University Hospitals of Leicester Strategic Workforce Strategy and Plan 2018-2023

Contents

Executive Summary

Context:

This Strategic Workforce Strategy and Plan forms part of the UHL Annual Priorities supporting the Strategic Objective to ensure:

We will have the right people with the right skills in the right numbers in order to deliver the most effective care

Given the critical importance of the workforce to service delivery and the current national context of significant vacancies (in particular hotspots such as nursing, key medical specialties such as acute medicine, geriatrics, emergency medicine and oncology and radiology, pharmacists, diagnostic radiographers, sonographers and cardiac technician roles) our workforce plan needs to be transformative and innovative in nature in seeking solutions to these shortages.

The Trust is undergoing a significant period of transformation not only in terms of shifting demand for services in response to changing demographics and lifestyle illnesses but also locally as part of our Strategic Transformation Partnership. For UHL the biggest challenges in this partnership are:

- to address the needs of the frail older population
- to address urgent and emergency flow
- to move to a two site solution to enable a clearer alignment of elective and emergency pathways and achieve efficient working practices
- to increase efficiency of our back office functions

This transformation affords us the opportunity to revisit our service models and form new teams around the patient.

What is different?

Traditionally our plans have focused on short term actions to address immediate staffing issues such as intensifying recruitment campaigns and adapting education and training to different skill and competency requirements. Our units of planning have focused on current establishment levels across different cost centres and in response to acuity changes and demand changes we have frequently looked at more rather than different. The transformation agenda requires us to focus on different care functions such as assessment and crisis response and think about where those activities take place, what the needs of the patient cohort are and what level of staff is best placed to meet those needs, invariably as part of a multi disciplinary team.

How have we approached this in this plan?

Whether a plan is transactional or transformational, it is underpinned by a need to understand what problem we are trying to solve (step one -defining the plan), understanding the strategic context (step two- mapping the service change) and then thinking about what the required workforce needs to be (step three -define the required

workforce – demand). We then need to review the potential supply for our workforce (step four - understand workforce availability) and how we will bridge the gap between demand and supply (step five - action planning). In common with any plan this then needs to be monitored and evaluated (step six – implement, monitor and evaluate)

This plan therefore follows this process. How services will be delivered in the future is critical to defining the future workforce. Many of our service delivery plan are currently being shaped as part of the reconfiguration of our services and therefore this plan will be iterative in nature.

This plan also needs to capture our short medium and long term plans as we seek to:

- immediately reduce our costs associated with the non contracted workforce and address the need to plan effectively for winter following the experience of 2017/18
- in the medium term be clear about plans to meet the needs of the frail elderly population
- in the long term implement changing models of service delivery aligned to our reconfiguration schemes.

In each of our plans we have articulated where we are now in describing changes to patterns of demand and supply and what else needs to happen.

Our appendices describe a number of workforce planning approaches which are agnostic to traditional professional and organisational boundaries in order to ensure we focus on the care that the patient needs. Although ultimately we will revert to using traditional staff groups to describe our workforce, we have shown in the new roles section that many roles are emerging which can be undertaken by a range of professions.

Focus on Nursing and Medical Workforce

Many of our plans describe the importance of the multidisciplinary team but it would be remiss not to focus on the critical workforce gaps currently in nursing and a number of our medical specialties. We have therefore described how we will make improvements in these workforces. There are separate workforce strategies in development which describe our actions in more detail.

Monitoring and Implementation

As this document has deliberately been written as an iterative document we will be able to regularly report of achievements and next steps against steps three to five in our planning process

Defining the Plan: Workforce Plan Vision and Strategic Aims

Vision

The vision for our workforce is to ensure the right skills, competencies and behaviours are wrapped around the right patient, in the right place, at the right time in our LLR health and social care system. This will support a patient journey which is efficient and delivers an appropriate high quality outcome.

Strategic Aims of the Plan

- To ensure the capacity and capability of our workforce reflects changing demographics & healthcare needs and changes in service delivery models within UHL and the wider Leicester, Leicestershire and Rutland health and social care community (STP)
- To deliver a plan aligned to the National Workforce Strategy
- To ensure we address current challenges in the supply of the workforce by changing patterns of demand through new, more flexible roles which cross professional, specialist and organisational boundaries
- To seek new sources of recruitment such as retire and return and overseas recruitment taking into consideration 'Global Citizenship'
- To maximise opportunities presented by apprenticeship frameworks for improving the supply and quality of new roles and increased capacity for more traditional roles
- To reflect a need to improve the attractiveness of UHL as a place to work and develop
- To clearly articulate the right balance of generalist, educational and specialist roles to attract high calibre applications
- To articulate the workforce response to the Trust's reconfiguration programme in order to enable a transfer to a two site model and abate further bed growth
- To articulate improvements to efficiency and productivity utilising the outputs of Model Hospital and by realising the benefits of Electronic Rostering
- To address short term critical crises including plans for the winter of 2018/19; plans for the care of frail and multi morbidity patients; plans to reduce escalating paybill costs.

Defining the Plan: Workforce Plan Principles

Principles

- We will secure supply increasingly through grow our own practices including the use of apprenticeships
- We will adopt flexible working patterns
- We will develop flexible career pathways both within and across professional boundaries
- We will encourage diversity and aim to have a workforce reflective of our communities
- Our planning will be driven by the needs of the patient and service plans
- Multidisciplinary teams wrapped around our patients will form the basis of how the workforce is designed
- In addition to focusing on our role in the treatment of conditions, we will focus on our role in enabling patients to continue living independently at home
- We will regard ourselves as part of a high quality integrated, flexible, responsive health and care team
- Working practices will be underpinned by a Trusted Assessor Model
- Workforce efficiency will be maximised through staff working at the top of their licence
- Workforce efficiency as defined in Model Hospital will be maximised through appropriate rostering and limiting the use of non- contracted workforce
- Quality as well as financial indicators will be used to monitor the effectiveness of workforce transformation

Defining the Plan: Workforce Plan Scope

Scope of the Plan

The plan will cover actions required:

- immediately at the operational level
- medium term particularly covering efficiency and productivity interventions
- long term particularly covering transformational approaches to workforce change

The plan will describe the demand for future workforce (or where we are in that journey), the appropriate supply and actions to address the gap between demand and supply.

