skillsforcare

Rapid evidence assessment:

adult social care and factors associated with productivity and work performance

Rapid evidence assessment: adult social care and factors impacting on productivity and work performance
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About this paper

Productivity is falling in the UK. There is much discussion about the reasons for this and the impact on the economy. This has subsquently led to an increased focus on improving productivity across the workforce.

This paper focusses on this discussion in adult social care, drawing on the published literature to identify the main influences on productivity. Our aim is to begin a conversation with employers and managers in adult social about workforce productivity, what it is and what could be done to improve it.

Tell us...

Skills for Care wants to gather employer's views, perspectives and examples of workforce productivity in social care in action. This discussion, and the examples generated, will be used to look for future support or knowledge sharing in order to help adult social care organisations tackle workforce productivity issues.

We'd like you to answer the following questions:

1. What does workforce productivity mean to you?
2. Have you got examples from your own work that demonstrate workforce productivity in action?
3. Are there any gaps in the evidence presented in this paper from your perspective?
4. If we were to develop workforce resources around this for employers what would you like to see?
5. Any other comments?

You can either email your feedback to liz.burtney@skillsforcare.org.uk or we've put them into a survey which you can complete online.

Executive summary

Traditional definitions of productivity are being extended to focus on how well a system can use resources to achieve its goals and taking a more holistic view of additional impacting factors, e.g. staff training. This approach is starting to be applied within health and social care and the attention given to how we can improve productivity, given the current financial and policy context.

Currently, there are no straightforward measures of productivity in adult social care, although the Office for National Statistics (ONS) are working on this. Current advice focusses on identifying outcomes of productivity which are important to individuals or organisations and use these as a starting point for measuring improvements.

Factors that impact on productivity include:

- culture of an organisation
- leadership in an organisation
- employee wellbeing
- learning and development
- digital technology.

Organisational culture

There's a growing body of literature linking organisational culture to productivity, particularly focussing on presenteeism and absenteeism. Factors associated with a positive workplace culture include strong leadership, clear organisational vision, peer to peer support, strong policies, staff engagement, support for learning, teamwork and skilled staff, among others. There are toolkits available which can help social care employers consider current organisational culture and identify changes for improvement (e.g. our Culture Toolkit).

Leadership

Leadership links not only to culture but productivity. Important aspects include managing change, championing employee health and associated initiatives, supporting innovation, encouraging support, managing resources and appropriate allocation of resource. Social care employers can access guidance and frameworks to help support leadership across all levels as well as courses offering leadership training (e.g. our Leadership Qualities Framework and associated courses).

Increasingly a focus on **employee wellbeing** has reinforced the link with productivity. Turnover, innovation, change management, absenteeism and presenteeism all link staff wellbeing and productivity. Several factors impact on staff wellbeing:

- job satisfaction
- employee stress and burn-out
- relationships at work
- levels of staff engagement.

Measures of **job satisfaction** found a direct link between levels of satisfaction and productivity and while authors can't definitively state a causal link, the results are so robust and persistent over time that they replicate this strong link. Job satisfaction is impacted by levels of autonomy and control, reasonable demands, pay, job security, clarity and equity.

Employee wellbeing

Employee stress and burn-out are key concerns for health and social care, in part linked to the emotional demands from the job. Contributing factors include a poor and unsupportive working environment, unrealistic goals or high demands on staff etc. add to stress. Initiatives which focus on promoting a positive work environment, guidance to recognise signs and symptoms of stress and burnout, team level support for staff and individual opportunities for coaching and self care help minimize the impact of stress and burn out.

Relationships at work, again connecting culture with productivity, are important – in particular bullying in the workplace. The NHS Framework Developing People directly addresses this issue and sets out a condition for leaders to create an environment where there is no bullying and where staff feel safe and empowered to learn and develop.

Levels of staff engagement

Perhaps one of the most important factors associated with productivity is the level of staff engagement. Engaged employees feel a sense of attachment to the organisation and are more likely to invest in their role – some estimates suggest they perform 20% better than other less engaged colleagues. There are also lower rates of absenteeism and presenteeism associated with engaged staff. Drivers for engagement include purposeful and meaningful work, involvement in decision making, opportunities to engage with management, recognition and reward and organisational concern for staff members.

