



National Health and Social Care Workforce Planning: Discussion Document

The UNISON Scotland response to the Scottish government consultation March 2017

UNISON Scotland

National Health and Social Care Workforce Planning

Introduction

UNISON is the largest trade union covering the health and social care workforce in Scotland, with members in NHS Scotland, local government and the voluntary and private sectors.

Background

UNISON Scotland welcomes a renewed focus on workforce planning in the health and care sector given the challenges that lay ahead. The model set out in the discussion paper largely reflects the NHS approach workforce planning. This may not be easily applied to the social care sector without some significant structural change.

For the NHS we have good workforce statistics because NHS Scotland uses a common payroll system and therefore ISD can publish comprehensive statistics on current staffing levels and an analysis of trends over many years. However, even in NHS Scotland central workforce planning is only partial, with a focus on the largest staff groups; doctors, dentists and nurses. This is supplemented by workforce planning at regional and board level, which reflects local circumstances.

Workforce statistics, let alone workforce planning, is very limited in the social care sector. This largely privatised sector is hugely fragmented and data is heavily reliant on registration with the SSSC. The problem with reliance on the SSSC is that not all staff are yet registered and some important groups, like PA's and childminders, don't have to register. The interaction with volunteers is another complication. We are therefore reliant on partial employer data and trade union surveys to plug the gap.

For these reasons a plan needs to start with a review of data collection, analysis and the scope and extent of workforce planning.

However, statistics are only the start. Workforce planning also requires a clear understanding of how the sector is likely to develop in the coming years. This requires an assessment of issues like the shift from acute to community services, expanded roles, co-production and levels of administrative support.

Workforce challenges

The health and care sector in Scotland is facing significant recruitment and retention problems at a time when we need to expand the workforce.

The number of staff in NHS Scotland has now recovered to pre-crash levels at just over 138,000. Figures that claim more than that do not fully take account staff transfers. However, the establishment and real staff numbers on the ground are two different matters. We know that nursing vacancy rates have been growing and currently stand at 2566 WTE. There are similar proportional problems with doctors and allied health professions, including Occupational Therapists.

Figure 7: Nursing and midwifery vacancy rates by length of vacancy¹



In the largely privatised and fragmented social care sector we have very little data that helps inform workforce planning. From SSSC data (see below) we know that the workforce is over 200,000, broken down into broad categories. There is some classification of jobs, but probably too broad for effective workforce planning purposes.

Table 6: Headcount by sub-sector and employer type, 2015

Sub-sector	Public	Private	Voluntary	Total
Adoption services	360	0	100	460
Adult day care	4310	800	2970	8080
Adult placement services	110	0	70	180
Care homes for adults	6890	38180	8910	53980
Central and strategic staff	2930	0	0	2930
Child care agencies	10	180	230	420
Childminding	0	5570	0	5570
Day care of children	13140	13780	6540	33460
Fieldwork service (adults)	5070	0	0	5070
Fieldwork service (children)	5960	0	0	5960
Fieldwork service (generic)	2340	0	0	2340
Fieldwork service (offenders)	1880	0	0	1880
Fostering services	460	0	520	980
Housing support/care at home	16030	20280	33380	69690
Nurse agencies	0	3050	70	3120
Offender accommodation services	30	0	90	120
Residential child care	2380	2120	3150	7650
School care accommodation	130	1140	10	1290
Total	62040	85110	56050	203200

Care Inspectorate data shows just how fragmented the sector is with nearly 14,000 care providers. Nearly 1500 of these are care home providers and another 1000 providing home care.