This forms part of the overarching People Strategy and as such references the importance of critical dependencies including but not limited to:

The Attraction and Retention Strategy

Strategies in Clinical and Non Clinical Education

The UHL way with particular emphasis on creating the right (leadership) behaviours and culture for driving change

The Apprenticeship Strategy

Professionally led strategies including Nursing, the Medical Workforce Strategy; Healthcare Scientists, Imaging, Pharmacy and Therapies

Individual Reconfiguration business cases

STP associated plans

Defining the Plan:

Workforce Plan Approach

Approach

Approach to Workforce Plan is captured in appendix one

- Although there are three distinct timeframes to the plan immediate, medium and long term, it is recognised that long term transformational actions must occur now in order that the workforce is fit for purpose when our full reconfiguration of services is achieved
- Planning will take place across a number of units of planning:
- operational planning - how we best deploy the current workforce & address immediate gaps in demand and supply normally at level of cost centres through rota management & electronic rostering.
- medium term or tactical planning normally takes place at service or specialty level- seeking to define the demand & supply to deliver predicted activity – focuses on recruitment plans & plans for learning and development.
- long term strategic planning - promoting the development of plans at broad skill level (foundation, core, advanced or specialist) and a care function level such as crisis response or assessment or outpatient follow ups. This enables planning agnostic to organisational or professional boundaries
- At each level the principles of the six steps approach to workforce planning are adopted. These are summarised on our title page
- Most complex component of planning process is identification of demand for workforce. UHL has adopted number of methods of reviewing future requirements:
  Royal College recommendation on ratios contingent on demand eg Birthrate Plus©, Emergency Department Consultants to emergency episodes- Appendix 2a
- Nursing acuity and dependency tools (Safer staffing) Appendix 2b
- Electronic Rostering for defining and matching supply for daily rosters
- Allocate for determining safe on call junior doctor rotas
- Our internal Workforce Planning Tool which mirrors the NHSI approach and enables planning of substantive and NHS Contracted workforce within a financial envelope Appendix 2c
- Care function definition and assessment of skill level Appendix 2d
- Functional mapping which focuses on tasks within the care function and which level of staff should undertake these. This challenges thinking about which type of role should be undertaken. Appendix 2e.
- Use of Model Hospital data for defining critical opportunities for improved productivity and efficiency Appendix 2f

Defining the Plan: Benefits Realisation and Measurement

Benefits Realisation

This plan aims to impact on a number of performance measures across the Trust which are detailed within each transformational plan in the demand, supply and action planning section of this document. These include but are not limited to:

- Improved Friends and Family Test scores
- Numbers of patients referred to ambulatory pathways
- Improved ward length of stay
- Reduction in numbers of Delayed Transfers of Care
- Improvements in the average theatre case per list and less cancellations and improved efficiency
- Improvements in the full range of Emergency Department measures
- Improvements in RTT times across key access standards

Specific workforce improvements including:

- Reduction in vacancies (targets set at differential levels across different specialties and staff groups)
- Decrease in Waiting List Initiative, Overtime and Agency expenditure to enable better triangulation with financial plans
- Improved staff engagement scores due to better rota management, more opportunities for career development and better working conditions. Includes improved scores in relation to health and well being and team working
- Improved sickness rates to Trust stretch target of 3%
- Increased applications per advert and improved length of time to hire (60 day target)
- Improvements in turnover and stability indices
- Increased numbers of apprenticeships
- Improvements in workforce productivity

Map the Service Change: Changes since the 2014- 2019 plan

The 2014-2019 Plan

Original plan had six pillars of delivery:

- Reducing reliance on the non contracted workforce
- Safe Staffing
- Seven Day Services
- Urgent and Emergency Care
- Increasingly Specialised Services
- Shift to Community Services

Although these remain relevant, a number of factors have precipitated a change in the plan for 2018-2023:

- Our bed capacity is no longer reducing post reconfiguration and is in fact increasing putting pressure on already stretched resource
- Demand for emergency care increased – patients increasingly complex as a result of multimorbidity
- Greater and emergent understanding of the frail older patient – Clinical Frailty Score used to stratify patients to ensure right clinical intervention in right place. Impacts on which skills and competencies deployed and when and how
- Challenging winter 2017/18 giving rise to high absenteeism and heavy reliance on non contracted workforce. Underutilisation of staff rostered to undertake planned care. Leading to more seasonal approach to workforce planning
- Additional ward capacity opening in winter 2018/19. Demand for this workforce unlikely to met by traditional models of supply
- Need rigorous plans for reducing this bed capacity in future years as earmarked for generalist and specialist surgery in future reconfiguration plans

Map the Service Change:

SWOT Analysis – Planning Context

Planning Context: Strengths Weaknesses and Opportunities

A summary of the planning context, our response to date and what else needs to be done are summarised in appendix 3. This demonstrates the scale of the workforce challenge which requires us to:

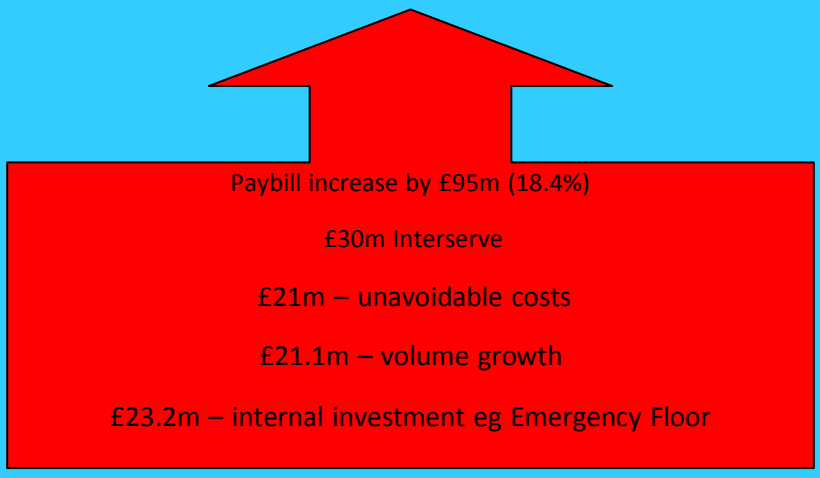
- Increase capacity of a number of specified professional groups through increasing supply of newly qualified staff, encouraging retire and return and a implement innovative retention strategies
- Develop employment Unique Selling Points which entice applications from very distinct generational groups who demand different types of flexibility
- Address the gap left by Brexit and attract from a wider overseas market without detrimental impact on exporting countries
- Tackle significant changes in culture including flexing availability of workforce on a seasonal basis; multidisciplinary teams brought together by the needs of the patient cohort; getting the right balance between the generalist and specialist workforce; moving people to ambulatory pathways rather than hospital stay; moving skills to different environment eg ward based to front door decision making; innovative adoption of digital interventions including better use of data and use of technology to speed up practices and processes
- Take proactive and bold action to improve equality and diversity with particular emphasis on BAME representation at a leadership level
- Respond Royal College guidance including Better Births, Royal College of Emergency Physicians etc
- Capitalising on opportunities in apprenticeship framework for promoting career development opportunities
- Flow of patients is a major inhibitor to efficient working practices

Map the Service Change: UHL Baseline Data

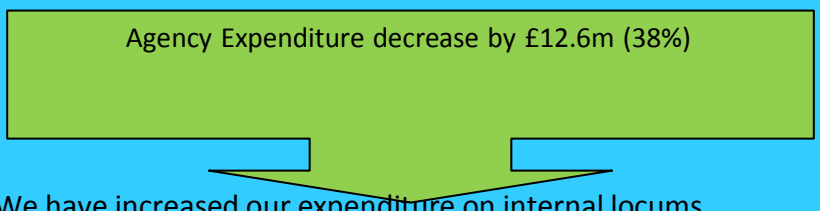
Our data

UHL's workforce has grown significantly although pressures on demand for our services limits this impact on overall capacity and staff health and well being.