Learning and development

Learning and development and the link to productivity has been explored by a small number of authors and they concluded that while the evidence was limited, it was worthy of consideration and further investigation. One of the most important findings was the link between using the right person with the right skills to do the job.

Digital technology

Digital technology is increasingly important in social care and several reviews have identified a role for technology to improve productivity. However, there was a sense that health and social care weren't maximizing the potential and work in the future could strengthen returns from technology.

Skills for Care is working to offer the sector a digital champions approach to workforce development in this area to improve staff skills and use of technology.

What is productivity?

The traditional view of productivity is outputs provided by the process and inputs consumed by the process. This is described as a productivity ratio and can be readily applied to industries where production of a 'unit' is the main business. This is sometimes referred to as 'labour' productivity (OECD 2001) and can be based around gross output or value added output.

However, according to Public Health England (2013) many are now rejecting this traditional view of measuring productivity as the nature of work changes toward service delivery and job roles, which rely less on hard outcomes. They propose that productivity should go beyond this and focus on 'how well a system uses its resource to achieve a goal', providing a more holistic approach by taking into account other factors such as staff training to improve knowledge and skills which will help individuals work toward their goals. Indeed, the ONS is currently working on a quality adjustment for its measure of productivity in social care. However, this is more complex as you move from measuring how many individuals are being cared for toward changes in care needs etc.

Regardless of approach, higher productivity is perceived to be better than lower productivity and some argue what is important is that organisations set up measures of productivity that reflect the needs of the organisation.

How can we measure productivity?

In adult social care, the ONS (2017) produced a measure of productivity based on direct quantity measure (e.g. care activities in residential care and nursing activities, domestic care provided etc.) and found that productivity has fallen between 1997 and 2014, although it has stabilised since 2012. White and Kearney (2013) also estimated the productivity of adult social care compared to other sectors, focussing on the average gross value added per full time work (calculated by dividing financial input by number of workers in the sector). However, this doesn't reflect quality or effectiveness of the input.

A new methodology for social care

The ONS, along with other authors, now recognise that traditional measures of productivity do not necessarily fit with health and adult social care (ONS 2017, Tavich 2017, Bryson et al. 2014, Crosswaite et al. 2010). The ONS state that their measures don't account for change in quality of care and Crosswaite et al. (2010) argue that data on levels of productivity in the health service is constantly mixed, in part reflecting the complexity around the impact of different factors on productivity. The ONS are currently working on a new methodology to measure productivity in adult social care.

In the meantime, the literature would suggest the following considerations need to be applied when thinking about productivity in this sector:

- observing behaviour – some argue that the 'Hawthorne effect' impacts on accuracy of productivity measures in adult social care as behaviour changes when observed
- self-report bias (if not direct observation) has limitations
- absence of market clearing prices (as adult social care services can be free or subsidised)
- differences between outputs and outcomes
- lack of a well-defined and measurable goal
- multiple inputs required to produce outcome e.g. co-production which are difficult to quantify input from the variety of organisations and individuals involved – even more pertinent as we move toward integrated services
- range of tasks involved in delivery of adult social care (e.g. administration, analytics, improving outcomes, care and support services)
- who is measuring productivity (see table 1 below).

Sources: Tavich 2017, Public Health England 2015

Table 1: Focus of productivity by role

Stance	Focus
Economist	Efficiency with which an organisation turns inputs into outputs
Accountant	Similar to above but with inclusion of financial ratios
Manager	Focus on other factors influencing productivity including absenteeism, presenteeism, quality, staff turnover, customer satisfaction etc. Focus on efficiency and effectiveness of achieving goals.

In a recent review of productivity for NHS acute hospitals (Carter 2016), several measures were drawn out which may be of interest to consider the potential implications or learning for an adult social care market. The review suggested there needed to be:

1. A new metric based on reference cost data, the adjusted treatment cost (ATC) and the associated potential savings opportunity
2. A new unit, the weighted activity unit (WAU) and its associated metric, cost per WAU
3. Specific measures such as revenue per whole time equivalent and the purchasing price index.

