Planning and preparing

Overview of actions

HRUC shifted from designing courses in isolation to listening first, embedding provider priorities into objectives, curriculum and facilities. This planning phase established a collaborative model focused on realism, reciprocity and sustainability, ensuring learners are genuinely work-ready and sector needs drive every decision.

Identifying the case for change

> **"If you want real embedded relationships with employers, you can't just send emails. You have to meet them, speak to them, and sometimes go to them before they come to you."**
>
> **Kelly Ocloo,** Assistant Principal and Sector Subject Area Lead for Health and Social Care, HRUC

The planning phase marked a decisive shift in mindset, and this re-framed every aspect of delivery.

- **Listening-first approach** – Shifted from selling courses to providers toward co-design, ensuring training reflects real workplace needs.
- **Workforce alignment** – Providers highlighted gaps in English, maths, digital fluency and person-centred care, making qualifications alone insufficient.
- **Sector fragmentation** – Adult social care lacked strategic representation, requiring new engagement methods via borough networks and forums.
- **Collaboration over transaction** – Moved away from a 'booking service' mindset to partnerships that deliver mutual benefit.

Setting objectives and benefits

The goal was clear: create pathways that genuinely prepare learners for work, not just for exams, while strengthening provider confidence in college provision. HRUC came up with the following objectives:

- **Consistent learner experience** – Look to standardise health and care delivery across campuses to guarantee equal access to high-quality resources.
- **Industry-informed curriculum** – Aim to embed provider priorities such as infection control, inclusive practice and scenario-based learning to mirror real-world complexity.
- **Structured enrichment** – Introduced practical ways to secure real-world exposure for students into adult social care environments.
- **Define meaningful engagement metrics** – Focus on depth (curriculum endorsement, joint CPD, placement quality) rather than attendance numbers.
- **Plan for incremental trust-building** – Engagement grows through repeated contact and authenticity, not one-off events.

Risks and mitigations

Early planning surfaced risks that could derail progress, requiring proactive strategies and clear accountability.

- **Provider disengagement** – Mitigated through flexible engagement formats, borough-level networks, and partnerships with Skills for Care to amplify care sector voices.
- **Under use of assets** – Prevented by requiring joint CPD when providers use facilities, keeping methods current, building trust and ensuring high-value resources deliver impact.
- **Funding dependency** – Planned sustainability beyond LSIF by embedding relationships, creating shared ownership and integrating provider engagement into core college strategy.

Key decisions

- Committed to a listening-first, co-design approach, ensuring provider priorities shaped curriculum, facilities and enrichment activities, rather than predefined course structures.
- Standardised health and care delivery across campuses, guaranteeing consistent learner experience and reinforcing provider confidence in training quality and resource parity.

Key learning

Listening and co-design were non-negotiable. Every decision aimed to close the gap between education and employment and strengthen sector confidence.

- **Co-design is critical** – Provider input transformed curriculum, facilities and engagement strategies, ensuring alignment with workforce needs.
- **Reciprocity drives engagement** – Providers contribute expertise and gain access to resources, creating shared value and reinforcing trust.
- **Quality through consistency** – Standardising practice across campuses reassured providers and learners, reducing duplication and improving progression pathways.