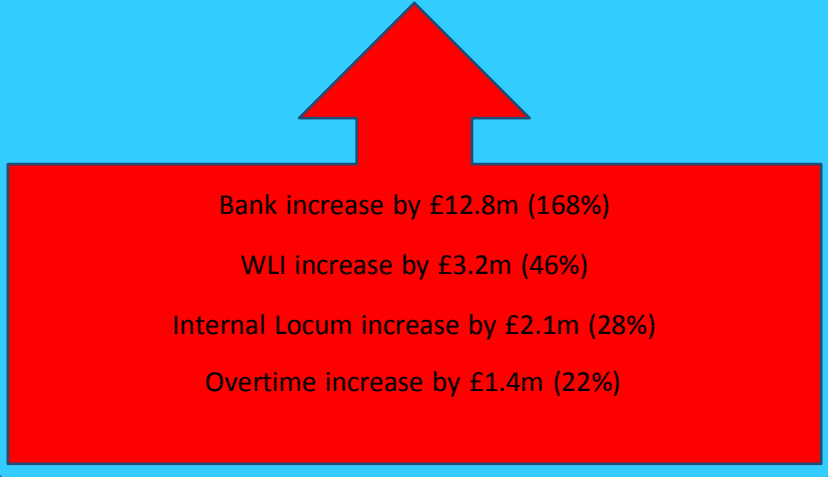
Our most significant growth has been in estates and facilities following a TUPE transfer of staff from Interserve but there has been significant growth in all staff groups in the period 2015/16 to 2017/18:



We have utilised the national introduction of capped rates and enhanced agency controls to improve our level of expenditure on agency:



We have increased our expenditure on internal locums, overtime and bank staff as part of our strategy to reduce agency expenditure. WLI expenditure has also increased as pressures in the emergency pathway have increased the cancellation of elective procedures:



Our Data (Continued)

Sickness

Although our sickness rates fell between 2015/16 and 2016/17, they increased in 2017/18 reflective of the pressure facing our staff

Sickness rate increase from 3.66% to 4.08%

Vacancy Rates

Vacancy rates have increased overall between March 2016 and March 2018 from 5.9% to 6.4%. Increases in our establishment have led to further vacancies in 2018 (8.9% currently). This indicates that we need a sharp focus on our recruitment and attraction strategies

Overall Vacancy Rate increase from 5.9% to 6.4%

Qualified Nursing Vacancies increase from 8.4% to 12.1%

Trainee Medical Vacancies increase from 5.2% to 7.7%

Consultant Vacancies decrease from 6.7% to 4.9%

AHP vacancies decreased from 6.7% to 0.6%

Turnover Rates

Most of the Trust gaps are driven by higher establishment figures (as a result of investments/acuity reviews etc) rather than an increase in turnover. Despite this our plans still to focus on improving retention as well as attraction

Overall Turnover decrease from 9.69% to 8.15%

Nursing and Midwifery Turnover decreased from 9.24% to 6.34%

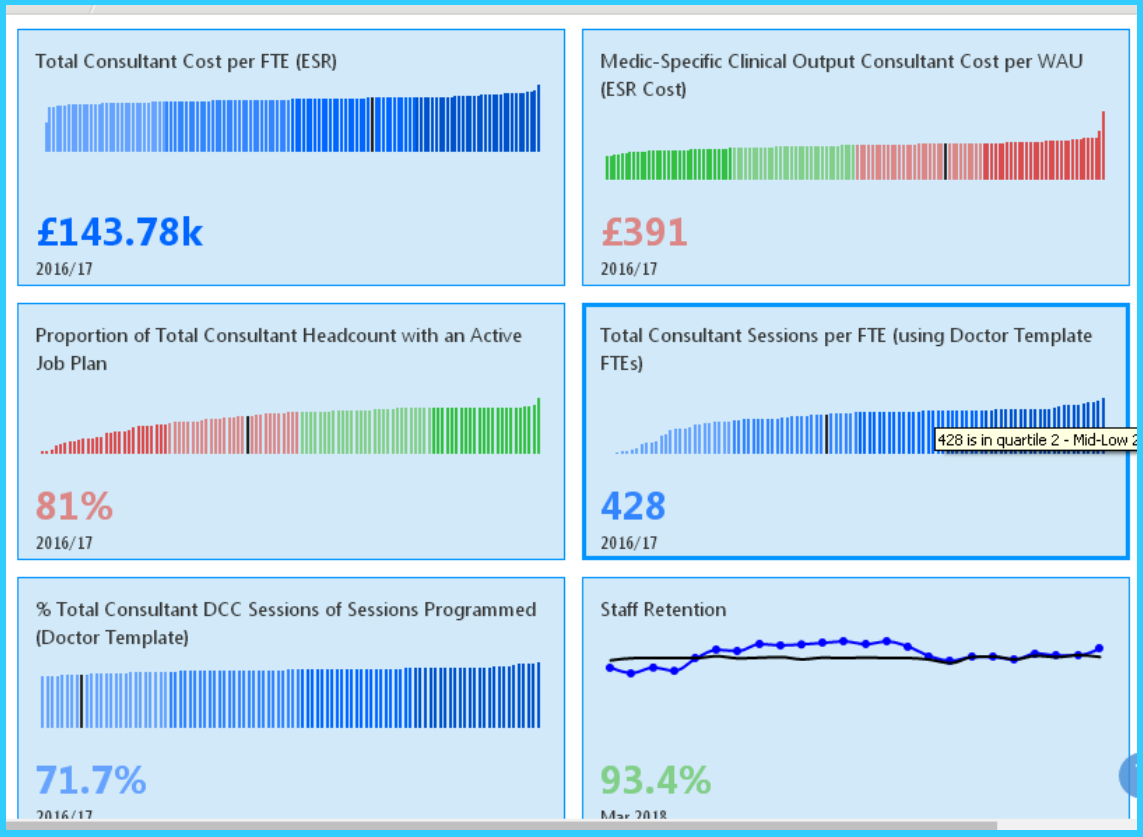
Admin and Clerical and Additional Clinical Services turnover relatively stable at circa 10%

Medical and Dental Turnover excl Junior Drs decreased from 10.09% to 7.95%

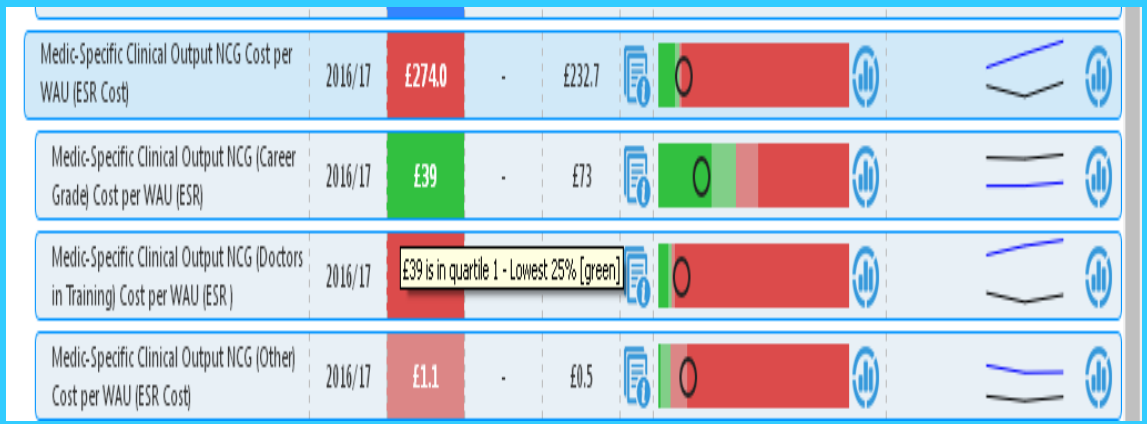
Our Data (Continued)

Model Hospital Data

Data relating to medics indicates we have work to do to improve our productivity per weighted unit activity. We know much of this is driven by our inefficient three site model and actions and service plans described in this strategy and plan are designed to address these inefficiencies



A deep dive into Drs below consultant grade indicates we benchmark poorly on our cost per WAU and this may be driven by high expenditure on internal locums and waiting list initiatives. This forms a focus of our short term workforce plan.



