

HEALTH AND SOCIAL CARE SECTOR GROWTH PLAN FOR LEICESTER, LEICESTERSHIRE AND RUTLAND

DEVELOPED FOR:

LEICESTER AND LEICESTERSHIRE ENTERPRISE PARTNERSHIP

LEICESTER CITY COUNCIL

LEICESTERSHIRE COUNTY COUNCIL

RUTLAND COUNTY COUNCIL

In support of NHS partners

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EXECUTIVE SUMMARY

Introduction

1. In 2016, Leicestershire County Council, working in partnership with Leicester City Council, Rutland County Council, Leicestershire Enterprise Partnership (LEEP) commissioned a growth plan for health and social care in Leicester, Leicestershire and Rutland (LLR).
2. This document is the growth plan. It has been informed by a quantitative assessment of the sector and by primary research with more than 150 frontline workers, managers and stakeholders from across LLR. Thanks are owed to everyone that took part.
3. This is an ambitious but achievable plan that can deliver demonstrable change and improvement in all parts of LLR. It is designed to operate alongside, and add value to, other significant programmes of reform in the sector, including the Sustainability and Transformation Plan (STP). The growth plan will succeed through a strong and transparent partnership approach to delivery.

Recognising our strengths

4. We have a large and committed health and social care workforce. The sector accounts for more than 54,000 jobs in LLR, contributes nearly £2bn each year to the local economy and underpins the productivity of all other industry sectors.
5. LLR is at the forefront of technological advancements in the sector. It is home to the Charnwood Campus – the UK’s first Life Sciences Opportunity Zone – which will foster a new eco-system of industry, research institutes and government organisations working together to accelerate growth and commercialisation. The Charnwood Campus builds on LLR’s rich legacy in pharmaceutical research, bioscience and medical equipment and devices.
6. The LLEP Strategic Economic Plan (SEP) refers to the Health and Social Care Sector as a large employing sector. The SEP is currently being refreshed and it does highlight the Health and Social Care Sector in the ‘important for employment’ category. The LLEP will be prioritising sector as part of the SEP refresh, this plan identifies that there is a case for the Health and Social Sector to be on that list.
7. LLR has well developed networks that work hard to address key issues in the sector. The Leicestershire Social Care Development Group, for example, has been supporting workforce development in the independent and voluntary sectors for over a decade, the recently formed Attraction and Retention Group and the LLR STP Workforce Development Group is developing responses to some of our most pressing workforce issues. These groups will play an important role in the implementation of this plan.

Acknowledging our challenges

8. We know that the sector – and social care in particular – has an image problem. This is a source of great frustration for the current workforce. More needs to be done to improve the public image of the sector, to address misconceptions and outdated stereotypes and to position jobs and careers in the sector in a more positive light. Those working in health and social care tell us that this should be amongst the highest priorities in this plan.
9. Participation in business support and business growth activities amongst health and care organisations in LLR appears to be limited. Eligibility issues of state-funded healthcare providers aside, this seems to be influenced by relatively low levels of knowledge of available products coupled with the constraints of operating in a difficult market. Yet there is some excellent business support available in LLR which could doubtless benefit health and social care employers. Helping the sector to explore and engage with this support is therefore important.
10. The skills requirements of many care-giving roles in the sector will change over the coming years, with the increase demand from a growing population, yet we know that it is currently difficult for social care providers to participate in structured or forward-looking workforce development activities. We need to make it easier for care providers to engage in workforce development and should give further consideration to skills development programmes that straddle health and care.
11. There is a strong view from providers that jobs and careers in the sector, especially those in social care, are undersold to young people and potential career changers. With forecasts predicting that few other sectors will need to fill as many vacancies as health and social care over the next 10 years, it is becoming increasingly important that LLR residents have access to good quality and up-to-date information about the full spectrum of career opportunities on offer.

A plan of action

12. The actions in the plan are structured under four key themes:
 1. Improving the image of the sector.
 2. Supporting the sector with resilience and growth.
 3. Developing and retaining the current workforce.
 4. Attracting a high quality workforce.
13. The next steps to deliver the plan should be managed and driven by an Implementation Group that includes senior representation from, the three LLR local authorities, the LLEP, the LLR Attraction and Retention Group and the STP Workforce workstream.
14. For the implementation of this plan to be successful, a strong and collaborative partnership approach is required. This should be managed and driven by an Implementation Group (or equivalent) with responsibility for the delivery,

monitoring and evaluation of the plan considering lead partners, timescales, funding and governance.

Key Theme #1:	Improve the Image of the Sector
Action:	LLR-wide multi-media campaign to improve the image of the sector – especially social care – and increase the number of quality individuals recruited.
Activities:	<ol style="list-style-type: none"> 1. Work with local media (e.g. written press and radio) to develop and publicise a series of positive news items about the health and care sector. 2. Recruit publicly recognised/celebrity ‘Care Champions’ to raise public awareness of the value of social care and the careers it offers.

Key Theme #2:	Support the Sector with Resilience and Growth
Action:	Enable and encourage more health and social care organisations in LLR to access business support services that can help them grow, expand into new/emerging market areas or become more resilient to current operating conditions.
Activities:	<ol style="list-style-type: none"> 3. Develop a ‘local authority contractors pack’ for social care providers containing information/signposting to business support services, workforce development support, recruitment and retention resources etc. 4. Active promotion of the LLEP’s ‘Business Gateway’ and the Greater Cambridge Greater Peterborough LEP’s ‘Signpost 2 Grow’ services to health and social care businesses, emphasising the availability of growth/expansion advice and access-to-finance services. 5. Ensure, where possible, that ‘health and social care’ be included within the list of eligible sectors for business support and workforce development programmes in LLR. 6. Introduce an LLR-wide workstream with a remit to consider how local authorities could invest in the social care sector with maximum impact/effectiveness. This may involve researching national and international examples of good practice and considering how the services and skills base of the private sector can be further developed.


Key Theme #3:	Develop and Retain the Current Workforce
Action:	Support and stimulate high quality workforce development activity in the health and social care sector across LLR.

Health and Social Care Sector Growth Plan for Leicester, Leicestershire and Rutland

Activities:	7. Develop and implement a business case for the introduction and ongoing operation of an 'LLR Integrated Health and Social Care Apprenticeship' project, drawing on learning from successful schemes in other parts of the country (e.g. Kent and Norfolk).
	8. Deliver a sector-wide promotional campaign to promote the workforce development potential of apprenticeships, the different levels of apprenticeship now available and the 90% funding available to SMEs under the new levy arrangements.
	9. Seek to establish an 'LLR lifelong learning pilot for health and social care' under the government's 2017 Spring Budget announcement on lifelong learning funding.
	10. Establish a 'workforce and training planning' network to encourage social care providers to share workforce plans and joint training opportunities.
	11. Work with partners to help ensure that (health and) social care is appropriately supported through discretionary funding for skills development (e.g. ESF and post-Brexit equivalents).
	12. Engage in discussions with partners in other LEP areas that have stated an interest in/preference for a formal care worker grading structure (e.g. D2N2) to explore the feasibility of a cross-boundary programme to raise aspirations and promote career pathways.

Key Theme #4:	Attracting a High Quality Future Workforce
Action:	Better promotion of job and career opportunities in the health and social care sector to young people in schools and other skills providers.
Activities:	13. Recruit Enterprise Advisors from social care to raise the visibility of the sector and improve careers insights.
	14. Develop/adapt/promote a 'careers pathway' tool for care (or health and care) to demonstrate routeways through the sector and career progression opportunities ¹ .
	15. Ensure that communication channels exist to keep education and skills providers abreast of service re-design (e.g. through the STP) and what that means for job and career opportunities in the sector.
Action:	Improve access to job opportunities in the sector for people out of work and potential 'career changers'
Activities:	16. Explore opportunities for closer working on recruitment strategies between large employers in the sector and DWP/JC+, drawing on practice elsewhere in the country.

¹ The forthcoming Skills for Care resource – 'Social care: a rewarding career for you' – may negate the need for the development of a new bespoke tool.

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17. Develop case studies of older entrants to the sector and promote these through local media to reach potential 'career changers' and through JC+ to reach unemployed workers.

1 ABOUT THIS PLAN

Introduction

- 1.1 The health and social care sector is one of the fundamental foundations of our national economy. It underpins our wellbeing and safety, employs one in ten of all working age residents in England² and fulfils an essential role in maintaining productivity.
- 1.2 In Leicester, Leicestershire and Rutland (LLR), the health and social care sector accounts for more than 54,000 jobs³. It serves a population of more than one million people and makes an estimated annual contribution of £1.8bn to the LLR economy⁴.
- 1.3 In 2016, the Leicester and Leicestershire Enterprise Partnership (LLEP), working in partnership with Leicester City Council, Leicestershire County Council and Rutland County Council, commissioned a growth plan for health and social care in LLR. This was in recognition not only of the scale of the sector and its importance to a vibrant LLR economy, but also of the opportunity it presented for key partners to work together on well recognised challenges.
- 1.4 The main output from the work is this document – the growth plan. It considers the scale and composition of the health and social care sector and identifies challenges and opportunities, both national and local. More importantly, it proposes a series of achievable and measurable actions that partners in LLR will take forward to deliver demonstrable change and improvement in the sector.

