

SKILLS ISSUES IN THE HEALTH SECTOR IN BOURNEMOUTH, DORSET, POOLE AND SOMERSET

**A report to
LSC Bournemouth, Dorset and Poole**

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1. Introduction

1. BMG Research has been commissioned by LSC Bournemouth, Dorset and Poole to assist the LSC to develop its policies and programmes in respect of eight local sectors. These are....
 - Health
 - Engineering
 - Construction
 - Hospitality
 - Retail
 - Financial services
 - Childcare
 - Social care
2. These sectors are regarded as current priorities for the LSC on a number of grounds. They each employ significant numbers of people in Bournemouth, Dorset, Poole and Somerset. Several of them have significant local focus (in the sense of employing above-UK average proportions of the workforce in the local area). They have an importance to local economies which extends beyond direct employment – generating wealth externally to the local area which is ‘imported’ into the local area for distribution as local incomes and wages, supporting or linking with other key activities, or providing fundamental services (in house building or social welfare, for example) which are essential underpinnings of an effective society and economy. There is also significant prima facie evidence to suggest that these sub-sectors face a substantial challenge to maintain the flow of labour and skills which they need to secure an optimal level of efficiency. This is not to say, of course, that other local sectors do not have these properties. But, with limited resource, the LSC’s intent is to seek progress in *some* sectors rather than dissipate resources too widely. Attention will turn to other areas of the economy in due course.
3. The essence of each study is broadly to undertake a desk review of available information on the sector which describes each local sector, recognises how the sector is developing and the challenges each sector faces, considers how this change process affects skills needs and supply, and, thus, identifies a set of ‘skills issues’ on which the LSC and its partners may focus with recommendations for appropriate action.
4. This report is the output of a study of the *health sector*. Because of the recent re-configuration of LSC activity in the South West Region, the study, whilst originally commissioned by the local LSC for Bournemouth, Dorset and Poole, now reports to the new local LSC sub-region area which combines *Bournemouth, Dorset, Poole and Somerset*. For convenience we will refer to this new operating area as ‘the BDPS area’ in the remainder of this report.
5. The report’s chapters consider:
 - The policy context in which the health service operates.
 - The structure and character of sector delivery in the BDPS area.
 - Key skills and labour demand indicators.
 - Skills supply into the sector.
 - Skills issues

2. The policy context of health services delivery

Introduction

6. Before considering skills and labour market aspects of the provision of health services in the BDPS area, we briefly review the policy context in which those services are delivered.

Health services: complexity of delivery

7. Firstly, therefore, we need to define the areas of activity with which health services are concerned. This can be done in several ways.
8. In terms of *Standard Industrial Classification* the task is quite simple. The Health sector is defined as a single classification – '85.1 Human Health Activities'.
9. From an *organisational* point of view, the position is more complex.
10. The NHS in England is managed at the top level by the Department of Health, which takes political responsibility for the service. Following recent re-organisation, it controls 10 Strategic Health Authorities (SHAs), which oversee all NHS operations in a particular area.
11. The SHAs supervise:
 - Primary Care Trusts (PCTs), which administer primary care and public health. There are 150 PCTs which oversee England's 29,000 GPs and 18,000 NHS dentists. In addition, they oversee such matters as primary and secondary prevention, vaccination administration and control of epidemics.
 - NHS Hospital Trusts. These 173 organisations administer hospitals, treatment centres and specialist care in the about 1,600 NHS hospitals.
 - Ambulance Trusts.
 - Care Trusts.
 - Mental Health Trusts.
12. In addition, several Special Health Authorities provide a health service to the whole of England. These include NHS Blood and Transplants, the NHS Direct and the National Institute for Health and Clinical Excellence (NICE).
13. In respect of the BDPS area, the relevant *Strategic Health Authority* is that for the South West Region. The BDPS area then has three *Primary Care Trusts* (for Bournemouth and Poole, Dorset, and Somerset) and four *Acute Trusts* (Poole Hospital NHS Trust; Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust; West Dorset General Hospitals Trust; and Taunton and Somerset NHS Trust). Other NHS Trusts relevant to the area include two regional ambulance trusts and three Mental Health Trusts (the Dorset Healthcare NHS Trust administered from Bournemouth, the Dorset PCT, and the Somerset Partnership NHS and Social Care Trust administered from Bridgwater).
14. The Primary Care and Acute Trusts manage or contract out services via a range of hospitals and specialist units. In addition, a range of independent-sector

institutions supply private and, increasingly, publicly-funded health care in a number of hospitals/units. These hospitals and units, in both sectors, in *Bournemouth, Dorset and Poole* are:

- Alderney Hospital (Poole) – Mental health services
- Blandford Community Hospital (Blandford Forum) – Community Hospital
- BMI – The Harbour Hospital (Poole) – Independent sector healthcare
- BMI – the Winterbourne Hospital (Dorchester) – Independent sector healthcare
- BPAS (Bournemouth/Dean Park Clinic) (Bournemouth) – Community Hospital
- Bridport Community Hospital (Bridport) – Community Hospital
- Christchurch Hospital (Christchurch) – General medicine and some specialisms
- Dorset County Hospital (Dorchester) – General Hospital
- Forston Clinic (Dorchester) – Mental Health services
- Hahnemann House (Bournemouth) – Mental Health services
- Herbert Hospital (Bournemouth) – Mental Health services
- Kimmeridge Court (Poole) – Mental Health services
- Kings Park Hospital (Bournemouth) – Mental Health services
- Oakley House (Wimbourne) – Mental Health services
- Pine Cottage (Canford Cliffs) – Mental Health services
- Poole General Hospital NHS Trust HQ (Poole) – General Hospital
- Portland Hospital (Portland) – Care of the elderly
- Royal Bournemouth General Hospital (Bournemouth) – General Hospital
- St Ann's Hospital (Poole) – Mental Health services
- Swanage Community Hospital (Swanage) – Community Hospital
- The Bournemouth Nuffield Hospital (Bournemouth) – Not-for-profit healthcare
- The Bournemouth Nuffield Hospital (Derwent Site) (Bournemouth) – Not-for-profit healthcare
- Wareham Community Hospital (Wareham) – Community Hospital
- Westhaven Hospital (Weymouth) – Elderly care
- Westminster Memorial Hospital (Shaftesbury) – Range of medical services and clinics

- Weymouth Community Hospital (Weymouth) – Community Hospital
- Woodlands Intermediate Care Unit (Poole) – Mental Health services
- Yeatman Hospital (Sherborne) – Community Hospital

15. Equivalent facilities in *Somerset* are:

- Barnfield House Residential Care (Minehead) – Mental Health services
- Beech Court (Bridgwater) – Mental Health services
- Bridgwater Hospital (Bridgwater) – Community Hospital
- Burnham-on-Sea War Memorial Hospital (Burnham-on-Sea) – Community Hospital
- Cedar Lodge (Yeovil) – Mental Health services
- Chantry House Day Hospital (Frome) – Mental Health services
- Cranleigh House (Day Care and Residential) (Bridgwater) – Mental Health services
- Crewkerne Hospital (Crewkerne) – Community Hospital
- Dene Barton Community Unit (Taunton) – dermatology and orthopaedics
- Evergreen Social Day Care Service (Taunton) – Mental Health services
- Frome Victoria Hospital (Frome) – Community Hospital
- Green Lane Houses (Frome) – Mental Health services
- Holford House (Taunton) – Mental Health services
- Little Court Day Hospital (Burnham-on-Sea) – Mental Health services
- Magnolia House (Day Care and Residential) (Yeovil) – Mental Health services
- Musgrove Park Hospital (Taunton) – General Hospital
- Orchard Lodge (Taunton) – Mental Health services
- Phoenix House (Wells) – Mental Health services
- Pyrland House (Residential and Day Care) (Taunton) – Mental Health services
- Ridley Day Hospital (Wincanton) – Mental Health services
- Rydon House (Taunton) – Mental Health services
- Shepton Mallet Community Hospital (Shepton Mallet) – Community Hospital
- South Petherton Hospital (South Petherton) – Services for disabled people

- South Street Social Day care Services (Wellington) – Mental Health services
 - St Andrews (Day Care and Residential) (Wells) – Mental Health services
 - Stratfield House (Day Care and Residential) (Wellington) – Mental Health services
 - The Bridge (Wells) – Mental Health services
 - Verrington Hospital (Wincanton) – Community Hospital
 - Wellington and District Cottage Hospital (Wellington) – Community Hospital
 - West Mendip Community Hospital (Glastonbury) – Community Hospital
 - Williton Hospital (Taunton) – specialist health care
 - Wyvern Court (Bridgwater) – Mental Health services
 - Yeovil District Hospital (Yeovil) – General Hospital
16. In addition to these institutions, whose provision, as we note, is subject to an increasingly blurred boundary between public and private delivery and funding, there is a range of other medical services provided by independent commercial operations including ‘High Street’ services (such as opticians and retail pharmacists) and ‘fringe’ medical services (chiropractic, physiotherapy, alternative therapies, for example).
17. The complexity of health service delivery can also be emphasised by considering services in relation to their *client groups*, thus....

Table 1: Health sector clients and services

Service user group	Health care services
Babies and Children	Primary health care (including maternity services, health visitors), general hospital services, mental health care, speech therapy, dentistry.
Adolescents	School medical services, primary health care, general hospital services, dental services, mental health care, health promotion (smoking, sexual health, drugs, alcohol).
Adults	Primary health care (including community provision of district and community mental health nursing), general hospital services, mental health care, family planning clinics, health promotion (smoking, sexual health, drugs, alcohol), complementary therapies, hospices.
Older people	Primary health care (including district and community mental health nursing), occupational therapy, complementary therapies, dentistry, chiropractic/podiatry, specialist hospital services (general and mental health), nursing homes, hospices.
Disabled people (additional services)	Any of the above according to individual and local needs. Additionally, specialist medical and nursing services, physiotherapy, psychology, occupational therapy, complementary therapies, specialist education and training services (work-related and rehabilitative training schemes, for example).

18. And can be further emphasised by considering the *occupational* variety of people employed in order to deliver health services. These are identified as:

Medical and clinical occupations

Medical practitioners
Dental practitioners

Clinical care and support to clinical and medical occupations

Biological scientists and biochemists
Psychologists
Pharmacists and pharmacologists
Ophthalmic opticians
Nurses
Midwives
Paramedics
Medical radiographers
Chiropodists
Medical and dental technicians
Physiotherapists
Occupational therapists
Speech and language therapists
Therapists not elsewhere classified
Nursing auxiliaries and assistants
Dental nurses

Other support occupations

Hospital and health service managers
Pharmacy managers
Healthcare practice managers
Pharmaceutical dispensers
Medical secretaries
Ambulance staff (excluding paramedics)
Routine laboratory testers
Hospital porters
Residential and day care managers
Housing and welfare officers
Sports and fitness occupations
Public service associate professionals
Communication operators
House parents and residential wardens
Care assistants and home carers
Housekeepers and related occupations
Lauderers
Physicists
Laboratory technicians
Filing and other records assistants and clerks
Telephonists
General office assistants or clerks
Personal assistants and other secretaries
Receptionists
Kitchen and catering assistants
Cleaners, domestics

19. The summary point relating to these analyses is simply that any discussion, as in the remainder of this report, of skills demand and supply in relation to health service provision needs to take account of enormous variety and complexity....

- A complex organisational structure encompassing both public and private sector organisations, with increasing numbers of service agreements between those two broad sectors.
- A large number of locations for delivery – not just the hospitals listed above but the large numbers of doctors and dentists surgeries and of private premises (such as opticians or small private chiropody or physiotherapy clinics).
- A whole-population client base with numerous client groups within it.
- A broad occupational spectrum ranging from low-skilled support occupations with little distinctive health content to some of the highest level occupations with specialist health functions.

