals may need to take on a 'knowledge broker' role, which is a big change in mindset. Professionals would make sure patients have all the information they need about the options available, and support them to make an informed decision about what is best for them. In 2010 Ipsos MORI conducted a study about what people want, need and expect from public services. Figure 18 highlights that 62 per cent of respondents selected the choice 'would like to be able to make the decision but would need advice and information to help me decide' (Ipsos MORI, 2010).

**Figure 18:** If your GP decided that you needed to be referred to hospital and offered you a choice of four or five hospitals, both in the local area and in the rest of the country, to choose from, which of the following would best represent your feelings? (Ipsos. MORI, 2010)



- What is the best way to teach the communication and engagement skills needed to carry out this role?
- How can we ensure the workforce is knowledgeable about the available options and that this knowledge is kept up to date?
- Evidence shows that some groups of patients such as males, those in lower social grades, the elderly (70+) or those with life-threatening illnesses do not want to be responsible for making these decisions; they want to be told what to do by health and care professionals (Bastianens, 2006). How can health and care professionals adapt the knowledge broker role to different patients?
- Some groups of patients do not have access to information sources such as the internet. How can health and care professionals ensure these patients have the information available to make informed decisions?

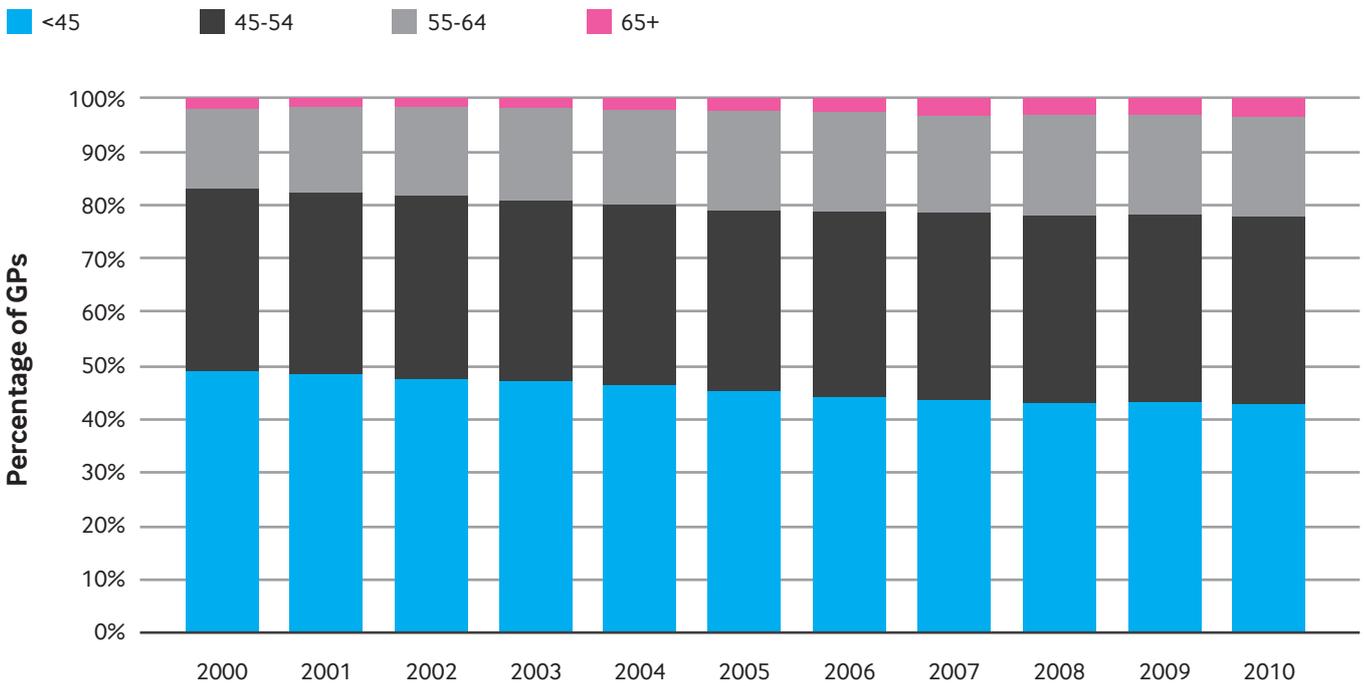
**How can the knowledge of the ageing workforce be leveraged and passed on to trainees/junior staff?**

The workforce is ageing. For example, only 42.5 per cent of GPs in 2010 were under 45 compared with 49.1 per cent in 2000. 22.2 per cent were over 50, compared with 21.8 per cent in 2009 and 17.5 per cent in 2000 (NHS Information Centre for Health and Social Care, 2011a). Figure 19 shows the age breakdown of GPs from 2000 to 2010.

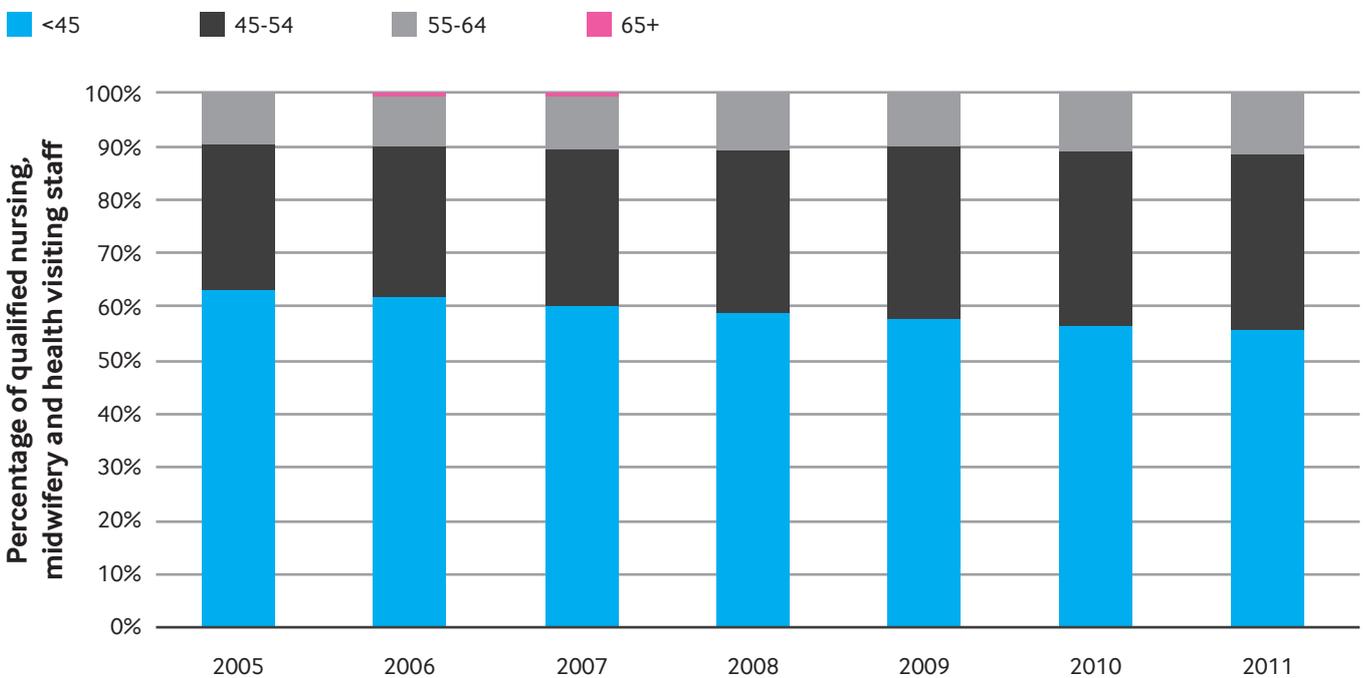
Similar trends are emerging with the nursing, midwifery and health visiting staff. 41,549 staff were aged over 55 in 2011, compared to 33,337 in 2005; over 55s made up 11.7 per cent of the nursing, maternity and health visiting workforce in 2011 compared to 9.67 per cent in 2005 (NHS Information Centre for Health and Social Care, 2011b).