DEMAND	SUPPLY	ACTION PLANNING
SUMMARY OF WORKFORCE PLANS		

IMMEDIATE PLANS

REDUCTION IN AVERAGE COST PER HOUR TO REDUCE PAYBILL

MEDICAL ESTABLISHMENT TRANSPARENCY

MEDIUM TERM PLAN

SEASONALITY OF WORKFORCE PLANNING TO ADDRESS WINTER PRESSURES

ALIGNMENT OF WORKFORCE TO FRAILTY COHORT

TRANSFORMATIONAL PLANS

BED ABATEMENT PLANS

EAST MIDLANDS CONGENITAL HEART PROGRAMME

EMERGENCY FLOOR

MEDICAL STEP DOWN

ICU

WOMEN'S

PLANNED AMBULATORY TREATMENT HUB/OUTPATIENTS

LGH PLAN

DEMAND	SUPPLY	ACTION PLAN
IMMEDIATE: REDUCTIONS IN AVERAGE COST PER WTE		
Workforce Plan needs to: • Apply lower WLI rates to staff groups where rates are not determined by supply led market • Rigorously apply the rules on agency and bank price cap breaches • Identify where an alternative to WLI is possible –eg re rostering of medical PAs/SPA time, more efficient rostering of theatres • Undertake cost/benefit analysis of enhanced nursing rates and propose alternative which will enable safe staffing at a lower cost where appropriate • Ensure that the plan deliver the planned paybill submitted to NHSI		
System needs to: • Ensure greater collaboration on rates for bank and agency • Support patient flow to prevent cancellation of elective patients		
Progress to date Opportunities for lowering /removing WLI schemes identified as part of Financial Recovery Plan Option appraisal for alternative to enhanced nursing bank rate in implementation phase. To be monitored for unintended consequences on fill rates		
Demand Summary Decrease hourly rates of WLI where demand and supply balanced to achieve cost saving opportunity of £0.5m Decrease hourly agency rates based on NHSI Rule (£900K) Decrease hourly rate of bank nursing (£900K)	Supply Summary Fill rates to be achieved at lesser cost Fill rates could be compromised by offering lower rate per hour	Actions Summary Refining savings calculations with a range of scenarios Communicate changes to rates as part of financial recovery WLI risk assessments to be reviewed and themed
Risks and Mitigations Limited fill will impact on income flows – monitor impact of rates reduction including unintended consequences		
Benefits to be Realised £0.5m WLI saving £900K agency saving £900K bank saving	Next Steps Agree rates with relevant Executive Board and enact communication	

DEMAND	SUPPLY	ACTION PLAN
IMMEDIATE: MEDICAL ESTABLISHMENT TRANSPARENCY		
Workforce Plan needs to: Review medical workforce demands across all cost centres and services to ensure there is clarity on coverage across wards, outpatient clinics and surgical sessions, balanced by training requirements where appropriate Consistently quantify medical establishments in budget profiles to reflect levels of trainee and non training posts – precursor to establishment of electronic rostering for medics Identify how to incorporate APAs into workforce planning to offset against vacancy levels Provide clarity of job plan match to service requirements		
System needs to: HEE to respond if funding shortfalls identified		
Progress to date ESR coding correct Work commenced on alignment and matching of budgets Work largely complete within ED		
Demand Summary Process will give clarity on actual demand for medical workforce across all grades. Funding gaps will be transparent	Supply Summary Risk that the supply is not funded Will clarify more transparently where there are gaps between supply and demand	Actions Summary Completed ESR coding Budget alignment commenced
Risks and Mitigations Underfunding for the demand of service and training mitigated by close negotiations with Health Education East Midlands		
Benefits to be Realised Transparent budgets which are aligned to training/service requirements Electronic Rostering ready Better balance of service delivery and training Ability to incorporate alternative roles/multiprofessional roles into a clearly articulated demand Ability to incorporate more flexible roles Clarity of baseline available to facilitate future workforce planning as part of reconfiguration	Next Steps Continue cleansing process to ensure alignment	

DEMAND	SUPPLY	ACTION PLAN

MEDIUM TERM: SEASONALITY OF WORKFORCE PLANNING TO COVER WINTER PRESSURES

Workforce Plan needs to:

Identify how additional in patient capacity can be staffed in the context of medical and nursing vacancies. Where new roles are required identify opportunity for supply and lead times

Identify how non ward based nursing resources can be deployed in the winter months

Identify the changes in working practice needed to ensure red to green is embedded throughout our in patient wards – adults and children's in order to protect the elective bed base during the summer and maximise the availability of medicine beds in the winter

Identify how elective medical staff capacity can be maximised in the summer and deployed during winter months

System needs to:

Ensure winter plans for care home and community beds facilities are available and compliment the risk areas identified in the Trust

Progress to date

Through functional mapping, clarified the tasks that need to be undertaken and the levels of mulitprofessional staff required for additional ward capacity

Utilised this knowledge to determine roles which can deliver required care for identified patient cohort

Proposed model introduces more Assistant Practitioner and Nursing Associate roles potentially, supported by more administration and clerical and pharmacy technician support to enable registered nurses to work at the top of their licence

Review how elective work teams could be mobilised to support the work of medical wards/contribute to loading their outpatient work during busier medical months etc

Review building bank GP staff or medical students as HCA type workers for holiday periods– train/induct/e learning in summer months etc ready to mobilise in winter months to GPAU/acute medical wards

Demand Summary	Supply Summary	Actions Summary
Shift of demand for nursing potentially to alternative roles where it has been ascertained it is safe to do so and for wards where there is an appropriate patient cohort. Shift of demand between elective and emergency according to seasonal pressures	First cohort of Registered nursing associates available in January 2019 Limited supply of pharmacy technicians due to lead time	Working group in place to determine how workforce is aligned to a seasonal pattern of delivery: Flexible annualised hours Flexible deployment of surgical staff to medical areas in the winter Alternative workforce models utilising roles which are currently in supply Over recruitment in therapies to minimise impact of seasonal variability Developing placement links with new Therapy degree at University of Leicester Development of pharmacy technician strategy utilising apprenticeship model to reduce locum expenditure and develop roles to compliment ward based staffing

Risks and Mitigations

Risks of barrier to change and work in alternative way mitigated by staff engagement in the solution and support from regulatory bodies.