Health sector policy: an evolving agenda

20. A further factor adding to the 'complexity' thesis is that there is little which is settled in the framework within which service delivery is managed. A brief review of just some changes in health service policy serves to illustrate this point.
21. Prior to 1990, a monolithic bureaucracy ran virtually all aspects of the NHS. However, constrained resources and inexorably rising demand for services had led to a range of problems of which growing waiting lists were a particular manifestation. The Conservative Government's response was the *NHS and Community Care Act (1990)* which introduced the internal market to the Health Service. It was designed to imitate the workings of private enterprise and required new staff skills applicable to running a business. It changed the balance between institutional and community care for social care services.
22. The aim of the move was to introduce competition and drive costs down. It included a far greater level of contracting-out of services, followed by schemes to address issues of quality and consistency, rendered essential where services were delivered by a number of providers.
23. To become a 'provider' in the internal market, health organisations became NHS trusts, independent organisations with their own managements, competing with each other. The first wave of 57 NHS Trusts came into being in 1991. By 1995, all health care was provided by NHS trusts. Over the same period, many family doctors were also given their own budgets with which to buy health care from NHS trusts in a scheme called GP fund holding. Not all GPs joined this scheme and their budgets were still controlled by health authorities, which bought health care 'in bulk' from NHS trusts. Patients of GP fund holders were often able to obtain treatment more quickly than patients of non-fund holders. This led to accusations of the NHS operating a 'two-tier system', contrary to the founding principles of the NHS of fair and equal access for all to health care.
24. Following the election of a Labour Government in 1997, further change was inevitable. Pledging itself to abolition of the internal market, the new Government set out an approach which aimed to build on what had worked previously, but discarding what had 'failed'. A new white paper issued by the Department of Health, *The New NHS: Modern, Dependable*, put forward a 'third way' of running the service – based on partnership and driven by performance. The paper set out an approach which promised to 'go with the grain' of efforts by NHS staff to overcome obstacles within the internal market, building on the moves which had already taken place in the NHS to move away from outright

competition to a more collaborative approach. The white paper described this approach as 'a new model for a new century', based on six key principles:

- To renew the NHS as a genuinely national service, offering fair access to consistently high quality, prompt and accessible services right across the country;
- To make the delivery of healthcare against these new national standards a matter of local responsibility, with local doctors and nurses in the driving seat in shaping services;
- To get the NHS to work in partnership, breaking down organisational barriers and forging stronger links with local authorities;
- To drive efficiency through a more rigorous approach to performance, cutting bureaucracy to maximise every pound spent in the NHS for the care of patients;
- To shift the focus onto quality of care so that excellence would be guaranteed to all patients with quality the driving force for decision-making at every level of the service;
- To rebuild public confidence in the NHS as a public service, accountable to patients, open to the public and shaped by their views.

25. An early manifestation of change was the launch, in March 1998, of NHS Direct, the nurse-led health advice service, intended to give people 24-hour health advice they could trust over the phone. In five years it grew into the largest single e-health service in the world, handling over half a million calls each month, plus half a million on-line transactions through its web-based service NHS Direct Online. It was the start of a growing range of alternatives to traditional GP services – including the launch of NHS Walk-in Centres, which offer patients treatment and advice for a range of injuries and illnesses without the need to make an appointment.
26. In line with the principle of partnership, the *Health Act, 1999* came into force in April 2000. It comprised the latest attempt to pull down the 'Berlin Wall' that had sometimes divided health services, funded and provided by the NHS, from social services run by local councils.
27. The legislation aimed to allow providers of both Health and Social Care to behave more flexibly in terms of delivery and to encourage joint working, removing barriers that resulted in a lack of continuity of care. The legislation made it possible to:
- Set up pooled budgets.
 - Delegate functions, by nominating a lead commissioner or integrating provision, such as the delegation of local authority functions to an NHS Body.
 - Transfer funds between bodies.
28. This allowed service providers to modify the ways in which services were delivered and to adjust the combination of providers and carers involved. To date, changes have concentrated around services for older people, people with learning difficulties (or learning disabilities), children, and mental health.

29. The *NHS Plan, 2000*, introduced a challenging agenda for modernising the Health Service, enabling Social Services and the NHS to come together with new agreements to pool resources – with new Care Trusts able to commission Health and Social Care through a single organisation.
30. Key workforce goals were....
- Increasing staff numbers
 - Improving working lives
 - Modernising pay, contracts and pay related incentives
 - Modernising education, training and development
 - Implementing new ways of working
 - Modernising workforce planning

National targets were....

- 7,500 more consultants
 - 2,000 more GPs
 - 20,000 more nurses
 - Over 6,500 more therapists and other health professionals
 - 1,000 more medical school places
 - Childcare support for NHS staff with 100 on-site nurseries
31. One of the key developments to come out of the NHS Plan was the introduction of Taskforces, to deliver the *Changing Workforce Programme*. New organisations were established: National Workforce Taskforce, National Care Group Workforce teams, Workforce Development Confederations. Linked to the HR directorate and supported by the Workforce Taskforce, the role of the Taskforce was to help the NHS and other Health and Social Care organisations to test and implement new ways of working to improve patient services, tackle staff shortages and increase job satisfaction by:
- Redesigning staff roles either by combining tasks differently and expanding roles, or moving tasks up or down a traditional, uni-disciplinary ladder.
 - Removing obstacles to change, in order to ensure that new ways of working become embedded within the NHS.
32. The aim of the *Health and Social Care Act, 2001* was to deliver many aspects developed from 'The NHS Plan: A plan for investment, a plan for reform' and 'The NHS Plan: The Government's response to the Royal Commission on Long Term Care'.
33. The rationale for change was identified as:
- Improve NHS performance.
 - Provide better protection for patients.
 - Provide better protection of patient information.

- Strengthen the ways in which the public and patients are involved in determining the way the NHS works.
 - Modernise pharmacy and prescribing services.
 - Extend direct payments for social services users and provide a fairer system of funding for long-term care, eg. measures to reduce the need to sell one's home on entering residential care.
34. The principal changes envisaged were:
- Changes to the way the NHS, including family health services, is funded and run and changes to the way long-term care is provided for.
 - Provision for the establishment of Care Trusts and for the transfer of staff in connection with partnership arrangements.
 - Encouragement for local and health authorities to merge their social services and NHS powers into 'Day Care Trusts'.
 - Long term care for the elderly – medical needs would be met by the state, but the living costs of staying in a residential home would still have to be paid.
 - Nurses' prescribing rights to be extended, and chiropodists, physiotherapists and pharmacists were also made able to prescribe certain classes of medicine.
35. Alongside these organisational changes there was also a focus on the potential of information technology to improve the care of patients. *Information for Health: An Information Strategy for the Modern NHS* was published in September 1998, and introduced a new more ambitious and strategic approach to the use of IT in the NHS. Among other things, the strategy aimed to deliver:
- Lifelong Electronic Health Records for every person in the country.
 - Online access to patient records and support on best clinical practice, for all NHS clinicians.
 - A National Electronic Library for Health to keep doctors and nurses, and other clinical professionals, up to date with the latest clinical research and best practice.
 - Integrated care for patients through GPs, hospitals and community services sharing information across the NHS Information Highway.
 - Fast and convenient public access to information, advice and care through online information services (such as NHS Direct and NHS Direct Online, as above).
36. Further changes occurred in the first half of this decade:
- *April 2001* – 'Shifting the Balance of Power' was launched to give greater authority and decision making power to patients and frontline staff. The main feature of the change was the creation in 2002 of locally-based Primary Care Trusts – organisations which control 80 per cent of the NHS budget and have the role of running the local NHS and improving the

health of people in their areas. At the same time, 28 new Strategic Health Authorities replaced the former Health Authorities and took on a strategic role in improving local health services, while also seeking to ensure local NHS organisations are performing efficiently.

- *October 2003* – consultants in England voted in favour of a new contract aimed at tying them more securely into the NHS, while also encouraging them to embrace new ways of working in, for instance, multi-disciplinary teams.
- *February 2004* – In examining future health trends and the factors determining the long-term financial and resource needs of the NHS to 2022, the Wanless Review (Securing Good Health for the Whole Population) identified that better use of the skilled workforce was one of the key factors in realising vital service changes and associated productivity gains. Wanless also described system-wide factors such as Agenda for Change, the Working Time Directive, new staff contracts and the skill mix of the workforce and IT reform [now being taken forward through Connecting for Health (2004)] as key to providing additional capacity and improving productivity.
- *April 2004* – new contracts were also introduced for GPs and local family practices, accompanied by new, extra funding for local health services. In principle, the new contracts meant, for the first time, that all practices are being rewarded for the quality of care they give and not just the numbers of patients they treat.
- *August 2004* – early patient Choice pilots were extended giving all patients waiting longer than six months for their operation a choice of an alternative place for treatment. This is called ‘choice at six months’. By the end of 2005, everyone referred by their doctor for hospital treatment was to be offered a choice of at least four hospitals and was to be able to choose an appointment that was convenient to them.
- *December 2004* – the new Agenda for Change pay system began national roll-out. Designed for nurses, ambulance staff and all other directly-employed NHS staff (except doctors, dentists and some senior managers) the new system aimed to ensure fair pay and a clearer system for career progression. A new Knowledge and Skills Framework supported this and, in principle, allowed staff to progress by taking on new responsibilities. The new system also introduced standard arrangements for hours, annual leave and overtime.
- *2004/2005* – the ‘patient-centred NHS’ agenda continued to develop with the publication of the *NHS Improvement Plan* in June 2004 and of ‘*Creating a Patient-led NHS: Delivering the NHS Improvement Plan*’. Amongst the more politically-contentious elements of this agenda were those which related to the further development of ‘Foundation Trust’ status for existing NHS Trusts:

‘The aim remains to offer all NHS Trusts the opportunity to bid for NHS Foundation Trust status by 2008. Experience shows that this requires a great deal of

development of Boards and internal systems. There will therefore be a renewed development programme for all NHS Trusts which will draw on the lessons from the first NHS Foundation Trusts. This is being sponsored by Monitor and SHAs and includes the development needs of SHAs and PCTs to operate successfully in a NHS Foundation Trust environment.

In the meantime, NHS Trusts will be helped to achieve the disciplines of foundation status through progressively introducing elements of the NHS Foundation Trust regime. Most of the financial disciplines will be introduced in 2006.'

(Creating a Patient-led NHS: Delivering the NHS Improvement Plan, Department of Health, March 2005)

37. In short, the NHS has been in a state of virtual constant revision over the last 2 decades – a circumstance which is unlikely to change in the foreseeable future. At the time of writing....
- The budgets of several UK Acute Trusts are so far in deficit, that significant staff redundancies have had to be announced.
 - Proposals to reduce (to around a third in each case) the numbers of SHAs and PCTs to enable efficiency savings have recently been carried through.
 - There are concerns as to how many dentists currently providing NHS treatment will continue to do so following their concerns about the terms of contracts on offer.
 - There are concerns that the new NHS IT system will run massively over budget and may not bring equivalent benefit to patient care and management.
 - As above, there is political concern that the continued development of Foundation Trusts will widen divisions between the quality of care in different areas.

Policy context: implications

38. This contextual chapter has briefly reflected, firstly, on the *complexity* of health service delivery and, secondly, on the *absence of a settled political/policy framework* for health service management and operations.
39. From the point of view of organisations such as the local LSC for the BDPS area and its partners in post-16 education and training, we would suggest that these characteristics carry a number of broad messages, in particular....
- Firstly, the sheer size of the health sector and its variety makes it particularly challenging to establish an 'external' role. We would argue that there is an essential first task to identify exactly in what segments and at what levels it is feasible for external organisations such as the LLSC to seek to support the sector.
 - Secondly, the continuous development of NHS delivery structures presents a particular challenge to intervention. For example, we might anticipate that current funding

difficulties throw open the question of what resources the NHS will itself be able to devote to workforce development, concerns about security of employment may have considerable effect on staff turnover levels (a significant factor driving training needs), and organisational change (eg. the reduction in the number of SHAs and PCTs) may lessen the ability of local management to work effectively in partnership with external agencies until new organisational structures are stabilised.

40. With these cautionary points in mind we now focus more particularly on the health sector in the BDPS area.

3. The health sector in Bournemouth, Dorset, Poole, and Somerset

Introduction

41. In this chapter, we seek to establish some of the basic dimensions of the health sector in the BDPS area.

Employment structure

42. Firstly, we can set out the basic structure of employment in the area:

Table 2: Employment in the health sector in the BDPS area, 2004

	Number of establishments	Number of jobs	% of all employment
Bournemouth	159	8,814	11.8
Poole	110	6,511	10.2
Christchurch	33	1,254	7.5
East Dorset	62	1,079	3.9
North Dorset	44	881	4.2
Purbeck	32	388	2.7
West Dorset	102	5,089	13.8
Weymouth and Portland	50	1,010	5.6
Dorset County (sub-total)	323	9,701	7.1
Mendip	94	2,219	5.7
Sedgemoor	82	2,228	5.7
South Somerset	107	4,455	7.0
Taunton Deane	120	7,025	13.4
West Somerset	28	682	6.5
Somerset (sub-total)	331	16,609	8.1
Total	923	41,635	8.7

Source: Annual Business Inquiry, 2004

43. The table shows that health sector employment accounts for around 1 in 11 of all jobs in the BDPS area. Concentrations of employment are seen in Bournemouth, Poole, West Dorset and Taunton, primarily because of the volume of employment in large general hospitals in those areas (Royal Bournemouth,

Poole General, Dorset County Hospital in Dorchester, Musgrove Park in Taunton).