In social care, staff are also ageing: the proportion of staff aged 45 and over was 43 per cent in 2011 compared to 39 per cent in 2009; among managers, the respective figures are 59 and 57 per cent (National Care Forum, 2011).

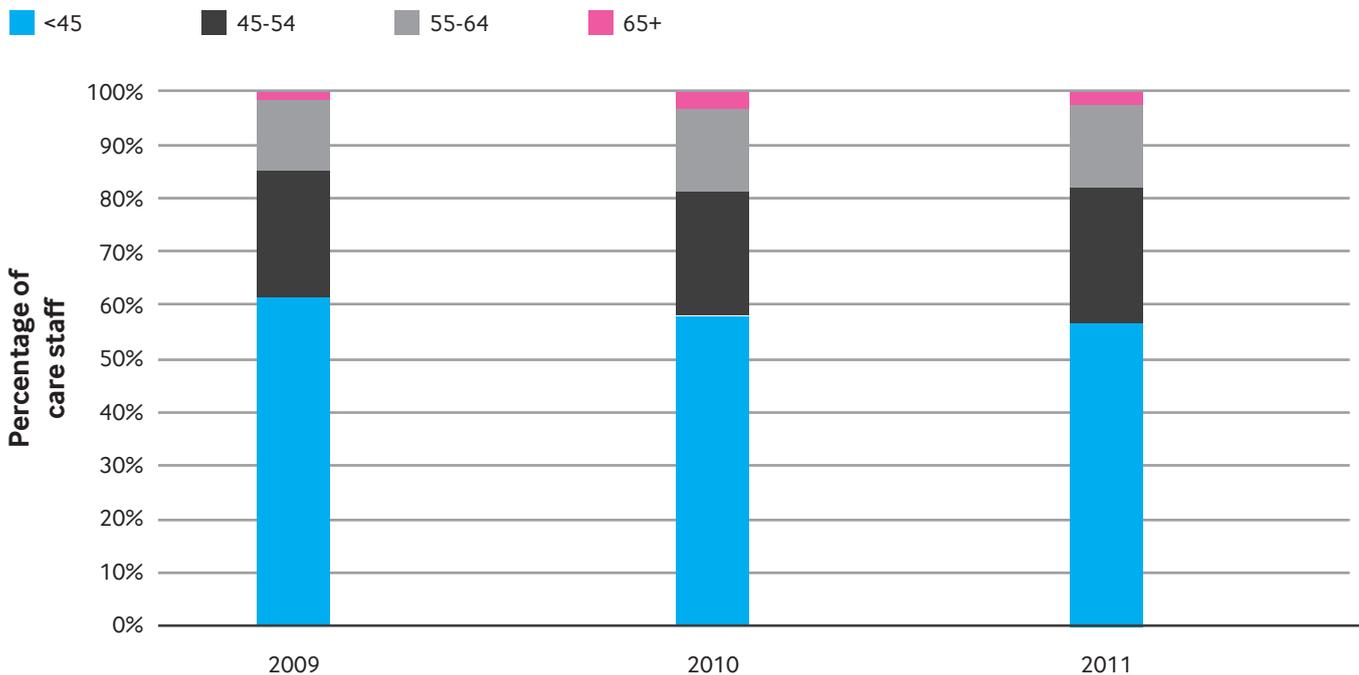
**Figure 19:** Age breakdown of GPs from 2000-2010 (The NHS Information Centre for Health and Social Care, 2011a)



**Figure 20:** Age breakdown of the nursing, maternity and health visiting workforce, 2005-2011 (The NHS Information Centre for Health and Social Care, 2011a)



Figures 21: Age profile of care staff (National Care Forum, 2011)



- How can mentoring roles be encouraged, while minimising impact on productivity?

**How can we ensure the health and social care system has effective leadership at all levels?**

Evidence from a number of recent studies indicates correlations between high-quality management and leadership and a range of outcomes such as higher-quality patient care and improved productivity (Baker, 2011). The CQC emphasises the importance of leadership, and states that a change of registered manager is often a necessary component for dramatic changes in the quality of care provided (CQC, 2012). Yet the average chief executive in the NHS spends only 700 days in post (The King’s Fund, 2011). The NHS spends less than 10 per cent of its overall budget on management. In 2010, the proportion of managers in the UK workforce as a whole was 15.4 per cent but, under the definitions used by the NHS Information Centre, in the NHS just 4.8 per cent of the workforce were “hospital or health service managers” in 2010 (The King’s Fund, 2011). These figures raise interesting implications for the future. The King’s Fund Commission on Leadership and Management in the NHS comments that this may suggest the NHS is undermanaged (The King’s Fund, 2011).

The National Quality Board (NQB) highlights that national and local leadership is essential for quality improvement to be embedded, encouraged and rewarded. The NQB identifies that clinical senates and clinical networks, health and wellbeing boards, professional bodies, royal colleges and the NQB itself all have critical leadership roles in improving quality at different geographical levels in the new system, whilst the providers’ leadership remains ultimately responsible for the quality of care delivered by their organisations (National Quality Board, 2012).

The NHS leadership academy aims to deliver outstanding leadership, at all levels and across all health professions, in order to improve people’s health and their experiences of the NHS. Their tools and programmes can help organisations to discover leadership, grow leaders, support leaders and celebrate leadership (NHS leadership academy 2013)

- Ensuring the development and succession planning of this workforce is as important as it is for front-line staff. The exceptionally high turnover of chief executives is one of the most intractable problems in the NHS. How can we reduce the impact of turnover among the top level of NHS management workforce? (The King’s Fund, 2011)
- Leadership is not just about developing individual competences and behaviour, but the development of the whole organisation, its practices and processes. How can we achieve this?

**With the focus on prevention, how can we ensure the workforce has a broad range of knowledge and skills about public health?**

The Marmot Review highlighted that many of the key health behaviours which are significant to the development of chronic disease – such as smoking, obesity, lack of physical activity and unhealthy nutrition – follow a social gradient and should be focused on to reduce health inequalities (The Marmot Review, 2010). Since then, the Department of Health has endorsed the Future Forum recommendation that all healthcare workers in the NHS should make ‘every contact count’ with the aim of improving the public’s health (DH response to 2nd Future Forum report, 2012c).

