Lancashire Health & Social Care Sector: Phase 2 Report

Final

A report for

Lancashire LEP

new economy

part of MGC

Contents

1. Introduction

1.1 In April 2015 New Economy was commissioned by Lancashire County Council, on behalf of its LEP, to undertake a sector skills study and develop an action plan for Health and Social Care in Lancashire.

1.2 The purpose of this report is to highlight the main findings from the second phase of work to deliver this project. This report should be reviewed in light of the findings of the desk-based phase one baseline report, agreed by the project steering group in May 2015. Drawing on the findings of the baseline report, extensive engagement and discussion with employers and key health and social care thought leaders was undertaken across Lancashire over a four week period beginning in early May 2015. This report presents the findings of this work, providing the evidential basis for a subsequent action plan which will form the third phase of this project, to be published in late June 2015.

Structure of the report

1.3 The remainder of this report is structured as follows:

- **Section 2** outlines the methodology deployed by the project team to gather evidence and feedback from a wide range of employers and key stakeholders across Lancashire. It will describe the approach and format of the 1-2-1 interviews that were undertaken, as well as the roundtables with employers and skills providers. This section will also summarise the potential limitations of the research methodology.
- **Section 3** provides a detailed account of the key findings of the second phase of this project. Information will be presented on a thematic basis, drawing together common messages which span multiple sub-sectors of the health and social care economy in Lancashire. Discussion of the feedback from interviewees and focus groups on the findings of the baseline report will be outlined, along with the identification of additional issues. Importantly, the drivers of these challenges will also be described.
- **Section 4** will summarise the findings from the interviews and roundtables, drawing the threads together as the project moves towards its final, third stage – action planning. A separate phase three report will be published in late June, highlighting how partners in Lancashire can work together to address the issues and drivers highlighted in this report.

2. Methodology

2.1 The objective of this second phase of work was to review, discuss and validate the findings of the phase one report via a mix of one-to-one and roundtable discussions with employers and skills providers. Discussions also focused on the constraints that limit the ability of Lancashire's skills and employment system to respond to these issues.

2.2 A series of employer 1-2-1s and roundtables was scheduled, followed shortly after by 1-2-1 and roundtable discussions with further and higher education skills providers. The sequencing of this was deliberate – our ambition was to secure a first wave of employer feedback to enable better-informed discussions with skills providers.

Identification of interviewees

2.3 The task of identifying key contacts for interview began as the project inception report was being agreed. A list of health and social care sub-sectors (eg domiciliary care, mental health, primary care, public health etc) was drawn up and input from Lancashire County Council, on behalf of its LEP, was sought to start developing a list of interviewees.

2.4 DH and BIS data on delivery by key health, care and skills providers was used to prioritise organisations that we wished to reach, ensuring that those with delivery specialisms were included in our research. Existing relationships between the project team and Lancashire employers, employer networks and skills providers were also drawn upon to gather contacts.

2.5 A draft list of consultees was presented to the project steering group on 20th April, with additional names recommended for inclusion. Once satisfied that representatives of all key sub-sectors of health and social care within Lancashire were included in our contact list, invitations to 1-2-1s and roundtable were developed and circulated. A list of all interviewees and roundtable participants can be found at Annex A.

Employer interviews, roundtables and survey

2.6 The project team member responsible for leading employer 1-2-1s and roundtables was Gill Boston. Gill is a former senior lecturer in Health and Social Care at the University of Salford, a current Governing Body member of Eastern Cheshire Clinical Commissioning Group, Chair of Salford Health Matters (a CIC providing primary care) and Programme Advisor for National Care Forum (NCF) and Voluntary Organisations Disabilities Group (VODG) on their DH Health and Care Voluntary Sector Strategic Partnership Programme. Gill's specialist knowledge, contacts and experience was critical in extracting feedback from Lancashire's health and social care employers.

