

WORKFORCE WORKSTREAM OUTLINE DRAFT REPORT TO MSG

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1. Introduction

- 1.1 This report seeks to set out some key developments that will be required to ensure we have a workforce that is motivated, competent and available to meet the care needs of older people over the next 20 years. It forms part of the Reshaping Care for Older People Programme and seeks to address the requirements of our terms of reference, as set out in Appendix (i).
- 1.2 The changes required will necessitate more than incremental shifts in our recruitment, training and OD programmes. A key theme running through the report is the need for strong alliances to be fostered and developed across the care provider interests, including with Scotland's unpaid carer "workforce" and across care training and education bodies, building on the good relations that already exist.
- 1.3 We also recognise the need for a greater level of integrated approaches to deliver good person centred care in an efficient and effective manner.
- 1.4 The proposals in this report are the product an intensive period of development work undertaken by a small number of individuals for the Scottish Government, NHS NES, ASD, SSSC and COSLA with inputs from others. As Chair of the small group that has prepared this report I am greatly indebted to the enthusiasm, commitment and skills of all who participated on the group.

2. Context

- 2.1 This report seeks to provide an agenda for developing the health and social care workforce required to deliver good quality care over the next 20 years
- 2.2 The broad context for the judgements made in this report are
 - Demographic changes that will both increase the number of older people requiring care and reduce the 'pool' of working age population available to provide care. At a time when there are increasing numbers of unpaid carers, who themselves will be older, and will be under pressure to support the demands of the labour market by continuing to work for longer.
 - Financial changes that will place severe pressure on commissioners and providers of care and create tensions between service priorities (eg critical and anticipatory care)
 - Service changes that will be increasingly outcomes focussed with a re-ablement or personal/patient centre bias and a shift towards a more "mutual approach" to the delivery of health and social care, which recognises and supports the contribution made by Scotland estimated 660,000 unpaid carers
 - Employment changes that will see a growth in the number of personal assistants and increased requirements for flexibility in approaches,

including employment arrangements which allow for greater integration across professions and agencies

- Technology developments that will change the scope, location and nature of care for both clients/patients and care workers
- Policy stability with a continuing consensus that the overarching goal remains to optimise the independence and wellbeing of older people in their own home or in a homely setting.

2.3 The above context has been translated into a number of “key assumptions” that help to characterise the workforce required for the future. We will require a workforce able and confident to:

- Provide personalised/patient centred care that is flexible, responsive and tailored to meet individual needs
- Offer a re-ablement/rehabilitation approach to care that seeks to optimise the capacity and capability of the individual/patient to ‘self care’ to achieve the best possible quality of life given their circumstances
- Work within a ‘whole systems’ environment providing seamless and integrated care to meet the whole needs of the person, requiring greater generic skills together with good co-ordination across disciplines and professional boundaries, at the same time building on the support that is currently being provided by unpaid carers
- Deliver care within a care pathway approach that recognises that individual needs change and the patient/individual may need to move up and down a care pathway to access particular forms of care at different times

3. Workforce Profile – Current Position and Future Requirements

3.1 This section examines the first of the bullet points in the remit “to determine the scope, size and the skills required for the workforce over the next 20 years based on demographic projections and the reshaping of services to be more patient centred”. Detailing the baseline position i.e. estimating the number of people who currently work providing care to older people. The NHS and social care sector are considered in depth. Volunteers and unpaid carers are also considered. Explores the age profile and qualifications of the current workforce and details the data sources used in the paper and the assumptions that have been made. Consideration of the drivers that will shape the *demand* for the workforce over the next twenty years primarily demographic changes but also changes in the way care is provided. The *supply* of the workforce is also considered and this will largely depend on the pool of workers available to work in the sector for older people services. Given the drivers discussed this will provide estimated projections for the size of the workforce in the next twenty years. Different scenarios are examined however the limitations to the analysis presented in the paper are presented and

discusses improvements in data that are needed to accurately assess the workforce for older people. The final section sets out conclusions and recommendations.

Data and assumptions

3.2 The data for the NHS workforce comes from NHS Information Services Division (ISD), while the data for social sector is taken primarily from the Care Commission's data set gathered from all registered service providers in December 2007 and January 2008. For this collection each registered service was asked to report on the number of people working within it at the point of the return.

Workforce baseline - NHS

3.3 The NHS provides care for all in society and the total workforce of the NHS split by staff group is shown in the table below.

Table 1 – NHS workforce by main staff group as at 30th September 2008

<i>Data as at 30 September 2008</i>	Headcount	Whole time equivalent (WTE)
All NHSScotland staff (including GPs & GDs)	165,551.0	-
All NHSScotland staff (excluding GPs & GDs)	158,978.0	133,095.3
Medical (Hospital, community and public health services)	11,783.0	10,752.6
General medical practitioners (GPs)	4,916.0	-
Dental (Hospital, community and public health services)	752.0	603.7
General dental services	2,703.0	-
Medical and dental support	1,667.0	1,439.6
Nursing and midwifery	67,965.0	57,749.6
Allied health professions	11,342.0	9,242.8
Other therapeutic services	3,722.0	3,135.1
Personal and social care	826.0	692.4
Healthcare science	5,781.0	5,158.4
Emergency services	3,681.0	3,557.7
Administrative services	29,755.0	24,966.1
Support services	20,086.0	14,367.9
Unallocated / not known	1,619.0	1,429.4

Source: NHS Information Services Division (ISD)

3.4 The total number of staff employed (headcount) including general practitioners (GPs) and general dentists (GDs) in NHS Scotland as at 30th September 2008 stood at 165, 551.

Older People's Workforce - NHS

- 3.5 Isolating those NHS staff employed in older care services is difficult, for example for some roles the majority of the care provided will be for elderly people for others it may only make up a small proportion of work time. The table below shows the numbers that were able to be identified as working in care of the elderly. The consultant figures identified are accurate. The nurse figures are less robust, these have been identified by ISD using post descriptors that state "care of the elderly" as the group staff work with. For example for Greater Glasgow only 31 nurses are identified with this post descriptor and for a Board of this size the number will clearly be far greater. The figure of 3,633 is only a minimum figure.
- 3.6 ISD is currently working on a data capture field that will ask for the age of the patient treated by staff group. This will be available for reporting at the end of the year and will give a far greater insight into the staff throughout the NHS that work with elderly patients.

Table 2 – NHS staff identified as working in care of the elderly

Staff Group	Number (headcount) as at end of September 2008	Growth since 1998
Consultants		
Old age Psychiatry	70	49%
Geriatrics	144	27%
Nurses	3,633	

- 3.7 For the purposes of this report for nursing staff an estimate is used to represent those working with the elderly. Government data on who uses community care services has been accessed and the breakdown of uptakes is shown in the table below.

Table 3- proportion of service users 65 or over by type of community care service

Type of service	Proportion of service users 65 or over
Adult day care	53%
All adult residential care	88%
Care at Home	81%
Housing Support Services	48%

Source: Scottish Government

- 3.8 The figure of 53% is applied to adult nurses numbers from ISD to give an estimate of the number of nurses working with elderly people in the NHS. This gives a figure of 20,066 (53% of adult nurses 37,861). Using this figure table 2 has been updated to show the estimated staff numbers working with the elderly.

Table 4 – NHS staff estimated as working in care of the elderly

Staff Group	Number (headcount) as at end of September 2008	Growth since 1998
Consultants		
Old age Psychiatry	70	49%
Geriatrics	144	27%
Nurses		
Adult	37,861	
Total	38,075	

3.9 All other staff groups including medical, allied health professionals and emergency services will also work with the elderly. It is very difficult to estimate how much time these staff groups will spend caring for the elderly. The figure of 38,075 is the **minimum** number of NHS staff that work in care of the elderly. At the end of the year when ISD have captured the age profile of patients that staff work with this can be updated to accurately reflect the number of staff involved in care of the elderly.

Workforce baseline – social services sector

3.10 The Care Commission gathers data annually on all registered care services in Scotland. Table 5 below breaks down the Care Commissions' data by type of employer

Table 5- Workforce headcount by type of employer

Type of employer	Headcount	No. of Services
Health board	330	20
Local authority	50470	3030
Private	66430	2480
Voluntary or not for profit	56320	3300
Not known	840	60
Total	174390	8880

Source: Care Commission data set 2007/08

3.11 From this it can be seen that the majority of staff working in registered care services are employed within the private sector, with the voluntary sector being the next biggest employer ahead of local authorities the smallest. This however is not the whole of the sector's workforce as in addition to the above registered services there are also services that are not required to register. The non-registering services are all provided by local authorities as part of their social work services.

3.12 Using the Scottish Government's annual census of local authority social work services staff it is possible to estimate the numbers of local authority social work staff who do not work in a registered service. The census conducted in October 2007 estimated the total size of local authority social work services

staffing at 56,837. When staff working within registered services are removed then the census identifies three remaining groups of staff, these are set out in table 6.

Table 6 - Non-registered service staff within local authority social work services

Type of location/activity	Headcount
Strategic/central staff	4,248
Criminal justice staff	1,923
Fieldwork staff	12,074
Total	18,245

Source: Staff of Scottish local authority social work services 2007

3.13 Table 7 below combines the data from tables 5 and 6 to give our current best estimate for a breakdown of the sector's workforce by employer type.

Table 7 - Workforce headcount by type of employer

Type of employer	Headcount	As % of whole
Health Board	330	0.2%
Local Authority	68,710	35.7%
Private	66,430	34.5%
Voluntary or Not for Profit	56,320	29.2%
Not known	840	0.4%
Total	192,630	100%

Source: Care Commission data set 2007/08 and Staff of Scottish local authority social work services 2007

3.14 From the combined data in table 7 we can see that in 2007 the local authorities continued to be the biggest employers in the sector – but only just. However, the private sector have grown substantially in recent years as has the voluntary sector and it seems likely that one if not both will overtake local authorities in the next few years. It is worth nothing that while local authorities remain the biggest employers, the 68,710 staff working within them will be spread in many authorities across two, or more, separate departments.