Benefits to be Realised	Next Steps
Alternative workforce models would lead to quality improvement and potential cost avoidance of temporary staff Learning from winter pilots can be utilised for rolling out new workforce models across a larger number of wards dependant on case mix of patients	Measure quality and safety impact of new roles metrics to include bed pressures, untoward incidents, infection control, friends and family test scores, patient outcomes Await NHSI guidance on the utilisation of the Nursing Associate role

DEMAND	SUPPLY	ACTION PLAN

MEDIUM TERM: ALIGNMENT OF WORKFORCE TO FRAILTY COHORT (interfaces with Bed Abatement

Workforce Plan needs to:
Clearly articulate the most appropriate workforce to support a frail elderly population
Enable MDT workforce – therapists, pharmacists, primary care coordinators
Identify educational needs around frailty and basics of identification, early Comprehensive geriatric assessment and support geriatricians as a resource not seeing all frailty. Frailty is everyones' business.
Elective teams eg surgical, gynae education in recognition of frailty and adapting pre-operative assessment processes to factor this in
Improve discharge planning prior to the operation and awareness of the impact on frailty during inpatient stay

System needs to:
Develop primary care and community teams recognising frail patients, enacting a care plan and gaining consent from the patient to enhanced summary care record which will enable clinicians within UHL to read care plans and support them while inpatients.
Develop social care/community teams and primary care supporting early discharge with support
Integrate locality teams which are emerging across LLR and will form part of this support

Progress to date

Taskforce on frailty lead by CEO commenced June 2018.
Driver diagram outlining 16 interventions across the system.
Recognition of frailty and creating MDT e.g. frailty emergency squad

Demand Summary	Supply Summary	Actions Summary
Demand for frailty skills across all clinical groups including clarity about what actions to take for patients with high frailty score ED team identified specific Frailty Emergency Squad supported by: Lead geriatrician Advanced Clinical Practitioner, Primary Care Coordinators, Pharmacists, Therapy workforce targeted at front door of ED Abatement of future bed demand to reduce requirement for additional ward staff (approx 2 wards of potential growth)	Ensure skills in place to deliver appropriate response to frailty patient Therapy posts in supply and recruitment in train Advanced Clinical Practitioner posts – solution combination of grow your own &advertise externally supported by robust attraction plan Pharmacists not currently available at right level therefore grow own Primary Care Coordinators – refocus of existing resources Will stabilise demand for further nursing in order that supply has opportunity to close current gaps	Design appropriate education /cultural change programme Revise recruitment material to appropriately market the frailty friendly front door Monitor impact of frailty emergency team to evaluate reduction in admissions

Risks and Mitigations

Ability to recruit pharmacy, Advanced Clinical Practitioners and Primary Care Coordinators mitigated by maximising the opportunity that a Frailty Front Door Unique Selling Point presents. Ensure appropriate grow your own programmes are in place

Benefits to be Realised	Next Steps
Less patients with CFS score of 7 and above spending extended periods in acute setting Limiting over medicalisation of frail elderly patients where it is not appropriate to do so	Progress Frailty Emergency Squad Recruitment Set up KPI monitoring eg length of stay reduction , reduction in admission, reduced reattendances

DEMAND	SUPPLY	ACTION PLAN
TRANSFORMATIONAL PLAN: BED GROWTH ABATEMENT (links to Frailty Programme)		
Workforce Plan needs to: Identify how changes in models of care can abate the potential workforce growth associated with the staffing of six wards at a cost of £1.2m per ward : Identify workforce impact of Red to Green Identify workforce impact of Medical Step Down Identify workforce impact of increased discharge team Identify workforce impact of Pre and Post Operative Length of Stay reduction Identify workforce impact of TTO operational change		
System needs to: Identify system wide actions to enable UHL to contain 2048 beds of activity – workforce implications will be worked up through LLR wide Frailty Board – care coordination, standardised care planning, system wide holistic checklist of care, clear identification of patient cohort, changed models of care		
Progress to date CMGs identified programmes of work to reduce potential bed growth Proportion have clarified the workforce implications of bed growth summarised below		
Demand Summary Cardiology: 8.0 Cardio Respiratory consultants to enable 20 beds of activity (1.2m) to be abated Consultant of week increasing frequency of ward rounds; increased CDU cover, consultant in reach to ED to prevent admission	Supply Summary To recruit in staged process to 8 cardio respiratory consultant – low risk of supply	Actions Summary Recruit to vacant posts with associated social media campaign
Red to green – ensure consistency of delivery of working principles	Deliver education programme to ensure consistency	Ensure red to green principles are embedded into operational working practices and education programmes
Medical step down – change skills mix to increase therapy and support worker impact to enable more rapid discharge	Therapists and Associate Practitioners recruited	Monitor impact of medical step down ward including assurances that quality outcomes are maintained
Pharmacy Increased investment in standard of one pharmacist per ward and investment for TTO project	Risk of limited supply of band 7 pharmacists	
Imaging –Consolidation of community imaging service enabling faster access to services across LLR system	More effective deployment of existing supply	
Risks and Mitigations Recruitment to cardio respiratory posts – adopt staged approach to recruitment Medical step down model mitigates against increasing demand for nursing workforce		
Benefits to be realised Cardiology training for junior doctors meets HEE quality standards and improved ability to attract trainees Alternative workforce models would lead to quality improvement and potential cost avoidance of temporary staff Reducing reliance on premium spend and creates less pressure for nursing teams	Next Steps Define workforce plans for increased discharge capacity and TTO operational change Requirement to review future wards using same principles as Medical Step Down in order to support appropriate skill mix of nursing and professions allied to health	

DEMAND	SUPPLY	ACTIONS

TRANSFORMATION – EMERGENCY FLOOR Phase 2

Workforce Plan needs to:
Identify additional/changing workforce requirements driven by:

- increases in physical capacity , space and enhanced facilities designed to speed processing
- enhanced facilities for frail patients
- cohorting of patients onto ambulatory pathways wherever possible dividing patients into 24 hours or less and over 24 hour stays
- higher levels of senior decision making at the front door

Identify workforce efficiencies driven by:

- colocation of services
- cost avoidance of agency staffing by reconfiguring tasks to be undertaken by alternative workforce

Aim is to improve ambulance waiting times, length of stay, waiting times, length of time from request to admit

System needs to:

- Streamline continuing healthcare processes
- 85% of all assessments for continuing healthcare take place out of hospital
- Implementation of end to end Continuing Healthcare Pathway
- Implementation of Trusted Assessor across health and social care
- Implementation of High Impact Changes for Managing Transfers of Care for reducing DToCs
- Increase in the proportion of calls to NHS111 receiving clinical assessment
- Embed Clinical Navigation System
- NHS111 to be able to direct book urgent face-to-face appointments where needed
- Roll out of evening and weekend appointments to 100% of the population of LLR
- Strengthen support to care homes so that they have direct access to clinical advice
- Implementation of recommendations of Ambulance Response Programme
- Development of a resilient general practice
- Further roll out of Core 24 across ward areas

Progress to date
Full plans developed for phases one and two – developed using rostering tools matching demand to workforce rotas and acuity/dependency tools for nursing.
New roles developed for generic support workers to enable patient flow through movement of supplies and patients
Revisited plans for junior doctors to enhance weekend and evening processing
Development of frailty emergency team to respond to high frailty score patients. MDT team bringing appropriate skills and competencies to patient including primary care coordination, pharmacy and therapy services
Increased therapy services to whole floor to prevent admission to AMU for service
Increased deployment of domestics to address increased en suite and toilet facilities and enable more rapid patient flow
Plan to deploy acute medics to front door to enable navigation of patients to ambulatory pathway