Occupational structure

44. It is difficult to obtain a precise occupational structure for health sector employment, distributed as it is across private and public sector organisations and based in many separate institutions. However, if we assume that the structure is *approximately* that of the health sector at national level then the occupational distribution in the BDPS area will be as:

Table 3: Estimated distribution of health sector staff in Bournemouth, Dorset and Poole*

	NHS and General Practice and Dental	Independent Sector	Private and Retail
Medical			
Dental	1,650		<u>80</u>
Total Medical and Dental	<u>80</u> 1,730		80
General Medical Practitioners	755		
General Dental Practitioners	<u>430</u>		
Total General M and D Practitioners	1,185		
Nursing, Midwifery and HV Registered	7,920	1,005	
Nursing, Midwifery and HV Assistants	<u>3,130</u>	<u>3,320</u>	
Total Nursing, Midwifery and HV	11,050	4,325	
Allied Health Professions Registered	1,265	230	215
Allied Health Professions Helpers	<u>225</u>	<u> </u>	<u> </u>
Total Allied Health Professions	1,490	230	215
Complementary Medicine Practitioners			990
Scientific and Professionals	1,270	135	565
Scientific and Professional	<u>565</u>	<u> </u>	<u>680</u>
Assistants/Technicians	1,835	135	2,235
Total Scientific and Professionals			
Practice Staff	2,395		
Health Care Assistants	700	1,660	
Support Staff	2,100	1,660	790
Ambulance Staff	415	1,150	
Management and Administration	5,015		
Works Maintenance	1,200		
Total Health Sector Staff	29,115	9,160	3,320
* Table assumes that the distribution of the local workforce is the same as that of the national workforce as set out in 'A Health Sector Workforce Market Assessment 2003', Skills for Health			

45. This table suggests some important messages when considering support to the sector:

- Firstly, around 70% of the local sector workforce is in the public sector whilst 30% is either in the independent (private medical) sub-sector or in the 'retail' sub-sector. [Note that these estimates based on national survey data may now be out-of-date in respect of some occupational groups – dentistry, for example, may have moved substantially in the direction of 'private' provision. General Practices are essentially SMEs. They are not part of the NHS but neither do they act entirely as commercial entities].
 - Secondly, within the area of public provision around 16,000 jobs are in occupations at relatively senior levels and/or in 'registered' occupations. These occupations include doctors, dentists, registered nurses and midwives, registered allied health professions (radiographers, etc.), scientists, and managers. For such jobs, various conditions apply in different combinations....
 - Regionally, nationally or internationally recruited.
 - Requiring Level 4 or 5 qualifications as a minimum entry.
 - Specialist training delivered wholly within the NHS itself.
46. These characteristics raise the question, when considering external support to the health sector, of *where* that support should be aimed. The analysis suggests that one 'area for support' is most likely to lie within lower level staff either in the public or independent sector, a maximum in the BDPS area of perhaps 20,000 or so people in assistant, technician, support, administrative and maintenance roles, where the required qualification levels are at Level 2 or Level 3 – the levels at which the LSC and its funded provision (in FE or the workplace) are best placed to secure progress.

Other workforce features

47. Other features of the health sector workforce are:
- It has a substantial part-time element. It is estimated (Labour Force Survey) that around 4 out of 10 workers in the sector work less than 30 hours per week (compared with about a quarter of the whole-economy workforce).
 - The workforce has a preponderance of female staff – around 80% of the workforce is female. Male staff, who account for around 20% of the total workforce, are more likely to work in particular occupational groups – as clinical staff, as scientists and technicians, in the ambulance service, in maintenance, as hospital porters and in hospital security. Women are, of course, more likely to be employed in the 'caring' grades – as registered nurses and midwives or as health care assistants – in administration and in support functions such as cleaning and cooking.
 - There is an interaction between gender and part-time working such that women employed in the sector are about twice as likely to work part-time as men who work in the sector.

48. The important point of these distributions is, perhaps, that skills development, more frequently than in other sectors, has to include many part-time staff, particularly at lower grades, for whom employment in the sector is not as firmly 'attached' as may be inferred from full-time status. Issues of staff retention and high labour turnover may significantly attenuate training effort, as people who are in relatively low-paid, part-time jobs move into other workplaces or other types of work.

Changing workforce numbers

49. Of course, the health sector workforce has not been stable in recent years. Driven generally by rising patient demands and expectations but particularly by NHS Plan 2000 objectives and by large increases in Treasury funding to the NHS, staff numbers rose nationally by 23% between 1998 and 2004 (compared with an all-economy increase in employment of 7%).
50. An even stronger growth trend was observed in Bournemouth, Dorset and Poole where employment grew from 30,898 in 1998 to 41,635 in 2004 – a rise of 35% in the six year period.
51. In terms of *future* change, the 'technical' forecast ('Working Futures') is that employment in the sector will rise by a further 1,250 people in the BDPS area by 2010 and by a further 900 people in Somerset. This would suggest a total workforce of around 43,800 by 2010.
52. The major components of this forecast change are:
- Almost all the rise is anticipated as a consequence of rising numbers of part-time jobs.
 - In occupational terms, areas of growth are forecast to include....
 - Managers
 - Clinical and other professional staff
 - Areas of employment decline are forecast to include....
 - Administrative and clerical staff
 - Low skill occupations
 - In respect of a key intermediate group of staff – caring occupations in the sector – the forecast is of some shift from full-time to part-time working (a decline of around 700 full-time jobs between 2004 and 2014 but a rise of around 4,000 part-time jobs in the same period) but with overall growth in the total 'full-time equivalents' employment in this type of job.
53. However, the 'technical' forecast is partly built on historical trends as well as factoring in assumptions about public spending. In the light of recent events in the NHS – basically shortfalls in Trust budgets as the impacts of substantial pay increases and shorter working hours have been felt – it seems likely that these forecasts are on the optimistic side and that the capacity of the health service to engage new staff will in fact be very restricted (or even that staff numbers will actually fall). Even those Trusts which are not in deficit will be encouraged towards caution as they observe redundancies in other localities.

Summary: employment patterns

54. A review of employment in the local sector suggests the following features....
- The sector employs around 41,500 people in the BDPS area – around 1 in 11 of all jobs. It is clearly an important sector just in terms of its size.
 - Employment, of course, is concentrated in those areas where the major general hospitals are situated. The sector is a lesser but still substantial factor in the economy of districts where health sector employment is concentrated in primary care.
 - Around 70% of the workforce is employed in public healthcare (ie. in the NHS) with 30% in varied forms of private sector delivery of health services.
 - Around half the local workforce – some 20,000 or so people – is employed in occupations below the professional/registered levels. It is suggested that it is this segment of the workforce in respect of which the LSC and partners may have the greatest contribution to make.
 - Around 4 out of 10 staff work on part-time terms – a higher proportion than the 25% of part-time staff in the economy as a whole. Part-time workers tend to have higher rates of turnover than full-time staff – a factor which raises training demand but also leads to some training ‘wastage’ as trained workers leave the sector.
 - The workforce has increased rapidly in size in the last few years following rises in public expenditure devoted to the health service improvements.
 - The *forecast* is for increased numbers (but at a slower rate of growth than hitherto). Growth is forecast for senior and caring occupations with some reduction in routine clerical staff and in low skilled support staff. However, in the light of growing deficits in respect of overall public expenditure and of localised deficits in some hospital trust budgets, we would be sceptical as to whether the available ‘technical’ forecasts are correct.

4. Labour and skills demand in the local health sector

Introduction

55. The pattern of employment set out in the previous chapter offers a basic description of 'employment demand' – clearly, around 42,000 people in the BDPS area are required to deliver health services to the general population of the area.
56. However, demand for labour and skills in the sector can be considered in several other ways. We set out a more elaborate analysis of local labour and skills requirements in this chapter.

Replacement demand

57. A first factor which modifies labour demand is the requirement not just to fill available posts in the sector but to refill them as people move jobs or move out of the particular posts or leave the sector entirely. This requirement is usually characterised in summary form as *replacement demand*.
58. A number of characteristics of replacement demand can be considered:
 - Firstly, replacement needs are usually highest where jobs are not well-paid and/or involve unusually arduous conditions of service.
 - Secondly, as we note above, part-time jobs usually turn over quicker than full-time ones.
 - Thirdly, replacement rates may vary with economic conditions. Basically, in buoyant economic conditions when jobs are plentiful and employers are competing for staff, more mobility occurs as people pursue promotion and better opportunities. When economic conditions are less propitious, people tend to hold on to what they have. Correspondingly, there may be local or regional variations in movement depending on the 'tightness' of local labour markets and the extent to which alternative employment is available.
 - Finally, there is a distinction between mobility which occurs in jobs where there is a clear progression structure and people move on at intervals as their greater experience and/or achieved qualifications allow and that which, as above, is driven simply by the poor wages or conditions of lower grade jobs. The former type of mobility is a desirable condition (attaching frequently to occupations in the intermediate and higher levels of the health sector). It would, on the other hand, be an objective at other employment levels in the health sector to eliminate any poor quality employment which leads to a high labour turnover by virtue of that deficiency.
59. When replacement demand is estimated for the health sector, there are, therefore, a number of factors generating movement out of and between jobs – retirement, people moving up career ladders, people leaving because they find their job to be unrewarding or unsuitable, and so on. These combine in various ways such that the predicted rates of replacement vary between broad occupational groups. For example, Skills for Health, the Sector Skills Council for the health sector, has produced the following national estimates:

Table 4: Replacement rates for broad occupational groups in the health sector, 1999-2010

Managers	20%
Health professionals	42%
Health associate professionals	65%
Caring occupations	78%
Administrative	22%
Elementary/clerical/support occupations	80%
<i>Source: Health Sector Workforce Market Assessment, Skills for Health, 2003</i>	

60. When *replacement needs* are added to forecasts for *absolute growth* in the number of jobs, an estimate for total *recruitment* requirements can be produced. These requirements for the BDPS area are set out below. The figures should be treated with *extreme caution*. They assume that forecasts for growth in absolute numbers of jobs are accurate (and, as above, we have cast doubts as to whether they are) and, secondly, they assume that national rates for replacement apply locally. This is quite unlikely in so far as local conditions (competition from other jobs in the area, local age profiles within occupational groups, and so on) are likely to vary quite considerably. The figures are useful only in so far as they indicate in very broad terms the scale of recruitment which *may* be necessary to ensure that the local sector is adequately staffed:

Table 5: Net recruitment needs in the BDPS area health sector, 2005-2015

	Total recruitment need 2005-2015 *	Annual average net recruitment need
General practitioners and dentists	710	70
Nurses, midwives, health visitors	5,890	590
Hospital doctors and dentists	1,010	100
Allied health professionals	880	90
Scientific professionals and technicians	900	90
Health care assistants	250	25
Ancillary and ambulance staff	315	30
Management and administration	2,340	235
Works maintenance	180	20
* Note in	<i>The net total recruitment requirement assumes that 'Working Futures 2' forecasts for change numbers of jobs in particular occupational groups and for replacement needs apply to particular occupations in this table. The calculation adds together the need for recruitment to fill new jobs and the need for recruitment to replace people who leave their jobs. Where the former is negative (ie. the absolute number of jobs is forecast to shrink) the recruitment needs equals replacement need minus the number of jobs expected to disappear</i>	

61. Overall, this data suggests that, making some assumptions about growth in health sector employment and taking replacement needs into account, the local

sector *may* need to recruit around 12,500 people in the next 10 years or so in order to ensure adequate staffing levels.

Changes in skill needs: drivers

62. We have noted in the first sections of this chapter that future growth in workforce numbers in the local health sector (uncertain) and the need to replace staff who move or leave the service (certain) will generate positive recruitment need across all occupational groups in the local workforce.
63. However, there is a second area of change – not just in how many people are employed and recruited but in what *skills* those people need.
64. The supposition is that, whilst many of the fundamental job skills required in health sector workers' jobs will remain steady (the basic competences of a doctor, nurse, hospital porter, radiographer or whatever will, of course, remain relevant), there will be a requirement for *additional* skills or for the *different development* of skills.
65. What is driving these changes?

The new policy agenda

66. Firstly, in Chapter 2 of this report, we briefly described some of the many changes in policy and policy developments which have swept through the health service in the last 10 years or more. The various legislation is extremely complex but a number of key themes are apparent. These include:
 - Breaking down boundaries between different areas of delivery – most particularly (1) between health services provided by the NHS and social and nursing care provided by local authority social services and the independent sector; and (2) between publicly-funded/publicly-provided health services and publicly-funded/privately-provided health services (including outsourced responsibilities within NHS institutions for services such as cleaning and the provision of meals).
 - Breaking down hierarchical management structures in favour of cross-disciplinary teams which aim to put much more focus on patient-centred delivery.
 - Increasing the penetration of IT systems into the health service in order to increase efficiency and promote capacity for patient choice.
67. Overall, across the recent policy agenda there is a clear recognition that traditional hierarchies and inflexible working practices need to be un-locked and replaced by increases in multi-disciplinary working and new roles for many staff groups. In particular, there is growing emphasis on the development of the 'assistant practitioner' role. This movement stems from the requirement to increase flexibility and increase productivity. Essentially, it is recognised that fixed demarcations as to 'who does what' in caring for and treating patients are inefficient. Rather it is perceived that efficiency can be increased by allowing lower grades of staff (the 'assistant practitioners'), providing they are suitably trained and competent, to take on the more routine tasks previously undertaken by the grade or grades above them – leaving the higher grades to concentrate on the more specialist tasks for which *they* have been prepared. Human resources

managers will need to support these shifts in the workforce through what the Department of Health describe as 10 'High Impact Changes' involving:

- Effective recruitment, good induction and supportive management.
 - Supporting and leading effective change management.
 - Developing shared service models and effective use of IT.
 - Managing temporary staffing costs.
 - Promoting staff health and managing sickness and absence.
 - Job and service re-design.
 - Appraisal policy development and implementation.
 - Staff involvement, partnership working and good employee relations.
 - Championing good people management practices.
 - Effective training and development.
68. More precisely, in terms of skill needs, it is recognised that new approaches to delivery will generate a growing requirement for:
- IT skills.
 - Leadership.
 - Team working, including the emphasis on multi-disciplinary learning in the NHS Plan and elsewhere.
 - Generic management skills.
 - Partnership working.
 - Customer focus.
 - Managing diversity.
 - Communication skills.
 - Adult basic skills.