Developing capability to improve productivity

It's not yet clear how these suggestions will be implemented in health or what might apply to adult social care. In the meantime, measures of productivity focus on national level datasets e.g. NHS staff survey, adult social care quality of life surveys etc. However, there needs to be more investment in a national scheme to collate and disperse successful productivity approaches and innovation in order to help individual trusts, in this case, develop their own capabilities to improve productivity (Appleby et al. 2014).

Currently the advice from the literature for employers is to focus on what outcomes of productivity are important to them individually/corporately/organisationally and use these as a starting point for measuring improvement within their own organisation.

What factors are associated with productivity?

Five main factors have been identified in the literature:

- culture
- leadership
- employee wellbeing
- learning and development
- digital technology.

Culture of the workplace

There's a growing body of evidence linking organisational culture to productivity particularly focussing on mitigating against absenteeism and presenteeism (Hitchcock et al. 2017, Wilkinson and Marmot 2003, Cancelliere et al. 2011, Bryson et al. 2014, Garrow 2016).

The World Health Organisation describes the relationship between health and workplace productivity as a virtuous circle, stating "There is no trade-off between health and productivity at work. A virtuous circle can be established: improved conditions of work will lead to a healthier workforce, which will lead to improved productivity and hence the opportunity to create a still healthier, more productive workplace" (Wilkinson and Marmot 2003).

A positive organisational culture

A number of studies identified characteristics for developing a positive organisational culture as:

- positive leadership and management (discussed below)
- a clear vision of and approach to delivering care, and a shared organisational understanding of these
- a sense of identity within the organisation
- peer to peer support
- intolerance of bullying and incivility
- strong management planning and practices
- supportive and clear staff policies and procedures, which are interwoven with the vision and approaches to care delivery
- job demands and levels of autonomy
- staff engagement, development and support for learning
- teamwork, good support and good communication between staff
- skilled staff who display a positive attitude
- work done with 'champions' (staff who display a passion for the work and have agreed to lead change in that particular area) who can become facilitators for action learning and person-centred approaches.

Sources: Skills for Care 2015, Australian Faculty of Occupational Health and Environmental Medicine 2013, Camble 2012, Lawrence et al. 2010, Smith 2009, Beadle-Brown et al. 2008, Broadhurst et al. 2007, Robertson et al. 2005, Emond 2003.

The Culture Toolkit

Our work with the sector to improve the culture of care in the workplace, led us to develop a culture toolkit (2017). This is for employers, to help understand the business case to improve culture, influences on culture and to help develop a better understanding of what a positive workplace culture looks like. This is supported by a range of tools to self-assess and implement change in the workplace to move toward a positive working culture.

More recently the NHS has published Developing People - Improving Care following a recommendation from the Carter Review on productivity (2016). The focus is on influencing culture to address bullying and discrimination at work and tackle stress levels, with an emphasis on developing leaders across the system. This will be implemented across organisations funded through the NHS.

Leadership

The literature identified leadership as important to productivity (van Dierendonck et al. 2004) and across a number of domains:

- setting the culture of an organisation, which as described above, is important for productivity
- managing change in an organisation and maintaining staff engagement through the process (discussed below)
- setting up peer support which is linked to stress and burn-out (discussed below)
- directly influencing stress among staff
- employee health more generally
- appropriate allocation of resources
- higher rates of innovation.

Source: Burtney et al. 2015, 2014, Australian Workforce and Productivity Agency 2013, van Dierendonck et al. 2004, Tepper 2000.

In adult social care, there's limited information on what leadership can look like (Owen et al. 2012) but there's a growing vision that it happens at all levels, can have different approaches, can be negative as well as positive, and needs developing.

Leadership styles

For some, the most important form of leadership is transformational and is focussed on changing whole systems. Whilst for others transitional leadership which focusses on stepped change and situational leadership which changes depending on circumstance is most important (Lynch et al. 2011). Others argue that leadership is conceptually driven and very few theories emerge from empirical research itself. Tamkin et al. (2010) identified three 'big ideas' for leadership:

- Thinking and acting systematically is central to leadership: outstanding leaders understand and consistently act in the knowledge that reaction follows action. Management and leadership follow seamlessly and they attend to the current and the future.
- People are the route to performance: time given to others builds social capital within and between people. Outstanding leaders understand that outcomes such as quality are achieved by engaging with others, entrusting them, growing them and creating conditions of trust and passing power.
- Outstanding leaders understand they achieve through their impact on others: personal ego doesn't feature and they are aware of the need to use themselves with care and respect, with full self-awareness and reflection.