3.15 It is probable that a number of staff working in the sector is still overlooked in these figures as the Commission's data does not include central or strategic staff working for large private or voluntary providers. Nor does it include personal assistants employed under Self Directed Support

Older people's workforce – social services

3.16 As with the NHS workforce data it is difficult to isolate those social services staff employed in caring for older people (i.e. people who are 65 or over). In calculating the size of that workforce, it was firstly decided that only data on community care services (namely, adult day care, adult residential care, care at home and housing support services) would be considered, as it seemed

reasonable to assume that the social services which older people access are primarily such services.

3.17 Table 8 below provides Care Commission data on the numbers of people working within these four community care services.

Table 8 - Workforce headcount by type of other adult care service

Type of service	Headcount
Adult day care	6,973
All adult residential care	52,848
Care at Home	13,350
Housing Support Services	53,591
Total	126,762

Source: Care Commission data set 2007/08

3.18 The figure of 126,760 is the total number of staff working within these Community Care Services. However, community care services are also accessed by people younger than 65. In order to estimate the number of community care staff who care for older people Government data on who uses community care services was accessed and a breakdown of the proportion of service users who are 65 or older is given in table 9. .

Table 9 Proportion of service users 65 or over by type of community care services

Type of service	Proportion of service users 65 or over
Adult day care	53%
All adult residential care	88%
Care at Home	81%
Housing Support Services	48%

3.19 It was then assumed that the proportion of service users 65 or over will accurately reflect the proportion of staff from within the services who actually work with older people. If accurate, this means that, 81% of care at home staff work with people 65 or over while just 48% of housing support staff do etc.

3.20 However, there is further difficulty, namely that the figures for care at home services and housing support services cannot be taken at face value. While the combined total of around 67,000 is thought to be robust the sub-totals are not. The reason for this is that some housing support and care at home services are jointly registered and their staffing figure is combined. The Commission in separating these out allocates the vast majority of such staff to housing support rather than care at home. That this approach is inaccurate is borne out by the Government's annual census of social work services staff where cares at home staff working only in local authorities numbered more than 19,000. Given the inaccuracies in the workforce data for these two service types, the figures in table 8 are likely to under-estimate the total numbers of social service staff working with older people in care at home services and over-estimate the numbers working in housing support services.

Therefore, for the purposes of calculating the numbers of staff working with older people, the number of care at home staff has been estimated as 20,000 and the numbers of housing support staff has been reduced accordingly to 46,941. Using these revised estimates and the proportions from table 8, table 10 below provides an estimate of the numbers of community care staff working with older people in the social services sector.

Table 10 - Estimated community care workforce working with older people

Type of service	Estimated no. of staff working with older people
Adult day care	3,696
All adult residential care	46,506
Care at Home	16,200
Housing Support Services	22,532
Total	88,934

3.21 The figure of 88,934 for the numbers of social services staff providing services to older people is therefore our estimate of the size of this part of the sector's workforce. It should be remembered however, that this data was gathered mainly in the latter half of 2007 and is therefore now almost two years old.

Unpaid Carers

3.22 The term unpaid carer can be defined as, "Individuals who care for a friend, relative or neighbour without receiving paid income in addition to income received through the benefits system." (Care 21: The Future of Unpaid Care in Scotland Report, 2002 p.4).

3.23 It is difficult to estimate the numbers that undertake such care because there is no official record in the way there would be if such individuals were in paid employment. It is also difficult to assess who it is unpaid carers are caring for. Estimates vary on the number of unpaid carers, for example the Scottish Household Survey in 2001/02 suggested that there were approximately 668,200 unpaid carers in Scotland. Other estimates are slightly lower for example the 2001 census estimated the number of unpaid carers was 480,000

3.24 Households with carers are significantly more likely to be located in urban areas rather than rural ones. Large urban and other urban areas account for 69% of households with a carer in the 2007/2008 SHS. Households with a carer are least likely to be in remote locations, small remote towns accounting for around 3% of households and remote rural locations approximately 6% of households with a carer

3.25 The largest proportion of Scotland's carers are located in Glasgow (14%), a highly urban area. This is also interesting in relation to the Scottish Index of Multiple Deprivation (SIMD) findings, with Glasgow accounting for 37% of the bottom 15% of the SIMD. The areas with the smallest proportion of Scotland's

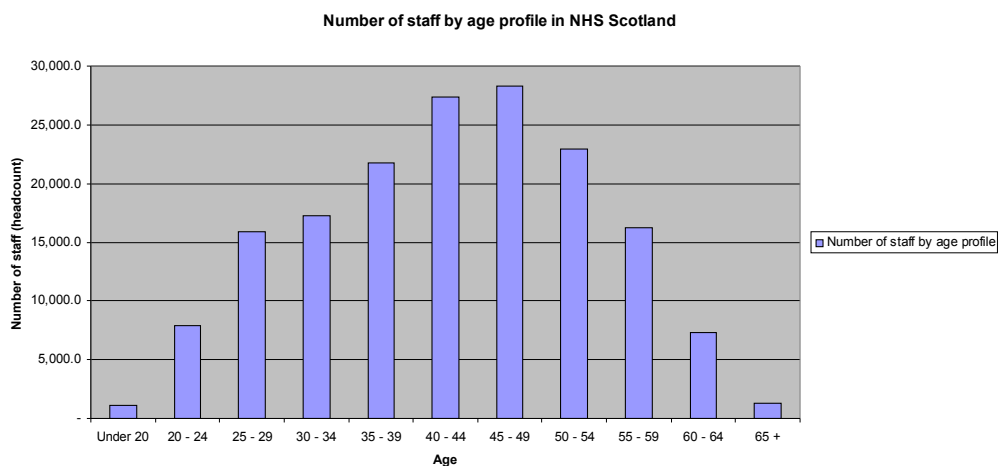
households with a carer are the most remote areas – the Shetland Islands, Orkney Islands and Eilean Siar.

- 3.26 The biggest proportion of households with a carer (28%) are in the 20% most deprived data zones in the SIMD. The proportion of households with a carer then decreases steadily as deprivation decreases, so that the least deprived 20% of data zones also has the least prevalence of households with carers in Scotland (13%). Also interesting in relation to the 2006 SIMD is the 15% most deprived data zones, 21% of Scottish households with someone needing regular help or care are in the 15% most deprived data zones.

Workforce Age Profile – NHS

- 3.27 The age profile of staff is important when planning the workforce of the future. If a workforce has a high proportion of people that is close to retirement age then to maintain the same size of workforce a number of workers will have to enter the sector (*replacement demand*). It is envisaged those staff that currently provide care to the elderly will experience a high retirement rate in the next 15- 20 years.

- 3.28 The graph below displays the number of staff by age in NHS Scotland. As can be seen the majority of staff (28,332) are in the 45-49 age bracket. There is also a significant number of staff in the 40-44 (27,326) and 50-54 (22,904) age category. If this profile of staff remained the same then in the next 15-25 years a large proportion of the staff will be ready for retirement.



- 3.29 It is also important to consider the age profile of staff by health board as geographical areas may experience differences in workforce ageing in the next 15-25 years. However, the graph above is reproduced for each geographic area in Scotland in Annex B and these illustrate that all areas are showing a similar age profile.

- 3.30 The table below draws out some of the difference between Boards by examining the percentage of staff aged 45-64 as a percentage of total staff.

Table 11 – Percentage of staff aged 45-64 as a percentage of total staff for each Board and at Scotland level

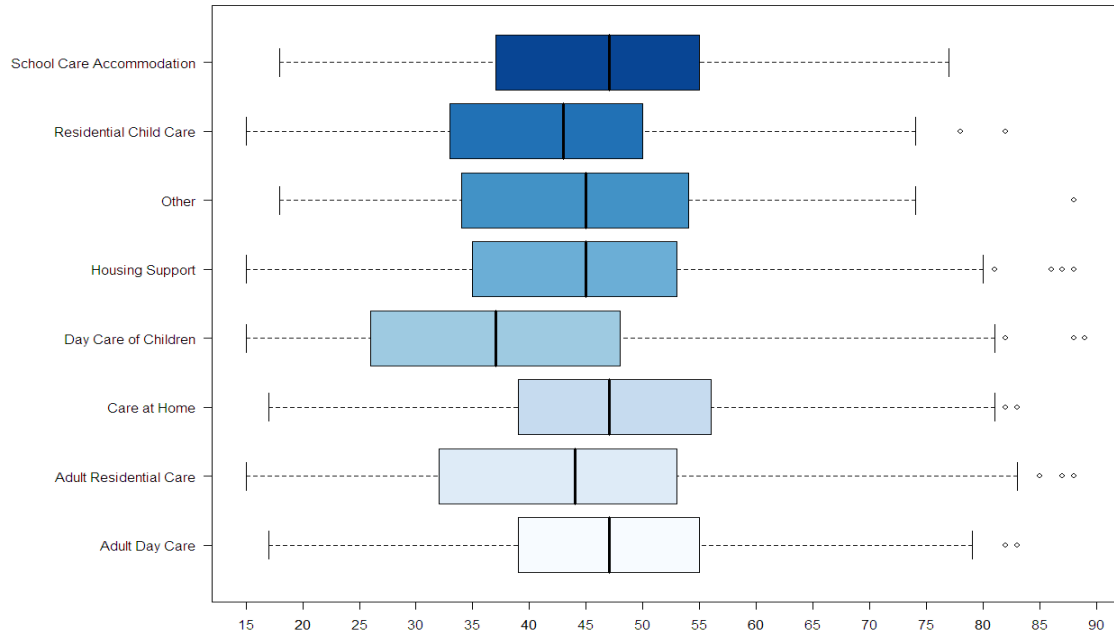
NHS Board	Percentage of staff aged 45-64 as a percentage of total staff
Ayrshire and Arran	45
Borders	46.5
Dumfries and Galloway	49
Fife	47
Forth Valley	46
Grampian	42
Greater Glasgow and Clyde	44
Highland	48.5
Lanarkshire	46
Lothian	42
Orkney	45
Shetland	44
Tayside	47
Western Isles	50
Scotland	45

3.31 As can be seen from the table there is variation across Boards from 42% of staff aged 45-64 as a percentage of total staff in Grampian and Lothian to 50% in Western Isles.