Demand Summary – phase 2 only phase 1 complete	Supply Summary	Actions Summary
2 WTE Acute Medics to increase cover in ED and improve capacity in ambulatory care unit 7 WTE Middle Grades to enable right skilling in frailty areas 9.7 WTE Therapists 6.0 WTE Pharmacy 2.0 WTE Advanced Clinical Practitioners Aligned role for Discharge Coordinators and Primary Care Coordinator	Challenged supply nationally, local phased plan of recruitment- early identification of potential applicants Given challenge to recruitment of middle grades – review medical international recruitment strategy and review scope for ANPs Able to recruit therapists due to previous over recruitment and attactiveness of roles Shortage of band 7 roles currently	Reviewing marketing and social media campaigns Embed International Recruitment strategies for medical posts Continue over recruitment of therapists and engagment of Leicester University students at early stage Review skills mix with view to creating band 6 pipeline to Band 7

Risks and Mitigations Difficulties recruiting into medical and ED posts – utilise marketing opportunities presented by front door, explore future scope for deployment of Advanced Clinical Practitioners	
Benefits to be Realised Improvements in ED performance to be monitored specifically frail patients with high Clinical Frailty Score Reduced reliance on agency and non contracted staffing Less' non productive time' as a result of rapid deployment of multidisciplinary team	Next Steps Develop ovearching plan for Advance Clinical Practitioners to cover gaps in medical rotas Review International Recruitment strategies Monitor impact of Frailty Emergency Squad

DEMAND	SUPPLY	ACTION PLAN

TRANSFORMATIONAL PLAN: EAST MIDLANDS CONGENITAL HEART PROGRAMME

Workforce Plan needs to:

Define a safe and sustainable estimate of the workforce numbers required to deliver the Congenital Heart Services for the East Midlands that meet the standards outlined by NHSE. This includes delivering to a timeline that supports co-terminus services, based at the LRI, by March 2020 and the growth in surgical (NICOR) cases to 500 in the next 3 to 4 years in line the NHSE delivery plan agreed in November 2017.

Plan to address impact of splitting cardiac services

System needs to:

Support the appropriate development of the EMCHC network for the East Midlands (referral and on-going support) as part of NHSE plans for congenital services across England

Progress to date

Phased growth plan with workforce implications costed and analysed, including ability to recruit and staff sustainably. Each service area within the congenital heart service at Glenfield was analysed looking at the baseline 3 years ago compared to 2017/18 and then modelled forward for the next 3 to 4 years in line with expected growth (to 500 NICOR reported surgical interventions per year) and any impact on splitting the service as it moves to LRI in March/April 2020 Demand analysis using activity projections and linked to the appropriate clinical standards indicates:-

- Growth of Medics (Consultant and Middle Grade) phased in line with surgical numbers
- Growth in Childrens Nursing to support extra beds (phased) in PICU, Ward 30 (GH), Cardiac Liaison Nursing
- Growth in diagnostic and support services in Physio, OT, Pharmacy, Dietetics, SaLT, Clinical Psychology, BMS staff working in Blood Transfusion , Clinical Engineering plus Theatre Practitioners (Nursing & ODP) and Anaesthetic staff (Consultants) (Confirm and challenge during June/July 2018)

Demand Summary	Supply Summary	Actions Summary
2.0 WTE Consultants (CHC) 19.75 Band 5 WTE nurses based on 7.01 wte per PICU bed – 2.5 beds over 3 years Theatre Practitioners, diagnostic and clinical support staff requires further confirm and challenge	High Children's Nursing vacancies but positive outlook with scope to recruit larger numbers of newly qualified staff Theatre practitioner workforce also has high vacancies plus ODP fallow year as UoL course moves from 2 to 3 years. Looking at new ways of working (e.g. dual trained ODP)	Benchmarking other CHC centres specifically in relation to theatre practitioner nursing Attraction strategy for Anaesthetic Consultant Post Recruitment plans include a video & EMCHC specific info

Risks and Mitigations

Nurse Supply – Trainee Nursing associates already recruited into CMG first cohort qualify in January 2019 plus innovative recruitment across CMGs

Theatre Practitioners – new ways of working & training plans leading up to service re-location

Benefits to be Realised	Next Steps
Improved retention of PICU and ward based staff and specialised consultant workforce	To deliver costed 4 year workforce plan by the end of August

DEMAND	SUPPLY	ACTION PLAN

TRANSFORMATIONAL PLAN 2 site model: ICU

Workforce Plan needs to:

Build on workforce plan developed for the Interim ICU business case to ensure safe and sustainable staffing assumptions are developed to address increased capacity and the development of two enhanced critical care hubs for LLR. This needs to address the direct consequences of the critical care workforce (ITAPS) but also the key clinical dependencies in all the surgical specialties, the diagnostic and clinical support services and any links to womens and childrens services and other associated services. A key element of the workforce plan will need to maintain and develop the educational support to ensure the changes to medical, nursing and other key professions to enhance the training experience of all staff groups and ultimately improve attraction and retention.

System needs to:

Alignment with the LLR STP to ensure this project supports the LLR Clinical Strategy and the drive to move from 3 to 2 sites for UHL. Work closely with HEEME and Post Graduate Deanery to ensure the "Shape of Training" developments are embraced as part of the transition and enhance the training experience for trainees. This includes numbers, skills and competencies

Progress to date

Interim ICU business case has been developed to look at the transition but has also begun to model the end solution that supports a sustainable workforce plan for Medical Staff (Consultants, Surgical and Anaesthetic Middle Grades and Junior Doctors), Surgical Nursing and Interventional Radiology.

Demand Summary	Supply Summary	Actions Summary
Development of sustainable Medical rotas, in the right numbers, in the right specialties has been developed to include key educational requirements. Growth off set by efficiencies but final numbers need to be modelled Future Surgical nursing numbers agreed for HPB, Urology and GI and Renal and Transplant work is on-going Interventional Radiology efficiencies modelled for transition and future on 2 sites Urology – improved scope for consultant on call facility with consolidation onto single site Renal split over 2 sites in current model demanding challenging medical rotas and increased consultant on call cover	Key workforce areas include Anaesthetic doctors across all grades Nursing supply a challenge but reconfigured and enhanced facilities should support attraction and retention and reduction in dependence on temporary staffing Key therapeutic and diagnostic workforce areas (IR, Therapies and Pharmacy) need further analysis Consultant in post can be deployed in more effective way Consolidation on 2 site will enable reduced premium expenditure and a more attractive work place enabling future recruitment. Service utilising alternative roles to support medical rotas including specialist nurses and physician associates	Activity driving bed number assumptions, including the desired level will drive workforce assumptions. Use opportunities to review patient need on surgical wards and potentially refigure staffing model to reduce dependency on nursing and junior medical staffing Interim ICU FBC approval will trigger development of baseline workforce plans assumptions in the current workforce plan – some of this cannot be progressed until Interim ICU project begins Impact on Renal is currently being modelled in line with EMCHC and Interim ICU business cases to ensure sustainability

Risks and Mitigations

Critical Care Nursing has high levels of vacancy as do some Surgical Nursing wards –. new and innovative ways of working

Shape of Training implementation in next 2 to 3 years – work closely with HEEME and education leads in UHL to ensure positive impact across a range of specialties

Benefits to be Realised	Next Steps
Impact on turnover, sickness and vacancies linked to attraction and retetion opportunities of new build, refurbished wards and co-located services and enhanced training and research opportunities afforded by reconfiguration Reduction in WLI expenditure due to more efficient theatre utilisation Removal of risk presented by not having LGH as designated training site	Develop baseline from Interim ICU FBC workforce plan once authorisation is achieved Clarify assumptions on estate and building on workforce for affected services Develop OD plan to support management of change - involve and engage staff in the development of old and new services in new