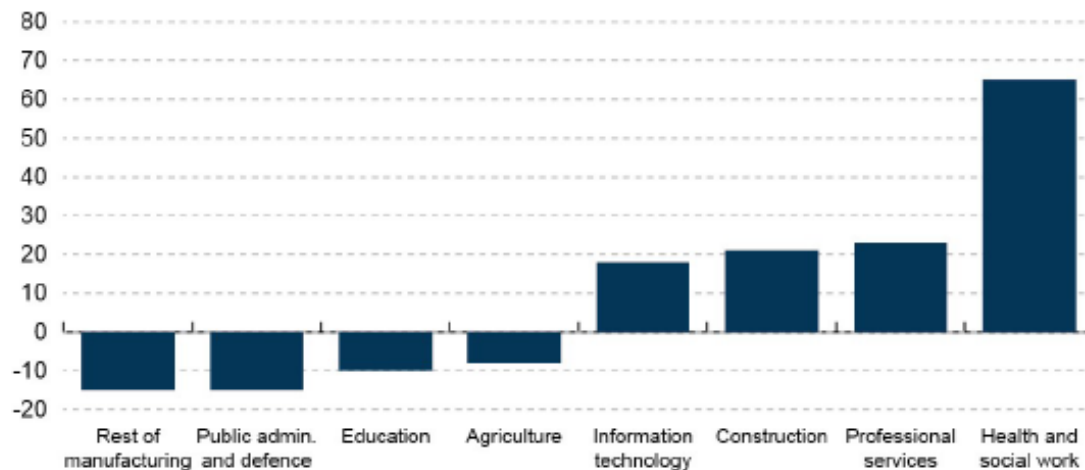
31 March 2015: number of care providers by sector

Type of care service	Health Board Service %	Local Authority Service %	Private Service %	Voluntary or Not for Profit Service %	Total services	Grand Total
Adoption service	0.0 %	82.1% 32	0.0%	17.9% 7	39	100.0%
Adult placement service	0.0 %	69.2% 27	0.0%	30.8% 12	39	100.0%
Care home service	1.3% 19	18.9% 278	53.5% 788	26.3% 388	1,473	100.0%
Childcare agency	0.0 %	3.6% 1	50.0% 14	46.4% 13	28	100.0%
Childminding	0.0 %	0.0%	100.0% 5,993	0.0%	5,993	100.0%
Daycare of children	0.1% 3	46.1% 1,728	29.2% 1,095	24.6% 920	3,746	100.0%
Fostering service	0.0 %	51.6% 32	0.0%	48.4% 30	62	100.0%
Housing support service	0.6% 6	17.4% 187	20.3% 218	61.7% 663	1,074	100.0%
Nurse agency	0.0 %	0.0%	92.7% 38	7.3% 3	41	100.0%
Offender accommodation service	0.0 %	33.3% 2	0.0%	66.7% 4	6	100.0%
School care accommodation service	0.0 %	11.1% 7	58.7% 37	30.2% 19	63	100.0%
Secure accommodation service	0.0 %	20.0% 1	20.0% 1	60.0% 3	5	100.0%
Support service	1.8% 25	26.0% 367	26.5% 374	45.8% 647	1,413	100.0%
Total services (%)	0.4% 53	19.0% 2,662	61.2% 8,558	19.4% 2,709	13,982	100.0%

From our own and employer surveys we know that many employers are holding high numbers of vacancies and have high turnover rates. Some of the better social care providers have turnover rates of 25%; the worst employers are even higher, with at least one approaching 40%. These are rates equivalent to worst outbound call centres, a notoriously high turnover business. NHS Scotland turnover rates are much lower, typically less than 10%.

The chart below shows one estimate of the demand for future jobs in Scotland. This shows a need for some 65,000 additional health and care workers by 2022.

Figure 6: Changes in employment 2012-2022 by industrial sector (,000s)



This is also an ageing workforce. In social care the median age in all sectors is in the mid to late forties and higher than the Scottish workforce as a whole. In the public sector the median age is 48, 44 in the private sector and 40 in the voluntary sector. We know from UNISON surveys and focus groups that younger staff are much more likely to be looking to get out of the social care sector.

This is also an issue for the NHS. For example, more than half of all health visitors are over 50, a staff group that needs to expand to address the named persons legislation. Well over a third of nursing and midwifery staff are also over 50.

There is also gender segregation with men making up only 15% of the social care workforce. One of the barriers in attracting young men into the sector is the prevalence of part-time working. The data actually understates the problem because the SSSC defines full-time as more than 30 hours per week.