Looking in more detail at one of these key health behaviours illustrates the education challenges which emerge from this. Whilst 'managing the impact of obesity is everybody's business' (Department for Business Innovation and Skills and Office for Life Sciences, 2011), regardless of the discipline or setting in which a professional works, there is limited information provided in both undergraduate and postgraduate training programmes and scant focus on weight management in specialist medical training (Royal College of Physicians, 2010).

- How can we ensure that every health professional is trained to identify those at risk from increasing body weight and skilled in the initial management of the condition?
- The Royal College of Physicians (RCP) report contains recommendations about the type of training professionals should be given and how this can be incorporated at different stages of careers (undergraduate, CPPD, etc.).

### 3. Flexible workforce receptive to research

The workforce is educated to be responsive to innovation and new technologies with knowledge about best practice, research and innovation, that promotes the adoption and dissemination of better-quality service delivery to reduce variability and poor practice.

#### Considerations based on big picture challenges

How will the ageing workforce affect the adaptability and flexibility of the formal workforce?

How can we better understand people's long-term career plans and objectives?

A quarter of the people who provide informal care in England are aged 65 or over. Will this age group provide informal care for the ageing population in the future?

How do we 'hardwire innovation into managerial and clinical curricula and CPD' to help create an innovative culture which assists in driving growth? (Department for Business Innovation and Skills and Office for Life Sciences, 2011)

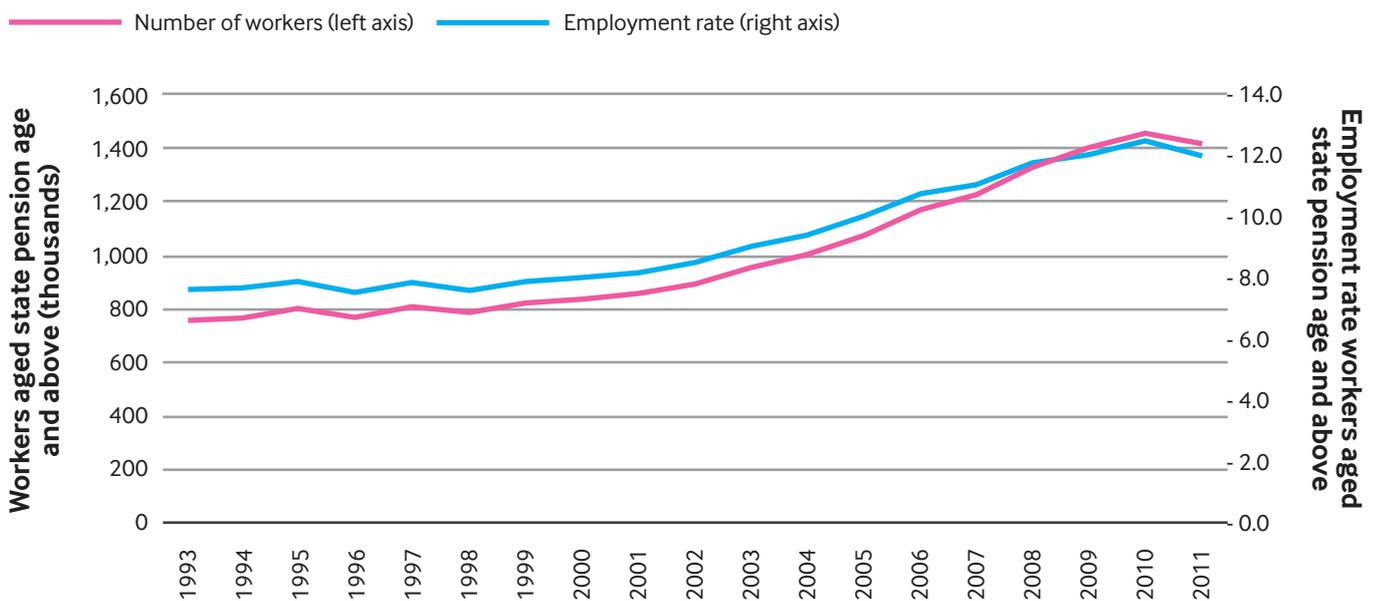
How will the ageing workforce affect the adaptability and flexibility of the formal workforce?

The number of people of state pension age and above in employment has nearly doubled over the past two decades, from 753,000 in 1993 to 1.4 million in 2011.

Workers over state pension age were twice as likely to be working part time (66 per cent) than full time (34 per cent) (Office of National Statistics, 2012c).

Figure 22 highlights the changing employment levels and rates for older people.

Figure 22: Employment levels and rates for older workers (in all sectors) annual averages 1993-2011, UK (ONS, 2011a)



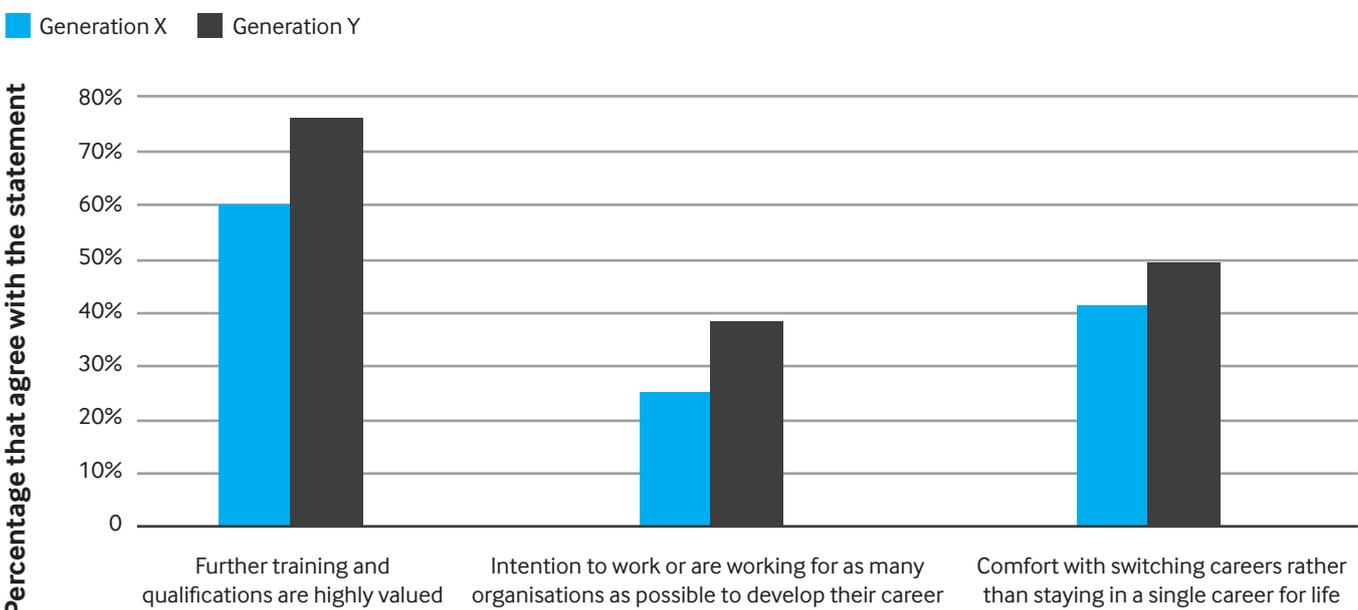
- How does this trend play out in the health workforce? Will older health professionals be more likely to work part time?
- How will this affect workforce supply?
- How can we ensure the workforce is used most effectively?