DEMAND	SUPPLY	ACTION PLAN
TRANSFORMATIONAL PLAN 2 site model: WOMEN'S		
Workforce Plan needs to: To deliver the Better Births standards which cannot currently be achieved sustainably over two sites Deliver sustainable plan for neonates, maternity and gynaecology services Midwifery plan to support Birth Rate Plus report undertaken at UHL in 2016		
System needs to: The transformational plan for maternity services in LLR is based around the national strategy for Better Births. BCT plan aims to ensure women have personalised care, choice and continuity of carer. The aim for LLR is to develop multi-professional working and integrating care pathways across primary, secondary and tertiary healthcare. BCT proposes to provide high quality, safe maternity and neonatal services based on best practice and which are easily accessible by consolidating all women's acute and neonatal services on a single site supported by appropriate infrastructure and a flexible, multi-disciplinary workforce that responds to changes in volume and complexity.		
Progress to date Staged approach to support the delivery of Better Births agreed through recruitment to midwifery Local Maternity System workforce plan developed to support Better Births Strategy		
Demand Summary 15 Midwives agreed for investment in year with phased increases over subsequent years Efficiencies of Gynae medical staffing and on call rota with one site working Reduction in gyane staffing associated with five day gynae ward Reduced demand for agency/overtime due to improved sickness rates by bringing sickness down to Trust average Consolidation of Paeds and Gynae onto one site enables decreased vacancy levels	Supply Summary Work underway with DMU and Leicester University to ensure plans in place to deliver increased supply over 4 years Will reduce requirement for non contracted workforce demand	Actions Summary Model midwifery requirements in accordance with national requirements and identify sufficient supply in local pipeline
Risks and Mitigations		
Benefits to be Realised Safer rotas more attractive to new supply Reduced sickness rates due to stress and fatigue	Next Steps Workshops planned for July and August to convert Models of Care into sustainable workforce model	

DEMAND	SUPPLY	ACTION PLAN
TRANSFORMATIONAL PLAN 2 site model: PLANNED AMBULATORY TREATMENT HUB/Outpatients		
Workforce Plan needs to: Develop and support the implementation of a workforce plan to deliver day case and outpatient services in a new dedicated facility Realise the efficiency benefit of investment in digital processes Realise the efficiency benefit of one stop clinic approaches for diagnostic and outpatient services Realise the efficiencies associated with a separation of elective from emergency flows Incorporate an MDT approach –right person, right skills, right time with right patient- consider role of specialist nurse /safe discharge Incorporate lean thinking in processes during patient journey in the hub /outpatients to reduce delays due to imaging, pathology, senior review Make use of virtual clinics for results or telephone clinics rather than face to face Redesign of patient pathway to one stop shop		
System needs to: Identify appropriate planned care activity which can take place in the community and Primary Care		
Progress to date Analysis at five key service levels of workforce benefits of consolidated models of care arising from planned ambulatory hub		
Demand Summary Urology/Orthopaedics Colocated clinics in diagnostic and outpatient services - efficient deployment of workforce Release of time through split of complex and virtual pre assessment Reduction WLI usage through consolidated pre and post operative assessment Increased utliisation of specialist nurses to free up consultant time 5 WTE investment in specialist nurses to enable ED in reach (Urology) Imaging – consolidation enables better provision of seven day services across 3 session days	Supply Summary Mitigate against requirement to use agency staff and WLI to deploy sufficient staffing - requires conversion of premium pay to substantive to cover weekend sessions Release consultant supply to emergency pathway Enables better capacity for the provision of seven day services within a two site model	Actions Summary Clarify models of workforce to be utilised in colocated service by reviewing functions undertaken and deploying the most appropriate workforce Clarify models of workforce to undertake virtual clinic model Determine 7 day work pattern to match to service demand and enable patient flow
Risks and Mitigation Ability to invest in special nurses in urology – to be mitigated by cash releasing savings elsewhere		
Benefits to be Realised Reduction in premium expenditure with particular emphasis on WLI and Private Sector usage as a result of minimisation of cancellation of elective activity Multi purpose meeting rooms to be created which will improve quality of learning from multidisciplinary meetings One site consolidation in new premises will enhance attractiveness of roles and therefore reduction in vacancies and time to hire Impact on sickness levels and well being with more streamlined split between elective and emergency pathways	Next Steps Undertake a review of the care functions taking place in the PACH and identify at a high level the appropriate skills mix for delivery of a dedicated elective service. (appendix 2d) Undertake more detailed functional mapping of workforce once tasks identified within care functions (appendix 2e)	

DEMAND	SUPPLY	ACTION PLAN

TRANSFORMATIONAL PLAN:LGH RECONFIGURATION: NB link to Women's and ICU and PACH Plan

Workforce Plan needs to:
Describe the current workforce baseline for all teams and services not accounted for in reconfiguration projects. Analysis of the current numbers will then provide the assurance that the plan will be developed to ensure safe and sustainable workforce numbers for services that either 'lift and shift', transform and move or stay at the LGH as part of the clinical strategy to move from 3 sites to 2 sites. Linked to estates plans and the DCP for UHL the staff impacted will also inform the appropriate management of change and HR resources required as well as consider the organisational development plans to maxmise efficiency and choice wherever possible and to support the smooth delivery of services across sites. Closer links between workforce, HR, OD and the communication team are essential, as are close links to the clinical reference group for the LGH rationalisation programme.

System needs to:
The plan for LGH needs to align with the STP, particularly around those services that will continue to provide links to community and primary care for the East of Leicester and the broader locality that this site serves. For example Imaging services will keep a hub as well as Diabetes as part of delivering an LLR wide service. The 3-to-2 element is intrisicially linked to the wider STP and LLR Clinical Strategy and needs to dovetail with plans with LPT as well as CCGs and Primary Care providers.

Progress to date
Initial scoping, including the development of an appropriate set of terms of reference for the LGH programme have indicated the need for some initial analysis and the development of a 'virtual' workforce, OD and Comms group to feed into both the LGH Programme Board and the Clinical Reference Group.

Demand Summary	Supply Summary	Actions Summary
No ongoing requirement for medical on call rota at LGH	Currently incurs premium expenditure and therefore expenditure will cease at the point of reconfiguration	• Develop Terms of Reference for combined Workforce/OD/Comms group • Identify LGH baseline (by service and staff group) • Identify links and co-dependencies
Developing more sophisticated site specific workforce analysis based on current numbers.	Early work is required to identify key workforce pressures for services remaining at LGH in the transition to future projects. Specific work has already been undertaken as part of ICU for example to look at medical rotas (Across all 3 sites)	

Risks and Mitigations	Next Steps
Size and scale of dispirate services & appropriate governance Management of change principles (OD & HR)	Develop LGH workforce baseline Alignment and prioritisation
Benefits to be Realised	Next Steps

NEW ROLES – OVERVIEW OF PROGRESS AND CAPACITY CHANGES

To describe outline of role, where currently deployed and how present a workforce model for the future

GENERIC SUPPORT WORKERS – currently deployed in ED and release time of clinical staff by undertaking activities to support patient flow such as improvement in the flow of supplies, movement of patients in rapid flow areas, scanning and copying of patient notes where appropriate