Ageing population

69. Secondly, the UK is witnessing an increasing number and proportion of people in the older age categories. This is a result of declining birth rates and increasing life expectancy and will have significant potential effects on the demand for skills within the health sector.
70. This is a particular significant factor for the BDPS area. 18% of the English population is of retirement age. Corresponding proportions are: Dorset 27%; Bournemouth 23%; Poole 24%; Somerset 23%. Christchurch has the highest percentage (33%) of retired people of any district in England.
71. Generally, despite the fact that many people stay healthier for longer, it would be anticipated that an ageing population will generate a raised requirement for the skills connected to the management and care of elderly patients with chronic and recurrent illnesses including dementias of various kinds.

72. In addition, there has been a recent change in social characteristics leading more old people to live on their own as opposed to with family or in care homes. This is partly a result of rising health levels within the population and partly as a consequence of fewer women carrying out the role of an informal carer as they enter the workforce. This change in circumstances is likely to entail a large increase in the demand for long-term care and hence an increasing demand for nurses who supply home care.

A more discerning and knowledgeable patient

73. Thirdly, health care systems are knowledge-based service enterprises which are becoming increasingly focussed on market-driven health care, ie. tailored to consumer needs and requirements, generated by more demanding and knowledgeable consumers. The health service faces patients who are more knowledgeable about their illnesses and diseases and their consequences and is often prepared with knowledge about preventative measures and cure. A consumer such as this now demands both more choice in the available services and more knowledge from the employees within the sector – a circumstance to which the development of a 'patient-centred' health service responds.
74. This is leading to an increased demand for the gatekeepers of primary health services to be much more highly qualified and expert. These include practice nurses and community nurses, who are often the first port of call for health related advice. It could also require up-skilling these nursing groups as a means of freeing up surgery time for general practitioners. Coupled with this is the shift from secondary to primary care, as more diagnosis is done at the first point of contact. The development of the 'expert patient' (as in the Wanless report) may also give rise to a need for the role of community pharmacists to be further developed to expand overall capacity in the increasingly important management of chronic conditions.

A widening public health agenda

75. Fourthly, besides this, the public health agenda has taken centre stage in the UK and in other countries in recent years. Cardiovascular disease is the main cause of death in Europe, followed by cancer, even though survival rates for both conditions have been improving in recent years. The incidence of other chronic diseases has been growing. The economic burden of obesity, diabetes, neurodegeneration and musculoskeletal disorders is significant. The incidence of obesity in the UK has seen a recent dramatic rise from 7% of the adult population in 1980, to 22% of the adult population in 2001 being diagnosed with the condition. Such epidemiological changes lead to an increased demand by people for specialist and intensive health care services, which would then translate to growing health expenditures for those services and associated workforce skills. The Wanless report identified three types of 'specialist public health workers' – specialists (consultants), public health practitioners and other wider public health workers from communities, local authorities and schools, etc.
76. A recent survey by the Faculty of Public Health in the UK (2004) concluded that a 40% increase in the current consultant workforce is urgently required in order to deliver a safe and effective public health service. It highlights shortages of public health specialists at a time when there is growing demand for changing roles due to soaring obesity levels, and focus on smoking and sexually transmitted diseases, an increasing awareness of healthy lifestyles and a global effort to ensure a health population.

Workforce changes

77. Fifthly, in addition to factors in the patient environment, there are also noticeable developments in the sector's workforce characteristics and needs. We can summarise these as:

- The health sector workforce has an age profile which is somewhat 'older' than that of the overall all-sector workforce....

	<u>Health sector</u>	<u>All economy</u>
16-24	8%	14%
25-34	21%	24%
35-44	28%	26%
45-54	24%	21%
55-64	13%	11%

- In a key workforce group, nurses and midwives, the proportion of those aged 40-49 has risen significantly since 2000. It is reported that the BDP area health sector workforce is particularly affected by the 'ageing' issue and has an age profile which has a more pronounced 'older' character even than the national one.
- Working patterns are changing – nursing has seen a decrease in applications as traditional 'male' occupations have opened up to women and female qualification rates have risen; there is greater demand for flexible working.
- Migration into the UK has led to substantial increases in the number of health workers coming into the UK (with some outflow of UK health workers particularly to the USA and Australia). We understand that this phenomenon has not been particularly strong in the NHS segment of the health sector workforce in the BDP area in recent years but may be more significant in local independent-sector health care.

78. There are no figures for the *precise* impacts of these national phenomena at local level in the BDPS area. However, if we assume that they do apply locally, their implications may include....

- Increasing replacement needs (as discussed earlier) and upskilling needs to replace the skills lost by retirement and/or the shift to 'flexible' (fewer hours) working.
- Increasing male recruitment into traditional 'female' roles in the health sector.
- Rising need (at present, perhaps concentrated in the independent sector) for language skills, cultural integration and other training in order to maintain the overall standards of a competent health sector workforce.

Technological drivers

79. Finally, ICT is a growing input in the production of effective health care systems and its interactions with capital and labour inputs. Health care systems and decision makers within the industry have begun to acknowledge the case of e-health defined as: *'the application of information and communication technologies (ICT) across the whole range of functions that affect health care,*

from diagnosis to follow up'. A central part of eHealth is the Electronic Health Record that allows the sharing of medical records between care providers and patients. Other developments include patient self-management, home care and sensor devices, telemedicine and telesurgery, electronic messaging, and electronic registries and databases.

80. In the UK, NHS Direct is a prime example of a policy response to meet the challenges posted by a technology aware consumer. The Electronic Staff Record, a database for sharing and analysing workforce information, is a further example.
81. eHealth has many implications for the health care workforce. Firstly, there is an overall need for enhanced ICT skills to manage and deliver eHealth effectively. Secondly, there may be some shift in diagnosis from general practitioners to specialists for advice through telemedicine and a further shift from secondary to primary care in the sector.
82. The UK economy has also witnessed an increase in investment in Health Research and Development such as basic and applied sciences, driven by the Treasury's emphasis on innovation as a significant driver in enhancing overall productivity and growth in the economy. Scientific knowledge, intellectual property and innovative approaches in health care delivery are all closely interlinked with technology driven factors, and are likely to increase the demand for health care scientists, researchers and laboratory technicians.

Summary: labour and skills demand

83. Thus, in examining labour and skills demand in the local health sector, we can see the following key demand characteristics:
 - A basic requirement to staff the varied occupational roles within the 41,600 strong current health sector workforce in Bournemouth, Dorset and Poole to adequate or better standards of competence.
 - A requirement to recruit, perhaps, 12,500 new staff over the next decade in order to meet possible but not certain growth in absolute levels of employment, but certainly to replace staff who leave their posts for various reasons.
 - A requirement for additional skills to be developed over and above the job-related competences of many staff. These skills include a range of generic skills – IT, leadership, management, team working, partnership working, customer focus, and communication skills – necessary to meet the demands of a new policy agenda focussed on team working, partnership and cross-organisational working and on patient-centred attitudes and delivery.
 - A requirement for more specialist skills to meet the needs of an ageing population.
 - A requirement for more specialist skills related to growing public and political concern about levels of heart disease, diabetes, obesity and other 'unhealthy lifestyle'-related conditions.
 - A requirement for greater capacity to integrate in-migrant health workers into the local independent health sector environment.

- A general increase in the availability of ICT skills to prepare for the widening use of IT systems in patient care – both as an addition to the job skills of practitioners and as IT-specialist skills of the technical staff required to establish and maintain systems and to support practitioners in their use.

5. Labour and skills supply in the local health sector

Introduction

84. The previous chapter indicated the characteristics of the labour and skills which the local health sector needs to maintain and expand its quality of delivery over the next decade or so.
85. In this chapter, we consider the mechanisms by which that demand will, to a greater or lesser degree, be met.

Broad labour supply

86. A first issue concerns the availability of labour in general. Of course, the health sector is in competition with other sectors for the supply of labour – particularly at lower levels and for generic skills which are readily transferable between sectors. The question is one of whether the local labour market is ‘tight’ (ie. fairly competitive for labour or skills) or not.
87. There are a number of indicators of ‘tightness’.
88. Firstly, the working age employment rate in Dorset and Poole is higher than in England and the SW as a whole though Bournemouth has a lower rate than both. Since 2001/02, the rate has grown in Dorset, but fallen in Poole and in Bournemouth. The national rate has remained static, and the SW rate has fallen slightly:

Table 6: Employment rates in Bournemouth, Dorset and Poole

Percentage of working age population	Jun 01-May 02	Jun 04-May 05	% point change
Dorset	79.4	80.9	+1.5
Bournemouth	73.0	68.1	-4.9
Poole	80.3	77.2	-3.1
South West	78.9	78.8	-0.1
England	75.1	75.1	0

Source: ONS Quarterly Labour Force Survey 4th quarter average May 05

89. Thus, although there has been some slackening, local employment rates in Dorset and Poole (though not Bournemouth) remain higher than national levels – suggesting that the number of people available to enter the labour market is lesser than elsewhere.
90. Secondly, the latest annual unemployment rates are 3.9% for Bournemouth, 2.4% for Dorset and 2.3% for Poole (SW: 3.6%, Eng: 4.7%). Bournemouth’s 12-month average claimant count rate of 1.7% is higher than the South West average of 1.4%. The rates for Dorset (0.9%) and Poole (1.0%) are below. All are less than the England rate (2.4%). Again, therefore, labour market tightness is evident. Unemployment rates remain very low in historical terms and local

unemployment may be reduced to the minimum of people in 'transitional' unemployment – between jobs – or who are difficult to employ because of low abilities and/or low motivation.

91. If these factors suggest that local labour supply is very constricted, then data on *house price* data emphasises the difficulty for prospective applicants for lower paid/lower skilled occupations to move into the area.
92. Thus, in Q3 of 2005, the average house price in Poole (£254,959) was the highest (out of 15) among SW county and unitary authorities, and was 29.3% above the English average (£197,201). (SW: £202,396). Dorset had the third highest average house price in the region (£230,261), and Bournemouth the ninth highest (£196,367).
93. More particularly, lower quartile housing affordability ratios show that lower quartile house prices are approximately 9.1 times lower quartile resident earnings in Bournemouth, and 9.6 times in Poole (SW: 8.5, England 6.8). For Dorset districts, ratios range from 9.2 (Weymouth and Portland) to 11.9 (Christchurch). The latter is the highest lower quartile ratio of any local authority in the South West. (*House Prices: OPDM Mean House Prices Q3 2005 (provisional)/Affordability: HM Land Registry house prices Q1-Q2 2005/ONS Annual Survey of Hours and Earnings 2005.*)
94. Data on *Somerset* is less comprehensive but it can be noted that:
 - Somerset's economic activity rate (81.6) remains higher than that of the South West (80.8) or the UK (78.1).
 - Unemployment (claimant count) is lower in Somerset (1.4) than the South West average (1.7) or the UK average (2.6).
 - House prices are below the average for England and Wales. However, because of relatively lower wages, their affordability is also less than average.
95. Overall, these statistics suggest that the labour market for 'generic' staff, particularly for those at lower skill levels, is competitive in the BDPS area. The health sector will retain its capacity to recruit and retain such staff only so far as its wages and conditions of service (as at present) retain their relative attractiveness. The statistics also suggest that migrant workers (from abroad or other parts of the UK) who seek to move into the local area to take up health service posts are likely to face significant housing problems (except for those in clinician or other well-paid higher level posts).

Skills supply: the development infrastructure for health sector skills

96. In Chapter 2 earlier, we noted that the health sector was complex in its organisational and occupational structures. The variety of agencies with an input to skills supply is also complex. There are numerous stakeholders:

Government Departments

97. The health department is responsible for overall education and training strategy for the NHS. The Department of Health directly funds much non-medical professional pre-registration education, through a devolved system using NHS organisations for commissioning, and some non-professional training (either directly or through a devolved system). The health department wholly or substantially funds postgraduate medical and dental education; post-registration

education for other professions is largely a matter for individual employers, although there is significant funding of post-registration education in nursing in England through the levy system. The Department of Health, with the other departments, is responsible for the legislation governing regulatory bodies. The departments are also the sponsors, in government terms, of the non-statutory health sector. DFES in England (and its equivalents elsewhere) is the other department with a major interest in the health field, by virtue of the significant size of the health sector within HE and in vocational training.