Dimensions of leadership

This was validated for adult social care, and The Work Foundation (Pearson et al. 2011) concluded there was commonality around creating a positive vision, environment and relationship, empowering people where possible, promoting excellence and communication, appreciation of strengths and good systems. However, they found that adult social care leaders display a vision that extends beyond their organisation which was different to other leaders. They had a stronger sense of inspiring others but lacked perhaps some of the confidence of leaders in the private sector. Pearson et al. concluded that 'the key to building outstanding leadership in adult social care is to enhance its existing strengths around inspiring a passion for purpose, developing people, relationships and networks, and working in collaboration to deliver the highest quality of care' (Pearson et al. 2011, p11).

In 2016 we defined seven dimensions of leadership:

1. Demonstrating personal qualities (self-awareness, managing self, continued professional development (CPD), integrity)
2. Working with others (networks, relationships, encouraging contribution, integrity)
3. Managing services (resources, people, performance)
4. Improving services (safety, reflection, improvement, innovation, change)
5. Setting direction (context, knowledge, evidence, decision making)
6. Creating the vision (development, communication, embodiment)
7. Delivering the strategy (framing, developing, implementing).

Framework for leadership

More recently the NHS have published a framework to equip and encourage staff in NHS funded services across England to deliver continuous improvement in local health and care systems. The vision is for leaders at every level to develop improvement and leadership capabilities among their staff and themselves to protect and improve services - in particular, through systems leadership and inclusive and compassionate leadership. There's a definite push to demonstrate inclusion and compassion in all interactions and to develop their own and staff's skills and capacity to ensure leadership is collective. The framework makes a strong connection between compassionate and inclusive leadership, high quality, high performing systems that drives improvement in the overall performance.

We developed this framework in partnership the Local Government Association and it states:

"While it is currently developing improvement skills and leadership among people doing NHS funded work, there is more work to do with our partners to ensure we develop and sustain truly integrated leadership across the evolving world of health and [adult] social care."

It would be appropriate to consider the potential benefits of these elements for the adult social care sector which is facing similar pressures.

Employee wellbeing

According to Bryson et al. (2014), employee wellbeing is increasingly a focus for government attention in the UK, in part to increase productivity. Turnover, innovation, change management, absenteeism and presenteeism all link to staff wellbeing and productivity (Robertson Cooper 2015, Sweetman et al. 2010, Luthans et al. 2007, Harter et al 2003).

A recent review of research states 'people are significantly less productive when unwell rather than welll' (Garrow 2016). Absenteeism is often the focus for measuring employee wellbeing and it is estimated that it costs the UK £8.4b a year (Centre for Mental Health 2011). It is a relatively easy indicator to collect data for and will give some insight into staff wellbeing.

However, research is increasingly focussing on presenteeism as a way to improve productivity in the workforce as people are significantly less productive when unwell but still presenting for work (Garrow 2016, Cancelliere et al. 2011). This presents a much bigger challenge as it is estimated that presenteeism costs the UK £15billion per year and can be a more accurate indicator of staff wellbeing. It will be discussed opposite in more detail.

Several factors have been identified in the literature which impact on employee wellbeing:

- job satisfaction
- employee stress and burn-out
- relationships at work
- levels of staff engagement.

Job satisfaction

Bryson et al. (2014) presented an analysis of the workplace employment relations survey conducted in 2011. The survey studied two aspects of staff wellbeing; job satisfaction and job-related affective feelings. They found:

- the average level of job satisfaction among employees was positively related to measures of workplace performance
- workplaces with 'very satisfied' employees had higher labour productivity, higher quality of output and over performance.

They do qualify that they cannot state definitively that the link is causal, but the findings were so robust and persistent over time, that the results are consistent with a causal relationship. The literature has identified a number of aspects of the job which can impact on job satisfaction and subsequently, employee wellbeing:

- demands of the job and wellbeing tends to be lower when demands are high
- autonomy over the job they do and time to perform the job
- control in relation to the broader organisation through participation in decision-making
- clarity over what is expected including feedback on performance
- security both in terms of physical security as well as job security
- pay and how this compares to peers and other workers rather than absolute pay
- equity and a perception of fairness in the organisation that all workers are treated in the same way.