Workforce age profile – Social services sector

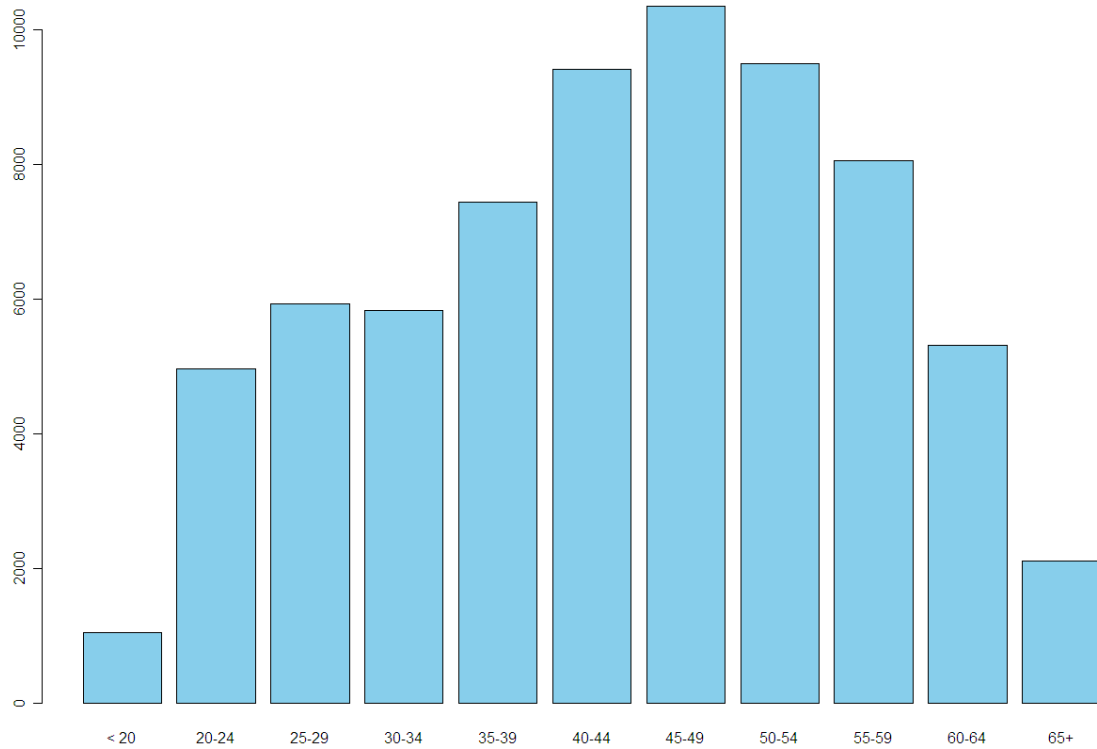
3.32 The age profile of the social services workforce varies across its different sub-sectors with the social work and social care elements having higher average ages than the childcare sub-sector. The box plot in figure 1 below looks at the age of the workforce in its 7 key sub-sectors.

Figure 1- Box plot of workforce age by sub-sector

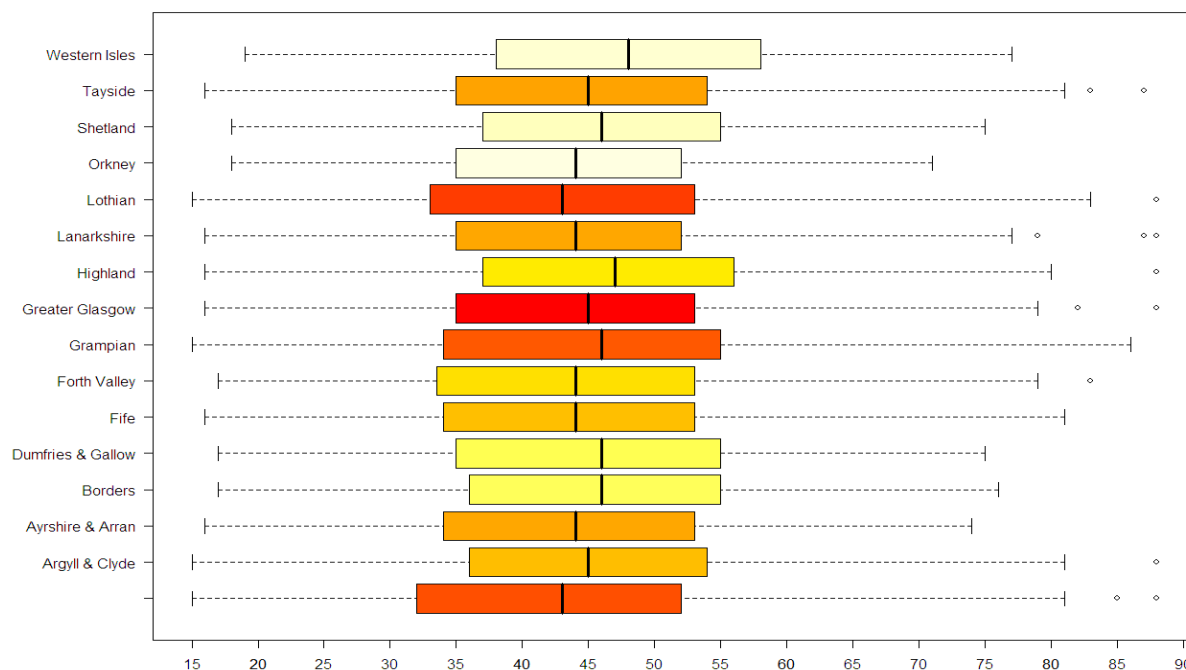


3.33 If we focus in on the workforce in those four sub-sectors (viz, adult day care, adult residential care, care at home and housing support) which are of most relevance to older people then we get the following line graph (figure 3).

Figure 2: age profile of all staff working in “community care” services



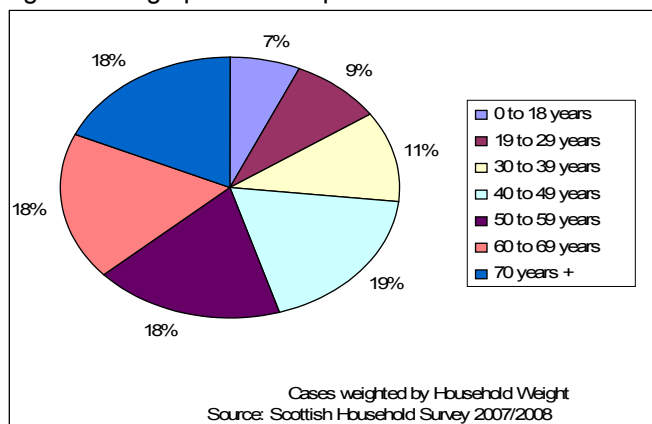
3.34 The following shows a box plot of the age of social services community care staff by health board area. As with the NHS data in appendix B, there appears to be little variation between health Boards although rural Boards appear to have a slightly older workforce.



Workforce Age Profile – unpaid carers

3.35 Figure 5 below shows the age profile of unpaid carers in Scotland, and indicates that most carers in Scotland are from the middle to eldest age groups in society. 40 to 49 year olds make up about 19% of carers; whilst the 50 to 59, 60 to 69 and the over 70 years age groups each make up about 18% of carers. The youngest in society make up the smallest group in carers, by this still account for 7% of all carers.

Figure 5 – Age profile of unpaid carers



Workforce Demand and Supply in Next 20 Years

- 3.36 One of the concerns going forward is that Scotland is projected to experience a significant demographic shift in the years ahead, leading to an increase in the average age, with only the 60 plus age group projected to grow in the period to 2031¹.
- 3.37 What is more startling however and will have an impact on care needs is the growth of the population over 75, 80 and 90 plus. The table below shows the number of people projected to live in Scotland in various older age categories in 2031 compared with 2006.

Table 11 – Projected growth of older age people living in Scotland 2006 and 2031

Age	2006	2031	% Difference
60	58,510	70,460	48
65	48,688	71,870	46
70	45,815	66,904	46
75	38,195	54,861	44
80	28,429	43,873	54
85	18,529	31,013	67
90 plus	32,413	100,519	210

- 3.38 As can be seen from the table it is projected that the number of people aged 80 will have increased by 54% by 2031, those aged 85 by 67% and those aged 90 or over by a staggering 210%. When considering the workforce needed for the future it has to be kept in mind that as people live longer their needs will not be the same as those of a 65 year old. Rather, it is likely that needs will be more complex.
- 3.39 Significant increases in the numbers of older people will also lead to increases in the numbers of unpaid carers in Scotland, who themselves will be older. Unpaid carers already make a very significant contribution to relieving health and social care services of demands that they would otherwise face. While this contribution is likely to grow, the increased numbers of unpaid carers will place greater demands on health, social work and voluntary sector agencies for the support, training, respite breaks that they need to sustain this caring contribution.
- 3.40 A change in the age structure of the population will affect the workforce through a change in labour supply. Unless there is an increase in labour participation among older people or more people of working age are attracted to Scotland, the availability of labour to work in the Scottish Economy (and the care sector) will be reduced. The Scottish Government has set a target to “match the European (EU-15) population growth over the period from 2007-

¹ General Register for Scotland 2006 based population projections.

2017, supported by increased healthy life expectancy in Scotland over this period"².

3.41 As the population ages there will also be an increase in the demand for health and other care services. Factors that have contributed to increasing demand in the health sector are as follows:

- Increases in life expectancy
- Medical advances that widen the range of conditions that can be treated, and,
- Increasing expectations from the public regarding access to services.

3.42 It is likely as the population ages there will be increases in demand for elective care i.e. non-emergency demand such as cataract and hip replacement surgery. Similarly, major health problems such as cancer and coronary heart disease are more common in later life as are complex care needs.

Workforce Projections

3.43 In order to work out what workforce needs will be in the future a simple approach has been adopted that examines the ratios of workers to those over 65 now and in the future.

3.44 The table below shows the total number of workers that were estimated to work with older people in the NHS and social care sectors and the numbers of the Scottish population over 65 in 2008. This gives a ratio of 0.13 workers for every person over 65.