Regulatory Bodies

98. These are numerous. All have functions relating to determining the professional competencies and academic awards required for admission to their register; must also have, or will shortly have, functions relating to post-qualifying training, continued professional development (CPD) and requirements for revalidation or re-registration. Their responsibility for specifying competencies and educational requirements is justified by their overall duty to protect the public by ensuring fitness to practise. In conventional health care, most are statutory bodies dealing with those who offer direct patient care.
99. In the NHS Plan, the government announced its intention to reform regulatory bodies which should change so that they:
- Are smaller, with much greater patient and public representation in their membership;
 - Have faster more transparent procedures; and
 - Develop meaningful accountability to the public and the health service.

Higher Education

100. Most Higher Education Institutions (HEIs) in the UK have some interest in teaching and research in the health field. In some cases, this is a major interest, with up to a third of some HEIs' income related to health (including research funding). The extent to which HE funding councils fund health professional education varies across the four countries.

Other Training Providers

101. Further Education (FE) is an important provider in the technical field and to some extent in the training of health care assistants, although some of this latter training is provided in-house in the NHS or independent sectors or by university nursing departments. GNVQs in health-related fields are provided in schools and FE colleges. There is a small amount of commercially provided training.

Sector Skills Councils (SSCs)

102. Skills for Health is the new SSC for the sector. Its activities are being more closely aligned with those of the UK Health Department to develop a more coherent approach to education and training for the sector. There are significant links to the work of other SSCs, particularly Skills for Care and Development. Links with training in social work and social care may become closer with the development of NHS care trusts in England, providing both health and social care.

Professional Organisations/Trade Unions

103. Some bodies in the health field are professional educational bodies and trade unions that have statutory (chartered) status. Examples include the Royal Colleges of Nursing and Midwifery and the Chartered Society of Physiotherapy. These are, to some extent, education providers in their own right, mostly in respect of CPD. Some also have a joint validation role for approval of qualifying courses together with the statutory regulatory body. Other trade unions are also heavily involved in providing or organising training, for example UNISON (with the Workers' Education Association) in respect of access and return to learning courses. There are signs of increased collaboration between employers and trade unions on education and training issues in the workplace.

Employers

104. Employers in the conventional health care sector in England have, from April 2001, formed Workforce Development Confederations, succeeding education and training consortia. These commission and manage education and training for all clinical staff covered by the NHS education levy; work with key professional groups to ensure the delivery of adequate numbers of properly trained staff; work with employers in developing and commissioning training programmes for all staff reflecting the needs of the sector; and work with Postgraduate Deans on the management and delivery of postgraduate medical and dental education. In addition to NHS Trusts, Health Authorities and Primary Care Groups/ Trusts, they will involve Social Services Departments, the voluntary and independent sectors, the armed forces and the prison service. Confederations are the key link between the health sector and Regional Development Agencies and local Learning and Skills Councils.
105. Within the NHS there is now a particular recognition that, whilst extensive arrangements exist to prepare professional and registered elements in the workforce, historically less has been done to develop skills in the non-qualified/non-registered segment. A central concept is that of the '*learning escalator*' to help staff, particularly lower grade ones, to progress from a point where they may need help with basic skills of literacy and numeracy, to NVQ 2/3, and thereafter into the more conventional Diploma/Degree/Higher Degree/Professional Qualification hierarchy. However, funding for the NHS Individual Learning Account (which, for 5 years supported learning, mainly by lower and intermediate staff) has now ceased. The NHS's Knowledge and Skills Framework (KSF) process has assessed the competences of virtually all staff in the service and identified the competences they need to acquire for progression but the capacity of the service to supply the training which would lead to those competences is heavily constrained by training budgets which have a heavy emphasis on clinician and nurse training.
106. External contractors employ substantial numbers of staff. The British Services Association, which is a subscription-based employer organisation, represents the major contract companies. It has been established for twelve years and has 19 member organisations, only one of which has a turnover of less than £2 million a year. It is estimated that 50-60,000 staff are employed by these and smaller companies in the health care sector. Agencies also supply significant numbers of locums, nurses and other staff (eg. temporary clerical staff).
107. Further provision is generated by the growing *independent* sector. In this sector, covering hospitals, clinics and nursing homes, there are, in some cases, well-developed workforce development systems. Commercial disciplines demand well-founded short-term workforce planning. The sector is a major provider of vocational training and also provides clinical placements for nursing and allied

health professions students. In a survey conducted in 1999, 69% of the acute providers who responded reported providing clinical placements in the previous year, 85% of the mental health providers and 71% of the community care providers. (However, in about half of the organisations responding there was no formal post for staff development.)

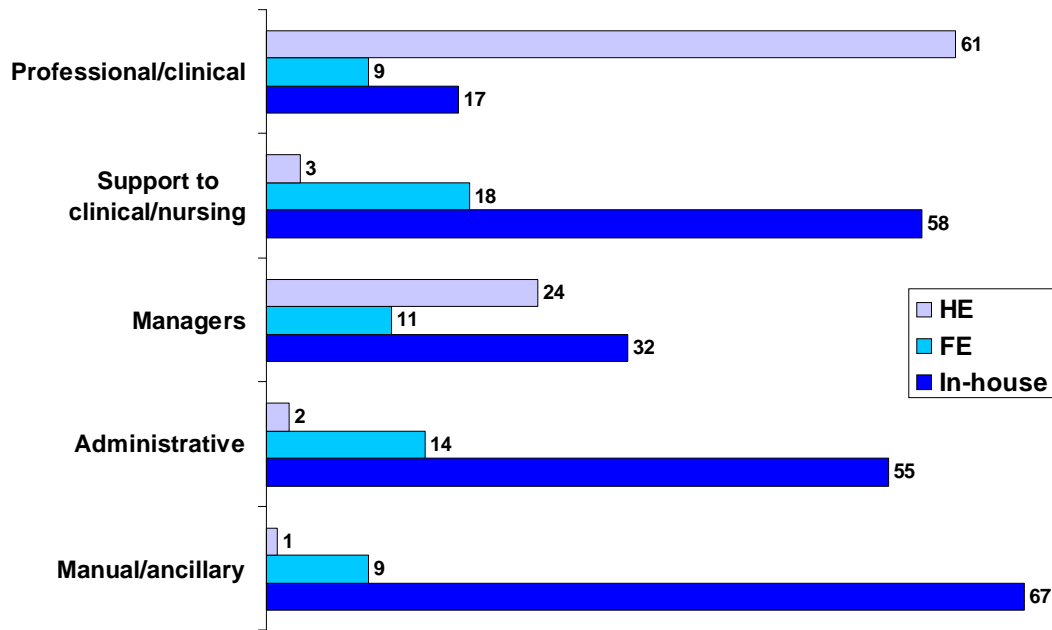
Post-16 Learning Frameworks

108. From April 2001 in England, the national Learning and Skills Council and its local councils (LSCs), the Regional Development Agencies (RDAs), the Small Business Service and Connexions (the new youth support service) have had responsibilities for the framework for post-16 learning set out in the Learning to Succeed White Paper. Links between the health sector and Training and Enterprise Councils were patchy. The new, more inclusive arrangements are intended to make for closer relationships.

e-learning

109. And an *e-learning strategy* is being developed for the NHS in England that will embrace all forms of education and training for all groups in the workforce. This includes links with the University for Industry (Ufi) and others in providing widespread and effective access to web-based learning and in developing relevant learning materials and packages, in addition to NHS based or accredited E-learning resources.
110. Thus, in respect of health sector workforce development, there is a national and well-developed infrastructure, extensively supported by government funding. Overall, the assessment is that the volume of provision is broadly adequate. Thus, an assessment of education and training provision for the Skills for Health SSC in 2005 (*Assessing education and training provision for the health sector*, SQW, 2005) concluded that 'In crude numerical terms ... (an) ... assessment of current education and training provision has shown that, for the core occupations in the health sector, provision of satisfactory to good quality is widely available and for the most part is relevant and effective, and that the volume of provision has kept pace with the rapid growth in the size of the workforce to date'.
111. The National Employer Skills Survey (NESS) for 2005 revealed that, at national level, 83% of health sector establishments supplied training to staff compared to the 65% which was average for the economy as a whole – with 55% of those establishments supplying training to at least 90% of their staff (compared with an all-economy average of 44% which trained at least 90% of their staff).
112. Overall, therefore, it can be asserted that in comparative terms, the health sector is a 'high training' sector with a much higher commitment to workforce development than many other sectors of the economy.
113. Much of this training is delivered to higher level and registered NHS staff. It is estimated (NESS 2005) that, at national level, the proportion of health sector establishments supplying training to managers was 68%, to administrative staff was 64%, to nurses and health care assistants was 42% and to professional (clinical) staff was 33%. In contrast, only 17% of establishments supplied training to elementary staff. The sources of training also varied:

Figure 1 Main sources of education and training, 2005



Source: SSC National Survey of health sector employers

- 114. It can be seen that the main source of supply at professional and clinical level was Higher Education whilst the main source for other grades of staff was the in-house training resource of the NHS. Further Education was a minority source of supply for all grades of staff.
- 115. On the assumption that this national pattern broadly applies in respect of the BDPS area, we can observe that major segments of training and education supply into the sector – Higher Education institutions and the internal resources of the health service – are not ones with which the LSC is centrally concerned nor ones on which it currently has influence.
- 116. The FE sector, and associated Work Based Learning provision, is, however, obviously of greater significance to LSC planning.

Local supply: Work-based learning (WBL)

- 117. Statistics for WBL participation in the BDPS area show that 29 Apprentices were in training in nursing and other medical vocations in 2004/05. 303 Apprentices trained in the health and social care sector. In combination, these were distributed by age and gender as:

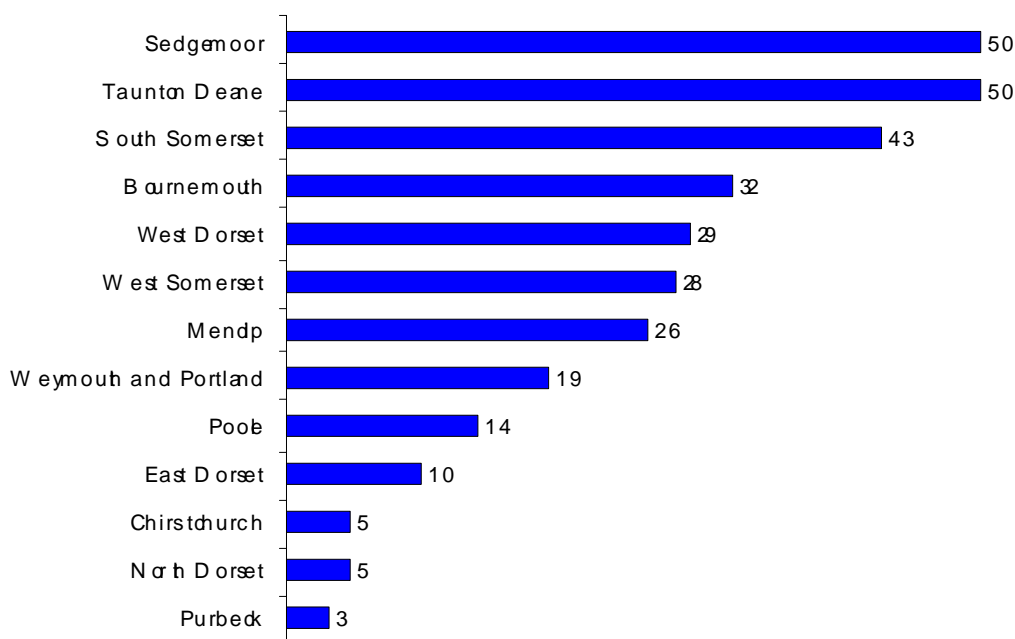
Table 7: Age and gender of WBL trainees who trained in nursing, other medical vocations, and health and social care in the BDPS area, 2004/05; numbers

	F	M	Total
16-18 years	114	7	121
19-20 years	99	7	106
21-24 years	96	9	15
Total	309	23	332

Source: ILR

- 118. It can be seen that the structure of Work Based Learners strongly perpetuates the bias towards female employment in the sector.
- 119. Locationally, Apprentices were resident in all BDPS Districts/UAs but it is notable that the distribution is quite uneven, with high numbers of Apprentices in Sedgemoor, Taunton, and South Somerset and quite low numbers in some Dorset Districts:

Figure 2: Numbers of WBL trainees who trained in nursing, other medical vocations and health and social care per District/UA, 2004/05