Approach

- 1.5 A three-stage methodology has informed the development of the growth plan:
 - **Stage 1:** a quantitative assessment of the health and social care sector, including sub-sectoral composition, economic contribution and characteristics of the workforce.
 - **Stage 2:** one-to-one and roundtable consultations with strategic stakeholders, local authority commissioners, NHS workforce planners and representatives (usually managers) from health and social care providers across LLR. These primary research activities gathered further evidence on the challenges and opportunities facing the sector and explored causal drivers. In addition, 60 frontline workers from social care completed a short online survey about their views of working in the sector. In total, more than 150 individuals have contributed to the work.
 - **Stage 3:** the development and validation (with stakeholders) of the proposed actions for the growth plan.

² <https://www.kingsfund.org.uk/time-to-think-differently/trends/professional-attitudes-and-workforce/overview-health-and-social-care-workforce>

³ Business Register and Employment Survey

⁴ Estimate by York Consulting LLP

Focusing on the Achievable

- 1.6 Unsurprisingly, issues related to funding and financial resources were regularly cited during the primary research as being amongst the most significant challenges in health and social care. For some of the consultees, and especially those working in social care, a perceived shortage of sufficient central government funding sits at the heart of many of the sector's difficulties.
- 1.7 This growth plan does not try to shy away from the issue of funding, nor does it attempt to downplay the significance attached to it by many of the individuals who contributed to the research. Nonetheless, the amount of funding that is available to the sector – which is driven by government policy and decision making – cannot realistically be influenced by this plan. Therefore, whilst it seems logical to assume that some of the issues in the sector could be made less severe through increased funding, none of the actions contained in this document make a direct call for government to channel more money into the sector. That said, this plan can be used to inform and support the lobbying of government on a range of important issues, including funding.
- 1.8 Funding aside, there are other macro factors that will have a bearing on how and at what pace the actions in this plan can be delivered. These include the implications of Brexit (noting the relatively high concentration of migrant labour in the sector), the restructuring of health and care provision via Sustainability and Transformation Plans and the extent and nature of future integration across health and social care.
- 1.9 It therefore follows that this plan can only be one determinant of change in the sector. Many other determinants, some backed by far greater resources, are also at play. What this plan can do, however, is influence partners' efforts around shared objectives, add value to other programmes of change and leave a positive legacy in each of the thematic areas around which it is structured.

Defining the Sector

- 1.10 In the context of this growth plan, the health and social care sector is defined as covering services delivered by the National Health Service (NHS) and private providers including hospitals, General Practitioner (GP) services, residential care homes, domiciliary care, day services and care in the community.

Acknowledgements

- 1.11 Thanks go to everyone that has made a contribution to the development of this growth plan. In particular, the managers and staff working in the sector who took part in one-to-one consultations, engagement events and surveys are thanked sincerely for their input.
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2 THE HEALTH AND SOCIAL CARE SECTOR

Introduction

- 2.1 The sub-sections below provide headline statistics on the scale and composition of the health and social care sector, starting with a national summary and then moving on to LLR.

National Summary: Healthcare⁵

209 Clinical Commissioning Groups	7,700 GP practices	150,300 Doctors (hospital and GPs)
315,000 Qualified nursing staff and health visitors	132,400 Scientific, therapeutic and technical staff	18,900 Qualified ambulance staff
21,900 Midwives	>£100bn Annual NHS expenditure	1m Patients seen by the NHS every 36 hours

- 2.2 The NHS in England employs approximately 1.2 million people. It is the fifth largest employer in the world and includes more than 350 job roles. Research⁶ has found the NHS to be the most impressive healthcare system in the world. Total spend on the NHS in 2016/17 was approximately £101bn. This equates to an estimated 13% of all government spending in that year⁷.
- 2.3 Organisations and individuals with key roles within the healthcare system in England include the following:
- **Secretary of State for Health:** overall responsibility for the work of the Department of Health.
 - **Department of Health:** responsible for strategic leadership and funding for both health and social care in England.

⁵ <http://content.digital.nhs.uk/catalogue/PUB23046/nhs-work-stat-oct-2016-pdf.pdf> and <http://www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx>

⁶ http://www.commonwealthfund.org/~media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf

⁷ http://www.ukpublicspending.co.uk/government_expenditure.html

- **NHS England:** sets the priorities and direction for the NHS, manages approximately £100bn of the NHS budget and commissions primary care services such as GPs, pharmacists and dentists.
- **Clinical Commissioning Groups (CCGs):** clinically led statutory NHS bodies responsible for the planning and commissioning of healthcare services in their local areas. CCGs replaced Primary Care Trusts in 2013. They commission most secondary care services (including planned hospital care and mental health services) and play a part in the commissioning of GP services.
- **Health and Wellbeing Boards:** established by local authorities to act as a forum for local commissioners across the NHS, social care, public health and other services. The boards aim to increase democratic input into strategic decisions, strengthen working relationships and encourage integrated commissioning.
- **Public Health England:** provides national leadership and expert services to support public health. Also works with local government and the NHS to respond to emergencies.
- **NHS Improvements:** most hospitals, ambulance services, emergency care and mental health services are provided by NHS Trusts and Foundation Trusts. The key difference between the two is that Foundation Trusts are free from central government control and are not performance managed by health authorities. They are able to raise capital from both the public and private sectors (within borrowing limits).
- **Vanguards:** introduced in 2015 as part of the NHS Five Year Forward View⁸, the 50 vanguards in England are tasked with developing new care models and redesigning the health and care system, where required. The LLR vanguard is known as the Leicester, Leicestershire and Rutland System Resilience Group⁹.
- **Health Education England:** responsible for workforce planning, education commissioning and education provision within the NHS in England. Health Education England recruits doctors and dentists into training and funds and supports the training of a range of multi-professional staff and apprentices.
- **Regulators:** responsibility for regulating particular aspects of care is now shared across a number of different bodies, such as the Care Quality Commission (CQC), NHS Improvement¹⁰ and individual professional regulatory bodies, such as the General Medical Council, Nursing and Midwifery Council, General Dental Council and the Health and Care Professions Council.
- **Healthwatch:** Healthwatch's were established across the Country in 2013 to give local people an effective voice about their local health and social care services. The key functions of Healthwatch are to; gather and share the views of members of the public who use health and social care services. Influence the planning, commissioning, delivery, re-design and scrutiny of health and care services. Assess

⁸ <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

⁹ <https://www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/uec/leic/>

¹⁰ An umbrella organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change Team and the Intensive Support Teams.

the standard of local health care provision and make recommendations for improvement based on the views of service users. Help people access and make choices about health and care services.

- 2.4 Compared with the nation's workforce as a whole, the healthcare workforce is well qualified. Three fifths (60%) hold at least one qualification at NVQ Level 4 or above (i.e. equivalent to at least a Higher National Diploma), compared with 37% across the full working age population of England¹¹. The healthcare workforce also differs from the national workforce in a number of other significant regards. For example¹²:
- The proportion of the workforce aged 16-24 in healthcare is approximately half that seen in the whole economy.
 - 80% of the healthcare workforce is female, compared with 49% of the country's workforce as a whole.
 - Part-time workers account for 42% of the healthcare workforce compared with 31% of the national workforce.
- 2.5 Whilst the NHS and its workforce is constantly evolving to respond to the changing health needs of the population, recent years have seen new strains placed on the system. For example:
- Increases in life expectancy have resulted in a sharp rise in the number of people with chronic conditions such as heart failure and arthritis.
 - The number of people with health issues related to obesity and other avoidable conditions has also increased substantially.
 - It is generally accepted within the sector that there is an over-reliance on emergency and urgent care.
- 2.6 In response, the NHS England Five Year Forward View¹³ places a clear focus both on prevention and on greater (and more effective) integration between health and social care. To support the implementation of the Five Year Forward View, the NHS and local authorities have developed Sustainability and Transformation Plans (STPs): place-based programmes of reform built around the needs of local populations.
- 2.7 Key excerpts from the draft STP for LLR are included towards the end of this section. Given that STPs are currently the main vehicle through which reform, including workforce reform, of local health and care systems are being taken forward, the significance of the STP for LLR to the implementation of this growth plan is clear.

¹¹ Annual Population Survey.