Table 13- Workforce to population ratio, 2008

Workforce	127,009
Population over 65	858,657
Workforce to Population Ratio	0.13

3.45 The table below shows how many workers would be required to keep this ratio constant in 2031. The number of staff would have to be around 204,000, an increase of 60% on 2008 levels.

Table 14- Workforce to population ratio, 2031

Workforce	204,016
Population over 65	1,360,111
Workforce to Population Ratio	0.15

3.46 This simple calculation illustrates that to keep this ratio constant more people will have to enter the workforce that cares for the elderly. This does not take account of the high number of people that are likely to exit this sector in the

² Government Economic Strategy - <http://www.scotland.gov.uk/About/scotPerforms/purposes>

next 20 years, indicating that as well as extra demand being created by an increase in the number of older people, more people will be needed to replace those leaving through retirement.

Data Limitations

- 3.47 One of the major limitations is that it is very difficult to estimate with any accuracy the number of NHS employees involved in care of the elderly. The analysis above only takes into account consultants that can be identified as working with the elderly and nurses using a proportion based on those who access adult care services. In reality a wide range of NHS professionals will be involved in care of the elderly and as the population continues to age the time spent by NHS professionals in caring for older people will only increase. The above analysis is likely to underestimate the number of NHS professionals that currently are involved in care of the elderly. ISD are currently updating their workforce system to include age of patient that NHS staff predominantly care for, once this is complete it will be interesting to revisit the number of NHS staff that care for the elderly.
- 3.48 Similar difficulties do exist in the social services sector and the approach taken in this report has been to focus solely on the four types of community care services delivered by that sector. Current data gathering processes do not provide an accurate breakdown of care at home or housing support services.
- 3.49 The data used in the paper has been headcount data, i.e. the number of people in employment and not whole-time-equivalent (WTE) data. In making projections of the size of the future workforce it has been assumed that the future workforce will have the same proportions of part-time and full-time staff as is currently the case.
- 3.50 In projecting the likely future demand for services it was assumed that the levels of need amongst older people will remain constant. So, if x% of older people currently require adult day care services now then it is assumed that in future the same proportion of older people will also require such support. It has therefore been assumed that the balance of services remains the same.
- 3.51 While this paper looks at the overall projections for the sector's workforce (expansion demand) in the light of the expected growth in need for services it has not attempted to distinguish between "expansion" demand and "replacement" demand within the workforce. Data on staff turnover within existing community care services was not readily available nor was an accurate picture of the age profile of those in community care services as a result an estimate of replacement demand was not attempted.
- 3.52 In view of the difficulties already outlined in identifying those who work with older people, robust data on the skills and qualifications of this workforce is not available.

- 3.53 It has been assumed that data on those currently receiving a community care service is a good proxy for the levels of need for such services. Therefore the issue of unmet need has not been examined.
- 3.54 It was assumed that the staff to service user ratios will remain the same in the future as they are now.
- 3.55 It has been assumed in the future workforce projections that the proportion of older people supported by unpaid carers will remain constant. This would seem to mean that the total numbers of carers in Scotland would increase.

Conclusions and Recommendations

- 3.56 The remit for the Workforce Group was defined as, "...determine the scope, size and the skills required for the workforce over the next 20 years based on demographic projections and the reshaping of services to be more patient centred." While not all elements of this remit have been able to be covered in this report, an overview of the numbers of people working within the health and social services sectors delivering services to older people has been presented. This work has identified a number of areas where improvements in data are required if the work outlined in the remit is to be completed.
- Distinguish between care at home and housing support staff within services which are jointly registered with the Care Commission as housing support and care at home.
 - Distinguish between those who provide services to older people (within the NHS and social services sector) and those providing similar services to other adults.
 - Improve quality of data on qualifications/skills within the social services sector.
 - Devise scenario(s) regarding preferred future shape(s) of older people's services.
 - Modelling of future workforce using scenarios and variable assumptions.
 - Improve understanding of role of volunteers.

4. Recruitment Requirements and Challenges

Introduction

- 4.1 This section considers a number of the key issues that care providers must consider as they attempt to plan the services that will be offered to meet the needs of Scotland's ageing population. Specifically, it considers the recruitment requirements and challenges that service providers will face in a climate of increasing financial difficulty and uncertainty.

Demographic pressures

- 4.2 As has already been outlined, there is likely to be significant demand for changed and expanded services as a result of the changing composition of Scotland's population. Indeed, it is clear that demographic change and, specifically, the ageing of the population, will have a major impact on how the social services workforce will have to be shaped going forward.
- 4.3 Not only is the number of older people in Scotland increasing, but the number of younger and economically active people is projected to decline too. The result is an imbalance in the number of older people relative to the economic base in society. Consequently, not only will there be an increasing demand for health and community care services but, crucially, society will become increasingly unable to afford to provide these services if the traditional model of care is maintained.
- 4.4 A further consideration is the extent to which those who need care will have their care needs met via informal care provided by family or friends. *The Future of Unpaid Care in Scotland* report (Scottish Executive, 2006) indicated that 1 in 8 of the Scottish population provide care on an informal basis. If levels of informal care drop in the future then greater demand will be placed on formal care. A recent European Commission report (2008) on the future of long term care predicts that informal care will decrease across Europe and links this primarily to greater numbers of women participating in the labour market and therefore not being free to provide informal care to the same degree. However, whether this will happen in the UK is unclear as women already have high levels of labour market participation.

Financial pressures

- 4.5 Another major challenge with respect to the delivery of care services for older people, is the current economic situation which is putting added pressure on all employers. The public sector is facing a £500m reduction in funding in 2010/11, while it is predicted that there will be a loss of resources in the order of 15% over the years of the next Comprehensive Spending Review. Furthermore, the funding situation for the public sector in the long term is also looking particularly bleak. Thus, local authorities and health boards will almost certainly have less resources available to deliver the care services that will be required going forward. Clearly, private and voluntary providers will be affected as well. For instance, it is likely that those organisations that deliver services on behalf of local authorities will not be immune from the effects of funding pressures faced by their commissioners.

Recruitment and retention issues

- 4.6 Aside from these significant pressures, the social services sector faces a number of particular challenges in relation to the recruitment and retention of staff. While there is not a great deal of information available regarding the career paths followed across the whole workforce, the independent care

home sector, through its umbrella organisation *Scottish Care*, carried out a survey of its workforce in 2007. The resultant report provides an interesting analysis, the findings of which may well point to wider trends within the sector as a whole.

4.7 Private and voluntary care homes employ approximately 85% of the total number of care home employees in Scotland who, in turn, make up over 25% of the total social services workforce. In terms of the composition of the workforce, 95% of staff are permanent, 86% are female and 59% work on a full time basis. 26% of workers are under 30 and 32% are over 50, although larger care homes tend to have younger age profiles. 13% of staff are from outwith the UK, while 7% are employed under work permits.

4.8 However, perhaps more pertinent for this paper are the following findings:

- Vacancies are as follows:
 - Managers: 5%
 - Supervisors: 12%
 - Practitioners / Support Workers: 27%
 - Ancillary staff: 16%
- The most difficult to fill vacancies are for Practitioners and Support Workers, with 74% of workplaces indicating difficulties in recruiting these staff;
- The key reasons given for recruitment difficulties were poor attitudes, motivation and personality and too few applicants;
- Turnover runs at approximately 19% (Note: This is considerably higher than the national average of 15.7% and an average of 12.6% for the public sector (CIPD, 2009));
- Only 4% of leavers moved out of the independent sector but, of these 50% move into public services (25% to local authorities and 25% to the NHS). Those who moved to local authorities did so to take up support worker roles, either in care homes or in care at home settings. Those who moved to the NHS took up nurse training or health care support worker roles. In both instances, the public sector was said to offer both greater security and improved pay and conditions.
- Overall, the main reasons given for leaving were improved pay (74%), working closer to home (33%), improved conditions (20%) and promotion (19%);
- Respondents indicated that a lack of access to funding and a lack of cover for training were the key obstacles to developing the workforce through training. Pay and conditions were noted as another important barrier.

4.9 Bearing such findings in mind, it seems clear that the independent care home sector has problems recruiting and retaining staff, and particularly staff in lower skilled jobs. With limited options for career progression, it may be that these roles are not viewed as particularly attractive to either current or would-be employees. What is more, the pay and conditions that are on offer do not seem to be sufficient inducements to attract and retain employees. Indeed, anecdotal evidence would suggest that the retail sector, and supermarkets in particular, provide the key competition in this regard, given that they tend to

offer slightly higher wages. On the other hand, the low qualification requirements and levels of flexibility that many of these roles offer may also be viewed as desirable for some workers, and this is perhaps reflected in the high percentage of part time and female workers that are in post.

- 4.10 Notwithstanding the advantages and disadvantages of following a career in the sector, it is likely that skills upgrading will be required to improve the quality of services that are offered – given the shift in the balance of care services to care at home, it is likely that those services provided outwith the home will increasingly be for those with higher levels of dependency. Consideration must therefore be given to the means of attracting and retaining appropriately skilled staff in sufficient numbers going forward.
- 4.11 The independent care homes report also notes that difficulties exist in the recruitment of appropriately skilled managers and supervisors. While their career progression options tend to be better, it seems that there are still issues attracting these staff. Therefore, while it would be unwise to make hasty generalisations about the whole sector, it would seem that there is a need for improved recruitment and retention of staff at all levels. It may be that consideration of means of raising the profile of the social services sector as a whole is required in order that it is viewed as a valuable area in which individuals would wish to establish a career. At the same time, thought should also be given to specific roles within the sector, so that appropriate numbers of staff, from ancillary workers up to managers are recruited and retained going forward.
- 4.12 It should also be highlighted that the challenges which exist in the sector are not necessarily the same for all employers. For instance, it would seem that private and voluntary providers are having particular difficulties in relation to recruitment and retention. Current procurement and tendering activities cause particular problems for the voluntary sector, while the disparities that exist in relation to terms and conditions also have a significant impact. Local authorities – and, indeed, the NHS – tend to offer greater security, pay and conditions than their voluntary and private sector counterparts and, as a result, it would seem that other employers tend to lose their workers to both.
- 4.13 There are also clear challenges to be faced with regard to the size of the workforce going forward. To meet the increased demand arising from demographic change, it is likely that a larger and more highly skilled workforce will be required to deliver both health and social care to a population with more complex needs. However, given the financial constraints that exist, consideration is required as to how the workforce can be recruited and deployed in the most effective manner. For instance, it is likely that the social services and health sectors will have to work much more closely together, while the workforce itself will have to be more flexible than is currently the case. Therefore, consideration should be given as to how the existing boundaries between health and social care can be broken in order that care providers and their employees are enabled to deliver services that are fit for purpose. More generally, it may also be the case that an examination of the shape and structure of broader structures is required to determine whether

these remain appropriate to deal with pressures on the scale that will be faced in the future. Cost pressures and resource squeeze can be mitigated by programmes such as efficient government and shared services, and by various policy initiatives, but it is unclear whether these will suffice.