Source: ILR

- 120. The majority of WBL trainees were Apprentices at Foundation level (63%; 210 cases) but a minority trained at Advanced level, Level 3 (37%; 122 cases).
- 121. Success rates for 249 Apprentices who ended their Apprenticeship in 2004/05 were moderate in terms of achieving some *part* of the Apprenticeship framework but *full* completion was not frequent:

Table 8: Success rates in WBL in nursing, other medical vocations and health and social care in the BDPS area, 2004/05

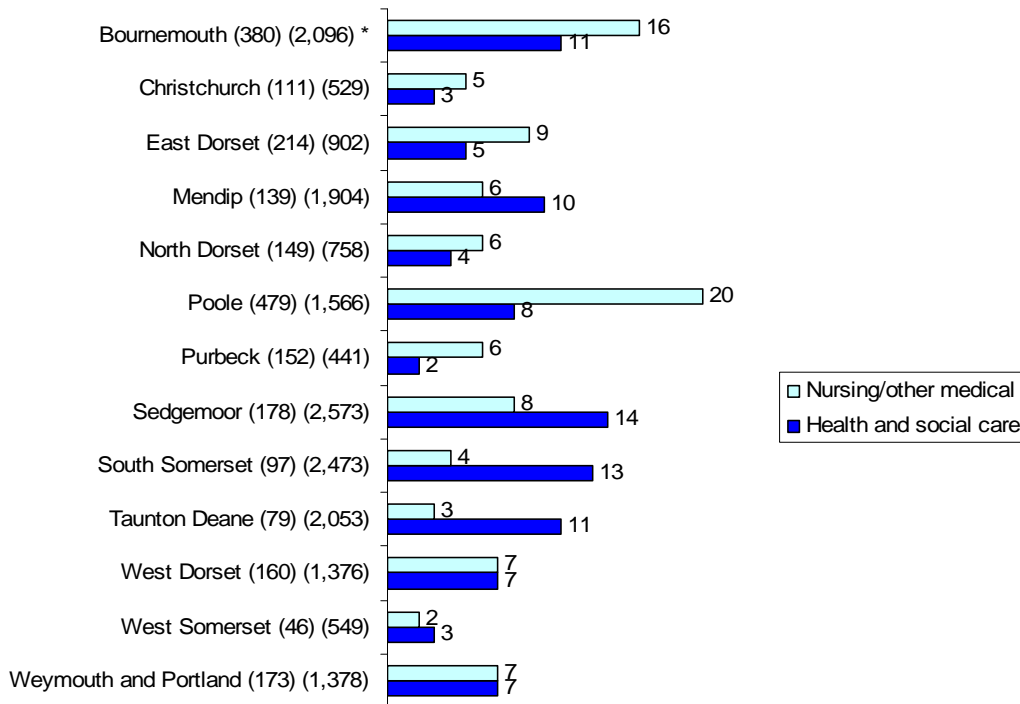
	Some achievement	Full framework completion
Apprenticeship (Level 2)	48%	35%
Advanced Apprenticeship (Level 3)	68%	21%

Source: ILR

Local supply: Further Education

122. In total, 20,971 learning aims in nursing, other medical vocations, and health and social care were pursued by residents of the BDPS area in 2004/05.
123. Of these, 2,359 learning aims were pursued in *nursing and other medical vocations*:
- 8% by those aged 16-18 and 92% by those aged 19 and above.
 - 75% by women and 25% by men.
124. 18,612 learning aims were pursued in *health and social care*:
- 14% by those aged 16-18 and 86% by those aged 19 and above.
 - 66% by women and 34% by men.
125. The places of residence of those pursuing these learning aims were:

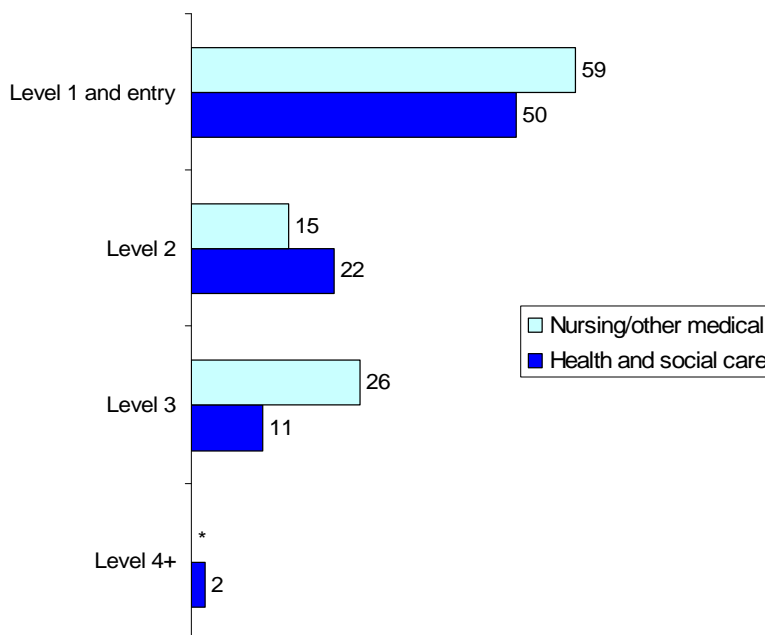
Figure 3: Place of residence of those with learning aims in nursing, other medical vocations, health and social care, 2004/05; percentages



* Actual numbers in brackets (Nursing/other medical)(Health and Social Care)
Source: ILR

126. The levels at which learning aims were pursued were:

Figure 4: Level of learning aims pursued by BDPS area students, 2004/05; percentages



127. The learning aims pursued by students in health-related subjects were:

Table 9: Learning aims of 16-18 year olds in nursing and other medical vocations; numbers and percentages

	No.	%
Access to Social Work and Nursing - Bournemouth and Poole College	1	0.5
BTEC National Certificate in Pharmacy Services	16	8.6
Certificate in Thermal Auricular Activity	2	1.1
Diploma in Anatomy and Physiology	8	4.3
Introduction to Indian Head Massage	6	3.2
Medic First Aid - Paediatric	145	77.5
Medicine Administration	4	2.1
National Certificate	2	1.1
NVQ in Oral Healthcare: Dental Nursing	2	1.1
Refresher Course and Examination (HSE approved)	1	0.5
Total	187	100

Source: ILR

Table 10: Learning aims of 19+ year olds in nursing and other medical vocations; numbers and percentages

	No.	%
Access to Higher Education : Nursing - Somerset College of Arts and Technology	15	0.7
Access to Higher Education: Nursing - Bridgwater College	41	1.9
Access to Social Work and Nursing - Bournemouth and Poole College	92	4.2
BTEC National Certificate in Pharmacy Services	29	1.3
Certificate in Thermal Auricular Activity	19	0.9
CG 3056 Certificate in Community Mental Health Care - Level 3	12	0.6
Diploma in Anatomy and Physiology	311	14.3
Diploma in Holistic Crystal Therapy	17	0.8
Diploma in Non-Medical Nutritional Advice	6	0.3
Diploma in Ophthalmic Dispensing - Theory 2	1	0
Ideals in Action	4	0.2
Intermediate Certificate in Dispensing Practice	4	0.2
Level 2 Certificate in Thermal Auricular Therapy	2	0.1
Medic First Aid - Care Initiator Course Plus	6	0.3
Medic First Aid - Paediatric	479	22.1
Medicine Administration	305	14
National Certificate	10	0.5

National Diploma in Science (Dental Technology)	1	0
NVQ in Oral Healthcare: Dental Nursing	24	1.1
NVQ in Pharmacy Services	14	0.6
Professional Development Award in Dispensing Doctor's Assistants	7	0.3
Proficiency in Medical Care	10	0.5
Red Cross World	43	2
Refresher Course and Examination (HSE approved)	704	32.4
Speech Therapy (City Literary Institute)	1	0
Trauma Management	15	0.7
Total	2172	100

Source: ILR

Table 11: Learning aims of 16-18 year olds in health and social care; numbers and percentages

	No.	%
1 day Appointed Persons First Aid Course	2	0.1
Abrasive Wheels Regulations	2	0.1
Accident and Incident Awareness and Response	3	0.1
Advanced Subsidiary VCE in Health and Social Care	15	0.6
Advanced VCE (Double Award) in Health and Social Care	143	5.3
Advanced VCE in Health and Social Care	127	4.7
Basic First Aid	122	4.5
Basic Health and Safety Certificate	67	2.5
Basic Health and Safety for the Construction Industry	1	0
BTEC Award in The Control and Administration of Medicines	13	0.5
BTEC First Diploma in Caring	18	0.7
BTEC Introductory Certificate in Health and Social Care	1	0
BTEC Introductory Diploma in Health and Social Care	15	0.6
BTEC National Certificate in Health Studies	3	0.1
BTEC National Diploma in Care	3	0.1
BTEC National Diploma in Health Studies	94	3.5
Certificate for Working in the Community	8	0.3
Certificate in Aromatherapy Massage	3	0.1
Certificate in Basic Health and Safety	6	0.2
Certificate in Care Procedures	1	0
Certificate in Care Skills	1	0
Certificate in Counselling Skills	1	0
Certificate in Food Hygiene	434	16

Certificate in Health & Safety (Entry Level)	7	0.3
Certificate in Health and Safety in the Workplace	245	9
Certificate in Infection Control	7	0.3
Certificate in Introduction to Counselling Skills	77	2.8
Certificate in Nutrition and Health	1	0
Certificate in Paediatric First Aid	8	0.3
Certificate in Personal Safety Awareness	95	3.5
Certificate in Positive Dementia Care	3	0.1
Certificate in Reflexology Techniques	23	0.8
Certificate in Safe Handling of Medicines	11	0.4
Certificate in Safety Compliance	3	0.1
Certificate in Salon Hygiene	14	0.5
Certificate in Swedish Massage	11	0.4
Certificate in Working Safely	1	0
Certificate in Working with Voluntary Organisations and Community Groups	47	1.7
Certificate in Youth Work	4	0.1
Conversion from Advanced Subsidiary VCE to Advanced VCE in Health and Social Care	23	0.8
Conversion from Advanced VCE to Advanced VCE (Double Award) in Health and Social Care	2	0.1
Diploma in Aromatherapy	2	0.1
Diploma in Body Massage	4	0.1
Diploma in Holistic Massage	5	0.2
Diploma in Holistic Therapies	1	0
Diploma in Reflexology	4	0.1
Domestic Natural Gas Core Safety	1	0
Emergency Aid	1	0
Emergency Aid at Work (Appointed Person)	3	0.1
Emergency Aid in the Workplace for Appointed Persons	210	7.7
Emergency First Aid (Appointed Person)	37	1.4
Emergency First Aid at Work	2	0.1
Emergency First Aid for Appointed Persons	1	0
Entry Level Certificate in Skills for Working Life (Health and Social Care)	2	0.1
First Aid at Work Certificate (certificate awarded by HSE approved organisations)	245	9
First Aid at Work Certificate (HSE approved)	28	1
First Aid for Child Carers	59	2.2
First Aid for Child Carers Certificate	3	0.1
First Aid Refresher Course and Examination (certificate awarded by HSE approved organisations)	1	0
Foundation Certificate in Health and Safety in the Workplace	82	3

GCSE Health and Social Care (Double Award)	2	0.1
GNVQ in Foundation Health and Social Care	52	1.9
GNVQ in Intermediate Health and Social Care	68	2.5
Infection Control	1	0
Intermediate Certificate in Food Safety	20	0.7
Intermediate Certificate in Safe Handling of Medicines	2	0.1
Introduction to Counselling	1	0
Level 2 Certificate in Manual Handling	1	0
Lifesaver First Aid Course	80	3
Lifesaver Plus First Aid Course	4	0.1
Medic First Aid - Care Initiator Course	33	1.2
Medic First Aid - Sports Medicine	16	0.6
National General Certificate	1	0
National Skills Profile - Care	9	0.3
NVQ in Care	12	0.4
NVQ in Health and Social Care	7	0.3
Principles of COSHH	2	0.1
Principles of Manual Handling	2	0.1
Professional Development Award in Caring (Communication Support Worker with Deaf People)	1	0
RYA First Aid Certificate	4	0.1
Safety in the use of Abrasive Wheels	1	0
Standard First Aid Certificate	2	0.1
Working Safely	33	1.2

Source: ILR

Table 12: Learning aims of 19+ year olds in health and social care; numbers and percentages

	No.	%
1 day Appointed Persons First Aid Course	291	1.8
1 Day Mobile Elevated Platform (refresher)	2	0
Abrasive Wheels Regulations	2	0
Access to Higher Education (Social Work, Teaching, Health Studies) - Yeovil College	40	0.3
Access to Higher Education: Social Work - Bridgwater College	10	0.1
Accident and Incident Awareness and Response	255	1.6
Advanced Certificate in Counselling	3	0
Advanced Certificate in Counselling Skills	41	0.3
Advanced Certificate in Food Safety	2	0
Advanced Diploma in Pest Management	1	0