2.7 Conducted largely on a face to face basis, each interview drew upon the phase one desktop review findings, seeking to review and validate its conclusions. Through semi-structured interviews, discussion was focused along the following key lines of enquiry:

- Understanding the employer's role in the market and anticipated future trajectory – how will their delivery change in the coming years?
- Confirming the employer's view of skills shortages, gaps and opportunities, now and, in light of their trajectory, in future

- Gathering feedback on the appropriateness, quality and impact of training for new recruits and existing workforce – where are the gaps in provision, how can skills delivery improve?
- The barriers to training take-up among new recruits and existing workforces
- Understanding the extent of employer involvement in the design and delivery of training by further and higher education providers
- Opportunities to review/refresh/overhaul existing skills delivery to better meet employer needs
- How employer networks, government agencies, skills providers, the local authority and the LEP can contribute to addressing skills shortages and gaps

2.8 A total of sixteen 1-2-1 employer interviews took place in May 2015, ensuring that the project gathered feedback from senior staff at key health and social care providers and networks in all major sub-sectors. Respondents were all in middle or senior management positions. At the large NHS trusts and other public bodies, discussions tended to take place with Director-level senior managers, while at smaller employers – such as companies providing care services – and employer networks, engagement typically took place with the CEO or centre manager.

2.9 To supplement the 1-2-1s, roundtables were held to ensure that a range of views was gathered from employers in the sector. The first of this was held with the support of the Lancashire Care Association, a not-for-profit organisation representing a wide variety of residential and domiciliary care providers across Lancashire. Hosted by the Lancashire Workforce Development Partnership, the roundtable gathered feedback from care providers in the domiciliary and residential sub-sectors. Facilitated by Gill Boston and James Farr, the key lines of enquiry were consistent with the 1-2-1 interviews. A second roundtable, featuring mental health service managers, was held in early June, hosted by Lancashire Care NHS Foundation Trust.

2.10 The growth of personal budgets and personal health budgets means that a growing number of care workers – mainly personal assistants – are employed by individuals, not public or private sector organisations. The challenge of reaching these employers was significant, however we worked effectively with care brokerage organisations to draft and disseminate a survey for individual employers, as well as place a note in a newsletter seeking employer feedback. The findings of this work have fed into our stage two analysis.

Skills provider interviews and roundtable

2.11 Gathering the input of skills providers such as colleges, independent training providers and higher education is of critical importance to shaping this project's analysis, conclusions and its proposed actions. Mark Hayes was the project team member with responsibility for leading this work – with nearly two decades' experience in business development and delivery of employer-responsive training, Mark was well placed to develop an informed, high quality dialogue with a mix of curriculum leads, Principals and senior members of faculty management.

2.12 A mix of telephone and face-to-face discussions were held with seven colleges, training providers and universities from mid-May to early June. Initial engagement was guided by HEFCE and SFA data, highlighting the organisations currently delivering the most significant volumes of training relevant to the sector. Key lines of enquiry for these discussions included:

- Confirmation of training delivery volumes, courses, mode of delivery
- Future plans to support the needs of employers in the sector
- How curriculum is planned, including whether employers are involved
- Staff capacity, experience and knowledge – do tutors understand employer needs?
- Are there any planned investments in facilities and estate?
- Whether employers account managed and if so, the depth of that management
- Are other supportive qualifications, such as customer service, management etc made available to employers?
- Suggestions on how to handle future demands in climate of austerity

2.13 In addition to this, a roundtable was held in early June to gather input from a wider number of further education providers. Hosted by Nelson and Colne College, the session proved extremely helpful in gathering further perspective from skills providers about the opportunities and challenges facing the health and social care sector.

Methodology - limitations

2.14 While the project has succeeded in engaging key stakeholders in all key subsectors of the Health and Social Care sector in Lancashire, key limitations to its methodology include:

- Tight timescales meant that not all those we contacted were able to meet before the final report was due. We also recognise that, to a degree, the participation of employers was partially self-selecting – ie. those most willing to respond are often the people and organisations that are interested in, and passionate about, the skills agenda. The views of those who are less engaged are less well represented.
- We had planned to organise a larger number of employer roundtables, however timescales and employer availability proved difficult to overcome in a handful of cases. The number of 1-2-1 discussions was scaled up to compensate for this
- We chose not to use survey methods in favour of fewer, better quality, in-depth interactions with key employers. This decision reduced the total number of employers that we contacted, however the large volume of data already published via surveys conducted by UKCES, Skills for Care, Health Education England and others proved an ample substitute. However we did use a survey method to contact individual employers, given the practicalities of reaching such a large, dispersed population

A note on language

2.15 Throughout this report we use a range of terms (eg client, customer, patient, service user) to describe those accessing health and care services. We use the term ‘skills provider’ to cover all further and higher education provision by colleges, independent training providers and higher education institutions. Occasionally the term ‘provider’ will be used, this refers to a provider of health and/or care services, such as a hospital or care home.