¹² Figures in the bullet points taken from Skills for Health (www.skillsforhealth.org.uk)

¹³ <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

National Summary: Social Care¹⁴

20,300 Residential care homes	19,800 Domiciliary care providers	£16.8bn Local authority expenditure on adult social care in 2015/16
£716 Average weekly cost of long term residential care per person	645,000 Domiciliary care workers	665,000 Residential care workers
6.8m Estimated no. of unpaid carers in England	17% Increase in unpaid carers between 2001 and 2015	85-95% Proportion of direct-care providing jobs filled by women

- 2.8 Social care in England is defined as the provision of social work, personal care, protection or social support services to children or adults in need, vulnerable or at risk, or adults with needs arising from illness, disability, old age or poverty.¹⁵ An estimated 1.6 million people work in social care¹⁶, three quarters of whom are in direct care-giving roles. The sector makes an annual contribution of approximately £40 billion to the national economy¹⁷.
- 2.9 Local commissioners, mainly based in local authorities, oversee a market that includes numerous different types of social care provision, including support/care for:
- The elderly.
 - People with mental health issues or addiction problems.
 - People with learning or physical disabilities.
 - Victims of abuse/neglect or domestic violence.
- 2.10 Social care is purchased either by public bodies after assessments or is accessed on a self-funded basis by the public. It is delivered via community support and activities, advisory services and advocacy, provision of equipment to manage disabilities, home/domiciliary care or day care, housing options with care support, residential nursing home care and support for informal carers.

¹⁴ www.ukhca.co.uk; www.skillsforcare.org.uk; www.nationalcareassociation.co.uk; www.ifs.org.uk

¹⁵ www.scie.org.uk

¹⁶ Business Register and Employment Survey.

¹⁷ Office for National Statistics.

2.11 Organisations and individuals with key roles within the social care system in England include the following:

- **Secretary of State for Health:** overall responsibility for the work of the Department of Health.
- **Department of Health:** responsible for strategic leadership and funding for both health and social care in England. The Department of Health works with the Department for Communities and Local Government to input to the spending review to determine the overall funding settlement for local authorities and the allocation of that settlement between authorities.
- **Local authorities:** responsible for meeting the needs of people eligible for care, supporting them and their carers, and funding care for those people with needs who meet financial eligibility criteria. Local authorities also contingency plan to ensure that care is maintained where providers fail financially and services cease. They work with the NHS to promote integration and joined-up services.
- **Professional associations:** the social care sector has various professional associations which seek to promote high standards of care and provide representation with local and national policy makers and regulators. National associations include (although are not limited to) the UK Home Care Association and the National Care Association. Regionally, the East Midlands Care Association (Emcare) has been in existence for 30 years and represents care home providers across LLR.
- **Social care providers:** covering a broad spectrum of care and support services including residential care, domiciliary care, community support and activities, day centres and supported accommodation. Social care providers employ over one and a half million people in England.
- **Care Quality Commission:** the CQC monitors, inspects and rates registered care providers to ensure quality. It takes enforcement action where quality is poor and has the power to close providers where appropriate.

2.12 In 2014/15, local authorities in England received an estimated 1.9 million requests for social care support from new clients¹⁸. This equates to an average of approximately 7,300 requests from new clients on each working day of the year. Over the same period, 890,000 people in England accessed long-term social care support¹⁹.

2.13 In the majority of cases, social care support appears to be well received by those who access it. Analysis of the Adult Social Care Outcomes for 2015/16, for example, shows that 85% of service users in England reported that the service(s) they received helped make them feel safe and secure. More than three quarters (76%) said it had helped to give them greater control over their daily lives.

¹⁸ <http://content.digital.nhs.uk/article/6750/New-requests-for-adult-social-care-support-actioned-by-councils-approaches-two-million>

¹⁹ *ibid.*

- 2.14 Turning to the workforce, it remains the case that the social care workforce is, on average, less well qualified than the country's workforce as a whole. In particular, 13% of the social care workforce have a qualification at Level 4 or above, compared with 37% of the nation's full workforce. Social care also has greater concentrations of workers with no formal qualifications and those whose highest qualification is at Level 2 (equivalent to 5 GCSEs at grade C or above)²⁰.
- 2.15 The qualification profile of the health and social care workforce naturally varies by occupation. Care workers and ancillary staff (not providing care) are the most likely to have lower level or no qualifications, while those in more highly skilled roles, such as occupational therapists, registered nurses and social workers, are much more likely to have qualifications at Level 4 or above²¹.
- 2.16 In part reflecting the qualification profile of its workforce, social care is a relatively low paying sector. It is estimated that almost a quarter (24%) of workers in the sector have a zero hours contract, including almost half (49%) of those providing domiciliary care²². Based on data from 2016, an estimated 2.5% of jobs – approximately 27,500 posts – were paid below the minimum wage. Only in hairdressing (7.0%), childcare (4.0%) hospitality (3.8%) and cleaning (3.7%) was this proportion higher²³. However, the true figure for social care is likely to rise considerably when it is considered that many domiciliary care workers are not paid for travel time.
- 2.17 Staff turnover in social care, compared with the vast majority of other sectors, is very high. While the average annual turnover rate in England is 15%, many social care roles far exceed this, with 32% of registered nurses and 27% of care workers leaving their job each year (this compares with average turnover of 11% in the NHS)²⁴. Much has been written on this topic, within which is the running theme that when staff turnover is high and unfilled vacancies are prevalent, organisations suffer. Experienced staff are put under more pressure, often resulting in new and inexperienced staff receiving less support. There can also be a damaging impact on the care experienced by service users (the Care Quality Commission found in 2015 that 20% of nursing homes did not have enough staff on duty to ensure safe care for residents) and can lead to poor staff morale.
- 2.18 Yet social care needs more workers. Demographic trends and population projections consistently predict that demand for social care services for adults and older people will increase significantly over the years ahead. For example:
- The number of people in the UK aged 85+ is forecast to double over the next two decades²⁵.

²⁰ Annual Population Survey

²¹ <http://www.skillsforcare.org.uk/NMDS-SC-intelligence/NMDS-SC/Workforce-data-and-publications/State-of-the-adult-social-care-sector.aspx>

²² <http://www.skillsforcare.org.uk/NMDS-SC-intelligence/NMDS-SC/Workforce-data-and-publications/State-of-the-adult-social-care-sector.aspx>

²³ <https://www.ons.gov.uk/releases/peopleinemploymentonazerohourscontractmar2017>

²⁴ <http://www.skillsforcare.org.uk/NMDS-SC-intelligence/NMDS-SC/Workforce-data-and-publications/State-of-the-adult-social-care-sector.aspx>

²⁵ <http://www.local.gov.uk/adult-social-care-funding-2016-state-nation-report>

- Over the same period, the number of adults with a learning disability is expected to increase by at least a third²⁶.
- The number of people in England and Wales aged 65+ with dementia is forecast to reach almost 2 million by 2030 – an increase of more than 80% on 2010 levels²⁷.

2.19 To meet the changing profile of demand, services will need to be delivered differently and the skill-sets of some roles in social care will need to change. The shape, composition and skills base of the social care workforce will also be affected by the government's focus on promoting greater choice. This includes increased take-up of direct payments and personal budgets and greater community based, integrated delivery.

2.20 These changes are reflected in The Future of Work: Jobs and Skills in 2030²⁸ (UKCES) which predicts:

- Increased demand for home care and tele-care services, particularly for the elderly, as the high costs of nursing and residential care stimulate more home-based provision.
- Growth in community models and social entrepreneurship (e.g. home-based care networks), based on principles of decentralisation.
- An increasing requirement for social care workers to handle advanced care technology, e.g. care robots.
- Increased demand for digital skills in the workforce.
- Increased demand for inter-disciplinary skill-sets.

2.21 The topic of funding in social care has been a high profile issue for some time. Spending on social care fell by 9% in real terms in the five years to 2016, and the Local Government Association, representing leaders of 370 English and Welsh authorities, has predicted a funding shortfall of between £1.3bn and £2.6bn by 2020, with fears that some councils could be challenged in the high court for not providing a statutory minimum standard of care²⁹. Other concerns include:

- **Increasing numbers of care homes for the elderly becoming insolvent.** Research by the BBC found that 69 home care companies closed during the three months to March 2017, while 95 care firms had ended contracts with local authorities over the same period³⁰.
- **The risk of care providers focusing their business on the south east of England** (which has the highest proportion of self-funders) and, in doing so, leaving the less affluent parts of England under-resourced.

²⁶ ibid

²⁷ ibid

²⁸ <https://www.gov.uk/government/publications/jobs-and-skills-in-2030>

²⁹ www.local.gov.uk

³⁰ <http://www.bbc.co.uk/news/uk-39321579>

- **Growing pressures on the NHS as a result of funding issues in social care.** Recent research has found that 9 in 10 GPs believe that reductions in social care have contributed to the pressures faced in their surgeries³¹, while 99% of NHS leaders believe that cuts in social care funding are putting increased pressure on the NHS³².

2.22 As noted in Section One, this plan does not make any proposals or calls for additional government funding, as doing so extends well beyond the reach of what can realistically be achieved through the work. It is nonetheless important to acknowledge the operating/financial context that exists within social care and the extent to which many of the people consulted for this work feel it is impacting upon quality of care, staff retention and workforce morale. This first-hand feedback, gathered from all parts of the social care sector in LLR, could potentially support the lobbying of government on the topic of funding and related policy decisions.