Advanced VCE (Double Award) in Health and Social Care	3	0
Advanced VCE in Health and Social Care	3	0
Basic First Aid	649	4.1
Basic First Aid at Work Certificate	3	0
Basic Health and Safety Certificate	324	2
BTEC Award in Infection Control	1	0
BTEC Award in The Control and Administration of Medicines	3	0
BTEC National Certificate in Health Studies	1	0
BTEC National Diploma in Health Studies	6	0
CAB Certificate in Generalist Advice Work	4	0
Care Practices	5	0
CCNSG Nationally Accredited Safety Passport	2	0
Certificate for Working in the Community	1	0
Certificate in Aromatherapy Massage	9	0.1
Certificate in Basic Health and Safety	43	0.3
Certificate in Care Practices	3	0
Certificate in Care Procedures	6	0
Certificate in Care Skills	56	0.4
Certificate in Community Mental Health Care	6	0
Certificate in Control of Infection and Contamination	1	0
Certificate in Counselling Concepts	2	0
Certificate in Counselling Skills	224	1.4
Certificate in Counselling Skills and Theory	11	0.1
Certificate in Counselling Studies	154	1
Certificate in Drugs Awareness - Level 2	1	0
Certificate in Drugs Awareness	23	0.1
Certificate in Food Hygiene	1829	11.5
Certificate in General Practice Reception	12	0.1
Certificate in Health & Safety (Entry Level)	23	0.1
Certificate in Health and Safety in the Workplace	653	4.1
Certificate in Health and Safety Management	1	0
Certificate in Holistic Therapies	2	0
Certificate in Housing	2	0
Certificate in Infection Control	442	2.8
Certificate in Introduction to Counselling Skills	152	1
Certificate in Medical Terminology	12	0.1
Certificate in Moving and Handling Clients	10	0.1
Certificate in Nutrition and Health	36	0.2
Certificate in Occupational Health and Safety	9	0.1

Certificate in Occupational Safety - Managing Health & Safety	2	0
Certificate in Occupational Safety - Manual Handling	1	0
Certificate in Occupational Safety - Risk Assessment	16	0.1
Certificate in Occupational Safety - Safety Essentials	8	0.1
Certificate in Paediatric First Aid	3	0
Certificate in Personal Safety Awareness	23	0.1
Certificate in Positive Dementia Care	76	0.5
Certificate in Reflexology Techniques	47	0.3
Certificate in Risk Assessment Principles and Practice	36	0.2
Certificate in Safe Handling of Medicines	520	3.3
Certificate in Safety Compliance	145	0.9
Certificate in Salon Hygiene	26	0.2
Certificate in Supervising Health and Safety	4	0
Certificate in Swedish Massage	62	0.4
Certificate in Welfare Studies	20	0.1
Certificate in Working and Operating Safely	33	0.2
Certificate in Working Safely	9	0.1
Certificate in Working with People who have Learning Disabilities	12	0.1
Certificate in Working with Voluntary Organisations and Community Groups	661	4.2
Certificate in Youth Work	29	0.2
CG 2078 Handling of Refrigerants	2	0
CG 7410-01 Radiation Safety Practice Stage I	2	0
Changeover Domestic - ESP Safety	3	0
Changeover Domestic Natural Gas safety to Commercial Natural Gas Safety	7	0
Changeover Domestic to Commercial Catering (Appliances) Gas Safety Assessment	1	0
Commercial Catering Safety (Natural Gas)	4	0
Commercial Natural Gas Safety	16	0.1
Conversion from Advanced Subsidiary VCE to Advanced VCE in Health and Social Care	2	0
Core Domestic Gas Safety	6	0
Counselling Diploma	1	0
Counselling Skills in the Development of Learning Certificate	44	0.3
Diploma in Aromatherapy	9	0.1
Diploma in Body Massage	32	0.2
Diploma in Case Work Supervision	2	0
Diploma in Counselling	7	0
Diploma in Diet and Nutrition for Complementary Therapists	9	0.1
Diploma in Holistic Massage	178	1.1

Diploma in Holistic Therapies	9	0.1
Diploma in Housing	2	0
Diploma in Lymphatic Drainage Massage	6	0
Diploma in On Site Massage	2	0
Diploma in Reflexology	113	0.7
Diploma in Therapeutic Counselling	131	0.8
Diploma in Welfare Studies	18	0.1
Diploma in Youth Work	26	0.2
Domestic Natural Gas Core Safety	64	0.4
Early Years First Aid	1	0
Emergency Aid	33	0.2
Emergency Aid at Work (Appointed Person)	50	0.3
Emergency Aid in the Workplace for Appointed Persons	325	2
Emergency First Aid (Appointed Person)	30	0.2
Emergency First Aid for Appointed Persons	5	0
Emergency First Aid for Children	11	0.1
Equality 18 glh	1	0
Equality 6 glh	14	0.1
First Aid Appointed Persons	15	0.1
First Aid at Work Certificate (certificate awarded by HSE approved organisations)	1723	10.8
First Aid at Work Certificate (HSE approved)	997	6.3
First Aid for Beginners	12	0.1
First Aid for Child Carers	27	0.2
First Aid for Child Carers Certificate	11	0.1
First Aid for Childcarers	83	0.5
First Aid Refresher Course and Examination (certificate awarded by HSE approved organisations)	717	4.5
Foundation Certificate in Health and Safety in the Workplace	189	1.2
Foundation Course in Welfare Studies	16	0.1
GNVQ in Intermediate Health and Social Care	4	0
Health and Safety 12 glh	10	0.1
Health and Safety 18 glh	14	0.1
Health and Safety 30 glh	25	0.2
Health and Safety 6 glh	22	0.1
Health and Safety 60 glh	72	0.5
Health and Safety Environmental Awareness (Fencing)	3	0
Health and Safety Passport	31	0.2
Infection Control	185	1.2
Intermediate Certificate in Counselling Skills	26	0.2

Intermediate Certificate in First Aid	1	0
Intermediate Certificate in Food Safety	95	0.6
Intermediate Certificate in Introduction to Counselling Concepts	8	0.1
Intermediate Certificate in Occupational Health and Safety	36	0.2
Intermediate Certificate in Safe Handling of Medicines	161	1
Introduction to Counselling	64	0.4
Introduction to Health & Safety	7	0
Introduction to Health and Safety in the Workplace	3	0
IOSH-SPA Safety Passport Scheme (Core + Sector Specific)	4	0
Level 2 Certificate in Manual Handling	17	0.1
Level 3 Diploma in Counselling	5	0
Lifesaver First Aid Course	53	0.3
Lifesaver Plus First Aid Course	9	0.1
LPG Safety Permanent Dwellings	1	0
Managing Safely Certificate	97	0.6
Medic First Aid - Care Initiator Course	96	0.6
Medic First Aid - Sports Medicine	9	0.1
Modules in Specified Aspects of Occupational Hygiene	1	0
Morley College - Programme Area 7; Health & Community Care (CWF B)	1	0
Moving and Handling	1	0
Moving On - Moving and Handling Training	14	0.1
National Certificate in Construction Safety and Health	2	0
National Certificate in Housing	8	0.1
National Diploma in Occupational Safety & Health Part 2	3	0
National Diploma in Occupational Safety and Health Part 1	1	0
National General Certificate	119	0.7
National Skills Profile - Care	1	0
Non-schedule 2 Health/Community Care CWF A (WEA)	27	0.2
Non-schedule 2 Health/Community Care CWF B (WEA)	1	0
NVQ in Advice and Guidance	47	0.3
NVQ in Care	1459	9.2
NVQ in Health and Social Care	380	2.4
NVQ in Learning, Development and Support Services for Children, Young People and Those who Care for Them	38	0.2
NVQ in Occupational Health and Safety Practice	1	0
NVQ in Registered Manager (Adults)	225	1.4
NVQ in Registered Managers (Adults)	1	0

NVQ in Youth Work	2	0
Offshore First Aid Certificate (certificate awarded by HSE approved organisations)	7	0
Principles of COSHH	44	0.3
Principles of Manual Handling	80	0.5
Resuscitation Support Module	13	0.1
Risk Assessment Principles and Practice	2	0
RYA First Aid Certificate	155	1
Standard First Aid Certificate	75	0.5
STCW 95 Basic Training - Elementary First Aid	1	0
STCW 95 First Aid at Sea/Proficiency in Medical First Aid	1	0
Supervising Health and Safety	1	0
Working Safely	70	0.4
Total	15902	100

Source: ILR

128. Completion rates were:

	16-18 year olds		19+ years	
	Nursing/other medical	Health and social care	Nursing/other medical	Health and social care
Completed/continued working towards	90%	75%	92%	90%
Failed to complete	10%	25%	8%	10%

129. Key providers for 16-18 year olds were:

Table 13: Key providers, 16-18 year old learners; percentages of total

	Nursing/other medical	Health and social care
Bournemouth and Poole College	62	8
Strode College	14	5
Brockenhurst College	11	3
Weymouth College	2	21
Bridgwater College	4	24
SCAT	-	15
Richard Huish College	7	18
Other providers	7	18
Total	100	100

Source: ILR

130. Key providers for those aged 19 and over were:

Table 14: Key providers, 16-18 year old learners; percentages of total

	Nursing/other medical	Health and social care
Bournemouth and Poole College	29	16
Dorset County Council	34	7
Weston College	6	4
Weymouth College	6	8
Strode College	6	7
Bridgwater College	4	8
SCAT	2	18
Other providers	13	32
Total	100	100

Source: ILR

Quality of provision

131. Of course, it is not just the scale and type of provision which is important. It is also important that the *quality* of provision is good. However, information on quality is largely limited to that derived from Ofsted/ALI inspection reports. These are sometimes not recent. However, such information as is available reveals:

College	Department	Date of inspection	Grade awarded
Bournemouth and Poole	Health and social care	March 2003	2 (Good)
Somerset College of Arts and Technology	Health, care and public services	May 2003	3 (Satisfactory)
Yeovil College	Health and social care	February 2005	3 (Satisfactory)
Bridgwater College	Health and social care and public services	February 2002	1 (Outstanding)
Weymouth College	Health, social care and early years	April 2004	3 (Satisfactory)
Strode College	Health and social care and counselling	March 2003	2 (Good)

132. As we noted above, information on the quality of FE provision for health and care is somewhat tangential. The reports are mostly not very recent and they cover a much wider spectrum of courses than just those concerned directly with health. We can, therefore, perhaps do no more than note that, at least at the latest date available, provision in the health and social care area was rated no better than Grade 3, 'satisfactory' in 3 out of 6 Colleges (with some WBL provision in one College being graded 4, 'unsatisfactory'), whilst provision in two Colleges (Strode and Bournemouth and Poole) was rated at Grade 3 ('good'). Only in one College, Bridgwater, was provision rated as Grade 1, 'outstanding'.

133. Considering this data (on WBL and FE participation) we would suggest:
- Almost all WBL (mainly Apprenticeships) in the general health and social care area is concerned with 'Health and Social Care' rather than with 'Nursing and subjects allied to Medicine'. We might suppose that these former Apprenticeships are concerned rather more with 'care' than with 'health' and that, therefore, WBL actually contributes very little to the development of 'health' skills other than in a very basic sense (we would also note that, in any case, numbers are low to start with and full completion rates can be described only as moderate at best.).
 - Similarly, in FE, the majority of learning aims are again weighted to 'Health and Social Care' (89%) as against 'Nursing and subjects allied to Medicine' (11%). Again, we may suppose that, despite the 'health' part of the 'health and social care' label, the actual content of the former learning is in fact weighted towards social care and has only a tangential or generic connection with health care delivery.
 - In terms of gender balance of participation, statistics suggest that current training, whilst still significantly weighted to women, is not as strongly weighted as current employment in the health sector – thus 25% of learning aims in respect of 'Nursing and subjects allied to Medicine' were pursued by men whilst men currently represent only about 20% of the sector workforce.
 - FE provision is strongly weighted to Entry Level/Level 1 study – nearly 60% of learning aims in 'Nursing and subjects allied to Medicine' are at this level and only a quarter of study is directed to Level 3 qualifications.
 - Achievement rates are high – at least 90% of students in 'Nursing and subjects allied to Medicine' achieve their learning aim.
134. Overall, therefore, we would suggest that Work Based Learning makes little contribution to skill stocks in the health sector. FE clearly makes a larger contribution but we would suggest that much learning under the 'Health and Social Care' heading may have only a peripheral connection to the specific needs of the health service and both in 'Health and Social Care' and 'Nursing and subjects allied to Medicine' much study is at a basic level. The statistics, allied to our observations above about course content, may suggest that the FE contribution is mainly to offer foundation education in the basic concepts of care – obviously a starting point for health sector employment but, perhaps, not much more. We will return to these observations when we report directly on the views of health sector employers (represented by the Skills for Health SSC and the SHA) in later sections of this report.