**How can we better understand people’s long-term career plans and objectives?**

People currently entering the workforce expect to work for longer into old age, given changes to retirement ages. Currently, 25 per cent fewer 16- to 17-year-olds are in work compared to 20 years

ago. The proportion of 50- to 64-year-olds working has increased by 8.7 per cent in the last 20 years (The King’s Fund, 2012b). It is possible that people no longer enter the UK workforce thinking they have a job for life; they are more likely to have a number of careers. Job mobility could greatly increase the flexibility of the workforce by supporting upskilling, reskilling, and experience of different environments and working contexts (Skills Development Scotland, 2011). Research carried out by Ipsos MORI indicates that people in Generations X (born in the 1980s) and Y (born in the 1990s) are more likely to value further education and training and are happy to work for a number of organisations in order to progress (Ipsos MORI, 2007).

**Figure 23: Generation X and Y career expectations (Ipsos MORI, 2007)**



- How will longer careers affect people’s decisions about moving in and out of a career in health and social care, or moving to work abroad?
- Do people regard healthcare as a job for life? How could this affect the long-term view of the supply pipeline?

**A quarter of the people who provide informal care in England are aged 65 or over (NHS Information Centre for Health and Social Care, 2010). Will this age group provide informal care for the ageing population in the future?**

The ageing population should be seen as a rich resource that, if used effectively, represents a significant opportunity for health and social care. The number of people over 65 who are working has grown significantly over the past 10 years (Office of National Statistics, 2011a). One of the factors that this may reflect is the improved health and well-being of this group. We also know that about 960,000 people aged over 65 provide unpaid care for a partner, family, or others (Parliament UK, 2012). Recent research has estimated that older carers (aged over 60) in the UK are providing up to £4 billion in unpaid volunteering and up to £50

billion in unpaid family care (Parliament UK, 2012). An analysis of UK census data in 2003 highlighted that about one in 20 older people in the UK spent long hours caring for sick family members. Figure 24 displays the number of people providing care by age groups and states of health.

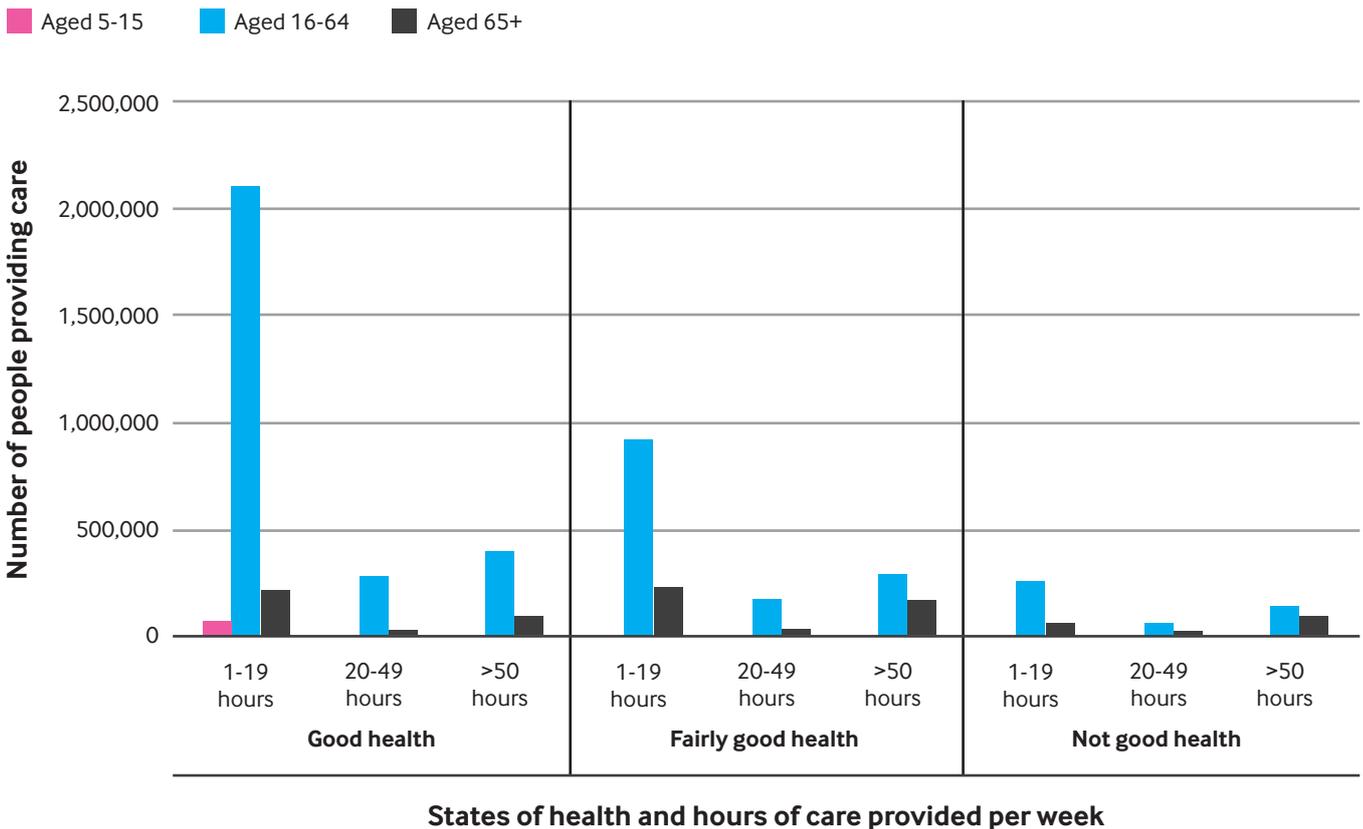
The draft Care and Support Bill proposes that carers will be put on the same legal footing as those that they care for, and will have a legal right to an assessment of their needs by local authorities (Secretary of State for Health, 2012). The Survey of Carers in Households 2009/10 found that only 6 per cent of carers had been offered a carer’s assessment. Of those who had been assessed, 67 per cent had received a service as a result of the assessment, the most common services were equipment such as mobility aids, services for the person they care for, an assessment of the person they care for and information about benefits (NHS Information Centre for Health and Social Care, 2010).

One of the key messages from an analysis of the needs of informal carers of those living with dementia was that services must be varied and flexible in order to be able to respond quickly to carers’ changing needs, and recommended involving carers in

training and education for new carers and professionals (Spencer Grey, 2011). As, for example, the prevalence of complex long-term conditions and co-morbidities increases, how can the needs of informal carers be met?