The Health and Social Care Sector in LLR³³

3 NHS acute hospitals	7 NHS Community hospitals	2 NHS Mental health hospitals
130 NHS GP surgeries	90 NHS Domiciliary care providers	299 NHS Residential care establishments
34,250 NHS Jobs in healthcare	19,900 NHS Jobs in social care	109,500 NHS Estimated number of unpaid carers

The Population

2.23 The health and social care sector in LLR serves a population of almost 1.1 million people. Across LLR as a whole, the age structure of the population is in line with the age structure nationally, although there are local variations. Most notably, the city of Leicester has an above average proportion of younger residents, while East Leicestershire and Rutland has an above average proportion of residents aged over 50³⁴.

³¹ Medeconnect survey of 1,000 regionally representative GPs in February 2017.

³² <http://nhsconfed.org/news/2015/06/2015-member-survey>

³³ Office for National Statistics, Skills for Care and York Consulting estimates.

³⁴ STP for LLR, available at <https://www.leicestercityccg.nhs.uk/about-us/local-sustainability-transformation-plans-stp/>

2.24 Variations are also evident in terms of the health and wellbeing of the population in different parts of LLR. For example³⁵:

- **Life expectancy:** in Leicester the average life expectancy is 77 years for males and 82 years for females. This is lower than in both Leicestershire (81 for males and 84 for females) and Rutland (81 years for males and 85 for females).
- **Mental health need:** East Leicestershire and Rutland and West Leicestershire have relatively high levels of dementia (reflecting the older population in these parts of LLR), whereas the city of Leicester has high levels of psychosis. Levels of depression are relatively high across LLR.
- **Cancer survival rates:** one year survival rates from cancer vary notably across LLR, from a low of 66.9% in Leicester to a high of 70.2% in East Leicestershire and Rutland.
- **Diabetes:** 43.8% of diabetes patients in Leicester city have all three of the NICE recommended treatments targets compared with 41.9% of patients in East Leicestershire and Rutland.

The Patient Experience

2.25 Data from the National Patient Survey Programme shows that in most categories, the views of patients in LLR are broadly in line with the views of patients nationally. This includes emergency/A&E services, waiting lists and planned admissions, maternity services, operations and procedures and the overall patient experience³⁶. There are also a number of areas where the CQC has praised the services provided in LLR. These include intensive/critical care at Leicester Royal Infirmary and Leicester General Hospital, and provision for children and young people at Glenfield Hospital, amongst others. Domiciliary care in LLR is also rated well.

2.26 However, there are areas where it is acknowledged (including in the STP) that patients in LLR have an experience of care that is not as good as it should be. These include:

- **GPs:** National GP Survey data (2016) shows that patient feedback on GP services is less positive (although not significantly so) than the national average³⁷. Across LLR, 10% of GP practices received a 'Requires Improvement' rating. An 'Inadequate' rating was given to 3% of LLR GP practices.
- **Hospitals:** the three main hospitals in LLR have each been rated by the CQC as 'Requires Improvement' in their most recent inspection.
- **Residential Care:** across LLR, 40% of care homes have been rated as 'Requires Improvement'. This compares with approximately 34% nationally.

2.27 The STP for LLR makes clear its commitment to addressing care and quality gaps and eradicating poor patient experience.

³⁵ All figures in the bullet points: ibid

³⁶ <http://www.cqc.org.uk/provider/RWE/surveys>

³⁷ <https://gp-patient.co.uk/slidepacks/January2016>

The Workforce: Key Characteristics

2.28 Health and social care accounts for 11.7% of all jobs in LLR. Based on employment volume, only wholesale and retail and manufacturing are larger (Table 2.1). It is estimated that the number of jobs in health and social care has increased by 14% (+6,750 jobs) since 2010.

Sector (one-digit Standard Industrial Classification)	Jobs	% of LLR total jobs
Wholesale and retail	75,750	16.2%
Manufacturing	62,750	13.4%
Health and social care	54,150	11.7%
Education	50,000	10.7%
Administrative and support service activities	41,100	8.8%
Professional, scientific and technical activities	34,550	7.4%
Transportation and storage	26,500	5.7%
Accommodation and food service activities	25,450	5.4%
Construction	21,650	4.6%
Public administration and defence	19,500	4.2%
Total	469,000	88.1% of all LLR jobs

Source: Business Register and Employment Survey (2015)

2.29 Over three fifths (61%) of LLR's health and social care workforce is based in Leicester. Leicestershire accounts for 37% of the workforce and Rutland for 2% (reflecting its much smaller population). The healthcare workforce, in particular, is concentrated in Leicester (Table 2.2). This is influenced by the prevalence of large NHS hospitals in the city.

	Health		Social care	
	No.	%	No.	%
Leicester	25,675	75.0%	7,400	37.3%
Leicestershire	8,195	23.9%	11,880	59.8%
Rutland	375	1.1%	580	2.9%
Total	34,245	100%	19,860	100%

Source: Business Register and Employment Survey (2015)

2.30 The health and social care workforce in LLR is predominately (80%) female. In terms of its age structure, it is older than the LLR's all-industry workforce, the most notable difference being the under-representation of workers under the age of 25 (Table 2.3). However, this is by no means an LLR-specific anomaly; the health and social care workforce nationally has an older age profile than the all-industry workforce.

	LLR health and social care workforce (%)	LLR all-industry workforce (%)
50 and over	30.8%	29.6%
25-49	59.5%	57.4%
Under 25	9.7%	13.0%
Total	100%	100%

Source: National Census (2011)

- 2.31 Turning to qualification levels, the data unsurprisingly shows that the LLR health and social care workforce is, overall, more highly qualified than the LLR workforce as a whole. As shown in Table 2.4, nearly half of the health and social care workforce (46.7%) is qualified to at least Level 4, compared with 32.2% across all industries combined.
- 2.32 Whilst more localised data for the qualification profile in health and care is not publicly available, LLR is likely to reflect the rest of the country in that a far greater proportion of the highly qualified workers in the sector will be in healthcare than in social care.

	LLR health and social care workforce (%)	LLR all-industry workforce (%)
Level 4 qualifications and above	46.7%	32.2%
Level 3 qualifications	16.3%	15.3%
Apprenticeships and other qualifications	5.1%	9.6%
Level 2 qualifications	16.1%	16.6%
Level 1 qualifications	9.6%	14.8%
No qualifications	6.1%	11.5%
Total	100%	100%

Source: Annual Population Survey (2015)

- 2.33 There is very little difference between the qualifications profile of the LLR health and social care workforce and the health and social care workforce nationally (Table 2.5). In fact, against none of the categories in the table does the difference exceed one percentage point.

Table 2.5: Workforce qualification profile (2 of 2)

	LLR health and social care workforce (%)	National health and social care workforce (%)
Level 4 qualifications and above	46.7%	47.6%
Level 3 qualifications	16.3%	16.3%
Apprenticeships and other qualifications	5.1%	4.8%
Level 2 qualifications	16.1%	16.4%
Level 1 qualifications	9.6%	9.5%
No qualifications	6.1%	5.4%
Total	100%	100%

Source: Annual Population Survey (2015)

Composition of the Workforce

2.34 Based on data from 2015, almost two-fifths of the LLR health and social care workforce can be categorised within the (somewhat broad) definition of ‘hospital activities’ (Table 2.6). This is by far the largest category used in the data; only one other category (‘other human health activities’, which includes disciplines such as occupational therapy, speech therapy and chiropody) accounts for more than 10% of the workforce. In the table, the green shaded rows are healthcare and the purple shaded rows are social care.

Table 2.6: Composition of the health and social care workforce in LLR

Sub-sector	No.	%
Hospital activities	20,750	38.4%
Other human health activities	8,230	15.2%
Social work activities without accommodation for the elderly and disabled	5,005	9.3%
Other social work activities without accommodation not elsewhere classified	4,445	8.2%
Other residential care activities	3,900	7.2%
Residential care activities for the elderly and disabled	3,475	6.4%
General medical practice activities	3,350	6.2%
Child day-care activities	2,075	3.8%
Dental practice activities	1,575	2.9%
Residential nursing care activities	760	1.4%
Specialist medical practice activities	250	0.5%
Residential care activities for learning disabilities, mental health and substance abuse	200	0.4%
Medical nursing home activities	90	0.2%
Total	54,105	100%

Source: Business Register and Employment Survey 2015 (note that figures on workforce size differ to other figures stated in the report due to sub-sector rounding).

Comparing the Size of the Workforce with Other Areas

2.35 The health and social care workforce in Leicester and Leicestershire serves a population of approximately 1,017,900 people. This equates to 53.2 health and social

Health and Social Care Sector Growth Plan for Leicester, Leicestershire and Rutland

care jobs per 1,000 residents (note that data availability prevents Rutland from being included in this aspect of the analysis). The national average is 58.5 jobs per 1,000 residents. As shown in Table 2.7, there is considerable local variation, ranging from more than 70 jobs per 1,000 residents in the Liverpool City Region, the Tees Valley and the West of England, to fewer than 50 in Hertfordshire.