By addressing these aspects, employers can increase the potential productivity of the workforce.

Source: Deloitte 2016, Hafner et al. 2015, Bryson et al. 2014, Robertson Cooper 2015.

Employee stress and burn-out

Staff stress and burn-out are associated with both absenteeism and presenteeism in the workplace, (both of which are discussed above) and they are often used as proxy measures of employee wellbeing in the workplace.

Stress and burn-out are tangible issues for adult social care and can result in mental and physical exhaustion and negative professional consequences (Keidel 2002, Sharp et al. 2002, Campbell 2007, Pillemer et al. in Lawrence et al. 2010).

While there are specific issues for different settings in adult social care, there are some over-arching areas identified in the literature associated with stress and burn-out:

- work related demands which include a heavy workload, need for continuous high quality of care, changing environment, emotional demands
- unsupported staff who feel alienated from managers and other staff or have poor support generally
- organisational aspirations beyond resources available.

Source: Broadhurst et al. 2007, Mansell 2007, Peters et al. 2012

Although evidence is limited, there are a number of factors which might mitigate positively on staff stress and burn-out, including:

- organisational level - positive working environment, no blame culture, guidance to recognise signs of stress and burn-out, balanced workload etc.
- team level - peer support and good relationships, debriefing, good leadership, access to management
- individual level - mentoring and coaching, supervision, self-care advice and support.

Source: Burtney et al. 2014

One practice example used in health is the Schwartz Care Round which has been evaluated in the USA and proven effective at building teams, reducing stress, improving engagement with self care and a more coordinated approach to working to the same goal (Goodrich et al. 2012). The aim is to offer an opportunity to reflect on experiences of care through multidisciplinary settings where staff can discuss non-clinical aspects of caring for residents, including the emotional and social challenges associated with their job.

Relationships at work

Again connecting with the culture and working environment, relationships at work are important for productivity. One aspect that is often used as a measure is bullying in the workplace. In the UK recent figures estimate nearly a third of people have been bullied at work (29%) and innearly three quarters of all cases (72%), the bullying is carried out by a manager (TUC 2015).

The same study directly looked at the effects of bullying on performance at work and found that half of those questioned said that bullying had an adverse impact on their performance and mental health. More than a quarter felt it had a physical impact and a fifth report time off work as a direct result of bullying. Other studies have negatively linked bullying to productivity (Hafner et al. 2015) and call for leaders and managers to tackle workplace bullying.

The NHS framework Developing People directly addresses this issue and sets out a condition for leaders to create an environment where there is no bullying and where staff feel safe and empowered to learn and develop.

Levels of staff engagement

Staff engagement is a broad concept and has been defined by the Institute of Employment Studies as follows:

> "A positive attitude held by the employee toward the organisation and its values. An engaged employee is aware of the business context, and works with colleagues to improve performance within the job for the benefit of the organisation. The organisation must work to develop and nurture engagement, which requires a two way relationship between employer and employee." (Robertson 2007)

Staff engagement can be defined as a function of good management, teamwork, staff satisfaction and health and there is a growing body of evidence to link engagement to productivity (Hitchcock et al. 2017, Carter 2016, PWC 2014, MacLeod & Clarke 2014, Rayton et al. 2012, Robertson-Smith et al. 2009). Engaged employees feel a sense of attachment toward the organisation and have been found to invest in both their role and the organisation. They are more likely to stay with the organisation and perform 20% better than other colleagues thus contributing greatly to the productivity of the organisation. On a personal level, staff engagement can also have a positive impact on an individual's health and wellbeing (MacLeod & Clarke 2014, Brunetto et al. 2012, Robertson-Smith et al. 2009, Schaufeli et al. 2008).

High staff engagement

High staff engagement is also linked to lower rates of absenteeism (Soane et al. 2013, Rayton et al. 2012, West et al. 2011). Estimates suggest employers spend around 10% of the annual pay bill managing either direct or indirect consequences of sickness absences (Bevan 2010). In addition, staff turnover is lower, reducing HR costs (Bevan 2010, CLC 2008).