- 4.14 The extent to which migrant labour is and can be used also needs to be considered. Recent SSSC research has shown that, at present, migrant workers only represent a small percentage of the total social services workforce. In a survey of 611 care establishments, excluding adult residential care, approximately 17 per cent of the establishments employed migrant workers, while only 2.5 per cent of their workforce was migrants. Similarly, in a survey of 200 care homes, migrant workers comprised 5 per cent of their total workforce, with the majority employed in the private and voluntary sectors.
- 4.15 The proportion of migrant workers in residential care settings therefore lower than many other sectors of the economy. For instance, 22 per cent of workers in the UK hospitality sector are migrants, while they make up approximately 11 per cent of the total UK workforce. Consideration should therefore be given to the extent to which a larger migrant labour force can be attracted to this sector should the need arise. With that in mind, the UK Government's Migration Advisory Committee (MAC) currently advises on sectors to which migrant workers from outwith the European Economic Area can be recruited as a means of militating against labour shortages. At present, only skilled senior care workers are on the MAC shortage occupation list. Therefore, it may be that consideration is required as to whether that list may be extended to cope with the increased demand for workers in the sector that is likely to arise in years to come.

Strategic workforce planning

- 4.16 Bearing such issues in mind, it is vital that employers work together in order that the workforce of the future is able to deal with the pressures that are to be faced. There is already recognition across the health and social services sectors of the importance of strategic workforce planning. Indeed, there are a number of different organisations engaged in workforce planning activities on a national level. These include COSLA and the Improvement Service on behalf of local government, the NHS, the Private Care Sector Workforce Initiative, the Voluntary Sector Social Services Workforce Unit, the Joint Improvement Team, and the Scottish Social Services Council (SSSC). Similarly, on a local level, individual employers and the Social Services Learning Networks are also involved in workforce planning. However, it would seem that the planning which is currently undertaken, whether locally or nationally, is not necessarily carried out in a coordinated and strategic manner. Rather, it frequently amounts to little more than workforce profiling and succession planning. While this is certainly necessary, it is not a sufficient means of tackling the pressures caused by the economic and demographic situation outlined above.

- 4.17 To be successful, workforce planning must be connected with wider service and financial planning. It must also be carried out collaboratively, with whole systems planning taking place at both a local and national level. Thus, a strong interface must be developed between the work of local government, Health Boards, private and voluntary providers. There is some evidence that this is already taking place with initiatives such as the integration of job roles. Single Outcome Agreements can also facilitate joint working between community planning partners on a local level, as can the development of joint community care plans. Furthermore, strategic fora such as the National Workforce Group, can ensure that all of the key stakeholders not only share intelligence, but also map out future collaborative initiatives for the development of the social services workforce.

Education and training

- 4.18 Consideration must also be given to innovative means of attracting and retaining motivated employees. Attractive career paths should be developed to ensure that public, private and voluntary providers are employers of choice. One means of facilitating this is by providing education and training options for employees at all levels. There is a strong argument that employers should take responsibility for improving the skills of their entire workforce – opportunities for development should not just be luxuries afforded to those who are already highly skilled and qualified. However, it is frequently the case that those in lower skilled jobs are not given sufficient opportunities to increase and adapt their skills, while there can also be a lack of financial recognition of any new competencies and skills that they do develop. There is also concern within the independent and voluntary sectors that their staff are not afforded the same education and training opportunities as their counterparts in the NHS and local government, thus causing further drift towards the public sector. Therefore, consideration requires to be given to means of improving approaches in this regard in order that disparities are diminished.
- 4.19 Again, action is already being undertaken in this area. While the public sector is often seen as the main beneficiary with regard to training opportunities, the new Modern Apprenticeships in Health and Social Care have opened up opportunities for those in the private and voluntary sectors as well. From a regulatory point of view, the National Care Home Contract between local authorities and private care homes ensures that certain criteria are met with regard to qualifications of care home employees, while the SSSC has a particular role to play as a Sector Skills Council, carrying out analysis of the sector's skills needs and ensuring that a suitably skilled and trained workforce is in place by means of its registration programme.
- 4.20 Consideration should also be given to issues around management and leadership and the development of a greater capacity to deliver the change that is required in the care of older people. While targeted courses such as the national Leading to Deliver programme and the partnership programme developed by West Lothian CHCP have been developed in the past,

consideration should be given as to whether the courses that currently exist are fit for purpose given the significant changes that are likely to occur going forward.

Rewards

- 4.21 Both financial and non-financial rewards should also be considered as means of recruiting and retaining workers. In the constrained financial environment that exists, it may be that employers can place more emphasis on the non-monetary benefits that exist for employees. Such non-monetary benefits not only reward employees, but they also reap benefits for employers in terms of improved recruitment, retention and performance and the resultant efficiencies that these bring. The public sector provides many such benefits, from holidays and pensions on a national basis, through to the large variety of preferential benefits, recognition schemes and flexible working arrangements which individual employers offer. However, their total value is often not emphasised fully enough, while, again, a disparity exists between what the public, private and voluntary sectors can offer in this regard. Thought must therefore be given as to how this disparity can be tackled if the different providers are to work together in a more coordinated and complementary manner going forward.

Tackling sickness absence

- 4.22 As well as continuing to recruit and retain the right staff, consideration also has to be given to means of ensuring that these staff then work in an efficient manner. With that in mind, sickness absence continues to be a significant source of lost productivity and service disruption. There are substantial financial implications associated with this, not only in terms of the cost of absence management itself through the provision of sick pay, but also the impact of having to resource overtime and additional members of staff to ensure the necessary work is completed. This is therefore one of the key areas where efficiency savings can be made if tackled effectively.
- 4.23 Across the UK, it is estimated that around 175 million working days are lost to illness each year with the annual economic costs of sickness absence and worklessness associated with working age ill-health assessed to be over £100 billion. In Scotland, local authorities reported that, on average, 5.7% of all working days were lost due to sickness absence for 2007/08. The equivalent figure for the NHS is 4.96%. As such, more robust means of tackle absence must be considered and a more strategic approach is required to ensure that a healthier workforce is maintained. With that in mind, and in the light of Dame Carol Black's report 'Working for a Healthier Tomorrow', the Scottish Government and key partners have begun a review of the Healthy Working Lives strategy. This is a further means through which the sector can bolster and protect the health of its workforce going forward.

Conclusion

- 4.24 The issues outlined above point to the need for an overarching review of how care for older people is delivered if a workforce that is fit for purpose is to be created. It is vital that such workforce planning is carried out in a strategic, holistic manner and not in the piecemeal fashion that is often the case at present. Careful consideration is also required as to the career paths that need to be developed in order that an appropriately skilled workforce is in place. Any restructuring or realignment of the workforce will require employers to work in partnership with the relevant education and training providers and other key stakeholders in order that there are sufficient numbers of appropriately trained workers in future.
- 4.25 It is also clear that the information which we have on the current workforce is incomplete. Thus, there is perhaps a need for a better understanding of its skills and makeup in the first instance. Such intelligence can then be used as a means of informing discussions on how the workforce should change going forward. A number of questions are suggested below as a means of improving the intelligence that currently exists:
- What qualification levels do entrants to the sector have?
 - What occupational backgrounds are entrants recruited from?
 - What are the reasons for employees joining the sector?
 - How long, on average, do employees stay in the sector?
 - What are the reasons for employees leaving the sector?
 - What do other employers offer that the sector does not?
 - What other obstacles to the recruitment and retention of appropriately trained staff are currently in place?
 - How do public, private and voluntary providers differ with regard to the above questions?
- 4.26 More broadly, some further questions are also set out as a means of igniting debate as to the shape of the workforce going forward:
- How can career pathways be established to make social care more attractive?
 - To what extent should consideration be given to the professionalisation of the workforce by means of improved formal education?
 - Could methods of joint workforce planning address some of the disparities that currently exist between the public, private and voluntary sectors?
 - Is there scope for using non-monetary benefits such as free or subsidised physiotherapy to tackle sickness absence? If so, could resources be pooled across local authorities, the NHS and the independent sector to improve provision of such benefits?

5. **Educational and Training Programmes to Support Working with Older People and National Career Frameworks**

- 5.1 This section provides an overview of education and training provision to support Older People. Initially undertaken by a desk top scoping exercise of education and training provision of undergraduate and postgraduate level programmes provided by Scottish Universities and the range of vocational qualifications provided by Scottish Colleges. Specific education to support working with older people provided by NHS Education for Scotland is discussed along with other providers, namely charitable organisations

Scottish Universities and Colleges Provision

- 5.2 A scarcity of named academic awards for programmes of study working with older people at undergraduate and postgraduate levels across Scottish higher education institutions exist. Although it should be noted that this information is from academic years 2006-2007, it is unlikely that there would have been significant changes to the provision.
- 5.3 Whilst named academic awards in the form of Bachelor and Masters degree are sparse a desktop search identified a number of individual stand alone modules that would be suitable for those who work with older people with many being professional discipline based e.g. Foundations in Nursing Older People, Nursing the Older Person: An Evidenced Based Approach. Whilst other modules support health and social care professionals: Safeguarding Vulnerable Individuals and Families. Others multi disciplinary modules available include Exploring Ageing, Maximising Older Peoples Potential and Reconstituting Older Peoples Personal Lives in Uncertain Times.
- 5.4 However, there is widespread provision of modules / professional developments programmes which may support working with older people but all predominately focus on medical conditions; for example; Management of Stroke, Cancer and Palliative Care; Mental Health; Long Term Conditions. University of Stirling offers named postgraduate / Masters academic award in Dementia Studies.
- 5.5 Undergraduate professional preparation programmes in health; namely; Nursing, Medicine, Physiotherapy, Speech & Language Therapy and Occupational Therapy all provide both theoretical and practical experiences with working with older people.
- 5.6 Scotland's Colleges similarly have a range of 'mix and match' units of study approach at a range of SCQF levels 4-8, Professional Development Awards but again focus on predominately medical conditions associated with ageing e.g. Dementia Care, Continence Management.
- 5.7 Scottish Colleges are proposing to develop modular training opportunities that provides scope for a "passport" approach to facilitate transferability of qualifications across sectors and learning institutes.