- What training/support should be offered to meet the needs of this informal workforce?
- How can we understand the potential supply of informal carers?

**Figure 24:** Number of people providing care by age, general self rated health and hours a week spent providing care, United Kingdom 2001. (Doran, 2003)



Traditional household structures are changing. The biggest change has been the increase in single person households. According to the National Council for Voluntary Organisations, by 2021, 35 per cent of all the households in the UK are expected to be habited by solo livers. By 2031, it has been projected that 18 per cent of the entire UK population will be living on their own. It is less likely that generations of the same family will be living in the same household. It is also less likely that generations will be living in the same geographical area. This does not necessarily apply to some ethnic minority groups (National Council for Voluntary Organisations, 2011).

- How will people’s opinion to taking on informal carer roles be impacted by the changing role of family and breakdown of strong family structures? Will this change be more apparent in certain social groups?

**How do we 'hardwire innovation into managerial and clinical curricula and CPD' to help create an innovative culture which assists in driving growth?** (Department for Business Innovation and Skills and Office for Life Sciences, 2011)

Training curriculums, both pre and post qualification, need to be flexible to innovation and changes in how services are delivered. It is important to understand the innovations currently in the pipeline that will shape the future requirements of the workforce. It can be difficult for regulatory bodies to fulfil roles of coordinating education because of the increasing authority of royal medical colleges due to rapid medical technological development and associated specialisation (Wallenburg, 2012). Table 5 highlights potential medical advancements that may impact significantly on future service delivery.

**Table 5: Potential medical advancements (Imison, 2012)**

Potential medical advancement
<ul style="list-style-type: none"> <li>Low-cost genetic sequencing, genome mapping, biomarker tests and targeted drugs and treatments</li> </ul>
<ul style="list-style-type: none"> <li>Video-conferencing supported by the digital transfer of clinical information</li> </ul>
<ul style="list-style-type: none"> <li>Home-based technologies that support individuals and their carers to manage their long-term conditions</li> </ul>
<ul style="list-style-type: none"> <li>Robotic-based surgical procedures</li> </ul>
<ul style="list-style-type: none"> <li>Advances in diagnostics and medical devices</li> </ul>
<ul style="list-style-type: none"> <li>Advances in drug delivery, including the use of microchips</li> </ul>
<ul style="list-style-type: none"> <li>New therapies that are able to cure cancer or stay the progression of dementia</li> </ul>

There is a need for the current workforce to have the skills to be involved in innovation and for them to be supported to do so. Results from the NHS Innovation and Improvement Survey 2009, shown in table 6, demonstrate the different perceptions of front-line and strategic staff of their skills and ability to support in innovation.

**Table 6: Comparison of assessment of front-line staff capacity to support innovation and improvement (NHS Institute for Innovation and Improvement, 2009)**

Capacity area	Assessment by strategic staff	Front-line staff self-assessment
Most front-line staff have the necessary skills to get involved in innovation	24%	54%
Front-line staff are generally supported by senior managers to undertake innovation and improvement activities	45%	33%

- How are new models of care and the use of innovative practice built into health workforce education and training?
- How can innovative best practice from other countries be leveraged in training in the UK? Does NICE regulate this?
- How quickly can these changes be adopted into the curriculum?
- How quickly can these changes be transferred to the existing workforce?

## 4. NHS values and behaviours

**Healthcare staff have the necessary compassion, values and behaviours to provide person-centred care and enhance the quality of the patient experience through education, training, and regular continuing personal and professional development (CPPD), that instils respect for patients.**

### Considerations based on big picture challenges

How can we ensure that the workforce possesses the values and behaviours to deliver high-quality care?

With the shift towards prevention, what is the correct balance for the workforce between treating the population and treating the individual?

How will 'Any Qualified Provider' impact NHS values?

How do we support the health and well-being of staff so that they are able to deliver high-quality care?

### How can we ensure the workforce possesses the values and behaviours to deliver high-quality care?

Health and social care professionals have always needed strong interpersonal skills, an understanding of NHS values and a desire to help people. The ageing population will make these skills even more important because they are highly valued by this group of patients who often require support and encouragement rather than just clinical care and treatment.

The NHS inpatient survey 2010 asked patients the question 'Overall, did you feel you were treated with respect and dignity while you were in the hospital?'. In response, 78 per cent of patients responded 'yes, always', 18 per cent 'yes, sometimes' and 3 per cent 'no'. Analysis of responses to previous surveys (2005–10) shows that these response levels have not changed over time (NHS patient survey programme, 2010). The 2010–11 adult social care survey asked service users 'How happy are you with the way staff help you?' Average data for England shows that 69 per cent responded 'I am very happy with the way staff help me, it's really good', 22 per cent responded 'I am quite happy with the way staff help me', 7 per cent responded 'the way staff help me is OK', 1 per cent responded 'I do not think the way staff help me is that good' and 1 per cent responded 'I think the way staff help me is really bad' (Adult Social Care Survey, 2010).

In the 2011 NHS Staff Survey, 38 per cent of people surveyed reported that they did not receive any training, learning or development (paid for or provided by their trust) in how to deliver a good patient/service user experience (NHS Staff Survey, 2011). The survey also reported that only 56 per cent of respondents strongly agreed/agreed with the statement 'care of patients/service users is my trust's top priority.' According to the Care Quality Commission's first market report, of the poorest performing NHS trusts, 15 per cent were reported to be non compliant on the staffing standard and 11 per cent were reported

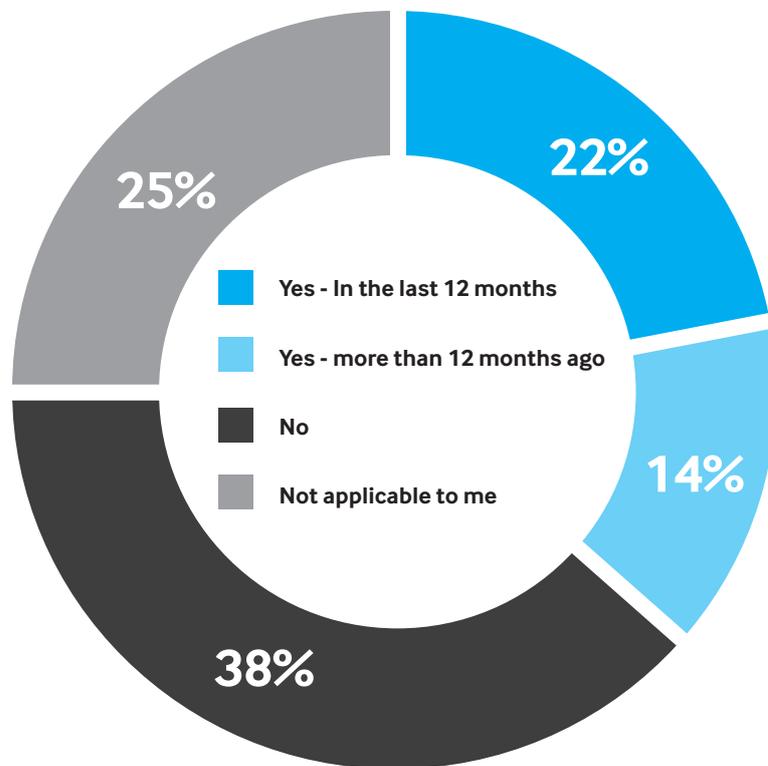
to be non compliant on the supporting staff standard (Care Quality Commission, 2012a). In November 2012, the CQC also reported that the three factors that underpin poor care are: cultures in which unacceptable care becomes the norm; an attitude to care that is 'task-based,' not person centred; and managing with high vacancy rates or poorly deployed staff (Care Quality Commission, 2012c).