3. Findings

3.1 Detailed below are the findings from the phase two discussions with employers and skills providers. Allowing the report to distil a large volume of feedback in an accessible format requires the identification of common themes across the whole sector – however important geographical and sub-sector issues are also highlighted.

Skills Shortages

3.2 The phase one report identified a common issue of skills shortages across the health and social care sector. Discussions with consultees confirmed this pattern, with feedback highlighting specific issues and underlying causes that, while rarely unique to Lancashire, point to the need for a response from within the county.

3.3 Skills shortages arise when employers find it difficult to recruit new staff with the required skills from the pool of available labour. Almost all employers we consulted reported these difficulties, one hospital trust in Lancashire reported that it is currently unable to fill over 250 vacancies.

3.4 The issue appears to vary according to geography. In locations that are considered less attractive because of negative perceptions about the area or employer, fears were expressed that a lack of available skills, combined with recent Government plans to restrict the use of agency staff, could jeopardise the ability of some NHS providers to operate services. This could contribute to decisions to scale down delivery/close hospitals, if mergers and consolidation become a prospect. Skills shortages were reported to be less significant in locations close to major BME populations and in Preston/West Lancashire. Some respondents also highlighted the problem of being outcompeted for recruits by the major teaching and research hospitals in the Manchester and Merseyside area.

3.5 Employers reported that rising demand and an ageing workforce were common causes of skills shortages. However other factors tended to vary according to the role in question. For example:

- Issues recruiting hospital doctors were also attributed to the perceived elitist nature of medical training (such as UCAS entry requirements of 4 A*s etc) driven perhaps in part by the limited number of commissioned HE places available. This suggests that opportunities to widen access to medical school may be required, in the mould of the Lancashire Teaching Hospital's recent initiative with the University of Manchester. In specialist roles, several reported that without many major health research specialisms in the county (such as the Christie in Manchester for cancer; or Alder Hey in Liverpool for paediatrics), trusts face an uphill battle recruiting the 'brightest and best'.
- In General Practice, feedback identified a drop in newly qualified doctors choosing to become GPs as a major concern, linked to worries about workload and stress. The ageing profile of GPs has meant that in addition to a drop in new recruits, many older GPs are choosing to retire early. With the pivotal role of GPs in the transformation agenda, a shortage of GPs could hamper attempts to deliver more care in the community.
- Shortages in nursing staff in all settings (hospital, community, GP practices etc) were highlighted as a particular concern. Within mental health, enhanced pension schemes exacerbate the issue of an ageing workforce by promoting more early retirements.

Concerns were expressed about the effectiveness of workforce planning in meeting future needs; the expectations of newly-qualified nurses (ie the reality of the job not matching pre-conceptions); and even the potential that the bursary paid to those studying to join the profession, could act as a perverse incentive by attracting learners who are not committed to becoming nurses once qualified. For those with experience, the use of job descriptions that require NHS experience was highlighted as an issue, limiting applications from those working in non-NHS settings. Demand for nurses is also developing in new areas of the NHS – for example, the targeting of nurses by Ambulance service providers, to help plug shortages in paramedics.

- Within residential and domiciliary care, widespread struggles to recruit good quality staff were reported by employers. Additional challenges highlighted included the fragile nature of many employers in these sub-sectors and the perceived lack of progression opportunities compared to a larger employer such as a hospital trust. Pay and conditions were also noted a major issues, with competition from better paid hospital roles (including training bursaries). Care workers have rarely been high earners but cutbacks in publicly-funded contracts from local authorities and difficulties in growing private income has led to a growth in flexible working practices that do not provide security of income. Compounding this is a sense that, at a time when the needs of clients are getting more complex, salaries are uncompetitive. As one care sector employer said:

  "Staff can earn more working at a supermarket or call centre than in a care home. And they quickly learn that at Asda and Tesco, if you get something wrong you're not going to be held accountable for someone's life. The accountabilities and responsibilities that come with a job in care don't match the rewards."