2.36 There could be several reasons why these differences in job density exist. They include the health and care needs of different local populations, the way in which services are structured and the extent and impact of efficiency measures. This plan certainly does not make any recommendation that the health and social care workforce in LLR should be increased simply on the basis of achieving parity with other areas. However, by way of illustration:

- The health and social care workforce in Leicester and Leicestershire would need to grow by approximately 5,150 jobs to achieve the same 'jobs per 1,000 residents' as the current national average (Figure 2.1).
- Approximately 4,300 more health and social care jobs would be needed in Leicester and Leicestershire to have the same job density as the Derby, Derbyshire, Nottingham and Nottinghamshire LEP area³⁸.

Rank	Local Enterprise Partnership area	Health and social care jobs per 1,000 residents
1	Liverpool City Region	72.2
2	Tees Valley	71.9
3	West of England	71.0
4	Solent	67.9
5	Lancashire	66.8
6	Heart of the South West	66.7
7	Gloucestershire	65.2
8	Oxfordshire	64.4
9	Dorset	63.8
10	Cumbria	63.7
11	Sheffield City Region	63.3
12	North East	62.3
13	Coast to Capital	61.4
14	Cheshire and Warrington	61.3
15	Leeds City Region	60.1
16	Greater Manchester	59.7
17	Humber	58.7
18	London	58.6
19	York, North Yorkshire and East Riding	58.2
20	Derby, Derbyshire, Nottingham and Nottinghamshire (D2N2)	57.7
21	New Anglia	57.0

³⁸ York Consulting estimates.

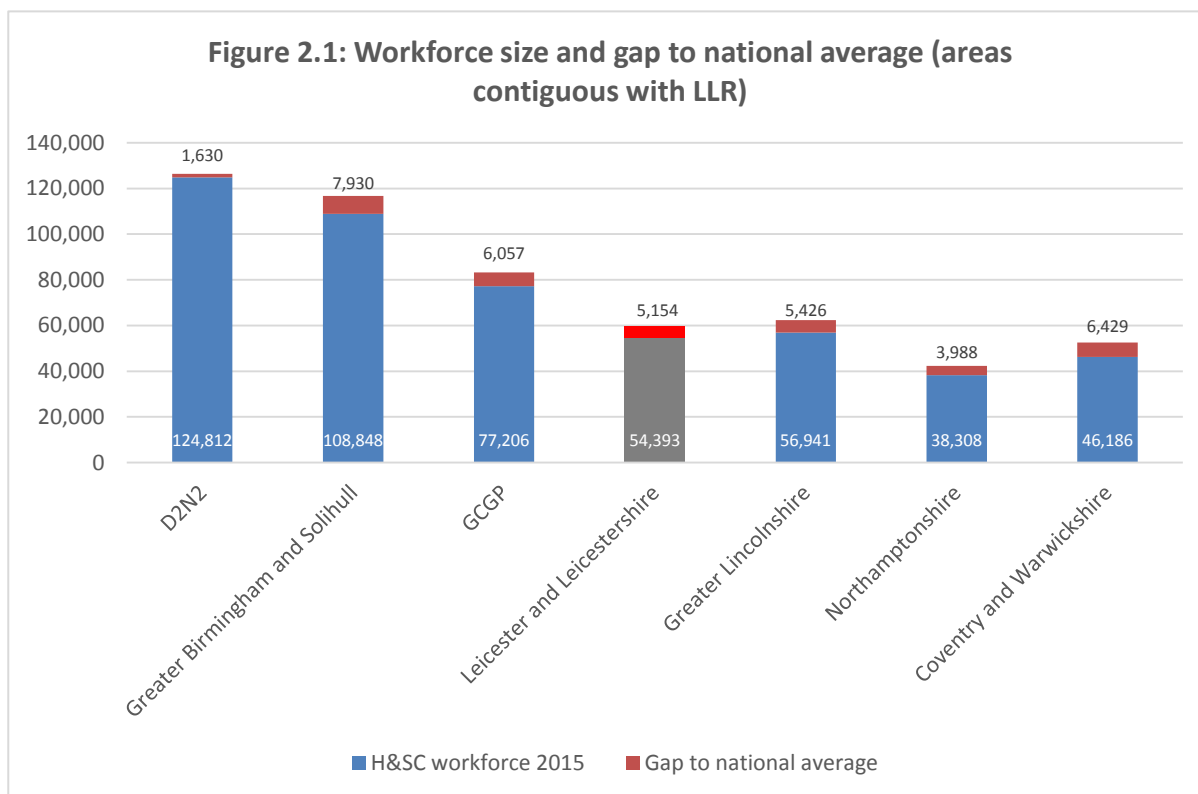
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Table 2.7: Employment in health and social care per 1,000 residents		
22	Cornwall and Isles of Scilly	55.1
23	South East	54.7
24	Greater Birmingham and Solihull	54.5
25	Stoke-on-Trent and Staffordshire	54.4
26	Greater Cambridge and Greater Peterborough (GCGP)	54.2
27	Greater Lincolnshire	53.4
28	Leicester and Leicestershire (excludes Rutland)	53.2
29	The Marches	53.0
30	Northamptonshire	53.0
31	Enterprise M3	52.4
32	Swindon and Wiltshire	52.1
33	South East Midlands	51.6
34	Coventry and Warwickshire	51.4
35	Worcestershire	51.2
36	Buckinghamshire Thames Valley	50.7
37	Black Country	50.2
38	Thames Valley Berkshire	50.1
39	Hertfordshire	46.2
	England average	58.5

Source: York Consulting (derived from 2015 Business Register and Employment Survey and population data)

2.37 Figure 2.1 shows the gap to the national average job density in health and care, expressed in numbers of jobs, for Leicester and Leicester and the six LEP areas that are contiguous with LLR. The key points to note are that:

- In all seven areas, more health and social care jobs would be needed to achieve parity with the national average. This ranges from an estimated increase of 1,630 jobs in D2N2 to 7,930 jobs in Greater Birmingham and Solihull.
 - The picture changes somewhat when the gap in job numbers is considered as a proportion of the current health and social care workforce. The variation across areas against this measure is significant: it ranges from 13.9% in Coventry and Warwickshire to 1.3% in D2N2. It is 7.3% in Greater Birmingham and Solihull, 7.8% in Greater Cambridge Greater Peterborough, 9.5% in Leicester and Leicestershire, 9.5% in Greater Lincolnshire and 10.4% in Northamptonshire.
-



Source: York Consulting (derived from 2015 Business Register and Employment Survey and population data)

Unpaid Carers

2.38 Data from the 2011 Census suggests that, at that point in time, there were approximately 103,500 unpaid carers in LLR³⁹. This equates to 11.4% of the LLR population providing some form of unpaid care. The equivalent figure nationally was 10.2%. In other words, the LLR population includes an above average proportion of unpaid carers.

2.39 Between 2001 and 2011, the number of unpaid carers in LLR increased by 10.6% (+9,900 unpaid carers). If the same rate of increase were to have continued between 2011 and 2017, then at the time of writing there would be approximately 109,500 unpaid carers in LLR.

Economic Significance

2.40 Annual GVA⁴⁰ in LLR is approximately £22.5bn⁴¹. Approximately 8% of this (£1.8bn) can be attributed to the health and social care sector. Whilst this in itself is a very significant contribution, it is also important to consider the GVA in other sectors that health and social care *enables* via the provision of effective health and wellbeing services to the population. Whilst it is not possible to quantify this, it is fair to assume that it would amount to a significant value.

³⁹ National Census.

⁴⁰ Gross Value Added (GVA) is a widely used measure of the goods and services produced in an area, industry or sector.

⁴¹ Office for National Statistics.

2.41 As shown in Table 2.8, the median salary for health and social Care in LLR was £17,308 in 2015. This is 63% of the all-industry average for England. It is also lower than the national average for health and social care, although this is influenced (in part at least) by the inclusion of London and South East salary data in the national figures.

2.42 Breaking the data down into ‘health’, ‘residential social care’ and ‘non-residential social care (also Table 2.8) reveals significant, although unsurprising, differences:

- Average salaries in health are around a third higher than they are in non-residential social care;
- They are higher still than in residential social care.

	Health and social care		All industries
	LLR median	England median	England median
Health	£20,762	£22,342	-
Residential Social Care	£13,227	£14,258	-
Non-Residential Social Care	£13,921	£15,007	-
Total	£17,308	£18,658	£27,600

Source: Annual Survey of Hours and Earnings (2015)

Looking Ahead: the STP, Integrated Teams and Changes in the Market

2.43 It is not the intention here to cite the STP for LLR extensively, not least because it is soon to be updated. However, it is of note that the November 2016 draft (the most recent in public circulation at the time of writing⁴²) contains the following observations, priorities and proposals (amongst much else) which together not only make the case for change but also outline how that change will be delivered:

- **Total spend on health and social care in LLR in 2016/17 was £2.1 billion.** It is estimated that under a ‘do nothing’ scenario, the system deficit by 2020/21 will be £399.3m, comprising a £341.6m deficit in health and a £57.7m deficit in social care.
- **Service re-configuration is required to ensure clinical and financial sustainability.** Subject to consultation, this may include consolidating care onto two acute hospital sites, consolidating maternity provision onto one site and moving from seven community hospitals with inpatient beds to six.
- **New models of care focused on prevention, moderating demand growth are needed.** These include integrated locality teams, a new model for primary care, effective and efficient planned care and an integrated urgent care offer.