- 5.8 The provision of education and training programmes to support working with older people is in stark contrast to provision for those who work with Children and Young People where a range of named national awards are available. Many programmes are offered part time with students working in care environments whether in the public, independent or voluntary sector.

NHS Education for Scotland Educational Resources

- 5.9 'Working with Older People in Scotland – A Framework for Mental Health Nurses'- was launched in March 2008. This is a capability framework developed as a result of the findings and action plan of *Rights, Relationships and Recovery*, the report of the first national review of mental health nursing in Scotland (Scottish Executive Health Department (SEHD) 2006). The framework is made up of six domains covering:
- respect, rights and choices
 - communication
 - relationships
 - health and well-being
 - dementia care
 - end-of-life care
- 5.10 The capabilities are defined on 4 levels, growing in complexity in terms of knowledge skills and practice required from practitioner level to nurse consultant. Although the framework is aimed at mental health nurses working with older people the practitioner level could apply equally to all nurses working with older people. It should be used across the spectrum of care for older people with mental health problems. It also highlights the role Mental Health Nurses should play in supporting, advising and educating other professional and staff groups across the spectrum of care as well as promoting their specialty as a positive and exciting career option.
- 5.11 A generic competency framework relevant to the care of older people, *A Route to Enhanced Competence in Caring for Older People* was published by NHS Education for Scotland in 2003.
- 5.12 Connect in Care is a network supporting learning & practice development in the care of older people. It is a 3 year funded project which began in February 2007. It is funded by NES and NHS Quality Improvement Scotland and developed in partnership with the Care Commission. It is administered by *the Centre for research on families and relationships* at the University of Edinburgh. This is a web based network for all staff working in services for older people across all sectors. It supports collaboration and practice development across all care sectors. To facilitate working and understanding across all sectors and translation of knowledge to practice 4 Project Sites were initially established which involved at different care sectors and had a themed focus for development. These are Lanarkshire – Sharing Decision-Making; Highland – Supporting a Good End of Life, Tayside – Managing Transitions and Lothian – Supporting the workforce to be fit for purpose. This was extended to Shetland in the second phase of the project. The website

offers resources, details on each project and links to other relevant developments as well as sharing of best practice.

- 5.13 The Profile of Learning Achievements in Care Environments Project (PLACE) - Launched 2007. This is a 3 year research study funded by NES and QIS. The aim of this study is to develop a toolkit for assessing and developing the quality of a clinical learning environment; from a user perspective, in areas where older people are cared for. Users in this study include registered nurses, students of nursing, older people, family and paid carers. The PLACE toolkit will highlight areas of success and achievement in creating an enriched learning environment for user groups as well as highlighting areas for improvement. The aim of this study is to develop a toolkit for assessing and developing the quality of a clinical learning environment from the user perspective. The PLACE toolkit will use the 'Senses Framework' to begin to recognise, explore and create enriched learning environments in which the needs of learners in the clinical area (nurses, nursing students, older people, family and paid carers) are understood and met.
- 5.14 The underlying research objectives focus on enhancing clinical learning environments through:
- improving awareness of the needs of all learners in the clinical environment;
 - enhance the learning opportunities for nurses, care assistants and students of nurses in clinical areas;
 - enhance the learning opportunities for older people and family carers in clinical areas;
 - enhance the mutual understanding of the learning needs of all stakeholders in the clinical area;
 - increasing the availability of potential placements which meet NES quality practice placement standards by giving staff confidence in their abilities and resources to support and sustain learning in themselves and others;
 - capturing the imagination of student nurses in seeing the positive attributes of a career in gerontological nursing.
- 5.15 In supporting the Scottish Governments Dementia Strategy Work Programme: NES has a number of education resources to support this
- 5.16 Increasing access to evidence based psychological therapies (IAPT) for people with dementia and their families/carers. NES is establishing a multi-disciplinary working group to develop a plan in this area as part of the broader NES IAPT work stream which will report in April 2010.
- 5.17 Implementation of Part V of the Adults with Incapacity Act (AWI) and linkages with other related legislation. There is considerable evidence from a number of reports including '*Older and Wiser*' (Mental Welfare Commission, 2007) and '*Remember I am Still Me*' (Mental Welfare Commission/Care Commission, 2008) and the soon to be published *NHS QIS report of Learning Disabilities Services* - that implementation of Part V of the AWI is patchy with several

examples of poor practice. These reports and reviews highlight that staff have knowledge and skills development needs in applying the provisions of the Act to practice situations.

- 5.18 NES commissioned a scoping exercise in 2009 to ascertain the need for additional educational developments to support implementation of the Adult Support and Protection (Scotland) Act (2007). A report of the findings of the scoping exercise reported in June 2009 and highlighted similar issues relating to the AWI Act. In response NES will establish a Networking Group of trainers from NHS Boards to share best practice across Scotland and develop educational resources where gaps are identified for both the Adult Support and Protection Act and The Adults with Incapacity Act.
- 5.19 Supporting work force development in early intervention post diagnosis of dementia. In December 2008 NES commissioned the Dementia Services Development Centre to develop and deliver an educational programme to support early interventions for people receiving a diagnosis of Dementia. The first cohort of nurses/ AHP's completed the programme in 2009. A second cohort of 40 Nurses/ AHPs commenced in September 2009 and an educational resource based on the programme will be disseminated throughout NHS Scotland at the end of October 2009.
- 5.20 Supporting work force development in dementia care in A&E departments. In February 2009 the SGHD issued guidance on *'Recognising the Needs of People with Dementia in NHS Accident and Emergency Departments'*. In response NES are scoping the educational workforce requirements to enable front line staff working in accident and emergency departments to meet the needs of people with a diagnosis of dementia in this context. As an initial step in this process NES ran a workshop for key staff in A&E, Acute Care and other relevant stakeholders to identify current models of best practice in this area and begin to identify educational requirements.
- 5.21 Supporting Values Based and Recovery Focused Practice -As an outcome of *Rights, Relationships and Recovery-* the Report of the National Review of Mental Health Nursing in Scotland (SEHD, 2006) NES developed and disseminated educational resources to support values based practice in mental health, - *the 10 Essential Shared Capabilities (ESC) for Mental Health – Learning Materials (Scotland)* (NES, 2007). Thereafter NES and the Scottish Recovery Network (SRN) developed a framework *'Realising Recovery- A National Framework for Learning and Training in Recovery Focused Practice'* (NES 2007).
- 5.22 This framework outlines the knowledge, skills and values that mental health workers need to practice in a recovery focussed way and builds on the foundation provided by the 10 ESC learning materials. NES has continued to support the delivery and dissemination of the 10 ESC and recovery based training in NHS Scotland initially via a training for trainer's initiative over two cohorts to a total of 70 trainers. On going support is through NES provision of regional coordination to NHS Boards, multidisciplinary and agency networks of trainers. The learning materials and the training for trainers programmes

were developed in such a way that they are relevant to a wide audience - including people in all roles and settings who are involved in mental health work. This includes service users, families and carers, managers, practitioners, volunteers, peer support workers and all workers within the wider mental health community.

- 5.23 The ESC's are currently in the process of being developed for all sectors not just mental health. In addition as part of the support for implementation of '*Working with Older People in Scotland - A Framework for Mental Health Nurses*' (NES 2008) NES are developing learning activities specific to the care of older people which trainers can use as part of the ESC's training.
- 5.24 NES Palliative care work programme -As part of this wider NES programme to support the implementation of *Living and Dying Well* NES will develop the training and education needed to best support palliative and end of life care for people with dementia.
- 5.25 As a starting point NES has worked in partnership with Alzheimer's Scotland to modify and disseminate educational resources, originally developed for the Independent Care Home sector, more widely for NHS staff. Alzheimer's Scotland are currently disseminating these resources through training for trainer events which are multi –agency and include NHS staff.

Other Providers

- 5.26 This includes many National Carer Organisations providing training to unpaid carers to enable them to continue to provide care safely and effectively. Some are funded by Scottish Government directly and others supported through the funding provided to NHS Boards to advance their Carer Information Strategies.
- 5.27 Age Concern Scotland offer short open and in-house courses to people currently engaged in the care sector and longer term training to people who are employed or seeking employment. Short open courses of one and two day courses are open to people from any organisation or to individuals who wish to attend the training and pay for themselves. Popular topics include; Dementia, Creative Activities, Basic Welfare Benefits, Protection of Vulnerable Adults and Modern Management in the Care Sector.
- 5.28 Special initiatives include:
- Pre Retirement Training for groups of retiring people from any type of organisation
 - Through Other Eyes sensory impairment simulation workshop
 - Age Diversity in the Workforce for organisations who are keen to benefit from implementing the Government's Code of Practice on Age.