3.6 Extensive work is underway in some parts of the NHS to redesign roles and soften the impact of skills shortages. This includes the development of Advanced Nurse Practitioners (ANPs) and upskilling Pharmacists to assume tasks previously the preserve of GPs, reducing workloads for overstretched doctors. Similarly, Trainee Assistant Practitioner (TAP) programmes have sought to release nursing staff from elements of their role. This is a positive development, however these schemes sometimes recruit from the existing nursing and care sector staff, causing displacement issues rather than increasing the overall volume of staff available with the required skills.

3.7 Hospital trusts highlighted issues with workforce planning. All were sympathetic to challenges facing Health Education England, particularly the problem of national policy and resource allocation changing over short timeframes (when it can take 5-6 years to train a nurse). Frustration was expressed that hospitals often turn to costly agency staff or overseas workers at a time when learner demand for nursing courses is understood to exceed the volumes commissioned by HEE by at least 20,000 nationally each year.

3.8 One NHS trust – Lancashire Teaching Hospitals - has effectively 'opted out' of this system to develop its own recruitment and training models for nurses in partnership with the University of Bolton. This 'grow your own' approach has required the trust to effectively waive its entitlement to the nursing bursaries and training costs usually covered by HEE. But for the trust, the ability to recruit and train a more adequate quantity of staff (thus reducing agency staff and overseas recruitment), via a curriculum it co-designs with the universities, appears to outweigh the impact of losing access to a share of HEE's £5bn annual national budget.

3.9 A number of respondents highlighted the risk that skills shortages will grow significantly in some areas as transformation programmes gather pace. It is clear that the transformation of health and care is the single biggest challenge facing the current and future workforce in Lancashire. For years there has been a strong policy consensus that the only way rising demand for health and care services can be sustained is for health and care services to be better integrated, moving care increasingly out of hospitals and in to community settings that are often preferred by patients (and much more cost effective).

3.10 Achieving this will require increases in primary care staff – such as GPs, nurses, care coordinators and care workers – as part of integrated, well trained, well equipped workforces that are able to manage more complex care in communities, eg:

- Greater versatility in the training of new recruits at all levels – including hospital consultants - to ensure that they have a much enhanced understanding of how health and care services are delivered in the community
- An understanding that multi-complex care in the community does not just extend to older people – increasing numbers with learning and physical disabilities, along with mental health conditions, will be supported at home
- In a sector dominated by specialised roles and functions, new, multi-skilled practitioners whose remits span health and care are required, particularly in primary care settings.

3.11 Retention was felt to be a major challenge, particularly in the care sector and among nursing staff. Again, the issues of mismatched expectations of new recruits against the reality of the job were raised, with staff leaving on the first day / week (care) / month / year (nursing) of employment a common issue. This was felt to stem from a number of sources, including

- Perceived inadequacy of some further and higher education training programmes (from entry level to degrees) in preparing new recruits for the workplace. Employers, particularly in the care sector, felt strongly that much of the QCF training intended to equip learners with the knowledge and skills to do the job was not of the required quality or relevance. None of the care sector employers contacted reported any engagement with colleges and independent training providers to discuss curriculum design. One employer commented:

  "What we feel we get is people who have completed 'pseudo-training' that at best means they [new recruits] understand the theory, not the practice"

- The availability and quality of work placements was felt to be a major issue that requires addressing to improve retention. Skills providers often struggle to find sufficient high quality placements for HE and FE learners that offer a useful and appropriate introduction to working in the sector. Several respondents highlighted cases of inappropriate placements. This appears to be a collective action failure that Lancashire partners could engage with.
- In the care sector, employers reported significant difficulties recruiting staff to entry level posts. Poor experiences with those referred to vacancies by Jobcentre Plus and other DWP providers, combined with issues around DWP's '16 hour rule' and perceived disincentives in the system for employees to extend their working hours (eg 16 hour rule and tax credit withdrawal). Employers were not well sighted on the potential impact that the introduction of Universal Credit and further benefit cuts may have on this issue.

- Several employers reported developing effective induction programmes and over-recruiting as methods to address gaps in knowledge and manage the risk that new recruits will leave within a short time period, though these models were adopted by what appeared to be a minority of employers

3.12 Several respondents felt that staff retention is hampered further by 'poaching' of specialist staff by other employers, which is a major issue for employers undertaking schemes to grow this workforce. While employers in Lancashire sometimes struggle to compete with the salaries on offer in other parts of the country (especially London and SE England), the greatest concern revolved around experienced and highly qualified staff moving around within Lancashire. This was most commonly highlighted by those working at the large NHS provider trusts, who compete for the same staff. As one employer said:

"We (the major NHS trusts) talk about collaboration on this issue but nothing really ever happens"

3.13 Approaching to preventing poaching in other sectors – such as among engineering employers – have produced very mixed results. Some respondents suggested that health employers could better invest their time making their organisation a better place to work. Most agreed that the underlying issue is a lack of qualified professionals which, under the current system, is best remedied by increasing the number of commissioned training places in specialist roles.