2.44 Picking on the third of the bullet points above, the STP proposes that an increasingly large proportion of care will be delivered by locality based integrated teams. As these teams develop, they will:

⁴² <http://www.bettercareleicester.nhs.uk/>

- Be responsible and accountable for the care of all patients within their defined geographical area.
 - Operate under a single leadership team.
 - Have joint accountability for care coordination and outcomes for their population.
 - Provide care in local communities and people's own homes, in turn reducing dependency on acute care.
 - Create a standardised consistent offer for LLR citizens with interventions delivered at a local level.
 - Focus on prevention, the individual's responsibility for their own health and wellbeing, early diagnosis and management of risk factors.
 - Create a more cost efficient and clinically effective person centred model of care.
- 2.45 The geographic spread of integrated teams will be based on ten established localities across LLR, each with a population of between 63,000 and 121,000.
- 2.46 The significance of the new model to this growth plan is that will require significant change in how the workforce is aligned and led. There will be joint accountability for care co-ordination and outcomes across organisational teams and boundaries and current staffing and skill mix will be reviewed. As proposed in Section Four, it will therefore be very important for those responsible for this plan to maintain a regular dialogue with those responsible for the implementation of the STP.
- 2.47 Looking specifically at social care, the profile of the market is changing in LLR, as it is nationally. Amongst the most significant changes is the rapid growth in the market of the private sector. As an example, in 1993, 5% of state-funded home-care services were provided by the private sector. By 2012 this had risen to 89%⁴³. Across adult social care as a whole, the private sector is now by far the largest employer, accounting for over two thirds of all adult social care workers. The statutory sector now employs just over one in ten workers⁴⁴.
- 2.48 Accurately estimating the number of people who fund their own care and support ('self-funders') remains difficult, although the general acceptance is that this cohort is growing and will continue to do so⁴⁵. In LLR, there are significant variations by local authority area that are in keeping with local socio-economic characteristics. In Leicester, for example, self-funding is relatively rare (c. 1,200 people⁴⁶), whereas in Rutland, approximately 75% of all social care is self-funded⁴⁷. Self-funders are making very significant decisions which, if poorly informed or advised, can result in them falling back on to local authority funding.

⁴³ The Future of the NHS? Lessons from the market for social care in England. Centre for Health and the Public Interest (2013).

⁴⁴ The state of the adult social care sector and workforce in England. Skills for Care (2015).

⁴⁵ Older people who self-fund their social care: A guide for health and wellbeing boards and commissioners. OPM Group (2013).

⁴⁶ https://www.whatdotheyknow.com/request/direct_payment_and_self_funder_u_151

⁴⁷ Figure from Rutland County Council.

2.49 These significant changes to the profile of supply and demand in the care sector require local authorities to review their investments into the sector and to ask whether these continue to generate maximum impact. It is also the case that local areas are in competition for private sector investment and must seek to develop an attractive environment for such investment. This is evidently true in LLR, hence the inclusion of an action in this plan to introduce a workstream looking specifically at investments and areas for further development.

Recognising the Strengths of the Sector in LLR

2.50 Despite the challenges facing the sector (summarised under four key themes in Section Three), it is wrong to assume that the starting point for the delivery of this plan is one of universal challenge. On the contrary, there are many examples in the sector of where the direction of travel is positive and which, individually and collectively, provide a very solid foundation upon which to take forward the actions in the plan. These include (in no order of significance):

- **Charnwood Campus:** a new Life Sciences Technology Park situated in Loughborough offering an environment to “inspire discovery, encourage collaboration and accelerate business growth for the med-tech and biopharma community”⁴⁸. Charnwood Campus is the UK’s first Life Sciences Opportunity Zone and offers high quality, modern laboratories and production plants. It has been designed as a fully integrated drug discovery and development capability to support end-to-end drug development projects. The intention is that the campus will foster an eco-system of local business, leading research institutes (including the region’s universities) and government organisations to promote business growth, simplify access to support and accelerate the pathway from concept to commercialisation. It will further build on the East Midlands’ legacy of pharmaceutical research and development and its strengths in bioscience, medical equipment and devices, pharmaceuticals and biotechnology.
- **Leicestershire Social Care Development Group (LSCDG):** this LLR-wide network of social care providers has been in operation for over a decade and exists to raise quality and support workforce development in the independent and voluntary sector. The LSCDG provides free and subsidised training across a range of topics and provides and news and signposting service for providers. It is a legal partnership between Leicestershire County Council, Leicester City Council and Rutland County Council.
- **Recognising the importance of the sector to the local economy:** in all areas of the country, the health and care sector is amongst the largest in terms of employment volume. The recruitment and retention issues prevalent in LLR are mirrored elsewhere and forecasts consistently point to a large replacement demand challenge in the years ahead. Yet at the time of writing, only 11 of the 39 LEPs in England have identified health and social care as a priority sector for investment and development. The majority still make little or no mention of the sector in their strategic plans or statements of funding priorities. The Leicester and

⁴⁸ <http://charnwoodcampus.com/about/life-sciences-opportunity-zone/>

Leicestershire LEP is amongst the 11 that have identified health and care as a priority. Moving forwards this should bode well for the sector and its interaction with the business support community.

- **Strong Growth Hub offer:** both the Leicester and Leicestershire Enterprise Partnership and the Greater Cambridge Greater Peterborough Enterprise Partnership make considerable and regular efforts to promote their Growth Hub offers across the business base and to be as inclusive as possible.
- **A committed and motivated social care workforce:** feedback from frontline social care workers has not been obtained for this study on a scale that guarantees statistical robustness (i.e. it cannot be assumed that the opinions of the workers who contributed to the study are representative of workers across the sector in LLR as a whole). However, the anecdotal feedback that was gathered nonetheless demonstrates high levels of pride in the work and commendable commitment in circumstances that can be challenging. Perhaps most significantly, it highlights the personal and professional gratification that workers receive from helping their clients. The quotations overleaf, all of which are from social care workers in LLR, capture the essence of many of the responses when people were asked to identify what they enjoy the most about working in social care.

“Knowing I’m helping people to have the best quality of life they can have.”

“Helping the service users to gain new skills and be able to live with more independence.”

“Seeing service users accomplish things, the happiness this brings and the confidence that grows in them.”

“Being able to put a smile on their faces and feel like you have given them a purpose.”

Source: York Consulting Survey

3 CHALLENGES AND OPPORTUNITIES IN LLR

The Key Themes

- 3.1 The health and social care sector is large, diverse and complex. Each of its sub-sectors has its own specific issues and challenges. Some of these are locally nuanced. As such, it is neither desirable nor achievable, especially given the current context of sector reform and STPs, for this growth plan to try and reach across the sector in its entirety or to make inroads into all of its challenges. Any attempt to do so would result in a plan of such size, and with such resource demands, that its implementation would be impossible. It would also overlap directly with other significant programmes of sector reform, such as the STPs.
- 3.2 The aim here is therefore to focus on those issues, challenges and opportunities where a new, complementary programme of work – i.e. the actions proposed in Section Four – can make a measurable difference to the sector over the short to medium term. Explained in the shaded boxes on the following pages, these issues, challenges and opportunities can be categorised under four headings:
- The image of the sector.
 - The resilience and growth of the sector.
 - The development and retention of the current workforce.
 - Attracting a high quality future workforce.
- 3.3 It is these headings under which the actions in Section Four are structured. As such, the shaded boxes that follow introduce the key topics against which this plan intends to deliver demonstrable, positive change. Future iterations of the plan may focus on different topics as the needs of the sector change and the national and local policy landscape evolves.
-

Theme 1: Image of the Health and Social Care Sector

- Across the 150+ individuals who contributed to the development of this plan, there is almost unanimous agreement that social care suffers from a poor public image, that it has done for many years, and that high profile incidents of abuse and neglect, however isolated, have compounded the problem.
- This view resonates with national research/commentary which has exposed a lack of awareness about social care⁴⁹, a sense of distrust towards the profession⁵⁰ and concerns amongst a high proportion of the population about locating themselves or a family member in a care home⁵¹.
- At the consultation events undertaken to gather evidence for this plan, the public image of social care was repeatedly cited as being amongst the most significant challenges facing the sector. For many, it is one of the main causes of recruitment and retention problems in social care.
- The consultation events also revealed the common view, echoed nationally, that whilst the challenges of working in the sector should not be misrepresented to potential entrants, negative perceptions tend to dominate public opinion of the sector and crowd out the positive messages about the rewards, opportunities and job satisfaction that it can offer. This is a source of great frustration and concern, especially given the growth of other industries in LLR that are competing for labour from the same pool.
- Work has been ongoing for some time to raise the profile of jobs and careers in social care, including Skills for Care's *I Care... Ambassadors* programme and, more recently, the formation of the LLR's Attraction and Retention Group. Those working in the sector appreciate this, but there is a strong view that more needs to be done to successfully challenge engrained perceptions, however outdated they may be.
- There would be strong support from within the sector for a local campaign in LLR, endorsed/fronted by a recognised local figure or celebrity, that sought to position the sector, its value to society and the jobs and careers it offers, in a more positive light.