If we look back at UNISON member surveys in the last 18 months, there is a striking similarity in the concerns of members from low paid home care workers, to professional posts such as district nurses and health visitors. They all point out that these are tough jobs, physically and emotionally, that are getting more complex. The job satisfaction that used to be a feature of the job has been undermined by cuts that leave them with not enough time to care. They also point to limited training and the loss of admin staff support and poor IT systems.

Pay and conditions are a big issue, particularly in the social care sector. The commitment to pay the Scottish Living Wage in social care is an important step forward. However, implementation has been poor from the Scottish Government down to councils and then employers. We also need to tackle poor working practices such as insecure work, zero/nominal hours contracts and the treatment of travel time. As many staff have said to us, why should we work in such a tough job, with registration standards, when we can earn more stacking shelves.

Any new approach has to include an assessment of safe staffing levels, from which required workforce numbers can be extrapolated. This is well advanced in the NHS, but less clear in social care.

Workforce planning also needs to recognise the of role training and development. This includes a review of traditional planning links to the numbers of student places to ensure a supply of qualified health and care staff. Some work has been undertaken on competence frameworks and common training modules, although as yet this has not reached the level recommended in the Christie Commission report.

The inclusion of new groups of care workers to professional registration brings significant training requirements. In addition, if we are to get the maximum benefit from extended roles, then there has to be commensurate training and development opportunities.

It is encouraging that an increasing number of councils and integrated joint boards are signing up to UNISON's Ethical Care Charter. That provides for a comprehensive approach to fair work for staff employed in the social care sector, with proper accreditation and monitoring.

Brexit

There is very poor workforce data on EU nationals in Scotland. For example, Audit Scotland relies on a 2008 survey and the NHS Scotland survey is voluntary, with significant opt out rates. The Scottish Government estimates that 4% of nurses and midwives in NHS Scotland are EU nationals, as well as 1400 doctors. Scottish Care, who represents private care providers, estimates that 14-16% of their workforce was born in Europe.

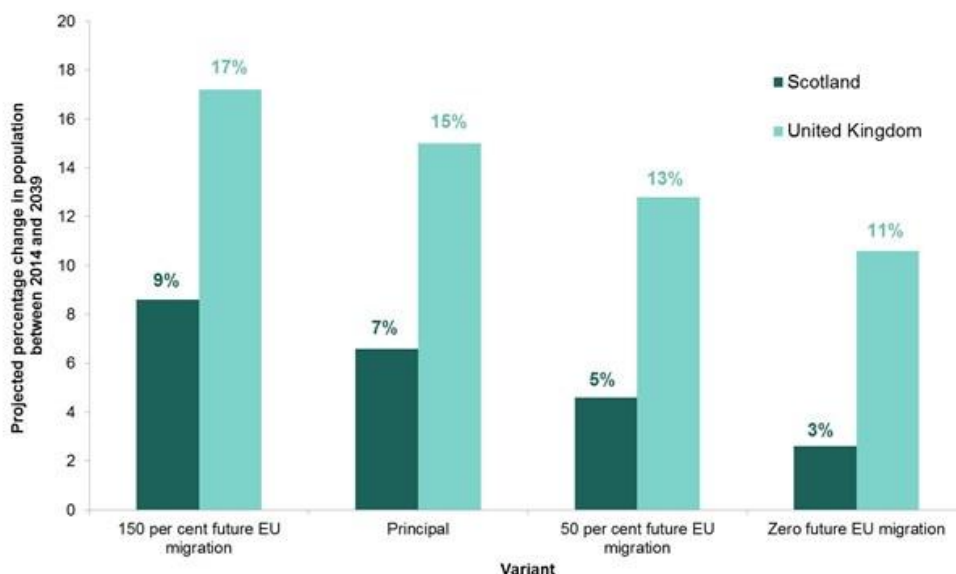
The latest published Scottish Government data (15 March 2017) taken from the annual population survey, finds that in 2015 there were around 181,000 non-UK EU nationals living in Scotland representing 3.4% of the total population, lower than for the UK as a whole (where non-UK EU nationals represent 4.9% of the total UK population). A higher proportion of these are in employment than the national average.