3.14 Further stimulating the supply of learners and potential new recruits was felt to be an issue in some roles but not others. For example, colleges in East Lancashire report that 'A' level learners keen to undertake HE courses in subject areas such as radiography, often prefer to study locally. However they face intense competition for the limited number of university places commissioned from HEIs each year. This leads to many deciding to move away to areas such as Eastern England, where competition for places is much less intense.

3.15 However others reported that stimulating demand for careers from adult residents was important. Three examples were highlighted by multiple respondents:

- An opportunity to capitalise on the high number of Muslim women graduates in parts of Lancashire who, though often qualified to degree level in bioscience courses, do not participate in the workforce
- Despite their misgivings about further education training provision, the care employers consulted had a positive approach to recruiting new staff via apprenticeships and other routes. Some employers commented that they would rather employ a an inexperienced new recruit who they can train, than some more experienced workers who have bad habits and practices ingrained
- It was felt that volunteers where/are a hugely underused resource who with the right recruitment, support and training could help to fill the skills gap whilst at the same time creating a pathway to paid employment and a way to address social isolation for some vulnerable and marginalised people.

Skills Gaps

3.16 Our research also focused on issues surrounding skills gaps – ie. the difference between the skills held by existing staff and the skills required to do the job, now and in future. While much state resource is understandably invested in training the next

generation of health and care workers, the bulk of the workforce in 2025 is already working in the sector now.

3.17 Many of the issues highlighted in the section above on skills shortages also apply when it comes to the existing workforce. Critically, the challenge of responding to the skills requirements of health and social care transformation appear even greater for the existing workforce than for new recruits. Existing staff are already in roles, have been trained in specialisms and will have established working practices and norms that may need reform in light of the new models of health and care delivery that transformation programmes will bring. Furthermore, the amount of public investment in workforces pales into insignificance compared to that devoted to training new recruits.

3.18 A number of respondents questioned whether Lancashire had enough health and care sector leaders willing to 'bang the drum' about service transformation and its implications for the future workforce. Good examples of high profile leaders were identified but some employers were concerned that there are other key individuals and thought leaders who have scope to play a bigger role. The infrastructure in place to enable employers to focus and galvanise around the challenge of providing integrated care was felt by some to be fragmented or lacking in places within the NHS. The NHS infrastructure was also felt to be lacking any kind of effective connection with care employers, however plans for the Lancashire and Cumbria Local Workforce and Education Group (LWEG) (accountable to the board of Health Education North West) to prioritise primary care provides an opportunity to change this.

3.19 The need to make existing workforces more versatile to deliver integrated care was a recurring theme amongst the employers we spoke to. Many commented on a perceived lack of flexibility from many staff – particularly doctors and those in specialist roles. This hampers the ability to provide the kind of support that enables patients and clients to smoothly transition from one part of the health and social care system to another. Rotating work placements between hospital and community settings was suggested for new recruits and existing workforces, however there were fewer suggestions about how staff in roles could build their knowledge of other parts of the system. One option highlight was an extension of the work undertaken by the Lancashire Workforce Development Partnership (LWDP), which provides training to existing care staff in the fundamentals of different health and care disciplines.

3.20 Investment in workforce development was felt to be patchy throughout. Broadly, feedback suggested that NHS organisations perform well in this regard, with the exception of some primary care employers. In particular, a number of respondents highlighted a lack of skills development for staff at some GP practices – where GPs simply do not see the value of investing in skills.

3.21 In care, the resources available to support workforce development in the sector have shrunk significantly in recent years – investment by Lancashire County Council in the care workforce via LWDP has dropped from c£2m to £500,000 annually, as local government cuts bite. Spend via the Skills for Care Workforce Development Fund has not suffered as much, but only amounts to c.£300,000 a year in Lancashire. The apparent mismatch between investment in skills for NHS health services (via HEE) and the care sector was a recurring theme of our research. Both health and care need to function effectively if the whole system is to succeed in reducing demand and treating the complex conditions of a growing, ageing population.