The public inquiry into Mid Staffordshire NHS Foundation Trust will examine why the serious problems at the Trust were not identified and acted on sooner, and will identify important lessons to be learnt for the future of patient care. The values and behaviours of the workforce were a feature of the Francis report published in 2010, and this is expected to be reemphasised in the 2013 report.

**Table 7: Developing the culture of compassionate care**  
(Department of Health and NHS Commissioning Board 2012f)

Developing the culture of compassionate care	
Care	Compassion
Competence	Communication
Courage	Commitment

**Figure 25: Number of people reporting that they received training, learning or development in how to deliver a good patient/service user experience in 2011 (NHS Staff Survey, 2011)**

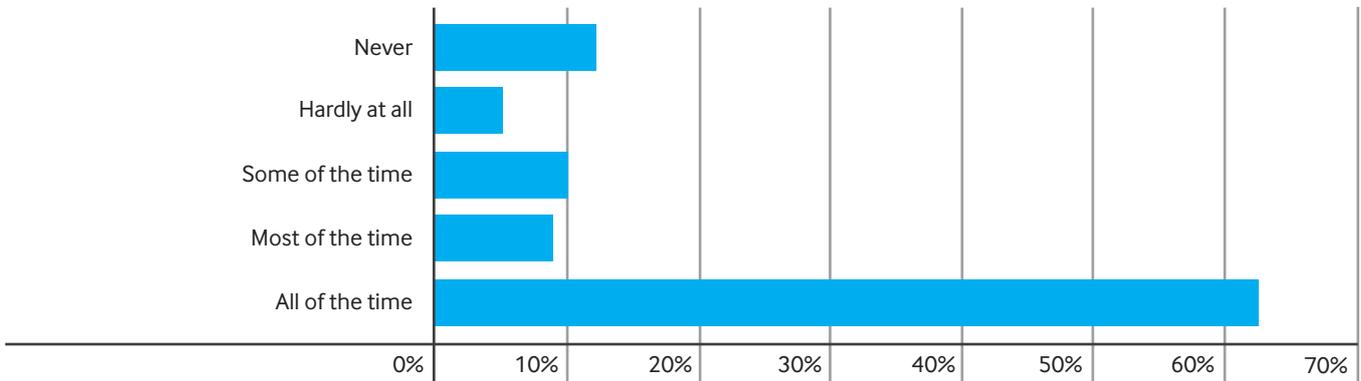


A report compiled by King's College and The King's Fund in 2011 aimed to establish what matters to patients, particularly in the non-acute sector. As part of this work, the project conducted a series of secondary analyses of postings made to the NHS Choices website. Only 63 per cent of respondents reported that they were treated with dignity and respect by hospital staff all of the time (The King's Fund and King's College London, 2011). Figure 26 outlines the responses. The same analysis also drew the conclusion that 'being treated with dignity and respect' and 'involves me' had the strongest correlation with patients' 'overall

rating' of their experience (The King's Fund and King's College London, 2011).

- How do we build more training related to NHS values into CPPD and undergraduate training?
- Should assessment of personality traits and characteristics form part of the assessment process when applying for courses, as well as academic qualifications?

**Figure 26:** Percentage of responses to the statement: 'I was treated with dignity and respect by hospital staff' (The King's Fund and King's College London, 2011)



Secondary analysis of NHS surveys of inpatient and outpatient care by the Picker Institute shows that being treated with dignity and respect strongly correlates with people's overall satisfaction with the care they receive in both of these settings (Sizmur and Redding, 2009, 2010). Survey questions on whether people were treated with respect and dignity are also part of the Outcomes Frameworks which will be used to set out high-level areas for improvement (Department of Health, 2012d). There are two composite indicators on patient experience in the NHS Outcomes Framework and a composite indicator on social care-related quality of life in the Adult Social Care Outcomes Framework.

**With the shift towards prevention, what is the correct balance for the workforce between treating the population and treating the individual?**

There is potential conflict between focusing on public health and a population approach to ensuring people are healthy, and focusing on delivering personalised care to individuals. While it is possible to do both, it will be important to ensure there is a clear strategy and approach about how the system delivers care.

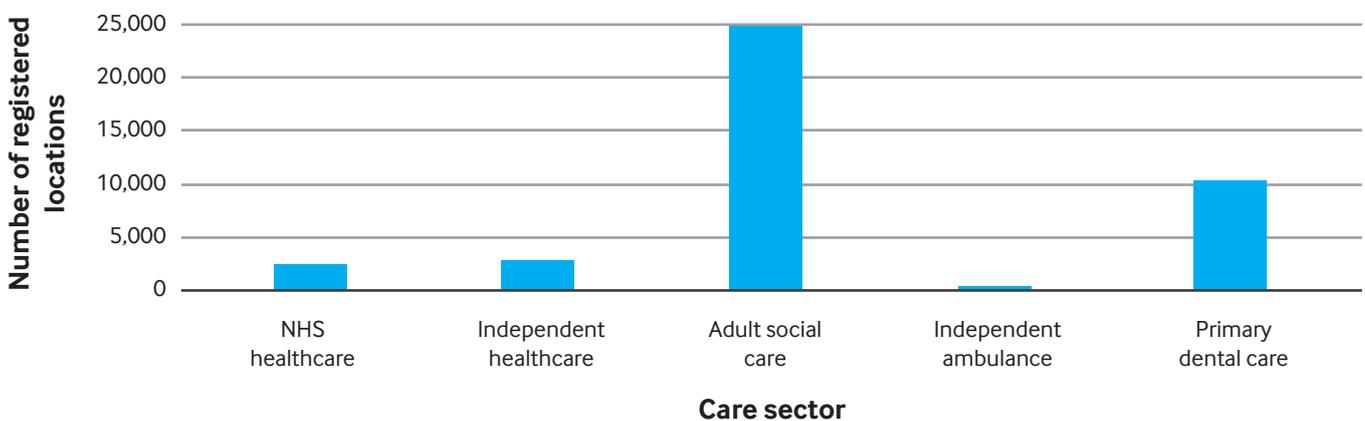
- How can this shift in mentality be embedded into training and ongoing professional development?

**How will 'Any Qualified Provider' impact NHS values?**

The implementation of *Any Qualified Provider* will widen the provider base in healthcare. Organisations from the public, private and third sector will all be involved in delivering services. According to the Care Quality Commission's (CQC) annual report, on 31 March 2012, there were 40,621 registered locations in England providing health, social care and dental services. Figure 27 compares the number of registered locations by care sector (Care Quality Commission, 2012b).