⁴⁹ Expectations & aspirations: public attitudes towards social care, IPPR and PWC.

⁵⁰ <https://www.theguardian.com/social-care-network/social-life-blog/2014/jan/10/social-work-needs-positive-news-stories>

⁵¹ <https://www.carehome.co.uk/news/article.cfm/id/1559073/care-homes-suffering-from-image-problem-as-medica-focuses-on-negative-dementia-statistics>

Theme 2: The Resilience and Growth of the Sector

- Consultation feedback gathered for this plan suggests that many social care providers operate with an immediate-term focus regarding business planning. Longer-term considerations around growth, diversification and exit/sustainability planning are far lower priorities than the here-and-now issues of tight operating margins and staffing concerns. This is not to suggest that providers are not business savvy, but rather that they feel it unavoidable to focus to any significant extent on anything other than immediate-term issues.
- Social care employers tend not to see themselves as typical users or recipients of business support services. Anecdotal feedback suggests that knowledge of the LLEP's 'Business Gateway' and the Greater Cambridge Greater Peterborough LEP's 'Signpost 2 Grow' services, for example, is relatively low amongst social care organisations.
- Knowledge of where and how to access workforce development support and resources to support recruitment and retention activities is also mixed. This is not to be critical of those that offer such support/resources; on the contrary, there is clearly some excellent support and information available. However, employers (and in particular smaller employers) report that they can become deterred and confused by what they perceive to be regularly changing funding streams and eligibility criteria.
- Consultation feedback suggests that employers in social care would welcome a single pack or 'reference manual' (physical or virtual) to help them navigate towards and through the business support and workforce development landscape.
- The above two points are predicated upon an assumption that good quality business support helps organisations to become more resilient and to grow. Relatively few robust research studies exist in this space, although where they do⁵², they typically reveal stronger business performance, growth and resilience to market conditions amongst supported organisations than non-supported equivalents.
- The social care market is changing, with private investment representing the biggest area of growth (both in terms of suppliers and customers) and self-funding on the rise in parts of LLR. Local authorities have the challenge of keeping pace with this changing market and ensuring that their investments deliver maximum value. This study has uncovered considerable enthusiasm for meeting this challenge and for cross-partner working to support those parts of the sector with the greatest development potential.

⁵² E.g. 'Exploring the Long-Term Impact of Business Support Services', Enterprise Research Centre, 2015 and 'Assessing the Effectiveness of Business Support Services in England: Evidence from a Theory-Based Evaluation', Warwick Business School, 2008.

Theme 3: Development and Retention of the Current Workforce

- Compared with other sectors and the national average, the rate of staff turnover in the health and social care is very high. This is especially the case in social care, where it is estimated that there are around 80,000 live vacancies on any given day⁵³.
- There are many reasons why this is the case. The demands of the work, the prevalence of jobs in other sectors with similar pay but less challenging conditions, the tendency of care workers to move employers for relatively modest pay increases and the general transiency of the workforce all play a part. The absence of a formal grading structure and pay banding system in social care is also seen by some as a contributory factor.
- Regardless of the reasons, the high rates of turnover are damaging to employers from both a cost perspective and in terms of continuity of care. Managers attending the consultation events spoke of the demands on their time caused by turnover issues and the extent to which this prevented them from giving sufficient attention to other issues such as longer term business strategy and planning.
- National data – most notably the UK Employer Skills Survey – shows that a higher proportion of employers in health and social care provide training for their staff than is the case for all industries combined⁵⁴. However, this is influenced by the heavily regulated nature of healthcare and the prevalence of induction/mandatory training in social care. Feedback at the consultation events supports findings from other research which states that many providers in social care find it very challenging (from a time and finance perspective) to make staff available for training beyond that which is legally required and/or is absolutely essential to the role⁵⁵. This is in spite of the glut of evidence demonstrating a positive correlation between workforce development and staff retention.
- Looking ahead, it is expected that demand for digital skills in the workforce will increase, as will demand for home care and tele-care services. Increased personalisation and the integration of health and social care services will generate greater demand for inter-disciplinary skill-sets, while care workers will be expected to work competently with advanced care technology such as care robots⁵⁶. Social care providers are aware of this general direction of travel, but for some the response will require a programme of upskilling and re-skilling for which they are not yet suitably prepared.
- Elsewhere in the country, integrated Health and Social Care Apprenticeship Pilots have been run very successfully. The indications from this research are that the introduction

⁵³ Skills for Care.

⁵⁴ UK Employer Skills Survey 2015. Results available at: <https://www.gov.uk/government/publications/ukces-employer-skills-survey-2015-uk-report>

⁵⁵ E.g. <https://www.theguardian.com/social-care-network/2013/oct/30/main-challenges-homecare-survey-findings> and <http://www.communitycare.co.uk/2015/04/23/home-care-training-gaps-risk-fatal-consequences-service-users-says-unison/>

⁵⁶ <https://www.gov.uk/government/publications/jobs-and-skills-in-2030>

of an equivalent scheme in LLR would have strong stakeholder support.

- More broadly, the consultation events undertaken for this plan, together with other literature⁵⁷ suggest that employers' knowledge of the Apprenticeship Levy and its consequences remains incomplete in many cases. It appears that the sector locally could benefit from concerted efforts to promote apprenticeships and to clarify the opportunities offered by the Levy.

⁵⁷ E.g. <http://www.cityandguilds.com/news/February-2017/Employers%20still%20in%20the%20dark%20about%20forthcoming%20apprenticeship%20changes#.WQMbg0n6uUk>

Theme 4: Attracting a High Quality Future Workforce

- Although difficult to prove objectively, the message from the primary research undertaken for this plan was clear: the full array of jobs and careers in health and social care sector and the progression opportunities they offer are not being accurately conveyed to young people in educational institutions, or at least not consistently. This is particularly felt to be the case for jobs and careers in social care.
- As a consequence, employers are concerned that they are missing out on good quality new entrants because advice and guidance is not enthusiastic or robust enough in making the case that social care can offer rewarding careers pathways.
- Employers also recognise that service redesign (e.g. through the STP) will, over time, have direct consequences for the definition of roles and responsibilities across the sector. They are very keen that educational institutions, young people and their parents, have access to up-to-date information on what the different roles in the sector entail as service redesign gathers pace across LLR.
- There is a risk, when discussing the future workforce, to focus solely on young people. Yet many employers at the consultation events said that they welcome older entrants as their life experiences, empathy and communication skills can make them more suited to some direct care giving roles⁵⁸. They would like to see steps taken to promote the sector to those considering a career change later in their working lives.
- In 2015, the government introduced the Enterprise Advisor Network: business volunteers who support local schools and colleges to develop strategies to increase careers, enterprise and employer engagement based on 'what works'. Across the Leicester and Leicestershire area there are currently 32 Enterprise Advisors. One of these is from the health sector but as yet none is from social care. It is not straightforward to recruit Advisors from a sector that faces well-documented pressures, but it can only be to the detriment of the sector to have such limited representation compared with other sectors looking to recruit from the same labour pool.

In Summary

- 3.4 **Theme 1:** LLR has a proud and committed health and care workforce, but more needs to be done to raise the public image of the sector, address misconceptions and to position jobs and careers in the sector in a more positive light. Activities designed to do this will receive strong backing from within the sector in LLR.
- 3.5 **Theme 2:** Participation in business support and business growth activities amongst health and care organisations in LLR appears to be limited. Eligibility issues of state-

⁵⁸ Most employers at the consultation events rejected concerns over an ageing workforce and said instead, especially in social care, that they would welcome applications from more older workers.

funded healthcare providers aside, this seems to be influenced by relatively low levels of knowledge of available products and services coupled with the constraints of operating in a difficult market. Yet there are some excellent support services available in LLR which could doubtless be to the benefit of organisations in health and social care. Supporting the sector to explore and engage with these services is likely to be important.

- 3.6 **Theme 3:** The skills requirements of many care-giving roles in the sector will change as services are re-designed, further integration takes place and technological advancements continue to impact upon how services are delivered. Yet it is very difficult for many social care providers to participate in structured or forward-looking workforce development activities, with time and financial constraints regularly cited. Activities designed to make it easier for care providers to participate in workforce development will be welcomed, as will skills development programmes that straddle health and care (e.g. integrated apprenticeships).
- 3.7 **Theme 4:** linked to the image issues in Theme 1 is the strong view from providers that jobs and careers in the sector – and social care in particular – could be more accurately and enthusiastically conveyed to young people and potential career changers. Given the number of educational institutions and employment advisors in LLR, this will clearly take time to achieve. A good starting point, however, will be the recruitment of a social care professional(s) to the Leicester and Leicestershire Enterprise Advisor Network, as will ensuring that LLR residents have access to good quality and up-to-date information about the full spectrum of career opportunities in the sector.
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4 Action Plan

Introduction

4.1 The actions below are structured under four Key Themes, each of which corresponds with a Key Theme from the previous section. They are:

1. Improving the image of the sector.
2. Supporting the sector with resilience and growth.
3. Developing and retaining the current workforce.
4. Attracting a high quality future workforce.