3.22 Workforce development activity was felt by employers to be more easily achievable in large employers than the SMEs that dominate primary, residential and domiciliary

care. Large employers have HR and OD functions, along with workforce development plans that are often linked to team, department and corporate business plans. This is much less common in SMEs, particularly in sub-sectors that feel hard-pressed after years of reductions in state funding. The fragile nature of many of these businesses hampers their ability to plan skills and staffing for the future – one care employer commented that he was unsure if his business would still be functioning in six months' time, such is the scale of the financial challenge facing his organisation. Despite this, the transformation agenda should help drive a growth in the number of care workers – particularly in roles such as domiciliary care, as part of an integrated community health and social care teams.

3.23 Furthermore, the nature of some types of care work makes workforce development more challenging to deliver. For example, many personal assistants work for individual employers in receipt of individual care budgets. This workforce is growing both in number and scope as more people in receipt of care start to access individual budgets. Largely unregulated and operating on a peripatetic basis, the task of ensuring PA skillsets are up to date a major logistical challenge. Currently the best route appears to be via brokerage agencies, who undertake checks on behalf of th individual employers who seek their support to recruit PAs.

3.24 In this context, the introduction of the Care Certificate (see the phase 1 report) should be a major opportunity. Employers we spoke to were supportive of the Care Certificate's aims and the principle of workforce development (many adhere to Investors in People standards), however there were significant reservations about the Care Certificate's implementation. These revolved around a belief that the Care Certificate is open to fraud and will be exploited by unscrupulous skills providers, employers and individuals, thus rendering it of little value. Employers expressed concern about their ability to create the staff time (from busy rosters) required to complete the certification process properly.

3.25 NHS provider trusts highlighted good examples of schemes to progress lower paid staff into more senior roles, thus addressing skills gaps and potential skills shortages. This approach has much to recommend, not least the feeling that staff currently in lower paid 'Band 2 / 3' roles are often very committed to quality service and remaining in the local area, thus are a lower risk of being poached. However we learned of a couple of examples where such schemes have been hampered by poor pre-existing numeracy and literacy skills among participants, limiting their ability to progress to more advanced, better paid roles.

Skills Providers

3.26 Our dialogue with employers provided an extensive amount of feedback that helped to inform subsequent discussion with skills providers, including colleges, independent training providers and higher education institutions.

3.27 All types of skills providers benefit from extensive state funding. Total annual investment in Lancashire across all sectors is estimated as:

- c.£200m by the Department for Education (DfE) in post-16 classroom-based training for young people via the Education Funding Agency, mainly to colleges
- c£80m by the Department for Business, Innovation and Skills (BIS) in adult learning and apprenticeships via the Skills Funding Agency, to colleges and independent training providers

- c£60m of recurrent grant funding by the Department for Business Innovation and Skills via the Higher Education Funding Council for England (HEFCE)in the three Lancashire-based universities
- c£18m of European Social Fund, prioritised by Lancashire LEP and procured via SFA, DWP and Big Lottery

3.28 The above sums represent approximate investment in all training across all sectors. Exact calculations of spend on health and social care-related courses is difficult, however with 1 in 6 Lancashire workers employed in the sector, we can safely assume that total investment is in the tens of millions of pounds per annum.

3.29 In addition to this, Health Education England will invest a proportion of its £5bn annual national budget in Lancashire, a rough estimate suggests this could be c£150m a year in training and bursaries. Adding in comparatively modest spent on community learning and LCC and SfC workforce development funds administered by LWDP, it is reasonable to assume that total investment in health and social care skills in Lancashire is around £200 million per annum.

3.30 Skills providers showed a strong understanding that the health and care sector in Lancashire is of strategic economic importance. Those we contacted were clear that skills providers should be delivering training and investing their resources in the sector. However understanding of how integrated health and social care delivery, as promoted by the transformation programmes, will impact on training was limited outside of higher education.

3.31 Data from the phase 1 report indicates that learner volumes in further education lean towards classroom-based delivery instead of work-based learning. We found limited evidence that classroom-based delivery, mainly through 16-19 study programmes in colleges, fed through into increased participation in work-based learning among young people. Likewise, some colleges identified how established working practices among many classroom-based tutors makes it difficult to shift skills delivery towards work-based learning which tends to be more valued by employers.