Characteristics which can impact on staff engagement include organisational factors (workforce culture, structures, management approach, equity policies) as well as individual factors (length of service, experience of workplace position in the workforce) (Carter 2016, Cornwell 2014, Robertson-Smith 2009, Robertson 2007).

Many companies are aware of the importance of staff engagement. For example, in a recent survey of the world's most admired companies, 94% believe that efforts to improve staff engagement have given them a competitive edge (Royal and Stark 2010).

However, there is some way to go in health and adult social care to fully exploit the benefits of staff engagement. For example, Carter (2016) reviewed productivity in the NHS, and concluded that staff resource is not just about policy and practice but rather that the focus should be on improving staff engagement and encouraging staff to contribute to solutions rather than being viewed as part of the problem.

Drivers for engagement include:

- work that has meaning and purpose
- staff involvement in decision-making
- opportunities for staff to voice their ideas with managers who listen to these views, and value employees' contributions
- opportunities employees have to develop their jobs
- timely recognition and reward
- organisational concern for employees' health and wellbeing.

Source: Deloitte 2016, Robertson-Smith 2009, Robertson 2007

Measuring staff wellbeing through presenteeism

As stated above, presenteeism is becoming a more widely used concept to provide an indication for staff wellbeing. The literature has identified four types of presenteeism:

- fully functioning presenteeism - healthy, engaged staff who rarely take sick leave
- sickness presenteeism - employees who turn up for work but whose health is suffering – often attendance linked to job insecurity but less productive staff
- job dissatisfied presenteeism - healthy staff with low levels of absenteeism but poor engagement and low commitment which impacts on productivity
- stressed unhealthy presenteeism - a combination of staff with health problems not linked to the job and those who have been affected by the job.

Source: Public Health England 2013

However, measuring presenteeism is challenging, and this might be part of the reason for its underuse as an indicator. It often relies on self-report methods of illness and productivity (Garrow 2016, Cancelliere et al. 2011). Garrow (2016) argues that longitudinal studies may present an opportunity for providing some more reliable data over time.

One example of this includes the NHS staff survey which is administered annually and includes a measure of presenteeism where staff are asked if, in the last three months, they have ever come to work despite feeling unwell due to pressure from their manager, colleagues or themselves. Interestingly in feedback from 2016 survey, 56% of staff reported coming to work despite feeling unwell (NHS 2016).

Most recently, (Monitor Deloitte 2017) estimated that presenteeism costs UK employers between c. £17bn-£26bn and turnover costs of c. £8bn per year. They suggest that presenteeism can present across various work characteristics and the table below illustrates the extent to which employees who have attended work whilst ill (in this case poor mental health) exhibit these characteristics.

Table 1: Response of employees exhibiting characteristics and presenteeism

Statement	Frequency (%)
I can find it difficult to concentrate	69.8%
I can find it more difficult juggling a number of tasks	52.3%
I sometimes put off challenging work	45.6%
I can take longer to do tasks	42.9%
I sometimes have difficulty in making decisions	39.1%
I can find it more difficult to learn new tasks	24.1%
I am more likely to get into conflict with colleagues	21.9%
I can be less patient with customers/ clients	20.9%
I rely more on colleagues to get work done	9.5%

Tackling presenteeism

There have been a number of reviews conducted to examine the evidence between presenteeism and workplace health and wellbeing programmes (Hafner et al. 2015, Bryson et al. 2014, Fenton et al. 2014, Rayton et al. 2012, Cancelliere et al. 2011).

Bryson et al. (2014) argue there are three levels which employers can target to improve staff wellbeing:

- Affect employee cognitive abilities and process – enable them to think more creatively and be more effective at problem-solving
- Affect employee attitudes to work
- Improve employee general health.

The other reviews concluded that while evidence linking workplace health and wellbeing programmes was limited and all recommend that more research is needed, the following factors did appear to be influential in their success:

- holistic interventions which are multi-component and see the connection between work and non-work related influences
- interventions targeted at high risk individuals
- sustained interventions over the long term
- interventions targeting organisational culture, practices and the work environment, as well as individual behaviours.