4.2 In reading and interpreting these actions, it is important to note the following:

- **The majority have a social care focus.** This reflects the point in time at which the plan has been written and other current developments in the sector, including the STP. In short, the actions concentrate on those areas where the two LLR LEPs and their partners in the local authorities can realistically have the most influence in the short to medium term. Future iterations of the plan may include more actions with a healthcare focus, depending on local circumstances and need at that time.
- **The actions typically refer to the sector in headline terms.** ‘Health and social care’ and ‘social care’ are referenced in the actions, rather than discrete service areas or types of provision. This is mainly to allow flexibility in the implementation of the actions. However, it does not imply that all parts of the sector are in equal need of support or are expected to grow at an equal rate. For example, at the time of writing the city of Leicester has an over-supply of residential care places and it seems unlikely that this part of the sector will expand over the next few years. By contrast, domiciliary care, community care services and support with independent living are more likely to grow, not least because of the LLR-wide push on preventative activities and reducing the burden on the area’s hospitals.
- **Each action has an indicative timeframe.** This refers to a period of elapsed time starting from when this plan is formally approved. The timeframes against the actions should be regularly reviewed, and where appropriate refined, by the group/parties responsible for the implementation of the plan.
- **Each action has a lead organisation.** In many cases this reads ‘local authority’. The group/parties responsible for the implementation of the plan will assign a specific authority to each action based on specialisms, available resources etc.

Further Development of an Implementation Plan

4.3 For the implementation of this plan to be successful, a strong and collaborative partnership approach is required. This should be managed and driven by an Implementation Group (or equivalent) with responsibility for the delivery, monitoring and evaluation of the plan.

4.4 The Implementation Group should include senior representation from:

- **Leicester City Council, Leicestershire County Council and Rutland County Council:** in their role as lead organisations for the majority of the actions in the plan and, in the case of Leicestershire County Council, the accountable body for the Leicestershire Social Care Development Group.
 - **LLEP:** in their role as lead or co-lead on selected actions within Themes 2, 4 and 5.
 - **The LLR Attraction and Retention Group:** to share progress, plans and joint working opportunities across Themes 1, 3 and 4.
 - **The STP Workforce workstream:** the service re-design proposed in the STP has direct implications for the implementation of this plan. Likewise, the actions in this plan can be of benefit to the workforce related activities in the STP. It is therefore important that regular and clear channels of communication exist between the two.
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Key Theme 1: Improve the image of the sector

Action: LLR-wide multi-media campaign to improve the image of the sector – especially social care – and increase the number of quality individuals recruited.

Ref.	Activity	Lead Partner (s) and Others to involve
1.	Work with local media (e.g. written press and radio) to develop and publicise a series of positive news items about the health and care sector.	<ul style="list-style-type: none"> - Local authority - Care providers (to source stories/ case studies) - NHS (as above) - Local media outlets
2.	Recruit publicly recognised/celebrity ‘Care Champions’ to raise public awareness of the value of social care and the careers it offers.	<ul style="list-style-type: none"> - Local authority - PR/marketing specialists (to design the campaign) - Local media outlets (to publicise/ promote the campaign)
3.	Develop case studies of older entrants to the sector and promote these through local media to reach potential ‘career changers’ and through JC+ to reach unemployed workers.	<ul style="list-style-type: none"> - NHS and local authority - Health and care provides (to source information/examples for the case studies). - Local media (to promote the case studies) - JC+ (to use the case studies with older people who are out of work)

Key Theme 2: Support the sector with resilience and growth

Action: Enable and encourage more health and social care organisations in LLR to access business support services that can help them grow, expand into new/emerging market areas or become more resilient to current operating conditions.

Ref.	Activity	Lead Partner(s) and Others to involve
4.	Develop a 'local authority contractors pack' for social care providers containing information/signposting to business support services, workforce development support, recruitment and retention resources etc.	<ul style="list-style-type: none"> - Local authorities (*3) - LLEP and GCGP LEP (for details/factsheets on business support services) - Skills for Care (for details/factsheets on relevant resources)
5.	Active promotion of the LLEP's 'Business Gateway' and the Greater Cambridge Greater Peterborough LEP's 'Signpost 2 Grow' services to health and social care businesses, emphasising the availability of growth/expansion advice and access-to-finance services.	<p>LLEP GCGP LEP</p> <ul style="list-style-type: none"> - Local authorities (to provide distribution lists of health and care organisations)
6.	Ensure, where possible, that 'health and social care' be included within the list of eligible sectors for business support and workforce development programmes in LLR.	<p>LLEP GCGP LEP</p> <ul style="list-style-type: none"> -

Ref.	Activity	Lead Partner(s) and Others to involve
7.	<p>Introduce an LLR-wide workstream with a remit to consider how local authorities could invest in the social care sector with maximum impact/effectiveness. This may involve researching national and international examples of good practice and considering how the services and skills base of the private sector can be further developed.</p>	<ul style="list-style-type: none"> - Local authority - Local Government Association (to assist in identifying examples of good practice) - Association of Directors of Adult Social Services (as above) - Social Care Institute for Excellence (as above) - Social care providers in LLR (to explore/validate emerging proposals)

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Key Theme 3: Develop and retain the current workforce

Action: Support and stimulate high quality workforce development activity in the health and social care sector across LLR.

Ref.	Activity	Lead Partner(s) and Others to involve
8.	Develop and implement a business case for the introduction and ongoing operation of an 'LLR Integrated Health and Social Care Apprenticeship' project, drawing on learning from successful schemes in other parts of the country (e.g. Kent and Norfolk).	<ul style="list-style-type: none"> - Local authority - NHS (as participants in the project) - Social care providers (as above) - Post-16 skills providers (for the knowledge based elements)
9.	Deliver a sector-wide promotional campaign to promote the workforce development potential of apprenticeships, the different levels of apprenticeship now available and the 90% funding available to SMEs under the new levy arrangements.	<ul style="list-style-type: none"> - Local authority - LLR Attraction and Retention Group (to ensure alignment with their own work on apprenticeships) - LLEP and GCGP LEP (as above)
10.	Seek to establish an 'LLR lifelong learning pilot for health and social care' under the government's 2017 Spring Budget announcement on lifelong learning funding.	<ul style="list-style-type: none"> - TBC when further details available from government.
11.	Establish a 'workforce and training planning' network to encourage social care providers to share workforce plans and joint training opportunities.	<ul style="list-style-type: none"> - Local authority - Leicestershire Social Care Development Group (the LSCDG may be best placed to take the lead partner role)

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Ref.	Activity	Lead Partner(s) and Others to involve
12.	Work with partners to help ensure that (health and) social care is appropriately supported through discretionary funding for skills development (e.g. ESF and post-Brexit equivalents).	<ul style="list-style-type: none"> - LLEP and GCGP LEP - Local authorities (to raise awareness of funding opportunities via their networks) - Skills for Health and Skills for Care (as above)
13.	Engage in discussions with partners in other LEP areas that have stated an interest in/preference for a formal care worker grading structure (e.g. D2N2 ⁵⁹) to explore the feasibility of a cross-boundary programme to raise aspirations and promote career pathways.	<ul style="list-style-type: none"> - Local authority - D2N2 local authorities

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Key Theme 4: Attract a high quality future workforce

Action: Better promotion of job and career opportunities in the health and social care sector to young people in schools and other skills providers.

Ref.	Activity	Others to involve
14.	Recruit Enterprise Advisors from social care to raise the visibility of the sector and improve careers insights.	<ul style="list-style-type: none"> - LLEP - Social care providers (to nominate Enterprise Advisors)
15.	Develop/adapt/promote a 'careers pathway' tool for care (or health and care) to demonstrate routeways through the sector and career progression opportunities ⁶⁰ .	<ul style="list-style-type: none"> - Local authority - Skills for Health and Skills for Care (to assist with the development of accurate and up-to-date careers pathways) - Hospitality Guild (as the owner of an existing good practice example in this area)⁶¹ - Technical specialist (to develop an online tool)
16.	Ensure that communication channels exist to keep education and skills providers abreast of service re-design (e.g. through the STP) and what that means for job and career opportunities in the sector.	<ul style="list-style-type: none"> - NHS - Education and skills providers (as the recipients of the information)

Action: Improve access to job opportunities in the sector for people out of work and potential ‘career changers’.

Ref.	Activity	Others to involve
17.	Explore opportunities for closer working on recruitment strategies between large employers in the sector and DWP/JC+, drawing on practice elsewhere in the country.	<ul style="list-style-type: none"> - Local authority - DWP/JC+ - Local authorities elsewhere where arrangements are well embedded

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