3.32 Discussion at the roundtable of FE providers highlighted the challenges colleges face in recruiting specialist tutors with recent knowledge of working in the sector. With skills providers often outcompeted on wages, this is a common pattern across all sectors. Examples of good practice were highlighted in higher education, such as the agreement between UCLAN and Lancashire Care NHS Trust to appoint a jointly-funded lecturer/practitioner role to help address the twin shortages of trained health care delivery staff and skilled tutors.

3.33 Work-based learning was overwhelmingly delivered as an apprenticeships, much of it to adults in the existing workforce. It was felt that for employers, this was the most cost-efficient route to securing NVQ training, given the reluctance of many colleges and providers to charge for the employer contribution to apprenticeship training costs. However many care sector employers highlighted doubts about the adequacy of many qualifications, including some technical certificates, in preparing learners for the workplace.

3.34 Knowledge of key recent skills policy and funding developments was patchy. There were isolated examples of FE staff knowing about the Care Certificate, how to deliver it and who would pay for it. Similarly engagement in the new trailblazer apprenticeships – setting the standards for all work-based learning – has, with one or two exceptions, been missing. This is important, not least in light of employers' desire to widen access to key roles. It suggests that both employers and skills providers in

Lancashire are largely not participating in the single biggest development of vocational routeways to higher skilled roles in recent times.

3.35 For many further education providers, significant emphasis in recent times had been placed on managing sharp reductions in SFA Adult Skills Budgets. With apprenticeship funding effectively protected, this meant that colleges and training providers have had to scale back their classroom-based delivery to adults except for English and Maths, which is a government priority. ASB can also be used to provide a short course taster to an employer, essentially to draw the employer in to participating in apprenticeships or other work-based learning. With Government keen to prioritise apprenticeship growth, we found few examples where ASB funds have been used in this way to stimulate employer demand for apprenticeships and other learning.

3.36 However there was some positive feedback around the approaches taken by some skills providers to develop FE loans for adult learners at level 3 and above (including Access courses, historically a popular route for adult learners seeking to upskill).

3.37 Linked to this, examples were highlighted of career pathways between FE and HE via partnerships between colleges and universities in Lancashire. Clear routeways outside of the traditional A level / university track are of pivotal importance if access to careers in health and care is to be broadened to reduce skills shortages. We found examples of FE/HE partnerships and connections between larger employers and colleges/training providers. Feedback suggested that the strength of these relationships is reasonable, but with scope to bolster further around curriculum planning, work placements and the establishment of more flexible, vocational learning routeways to widen access.

3.38 Employer engagement appears to be an area ripe for further development. A stated above, both FE and HE organisations have established links to larger employers, usually within the major provider trusts. However engagement with SMEs is much weaker; college representatives were keen to understand how the LEP could help to coordinate and better manage employer engagement. This could prove difficult in an environment where FE and HE providers are competing for business, however developing a mechanism to coordinate engagement could enhance the employer leadership within the skills system, while growing the market for skills providers.

3.39 Examples of partnerships between higher education and large employers were stronger than in further education. In part this is a product of HEE's commissioning of higher education places via competitive tendering amongst higher education institutions, however universities' employer relationships went beyond hospitals to include engagement (in the example of Edge Hill's Innovation Team) with Clinical Commissioning Groups and GPs. This is good to see, given the commissioning power of CCGs and the growing role that GPs will play as the transformation agenda starts to impact. However one potential area for development could be extending this type of relationship to include care providers.

3.40 HEIs were also keen that the profile of the health and social care sector – including its challenges and contribution to economic growth – should be better recognised by leaders outside of the sector, such as at the LEP. Employer feedback on Lancashire's three main universities was broadly positive, with both research and teaching felt to be a real asset to the county.

3.41 HEE's investment in HE provision in Lancashire was welcomed, particularly the role planned places have in providing the certainty required for capital developments. However there were questions about whether the potential of Lancashire's Higher Education providers to create new and innovative delivery models could be better

unleashed if employer-led investment, rather than planned allocations from HEE, were the norm.

4. Summary

4.1 Overall our phase two consultation largely validated the issues highlighted in the desktop literature review and data analysis. However the phase two research was extremely helpful in identifying the drivers behind many of these issues as well as particular local geographical and/or sub-sectoral nuances, which will be critical to shaping the subsequent action plan.