Aged Concern Scotland also provides a wide range of Scottish Vocational Qualifications (SVQ) in care at level I, II, III and IV. The four national Age

Concerns in the UK have joined together with Help the Aged to form new national charities dedicated to improving the lives of older people

- 5.29 Alzheimers Disease Scotland provides a Carer Training Programme which is a training and information service specifically for family carers of people with dementia. In addition the Learning Development Unit offers a variety of courses for Alzheimers Scotland staff also provides SVQ training
- 5.30 Skills for Health and Skills for Care provide a broad range of National Occupational Standards and competencies to support employers for working with older people

National Frameworks

- 5.31 Both the health and social care sector have frameworks which support the education and training of the workforce.
- 5.32 The NHS Knowledge and Skills Framework (KSF) has been designed to support the development of individuals in their post and in their careers. It provides a single, consistent, comprehensive and explicit framework on which to base review and development for all staff. The purpose is four-fold:
- to facilitate the development of services so that they better meet the needs of users and the public through investing in the development of all staff
 - to support effective learning and development of individuals and teams – with all staff being supported to learn throughout their careers
 - to support the development of individuals in the post in which they are employed so that they can be effective at work
 - to promote equality for and diversity of all staff – with everyone using the same framework, having the same opportunities for learning and development open to them and having the same structured approach to learning, development and review
- 5.33 The NHS KSF and associated development review process is about ongoing development for staff and maintaining high quality services for the public. However, as the KSF is a broad generic framework that focuses on the application of knowledge and skills, it does not describe the exact knowledge and skills that people need to develop. “More specific standards/competences would help to do this as would the outcomes of learning programmes” (DOH, 2004).
- 5.34 The Career Framework is an enabling tool which sets out a common language and currency to support career planning. It does this by mapping the entire NHS Scotland workforce into a nine level core skills and competences framework.

- 5.35 The nine levels represent a clustering of “roles” which are grouped according to complexity, responsibility and the level of experience and knowledge needed to carry them out. These nine levels do not directly read across to Agenda for Change (AfC) pay bands and it is important to note that the Career Framework has no direct link to pay. It is concerned only with defining the level of knowledge, competence, responsibility, and associated experience, required for the delivery of roles within NHS Scotland. It is designed to support NHS Boards with workforce planning and service redesign and to help individual members of staff, with transferable, competence-based skills to progress in a direction that meets workforce, service and individual needs. Use of the Career Framework is not mandatory and does not supersede or detract from the obligations on NHS Boards in relation to Agenda for Change.
- 5.36 The KSF remains the overarching competency framework for NHS staff.
- 5.37 The Continuous Learning Framework (CLF) was published in December 2008 and aims to improve outcomes for people who use social services by supporting the workforce delivering these services to be the best they can be. It sets out what social service workers need to be able to do their job well now and in the future and what their employer needs to do to support their lifelong learning. The CLF has four main areas:
- Knowledge, skills, values and understanding
 - Qualifications and training
 - Thirteen personal capabilities relating to how people manage themselves and their relationships with others in the workplace which are described across four stages of progression and
 - Six organisational capabilities which relate to the culture and conditions in the workplace that enable social service workers to be the best they can be and which are described across the same four stages of progression.
- 5.38 The CLF is currently being used to:
- support the induction of new staff
 - increase the effectiveness of staff supervision
 - improve practice of both individuals and teams
 - help staff to provide evidence of reflective learning for qualifications and continuing professional development
 - improve assessment of the attitudes and values of applicants in the recruitment process
 - improve existing performance review and development systems
 - support the development of leadership and management capacity
 - improve organisational learning culture
 - enhance quality improvement and outcomes.
- 5.39 Whilst the above frameworks share some similar characteristics the NHS KSF is mandatory whilst the CLF is more flexible for individuals and organisations to adopt but fundamentally all are to support the workforce. It is important that

any future education and training developments are cognisant of the current frameworks used by the health and social care sector.

6. Workforce Organisation and Development

Key Areas for Change and Development – An Introduction

6.1 There are three broad areas that require development

- Developing the current workforce
- Recruitment into the workforce
- Education and training for the future workforce

Developing the current workforce

6.2 The vast majority of people that will be employed in the care sector in 10 years time are already working there now. Developing our current workforce to therefore both our biggest challenge and biggest opportunity. Programmes at both national and local levels are required to reshape and retain the workforce. The key attributes for an O.D. programme are;

- To cover the entire workforce (including volunteer and unpaid carers
- To emphasis the need for integrated approaches; the need for outcomes focused/personalised care; listening skills and flexible/creative approaches
- To build competency and confidence

6.3 O.D. programmes should seek to build constructive and mutually reinforcing links across different sectors, including NHS, Councils, independent and voluntary sector providers, volunteers and unpaid carers

6.4 Differentials between the paid care sectors should be eroded and the movement of staff between sectors encouraged and enabled with the aim of describing a career pathway that facilitates the movement of staff between sectors as a normal part of a career pathway.

[The issue of differentials is significant and contentious – we need to form a view about how this should be addressed]

[A recommendation could be to commission a national O.D. framework to underpin a 5 year change and development programme that is delivered locally]

6.5 At present movement between sectors tends to be “one way” from independent to voluntary and/or council/NHS, drawn by generally better terms and conditions. It would be desirable to have movement in both directions and the potential for secondment into the independent/voluntary sectors from the statutory sectors should be enabled.

6.6 In addition to the broad O.D. support described above, there are a number of specific areas that should be addressed to ensure good retention. These include;

- Flexible working arrangements that enable working parents or employees with caring responsibilities to remain at work
- Retaining the older workforce and encouraging staff to remain beyond their eligible retirement date – this could be through an ability to reduce hours and/or change roles without detriment to pension entitlements
- Non financial rewards, particularly relating to “healthy working lives” (e.g. membership of leisure facilities, health checks and treatment etc)
- Positive management of sickness absence linked to supportive prevention/avoidance actions

Recruitment into workforce

6.7 There needs to be a better understanding of who the competitors are for the potential care workforce and where the recruitment is most challenging. A review of existing evidence/intelligence should be commissioned to identify the critical factors that “tip” potential care workers to other employers. [Is pay the critical factor or is it flexibility, stress/responsibility, perks, other?]

6.8 An alliance of care employers should be established at both national and local level to develop common recruitment programmes that seek to attract people into the care sector. This is probably most significant for generic care assistant/care worker roles.

6.9 The work being undertaken to develop a generic care assistant role should be completed to enhance the career development prospects for care worker regardless of their sector employer.

Retention of the workforce

6.10 There is a requirement to ensure that the experience of the current workforce is not lost. The health and social care national workforce planners should coordinate activities to support policy developments in supporting service development for older people. Consideration should be given by health and social care workforce planners to raise awareness, to develop a range of strategies to maximise workforce contribution and avoid staff leaving the sector early. Develop further workforce tools to inform retention strategies of the older workforce in order to maximise their contribution for as long as possible.

Education and Training for the future workforce

6.11 Education, training and continuing professional development are key to supporting new roles and new models of care in service delivery. The transformation and redesign of services should be underpinned by education and training in order for behavioural and cultural change to take place in the support and care of older people. Education and training resources will be

required to be developed based upon workforce plans, initially a gap analysis of the education and training resources available to support the workforce in working with older people will be undertaken and where appropriate joint commissioning of education and training to meet the needs of the wider health and social care workforce in meeting the needs of older people.

- 6.12 Education and training will aim to ensure the workforce is prepared to meet the needs of supporting older people and support to employers through guidance of the existing health and social frameworks: namely NHS KSF, NHS Career Framework and the Social Services Continuous Learning Framework will be developed.
- 6.13 Many Community Health and Social Care Partnerships (CHSCP) have developed 'Older People Strategies'. These plans require to be assessed and education and training requirements identified.
- 6.14 The framework will be developed as a result of the findings and action of the ministerial group and the several policy initiatives in health and social care that focus on the redesign of services that meet the needs of older people. Ensuring the continuing need for the health and social care workforce to be central in creating and developing a positive and enabling culture where the needs of older people are at the centre and are promoted has active participants in care decisions.
- 6.15 Education and training to ensure that all health and social care staff in all services are competent in the key components of caring for an older person. Existing staff who work in services that support care of older people should be developed to enhance their skills, to enable future role development opportunities,
- 6.16 In partnership with Scotland's Higher Education Institutions and Scotland Colleges a mapping of existing education and training opportunities to meet the needs of the workforce in working with older people should be undertaken. This will inform the need for future commissioning of education and training or service development infrastructures. The scoping of undergraduate, postgraduate professional education and vocational programmes to ensure that all professions in the health and social care workforce are prepared for working with older people.

Partnership working NHS Education for Scotland and Scottish Social Services Council

- 6.17 Achieving closer alignment of health and social care organisations is at the centre of ensuring better services for older people. Delivering the service within the challenging demographic context will require a joined up, flexible and mobile workforce with resources aligned across public, private and voluntary sectors ((A Force for Improvement). At a national level NHS Education for Scotland and Scottish Social Services Council have established a memorandum of understanding and as part of the ongoing programme of joint work NHS Education for Scotland (NES) and the Scottish Social Services

Council (SSSC) commissioned a scoping study into the potential for Joint Education and Training for Health and Social Care Support Workers In Scotland (SMCI Report- Exec Summary available at <http://www.sssc.uk.com> <http://www.nes.scot.nhs.uk>) This report, published in March 2009, highlighted a clear and growing demand in both health and social services for a range of support workers who provide direct care, and indicated the benefits of health and social care support workers at local level, particularly in CH(C)Ps.

- 6.18 The report also made several recommendations for further work, notably the need for a common /shared definition of the term Support Worker, and a shared set of values and principles to enable both employers and the workforce themselves to identify relevant education and training needs. joint working across a range of service boundaries, including statutory, voluntary and independent sectors currently exists and work is progressing on developing an explicit and inclusive statement of shared values, and a broad definition of the term 'Support Worker', to enable and support the design, commissioning and selection of relevant education/training and workforce development activities for support workers across the sectors. This supports the existing work around the regulation of Support Workers in health and social care

Supporting Volunteers

- 6.19 A programme to recruit and support volunteers should be developed with key voluntary sector organisations, recognising the need to invest to create an infrastructure that can provide the required support.
- 6.20 It is acknowledged that volunteers (informal or organised) currently make a significant contribution to helping older people sustain independence. [While only 3,000 people over 65 receive more than 20 hours paid home care per week over 40,000 people over 65 give over 20 hours 'unpaid' care per week – many of these will be unpaid carers rather than volunteers.]
- 6.21 Volunteers offer support in a wide variety of ways from individual actions by friends/neighbours in a completely informal manner through to well organised and supported complex care provided regularly, routinely and reliably.
- 6.22 It is difficult to assess the numbers of volunteers or their age, characteristics or commitments currently volunteering across Scotland. Equally it is difficult to predict the potential for a growth in the numbers of volunteers, indeed there appears to be conflicting anecdotal evidence, for instance one national voluntary organisation has reported a steep decline in volunteers to the point where they no longer feel able to recruit while another national voluntary body indicated that they have approximately 1,000 volunteers and if they had more capacity could easily recruit more.
- 6.23 The trend does appear to be a steady decline in the numbers of volunteers – and an EU report in 2006 predicted the decline would continue, largely

associated with increased level of female paid employment. [So probably less impact in Scotland than many other EU countries.]