- How can we ensure NHS values are demonstrated by the workforce in all provider organisations?
- How will this affect integrated working? Different providers may not be open to working together, instead focusing on the goals of their individual organisations (not necessarily financial goals).

**Figure 27:** Number of registered locations by care sector (Care Quality Commission, 2012b)



**How do we support the health and well-being of staff so that they are able to deliver high-quality care?**

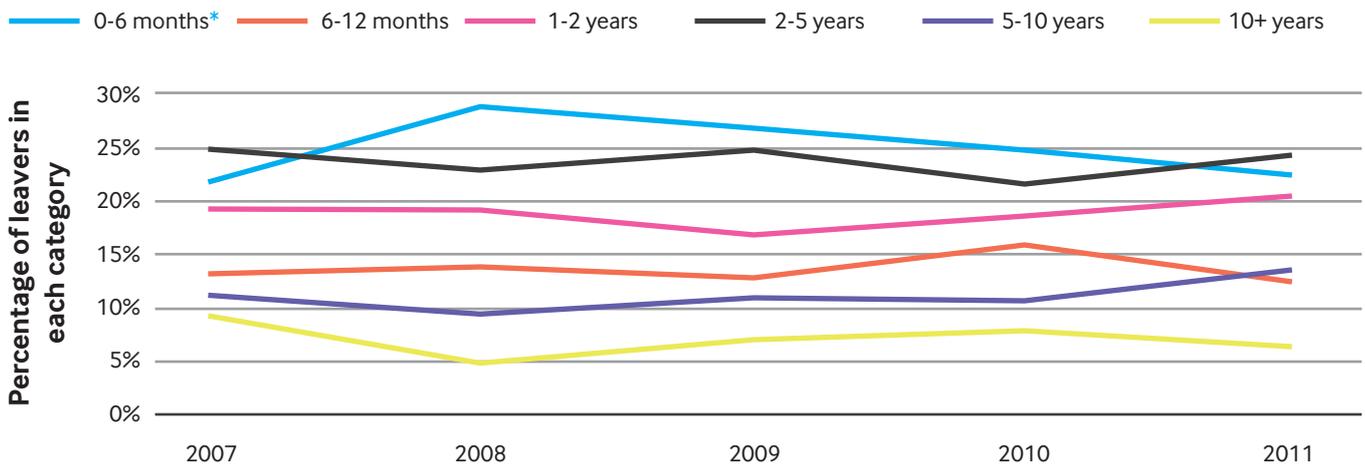
We lose 140 million working days to sickness absence annually (Black and Frost, 2011), with sickness absence of NHS staff costing £1.7 billion annually (Department of Health, 2009). A report prepared for the Department of Health in 2009 tested the benefit of good health and well-being of NHS staff on organisational outcomes. The outcomes evaluated included patient experience, health outcomes and overall performance (Dawson, 2009). As part of the research, the health and well-being aspects of the NHS staff survey were assessed to produce a 'health and well-being' rating for all acute trusts. Research showed that acute trusts that received a high health and well-being status also achieved a high patient satisfaction score.

In a King's Fund leadership report published in 2012, the following conclusion was made:

**...the findings make it clear that cultures of engagement, positivity, caring, compassion and respect for all – staff, patients and the public – provide the ideal environment within which to care for the health of the nation. When we care for staff, they can fulfil their calling of providing outstanding professional care for patients (West, 2012).**

The National Care Forum conducts an annual survey with its member organisations to gather personnel statistics from the carer workforce. Measuring the number of people leaving the workforce can be seen as an indicator of staff health and well-being. In the 2011 personnel survey there was a slight improvement in the number of workers in care settings who were leaving within 12 months (33.7 per cent of people). Figure 28 displays the five-year trend of leavers by length of experience.

**Figure 28: Percentage of workers in care settings leaving the workforce by experience over 5 years (The National Care Forum, 2011)**



\* 0-6 months category includes non-starters

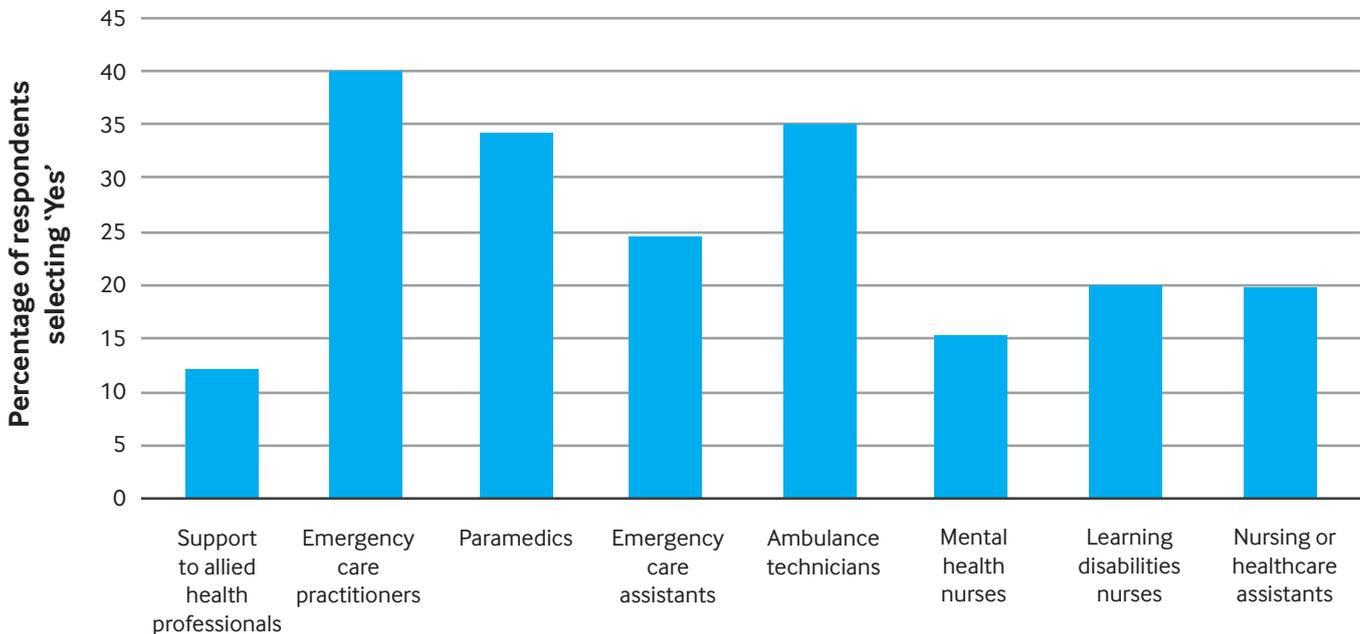
The survey also gathered the reasons for leaving. The main reasons for leaving in 2011 were: unknown/other, personal reasons, dismissal, career development, retirement (The National Care Forum, 2011).

Figure 29 identified the staff groups that reported a higher than 11 per cent 'yes' response to the NHS Staff Survey question 'In

the last 12 months have you personally experienced physical violence at work from patients/service users, their relatives or other members of the public?' Many of the staff groups that report this provide care in a community setting (NHS Staff Survey, 2011).