4.2 Many of the issues highlighted by employers in Lancashire cover ground that is well trodden at a national level by organisations such as HEE, the sector skills councils and think-tanks. However the challenges and opportunities facing skills providers, particularly in further education, are much less well known. Fusing the two into a coherent action plan represents an excellent opportunity for Lancashire to seize the initiative.

4.3 From employers, the key messages emerging include:

- The scale of the sector – employing 1 in 6 Lancashire workers – suggests that the profile of health and social care in the LEP's growth plans could be higher
- The transformation and integration agenda presents fundamental challenges to the configuration of health and care providers, roles and the entire training and skills system supporting the sector. Work to understand this in a skills context has barely begun
- There is a significant disparity between the infrastructure and available investment for NHS services, compared to care providers. The former is served by HEE's investment, existing regional and sub-regional employer groups, enjoying strong links to HE and some FE providers. In contrast, care providers access scant public resource and as employers tend to be smaller and fragile in nature. However both need to function together to ensure that the residents of Lancashire access the best possible care
- Visible leaders who take a high profile stance on issues of recruitment and training are welcome but are few and far between. More CCGs and provider trusts need to be signalling that the health and care system needs to address systemic issues that will see skills shortages and gaps continue both now and in future

4.4 The key messages from skills providers include:

- Further education's level of engagement with employers is variable, as is understanding of the health and social care policy and funding context
- There is ample scope to improve the way skills providers interact with employers, particularly SMEs, to ensure that the curriculum offer adapts to meet employer needs. Competitive pressures may make this difficult, but there is a role for the LEP to play in facilitating a better dialogue between employers and those who provide training
- Employers' desire to widen access to key health and social care roles has not been capitalised on by the skills system to date. Vocational career pathways remain largely under-developed, despite well-evidence skills shortages in key roles
- State investment in training for health and social care is not effectively marshalled and prioritised. Taken together, there remains significant investment of public

funds via a variety of funding agencies and skills providers. This money arrives with Lancashire residents and employers in Whitehall silos – there is a job to be done to ensure that this investment is better joined up, maximising its impact on employers, improving productivity.

5. Appendix A

Consultees (1-2-1s)

Janet Aspinall	Lancashire Workforce Development Partnership
Lesley Bamber	Lancashire Workforce Development Partnership
Mike Burgess	Health Education North West
Nicola Cunningham	Blackburn College
Diane Eden	Pennine Integrated Care Programme
Jeanette Grey	UCLAN
Dominic Harrison	Blackburn with Darwen Council
Mike Leaf	Lancashire County Council
Dave Lynes	Edge Hill University
Amanda Melton	Nelson and Colne College
Liz Mear	North West Coast Academic Health Science Network
Kevin Moynes	East Lancashire Hospitals
Jane O'Brien	Lancaster University
Charlotte Scheffman	Accrington and Rossendale College
Paul Simic	Lancashire Care Association
Stephen Sloss	Salvere CIC
Julie Stansfield	In Control
Karen Swindley	Lancashire Teaching Hospitals
Heather Tierney-Moore	Lancashire Care NHS Trust
Caroline Wareing	Blackpool and The Fylde College
David Wilkinson	University Hospitals Morecambe Bay
Andrea Willimott	Healthier Lancashire Programme

Consultees (roundtables)

Ken Barnsley	Blackburn with Darwen Council
Carol Gardner	Age UK
Bryan Griffiths	North West Coast Academic Health Science Network
Debbie Howard	Nelson and Colne College
Mel Howard	Stocks Hall Care Homes
Daniel Jones	Ormerod Trust
Gina Kidd	Cuerden Grange Residential Home
Carol MacDonald	BUPA
Rachael Mitchell	Lancashire Care NHS Trust

Caroline Openshaw	Lancaster and Morecambe College
Andrea Padgean	Blackpool, Fylde and Wyre Teaching Hospitals
Ian Parkinson	Lancaster and Morecambe College
Lesley Sergeant	Age UK
John Sharples	Lancashire County Council
Carol Smith	Priory Homecare and Lancashire Domiciliary Care Providers Network
Kay Vaughan	Via Partnership
David Ward	Carewatch
Claire Wilkinson	Burnley College