- 6.24 The threat is therefore that left unchecked, the numbers of volunteers available might decline over the next decade as the budgets to support the infrastructure necessary to recruit/organise volunteers gets squeezed and fewer people belong to traditional volunteering bodies, such as the Church. However, the opportunity is also present to expand the number of volunteers both at the younger age where unemployment is a problem and volunteering offers good experience and at the older population with increasing numbers of active older people with skills and experience who might see volunteering as a positive use for their time. [Though many of this group are also carers for either other older people or grand-children.]
- 6.25 From the perspective of the Reshaping Care Programme it seems clear that we should be looking to promote volunteering in the care sector and developing the infrastructure arrangements that can promote and support volunteering.
- 6.26 NHS Boards are currently developing plans in response to 'Investing in Volunteers – Refreshed Strategy of Volunteering in NHS Scotland' (February 2008). The key policy driver for the Refreshed Strategy is the Scottish Government Better Health, Better Care Action Plan, published in December 2007. The Action Plan states "Working together with Volunteer Development Scotland, we will refresh the strategy on NHS volunteering, recognising the various roles played by the third sector and considering how best to recognise the role played by volunteers." The Refreshed Strategy requires NHS Boards to:
- provide Volunteer Development Scotland (VDS) with details of a designated person within their Board area (possibly PFPI Designated Directors) who will lead on volunteering
 - equality impact assess their volunteering policy
 - develop a local strategic action plan for volunteering in partnership with key local stakeholders during 2008/09
 - ensure that their Units and Divisions maximise the opportunity volunteers offer for complementing the skills of their clinical staff
 - ensure co-operation and support is given internally to staff involved in volunteering and to VDS to ensure that the strategy and action plan outlined in this document are progressed in accordance with the targets set
 - work in partnership with VDS to achieve the Investing in Volunteers Standard by 31 March 2011
 - review and report progress on volunteering within their Annual Review self-assessment reporting process as part of their performance in relation to their PFPI responsibilities beginning in 2008/09
 - consider with Community Planning Partners whether a generic strategy for volunteering in the area is appropriate

VDS is working as a strategic partner of the Scottish Government to deliver the Refreshed Strategy for Volunteering in the NHS.

Proposal

- 6.27 It is important we do not cut across current volunteering arrangements and an initial priority should be to get a clear appreciation of the support for volunteering provided by Government, local government and NHS. Alongside this it will be necessary to contact the national organisations that support volunteering in the health and care sectors to build our intelligence regarding:
- Potential to expand the number of volunteers
 - The infrastructure required to recruit, support and deploy volunteers
 - The challenges/opportunities for developing the volunteer sector
 - The range/scope of care related activities that volunteers can reasonably undertake.
- 6.28 Further consideration is necessary to consider the contribution volunteers currently play and can potentially play. In particular consideration should be given to the range and nature of roles/support that volunteers can provide, broadly covering:
- Befriending/contact/company
 - Practical tasks (care and repair/handy person/gardening/transport etc)
 - Personal care tasks
 - Support for unpaid carers (any/all of above)
- 6.29 In developing a strategy to encourage and enable volunteering to support older people it will be important to identify what can and should be done at a national level and actions required at a local level. The national focus is largely to be on agreeing the requirements and costs for good infrastructure, setting broad aims and policy goals and potentially a national promotion campaign. Some volunteering may also be organised via national voluntary sector organisations, however it is likely that most volunteering will be promoted, organised and supported at local partnership level.
- 6.30 Through discussion with key volunteering interests both in government and directly with voluntary organisations we should develop a strategy that sets out arrangements that will support the recruitment, training and support of volunteers that can provide care and support for older people.

Organisational HR Issues

- 6.31 There remain a number of practical issues concerned with terms and conditions that need to be acknowledged as potential barriers to integrated working. Different terms and conditions between health boards and councils can inhibit joint working and integrated management although there are many examples of where local partners have overcome these complications with local protocols and agreements.

- 6.32 Difference in terms and conditions between Public and Independent/Voluntary sectors are more substantial and potentially significant. [What else can we say about this?]

Leadership

- 6.33 It is essential we develop leaders who are confident and comfortable to work in a partnership environment and in a context of outcomes focussed/personalised care. The NHS runs a good leadership programme but there is no equivalent programme for social care. Consideration should be given to developing a joint leadership programme.

7. Conclusions and Recommendations

- 7.1 It is clear that positive actions will be required to ensure we have a workforce with the skills and capacity to meet future needs. Growth due to demography and new skills due to shifts in the nature of care services both present challenges.

- 7.2 The key recommendations from the group are:

- Further work to assess the impact on workforce requirements due to demography and expected service changes to provide an indicative view of the size of workforce required over the next 20 years
- Prepare a general commentary regarding the care skills required for the workforce in recognition of the move toward personalised/patient centred care focussed on outcomes and personal goals and enablement
- Undertake an analysis of existing educational and training resources available within health and social care to support working with older people and to work with Scotland's Colleges, Universities and Scottish Funding Council to address gaps
- Through partnership with Scotland's Colleges, Universities and employers develop learning and career frameworks for working with older people based upon the SSSC CLF and the Career framework training framework for care workers that supports flexible, modular learning with recognised and transferrable awards
- Prepare, in collaboration with key stakeholders, a strategy to develop and support volunteering in the care sector which includes cognisance of the work in NHS Boards who are currently developing plans in response to 'Investing in Volunteers – Refreshed Strategy of Volunteering in NHS Scotland' (February 2008).
- Promote through a cross-sector employers forum a coherent and mutually supportive approach to recruitment and training

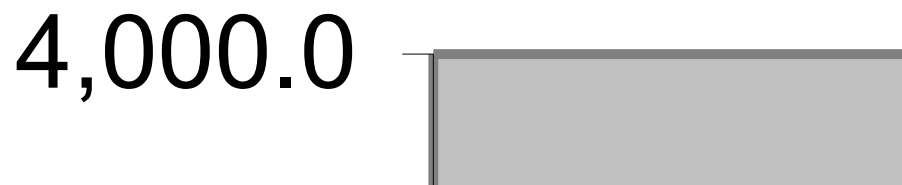
- Many Community Health and Social Care Partnerships (CHSCP) have developed 'Older People Strategies'. These plans require to be analysed and education and training requirements identified.
- Articulate the contribution made by unpaid carers and be ready to respond to proposals in the forthcoming carers strategy that impact on workforce issues, including in terms of extending training opportunities to unpaid carers.
- Working with the remote and rural programme develop specific proposals for supporting and developing the rural workforce
- Specify the data required in future to enable good intelligence to underpin future workforce planning
- Develop practical proposals that will enable and encourage older workers to remain at work and to enable flexibility of workers to exercise caring responsibilities
- Ensure that professional qualification courses have a curriculum that reflects future needs/skills, including integrated approaches, use of technology (telecare etc), developing a mutual partnership approach with unpaid carers and a focus on outcomes/personalisation/enablement.
- Consideration should be given to developing a joint leadership programme between health and social care.

Annex A - Workforce Stream Remit

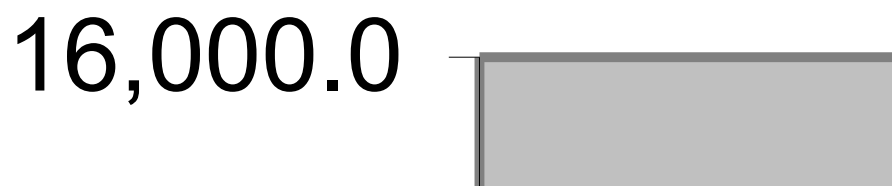
- to determine the scope, size and skills required for the workforce over the next 20 years based on demographic projections and the reshaping of services to be more patient/person centred (the Demographics group can support this and we will need to be cited on ideas/proposals that emerge from the 4 workstreams looking at various models of care);
- to consider the skills, training and qualifications that will be required to equip the workforce we will need;
- to consider how we will be able to recruit skilled, productive and motivated, paid and unpaid/volunteer care workers within the current and anticipated economic environment;
- to consider the scope for new (integrated) job roles across health and social care (building on the current work to develop a generic health and social care support worker role), addressing perceived structural and cultural challenges;
- to consider the scope for developing and supporting the role of unpaid carers/volunteers to encourage more people to take up this role, to consider how they can work alongside and be supported by paid carer workers to help them sustain this role and other measures that will make this role an attractive proposition for those considering volunteering.

Annex B - Age Profile of NHS Staff by Geographic Area

Graph 1 – Number of staff by age group North Region (Highland, Grampian, Orkney, Shetland, Tayside and Western Isles)

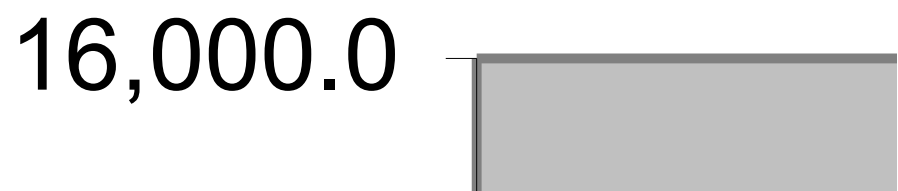


Graph 2 – Number of staff by age group West Region (Ayrshire and Arran, Dumfries and Galloway Forth Valley, Greater Glasgow and Clyde, and Lanarkshire)



Annex B - Age Profile of NHS Staff by Geographic Area

Graph 3 - Number of staff by age group East Region (Borders, Fife and Lothian)



Annex C - social services community care workforce distributed by employer type in each Health Board area