- How can we ensure that staff are fully supported and safe?

**Figure 29:** Top 8 staff groups reporting that they have personally experienced physical violence at work from patients/service users, their relatives or other members of the public in the past 12 months (NHS staff survey, 2011)



## 5. Widening participation

**Talent and leadership flourish free from discrimination with fair opportunities to progress, and everyone can participate to fulfil their potential, recognising individual as well as group differences, treating people as individuals, and placing positive value on diversity in the workforce, with opportunities to progress across the five leadership framework domains.**

### Considerations based on big picture challenges

**How can we ensure that the workforce as a whole develops effectively?**

**How can we encourage people from minority groups to enter the workforce and how do we ensure that everyone is treated fairly with regard to career progression?**

#### How can we ensure the workforce as a whole develops effectively?

There is a concern from some areas that resources for education and training are limited, and that increasing investment in one profession may result in a drop in quality of training in another profession.

- If resources for education and training are limited, how can we ensure that resources are allocated to ensure the workforce as a whole develops effectively to deliver the care required?

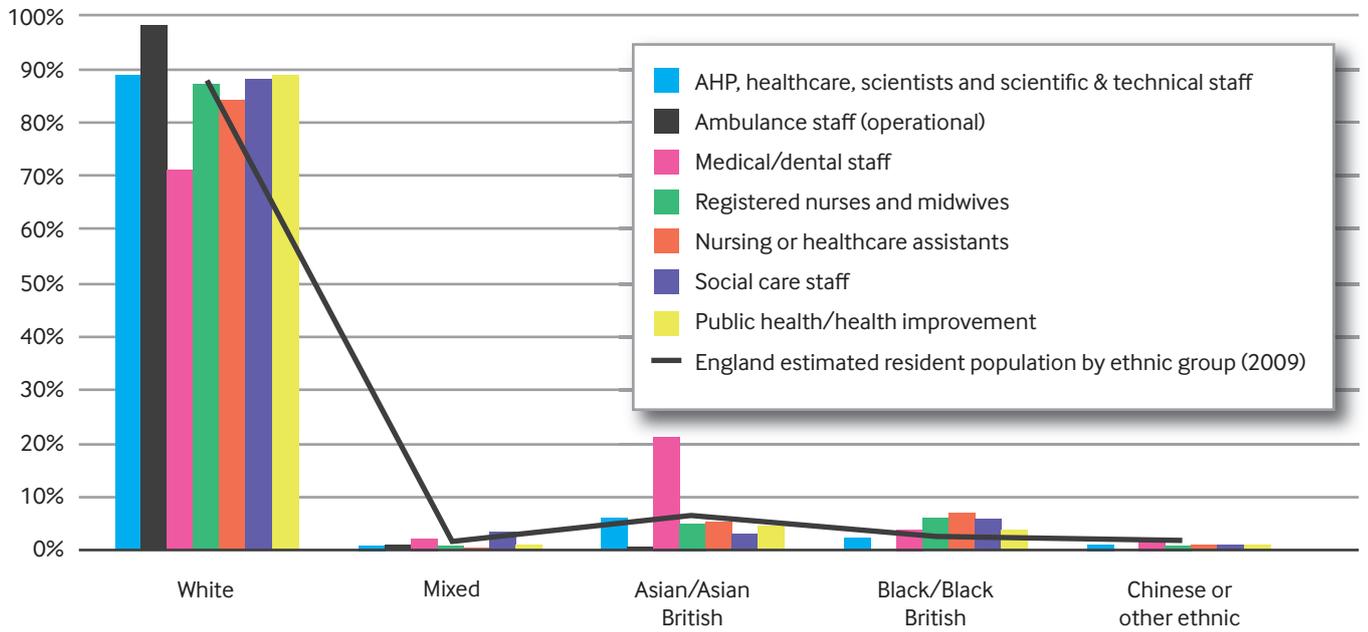
- The health and social care workforces are trained in different ways; many healthcare professionals receive extensive and advanced educational training, whereas many care workers do not hold education qualifications. How can we ensure that the social care workforce, medics, allied health professionals and other members of the workforce function together effectively, in an environment free from hierarchical behaviour and discrimination?

#### How can we encourage people from minority groups to enter the workforce and how do we ensure that everyone is treated fairly with regard to career progression?

It is beneficial if the workforce is representative of the population that it is treating. There are systems and processes in place for healthcare providers and education providers to ensure equality, such as the Public Sector Duty of Equality Act 2010, Office for Fair Access and the NHS equality delivery system. How will the big picture challenges impact the ability of these existing systems to deliver their goals?

- How can we ensure that access to education is truly fair? Will changes to tuition fees affect the numbers or types of people (e.g. from higher socioeconomic classes) that enter undergraduate education and training?
- Can there be new admission procedures to provide equal opportunities to applicants (Wallenburg, 2012)?
- How can we encourage people from minority groups to enter the workforce?

**Figure 30: NHS ethnic background (2011) (NHS Staff Survey, 2011) compared to UK estimated resident population by ethnic group (mid-2009) (Office for National Statistics, 2012b)**



## Conclusion

The CfWI will continue to build on our big picture challenges work in 2013. We are interviewing experts from across the sector to gather opinions on the key workforce questions posed by the big picture challenges. We will produce workforce briefings which synthesise existing work in these areas and include initial analysis to portray the scale of the workforce challenges. These workforce briefings, along with a context document outlining the big picture challenges, will be published for consultation later in the year. We hope that this will demonstrate the need to consider these workforce implications and generate discussion about what needs to be done to ensure the future workforce is able to meet demand.



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# Resources

## The CfWI Horizon Scanning Hub

Over the past year, we have been working with our horizon scanning partners at the University of Manchester and Futures Diamond to develop our new horizon scanning portal and we launched the HS hub ([www.horizonscanning.org.uk](http://www.horizonscanning.org.uk)) in October 2012.

The interactive site allows stakeholders to find and share information about future issues which may affect the health and social care workforce, and we warmly welcome additions and ideas from all our Friends of CfWI and everyone working in health and social care. The HS hub has been designed so that it is easy to find and identify new issues. The hub also maps and prioritises issues, so as to provide stakeholders with information that can be used in workforce planning and wider policymaking. Over the next year we will continue to develop this portal hub ourselves and it will be even more successful with your support.

If you have a new issue you wish to identify, or if you would like to be involved in this exciting project, please contact the horizon scanning team at [horizonscanning@cfwi.org.uk](mailto:horizonscanning@cfwi.org.uk).



## The CfWI's new workforce modelling framework revealed at the annual conference



The CfWI's new workforce modelling framework was launched at this year's annual conference. The framework links horizon scanning, scenario generation and workforce modelling to produce more robust workforce intelligence that can inform better decision making. This approach was successfully piloted on the medical and dental student intakes project, where the framework received positive feedback.

The CfWI plans to use the framework for other projects over the next year. Information about the framework is available at [www.cfwi.org.uk/how-we-work](http://www.cfwi.org.uk/how-we-work).

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# Notes

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