The recently published independent review (Stevenson and Farmer 2017) also highlights the importance of promoting staff mental wellbeing, and suggests that employers might want to build mental health core standards into a broader offer to attract or retain employees. The view put forward suggests that issues around mental health can be de-medicalised if embedded into organisation structures and processes.

Learning and development

The impact of a learning environment on employee productivity has been explored by a small number of authors in both health and adult social care and other areas (Crosswaite et al. 2010, Australian Workforce and Productivity Agency 2013, CSED 2007). Although limited, the evidence merits consideration.

A significant and positive impact

The Australian Workforce Productivity Agency (2014) conducted an evidence review across different sectors, and concluded that learning and development had a significant and positive impact on productivity at both micro (individual and organisation) and macro (economy) level. Primarily the impact of learning was seen on wages, which they argue is the best indicator of the productivity effects of learning. They also noted a difference in the level of learning, with foundation skills in particular likely to have the largest (positive?) impact on productivity.

A highly skilled workforce

Crosswaite et al. (2010) found that while skills and productivity have been the subject for research, this is predominantly within the manufacturing sector and there is a shortage of research in the health and social care sectors. However, there is agreement that investment in a highly skilled workforce will benefit the UK economy. Contrary to the Australian review cited above, Crosswaite et al conclude that doubt remains as to the link between investment in lower level vocational skills and productivity. Interestingly they point out that workers may be less productive because they do not focus on their core competencies and activities and that having the right person with the right training doing the right job is key. A point supported by Deloitte (2016).

Specially trained staff

There was only one study identified in this review which focussed on the care sector (CSED, 2007). It found that specially trained staff are more productive compared to care managers in managing provider bookings and updating care records and finance records (which in turn frees up care manager time and results in the speedier initiation of care) and have increased levels of data accuracy. Again reinforcing the view that use of the right person skilled to do the right job has an impact on productivity, job satisfaction and potentially engagement.

Digital technology

Several reviews have identified the role of digital technology in helping to improve productivity through reduced administrative and repetitive processes, increased mobile working and a range of other factors (Hitchcock et al. 2017, Carter 2016, Deloitte 2016, Vodaphone 2015).

Hitchcock et al. (2017) argue that public sector bodies will need to improve and include technology in their future plans, and highlight some of the successes that have already been noted in government department in increasing productivity through technology

Deloitte (2016), who argues that IT in public sector has suffered from under-investment, argues that in order for organisations to be more productive they need to equip employees with technology that helps them maximise their time (e.g. mobile technology reducing the need to return to an office base etc).

Carter (2016) focussed specifically on the NHS and in his review was ‘struck by the immaturity of trusts’ use of technology and recommended the need to incentivise them to fully utilise the opportunities that digital technology offers.

Vodaphone (2015) highlighted the benefits of technology for adult social care including reduction in the need to travel, reduced time spent on collection and processing of case notes, more efficient job scheduling and, importantly, the availability of up-to-date information at the time of contact with individual service users.

Conclusion

The focus on productivity in adult social care is increasing but with limited information on what to measure and how to measure.

There is more focus on how to improve, with literature focusing on the five areas outlined above (culture, leadership, employee wellbeing, learning and development, and digital technology). This will help employers potentially move forward but the problem remains, how will they know if and what they have achieved?

Work is underway to think about productivity in adult social care but there is scope to involve employers in this discussion and ensure their views are represented.

In the meantime, Public Health England (2013) suggest some areas for consideration for organisations considering measuring productivity with a view to improvement.

- Use meaningful indicators – indicators of productivity should be meaningful to the organisation's objectives and operations. They should be reliable and practical, consider all factors that might impact on productivity, and take into account quality rather than just hard outcomes.
- Use an integrated approach – get a comprehensive picture of organisational performance in order to analyse the relative contribution of each and diagnose problem areas.
- Involve employees in decisions that affect them – this gives employees a sense of ownership of the process and a perception of fairness.
- Review progress – productivity measurement is not an isolated task and should be reviewed regularly.
- Measure presenteeism – for example, by adding self-reported questions onto existing staff surveys.

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Skills for Care
West Gate
6 Grace Street
Leeds
LS1 2RP

T: **0113 245 1716**
E: **info@skillsforcare.org.uk**

skillsforcare.org.uk