Employer training

135. Some participation in public provision for the sector (via FE and WBL) will be funded and arranged by employers in the sector. However, such participation cannot be distinguished from that which individuals undertake for their own purposes without employer direction or support. It is valuable, therefore, to consider employer training from another perspective – that offered by the 2005 National Employer Skills Survey (NESS 2005). Some key indicator data is set out below drawn from this survey (and its precursor in 2003). To avoid the 'small sample' problem, regional data is used as a proxy for the BDPS area:

Table 13: Employer training indicators: health sector in Bournemouth, Dorset, Poole and Somerset (SW Region data used as proxy), 2003 and 2005

	Health sector in SW Region 2003 (%)	Health sector in SW Region 2005 (%)	All-sector average for SW Region 2005 (%)
Has a business plan	85	68	55
Has a training plan	67	73	44
Has a training budget	50	55	32
None of staff have a formal job description	0	6	26
Formally assess skill gaps	58	75	46
None of staff have an annual performance review	35	19	42
Have funded staff training in last 12 months	80	85	65
Average expenditure per training establishment	N/A	£3,990	£2,661
Training establishments used FE Colleges	48	40	30
% of those dissatisfied with FE provision	N/A	4	8

Source: NESS03 and NESS05

136. Broadly, this data shows the health sector:

- As one which supplies a high volume of training to its staff and does so within a planned framework.
- Is showing progress on most HRD indicators.

Labour and skills supply: summary

137. Consideration of labour and skills supply into the health sector suggests:

- The local labour market is fairly tight and it may be assumed that the health sector requires to maintain its current pay and conditions advantages to main an adequate flow of staff. House prices are high relative to earnings and it may be difficult for lower paid workers to move into the area.
- There is a large and complex structure of organisations and institutions through which health sector skills are developed.
- Generally, the health sector is a strong provider of training using HE for higher levels of skill and internal training resources and systems at lower levels. Further Education is a minority provider for most occupational levels.

- Work Based Learning makes a negligible contribution to health sector skill stocks in the BDPS area.
- Further Education makes a stronger numerical contribution.
- However, it appears that the FE sector's contribution is weighted to the development of general care skills, mostly at fairly low level and that, prima facie, FE may not make much specific contribution to the particular skill needs of the health sector. This view will be refined in the next chapter of this document which reports directly on the views of health sector employers.

6. Skills issues

138. In previous chapters we have presented a picture in which gross *labour* demand, assuming that absolute employment levels are restrained by current NHS budgetary constraints, will largely be driven by the need to replace people who leave their employment, particularly because of retirement from what is a relatively 'old' workforce; and in which *skills* demand is driven by a variety of factors, including:
- A changing health service policy agenda which puts a focus on patient-centred delivery, on the need to raise productivity, on breaking boundaries between traditional service providers, and on new, more flexible, occupational definitions.
 - An ageing client-base in the population.
 - A widening public health agenda.
 - New technologies and information management systems.
139. We presented a picture of supply in which a complex range of stakeholders ensure that the health sector is a 'high training' sector in comparison with much of the remainder of the economy with the HE sector and internal NHS training resources being major sources of training and development, whilst the FE sector has a much more modest input to skills development.
140. A first question is whether this supply of skills and labour meets the sector's demands.
141. The National Employer Skills Survey offers only an equivocal answer. Results for the BDPS area are highly unreliable because of a small sample of employers. At regional level, data for 2005 suggests that....
- 25% of health sector employers had current vacancies at the time of survey(35% in 2003)
 - 10% had hard-to-fill vacancies(18% in 2003)
 - 6% had skill shortage vacancies(7% in 2003)
 - And 12% had 'skills gaps' in their *existing* workforces at the time of survey(29% in 2003)
 - It can be seen that skill problems are observed, by the 2005 survey, as being at moderate to low levels and as having cooled very significantly between 2003 and 2005.
142. However, we cannot necessarily assume that these summary statistics, relating back to 2003/05 and having a regional base, apply in the BDPS area nor that they accurately identify the 'skills issues' which are currently pertinent to the sector in the local area. Rather, discussions with representatives from the Sector Skills Council and from the Strategic Health Authority give a more fine-grained and up-to-date picture of the skills demand and supply balance of the local area and of what issues arise with respect to that balance.
143. A first point which emerges from such discussions is that there is considerable uncertainty as to future employment numbers in the sector. Clearly there are constraints on employment placed by budgeted reductions in the recent fast rate of funding growth in the NHS and the requirement to raise productivity. Future

funding increases will be much more modest and existing levels of staffing will be expected to deliver more output. On the other hand, some particular service developments are planned which imply (modest) increases in staffing to service those developments. Generally, perhaps, it should be assumed that the 'technical' forecast (which we offered in Chapter 3 earlier) should be treated extremely cautiously. Employment growth in the short to medium term in the BDPS area, even though there is no 'budget crisis' as in some Trusts in other parts of the country, will be very modest (if it occurs at all) and will not, in itself, constitute a pressure on skills and labour supply in the foreseeable future.

144. The need to replace staff who leave *is* a factor in workforce planning. It is estimated that workforce stability in the SHA area runs at around 86% – that is, around 14% of staff turn over per annum. However, this level of turnover (actually considerably higher than that which we predicted from national statistics in Chapter 4 earlier) is not regarded as problematic; rather, it is viewed as a means by which the workforce can be 'refreshed' and as an opportunity to reconfigure workforce roles and structures as it occurs.
145. Nor is it regarded as difficult to replace staff who leave. It is reported that there is high demand for employment in the sector and that most staff vacancies are filled without difficulty. These points concur with survey data above which suggest that skill supply problems reduced markedly between 2003 and 2005 (and may have been on a downward trend which has continued since 2005). As an adjunct to these observations, it is also recorded that the NHS within the Dorset and Somerset SHA area has not been obliged to recruit in-migrant (overseas) staff in any significant number in order to fill vacant posts.
146. In short, therefore....
- Numbers employed in the sector are largely stable.
 - There is a need to replace staff who leave, but staff turnover is not regarded as problematic and some *benefits* of turnover are recognised.
 - There is no significant 'hard-to-fill' or 'skill shortage' problem affecting recruitment.
147. However, when *skill levels and skill development within the existing NHS workforce* are considered, a series of interlinked issues arise.
148. On the 'demand' side, it is apparent that there are a number of needs....
- The thrust of NHS policy towards flexibility has generated a broad demand that the 'assistant practitioner' role, now present only in sporadic locations, should be much extended.
 - The NHS's Knowledge and Skills Framework (KSF) staff assessment process has generated a high level of newly-identified latent demand for staff development.
 - Associated with these developments, a significant gap in 'Skills for Life' capability has been identified in those holding lower grade (Grades 1-4) posts alongside some lack of numeracy in nursing grades.
 - Changes in information systems in the NHS are generating demands for new levels of knowledge management and related ICT competences.

149. Each of these needs has generated an explicit need for training and development of varied kinds. However, on the 'supply' side....

- Internal funding for training and development of lower grades of staff has become tightly constrained – general pressure on NHS budgets, the end of previously 'ring-fenced' funding from the Department of Health for the NHS's internal ILA/NVQ programme for non-professional staff, and strong pressure on available training budgets for clinical and nurse training are all implicated.
- The NHS sees itself as currently a low priority for LSC funding in the South West region.
- Apprenticeship makes little or negligible contribution to the development of skills *directly* relevant to the NHS.
- FE courses in 'health and social care', even if funding were available to subsidise NHS staff participation, is seen as strongly weighted to the 'care' element and of little immediate consequence to NHS roles. There is a particular concern from within the SHA that this weighting to 'care' rather than 'health' ignores the strong trend in the sector towards closer integration of the two streams and that failure of FE institutions to reflect this integration in their courses will lead to a progressive diminution in their relevance. There is, however, more scope within FE to develop skills of staff in generic roles which are not specific to the health sector.

150. Thus, *from the NHS perspective*, the immediate practical issues are, in essence....

- A new training budget for non-professional staff (to replace that which has been lost with the demise of the internal ILA/NVQ budget) requires to be constructed if training capacity and infrastructure in respect of these staff is not to be sharply reduced.
- This budget could, in principle, be generated internally to the SHA but there are clearly difficulties in doing so – principally, as above, the tension between overall funding and the heavy commitment to training of professional/registered grades.
- Therefore, external funding should be pursued, with the LSC being seen as the obvious source.
- At national level, negotiations between the Skills for Health SSC and the LSC are taking place with the objective (for 2007/08) of securing a national fund to be regionally allocated and tied to particular workforce development objectives. However, there is as yet insufficient clarity as to how and whether these discussions will meet the SHA's immediate and longer term concerns.
- In the meantime, two lines of development may assist the SHA.
- The first is that the SHA should pursue funding under the LSC's Train to Gain programme to enable access to external training for *non-clinical* staff in *generic* areas (FE/independent providers seen as better placed than in-service training resources for this function). The SHA would

simultaneously seek to identify some providers as 'preferred suppliers' in order to better influence their delivery and to introduce economies of scale.

- The second is that NHS institutions (either the SHA or the Acute Trusts which actually deliver in-service training) should (1) themselves seek to establish themselves as LSC-funded and recognised providers in their own right and/or (2) seek partnership with FE institutions/independent providers in order to increase the capacity of those providers to deliver healthcare NVQs (FE/independent providers currently being seen as inadequate in this role). Again, the assumption is that external funding would support either of these developments (although there is also a view that the NHS would contribute 'in kind' by donating the time and expertise of its in-service trainers). Comparable models of large employers in other sectors are noted as examples of how model (1) arrangements already exist; it is noted that at least one other SHA has already become a CoVE for the development of specialist health staff in partnership with local Colleges; and the proposals may fit with the development of sector 'skills academies', a wider policy objective being pursued by DfES, LSC, and SSCs .
 - It is also noted that the SHA's attempts to widen the use of Apprenticeship in the local sector has not met with a high level of responsiveness from the LSC (despite the sector's inherent capacity to deliver high quality well-mentored programmes).
151. From the LLSC point of view there are three primary questions which, perhaps, require to be answered in judging its response to health sector needs as set out above.
152. These concern the questions of priority, organisation, and funding.
153. In respect of 'priority' there is, for the LSC, the difficult task of judging the significance of health service needs against those of other sectors. Does the need of the NHS to develop its assistant practitioner grades and to award NVQs to its lower grade staff rank higher than, say, the needs of the construction sector to increase its number of skilled craft workers or of the hospitality sector to improve its offer to tourists to the area by developing customer service and chef skills? Clearly, the health sector sees its own needs as paramount but then so do most other sectors. The LLSC is required to make its own judgement as to where it pitches its support and to what extent.
154. Secondly, both the LSC and the NHS are going through re-organisation processes in the broad direction of regionalisation of strategic planning. It is likely that the problems faced by the NHS in the BDP area – driven, as they are, by national factors – will be experienced across the region. The question arises as to how practicable it is, until settlement on both sides is reached, for the LLSC to engage with NHS issues, given the current uncertainties affecting organisational arrangements and staffing. There is a fundamental question as to whether the relationship between the NHS as a major employer and the LSC and its funded providers will be one which can be usefully developed at sub-regional level or will be one which realistically will require to be addressed at regional level.

155. And, thirdly, there is the question of what funding the LSC, should it want to, is able to allocate to NHS skills issues. The SHA, for example, seeks to resolve some of its problems by the use of Train to Gain funds, but it is not clear that the Train to Gain programme, with its emphasis on brokerage, on funding of Level 2 skills development, and on hard-to-reach employers, is a wholly appropriate vehicle to meet local NHS ambitions.
156. However, on the assumption that the obstacles implicit in these three questions are surmounted and deeper engagement with the health sector *is* pursued, whether at regional or sub-regional level, then there are clear and innovative routes forward in response to the overtures of the SHA, which would focus on the LSC's capacity to facilitate SHA aspirations.....
- 1) To secure a much stronger health sector foothold in the Apprenticeship programme.
 - 2) To develop a much closer partnership with local FE institutions such that the latter become more frequent providers of generic skills to the sector and develop stronger healthcare courses much more specific to the needs of the sector.
 - 3) To establish NHS institutions as registered providers of healthcare skills with the support of the LSC.
157. These routes - involving a much stronger linkage between a major employer (ie. the NHS), the LSC, and providers within a number of possible configurations - would actually move forward from what is virtually a zero base, in which the LSC and the FE sector have very little impact on local health service skill levels, to a point where the LSC/FE were considerably more significant to the health sector.
158. The key questions are whether the LLSC is 'ideologically' convinced that the health sector *is* a priority and should therefore be the subject of substantially stronger support (inevitably at the expense of other sectors); whether recent organisational upheavals allow useful progress to be made at local level in the near future; whether, in actuality, the LSC has the financial resources to meet SHA needs to any significant degree and within what timescale; and of the extent to which the major programmes through which LSC resources are allocated (Train to Gain, Skills for Life, Apprenticeship, FE funding) could be effectively configured to meet SHA needs and aspirations.

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