The main industries of employment were 'distribution, hotels and restaurants' followed by 'public admin, education and health' employing 19,600 (17.1% of all non-UK EU nationals in employment in Scotland).

113,000 non-EU nationals were living in Scotland (2.1% of the total population). They constitute 2% of the working population.

However, research by NIESR indicates a significant under reporting of EU nationals in the UK and this likely to be the same in Scotland. They estimate around 2.15m across the UK with 1.7m of those in employment.

The ONS has recently published population projections for Scotland based on Brexit projections. Scotland has a much lower projected population growth than the rest of the UK and that has significant workforce planning implications.



While staff recruitment and retention problems in the health and care sector pre-date Brexit, it is likely to make the current position worse and present even greater challenges in the coming years given the additional numbers of staff that the sector needs to recruit.

A new approach

A new approach to workforce planning in the health and care sector requires a range of policy interventions and structural approaches. These could include:

- Workforce planning may be more of an art form than a science, but widening the scope from the narrow group of professions currently included in central planning would help.
- A detailed review of workforce data, how it is collected and analysed.
- Take account of public service reform and changing workforce roles. UNISON's skills charter is relevant here.
- Cutting admin support is a false economy, leaving other operational staff to perform these functions, usually not as competently. Investment in IT systems and equipment also impacts on workforce planning.
- Structurally, in social care at least, fragmentation of providers has to be addressed. Does a country the size of Scotland really need several thousand adult care providers? In the meantime there is a need for a forum that engages the social care sector more strongly than the paper envisages.
- Training providers should also be included in the planning process.
- No amount of workforce planning will work unless we value the care workforce. Paying them properly with fair work principles being delivered through procurement and sectoral bargaining. That will also help to address gender segregation.

Consultation Questions

From the above it is clear that we believe the questions asked in the consultation paper do not cover the range of issues that need to be addressed. However, for completion we would respond as follows:

Question 1. Are these roles the right ones, or do you have an alternative model? What steps will be needed to ensure these proposals are fully effective?

The roles are broadly reasonable although further clarity is required on what 'regions' actually are. The steps will not be effective if we simply roll out the NHS model into social care, which has few structures to support that model.

Question 2. How can organisational and individual collaborative working be improved, and barriers removed, so that workforce planning can be effectively co-ordinated to ensure people get the care they need where and when they need it:

At national level there is a need for sectoral collective bargaining in the social care sector, which would include workforce planning in its remit. This should be part of a broader national workforce framework for Scotland.

Question 3. How should workforce data be best collated and used to undertake workforce planning in an integrated context based on current approaches of a nationally-led NHS system and a locally-led care system?

Data has to be collected on a consistent basis across the sector with a standard template. This could be done by legislation, through the regulatory framework (SSSC, Care Inspectorate etc), or through procurement. Our preference would be for a legislative framework.

Question 4a). How might employers and other relevant interests in the Health and Social Care sector work, jointly and individually, to identify and tackle recruitment and retention issues, ensuring priority gaps are identified and addressed:

Question 4b). Are there any process or structural changes that would support collaborative working on recruitment?

Better and consistent data collection is the starting point. That has to be followed up by structures that engage the stakeholders who have a direct interest and a current knowledge of the sector. (see 2 above).

Question 5. Based on what is said above, would it be helpful at national level to have an overarching process (or principles, or framework) for workforce planning across the Health and Social Care sectors?

Yes, see our analysis above.

Question 6a). How can a more coordinated and collaborative approach be taken to assessing student intake requirements across all relevant professions, and what other issues should be addressed to remove barriers to successful workforce planning?

Question 6b). What other issues should be addressed to remove barriers to successful workforce planning in both health and social care?

Yes, see our analysis above. Common modules as recommended by the Christie Commission would help break down silo working as well as a national workforce framework. A national framework for partnership working would also help breakdown barriers.

For further information:

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