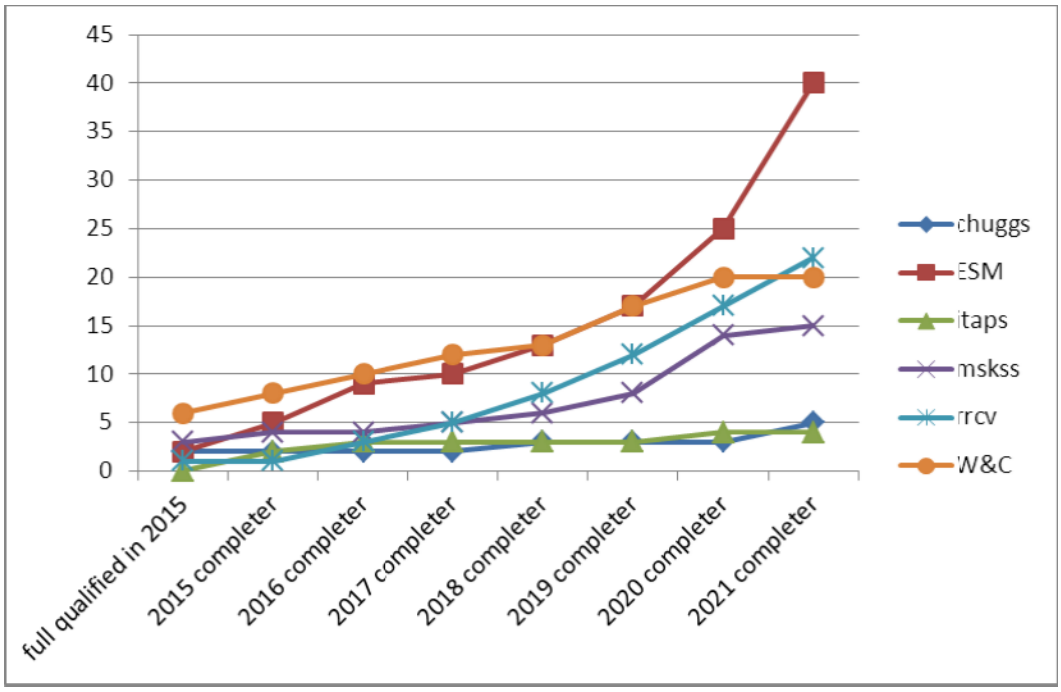
MEANINGFUL ACTIVITY COORDINATORS – currently deployed in wards and now in assessment areas to support frail older patients in order to release nursing time to care. Principally supporting patients with dementia who may wander and who have behaviours that challenge us

PHYSICIAN ASSOCIATES – currently supporting medical rotas by undertaking work previously undertaken by junior doctors including history taking, clinical assessments, diagnosing illness, analysing test results, reviewing patients with long term conditions. Trust has robust plans in place for 35 Physician Associates to be deployed across a variety of settings and specialities:

Specialty	FTE	FTE	FTE	FTE	FTE	FTE
Physician Associate/*******US Programme	4.00	4.00				
Thoracic Medicine		1.00	2.00	3.00	4.00	5.00
Cardiology		1.00	2.00	3.00	4.00	5.00
Thoracic Surgery			1.00	1.00	1.00	1.00
Renal		1.00	1.00	1.00	1.00	1.00
Obstetrics		2.00	2.00	2.00	2.00	2.00
Gynaecology		2.00	2.00	2.00	2.00	2.00
Paeds ACHD		2.00	2.00	2.00	2.00	2.00
Paeds Cardiology		2.00	2.00	2.00	2.00	2.00
Paeds General		5.00	5.00	5.00	5.00	5.00
Stroke		2.00	2.00	2.00	2.00	2.00
AMU and Medical Wards		6.00	6.00	6.00	6.00	6.00
Trauma			2.00	2.00	2.00	2.00
Total Other Staff	**4.00**	**28.00**	**29.00**	**31.00**	**33.00**	**35.00**

UHL has proactively developed the Physician Associate programme at DMU by using the expertise of Physician Associates on the US Physician Associate Expansion Programme. DMU currently has a potential supply of 12 associates due to complete September 2019. A further cohort of 28 has been recruited to commence in September 2018. It is critical these students are prepared for a career across LLR and including Primary Care. UHL is working with the education provider to ensure placements have the right focus for supporting careers across a range of clinical settings while ensuring high levels of success rates in the National Examinations.

ADVANCED CLINICAL PRACTITIONERS expanded significantly since 2015 and complimenting a range of medical rotas across a range of specialties including ED, cardio respiratory, trauma and orthopaedics



An in house programme of development as part of an in house Advanced Clinical Practitioner Unit has led to an extensive 'grow your own' programme with opportunities for rotational development in the community.

NURSING ASSOCIATES – currently part of national pilot and training 89 Nursing Associates to agreed model across LLR trained at the Leicestershire School of Nursing Associates . Working with NHSI and Regulators to determine safe workforce models incorporating Nursing Associates aligned to specific patient cohorts

ADVANCED PHARMACIST – expanding pharmacist prescribers to ensure staff are working at the top of their licence and supporting clinical staff in earlier access to medicines and subsequent reduction in hard to recruit areas

COMBINED PRIMARY CARE COORDINATORS/DISCHARGE COORDINATORS currently reviewing internal UHL Discharge Coordinator roles and Primary Care Coordinators to create a combined role to enable efficient discharge of patients with particular emphasis on the frailty cohort

GRADUATE MANAGEMENT TRAINEES- developed at UHL 2.5 years ago to address the development gap for management at Bands 7-8a. Developed in partnership with local universities to improve the BAME representation at a leadership level within the organisation. First cohort all acquired future roles the Trust and second cohort following apprenticeship framework for development of management and leadership skills

HIGHER APPRENTICESHIP IN HEALTHCARE SCIENTISTS – being used to attract A Level school leavers (or equivalent) into Healthcare Scientist roles. Apprenticeship levy used as marketing campaign to attract individuals wish to earn while they learn.

FOCUS ON SPECIFIC STAFF GROUPS

This Workforce Strategy and Plan has principally been focused on developing workforce plans which are closely aligned to changes in service planning in the short medium and long term. There is reference to new skills and competencies, new ways of deploying multidisciplinary teams around the patient and new roles to support the coverage of tasks normally undertaken by workforce currently in short supply. Given the challenges to our productivity, it is also critical that we ensure we are attaining value for money in the deployment of the higher skilled workforce, this means ensuring the workforce works to the 'top of their licence'. However, it needs to be recognised that, although we are ambitious in our proposals around role transformation, we would be remiss if this strategy did not address the specific vacancy levels for registered nurses and a number of trainee and consultant positions in core specialties. This is reflective of the very challenging national picture on vacancy levels. The following two sections outline our plans for closing the supply gaps for Nursing and Medical professional groups.

THE NURSING WORKFORCE

By the end of August 2018 we will have produced a detailed Nursing Workforce Strategy to detail a number of the actions we describe describe below. In order to drive our actions for improving the supply of registered nursing, it is important to review a number of key datasets:

VACANCIES

End 2017/18 -12%

Cancer Haematology General Surgery – 22.4%

Emergency Department – 34.2%

Emergency and Specialty Medicine – 27%

SICKNESS

End 2017/18 Nursing Sickness 4.56%

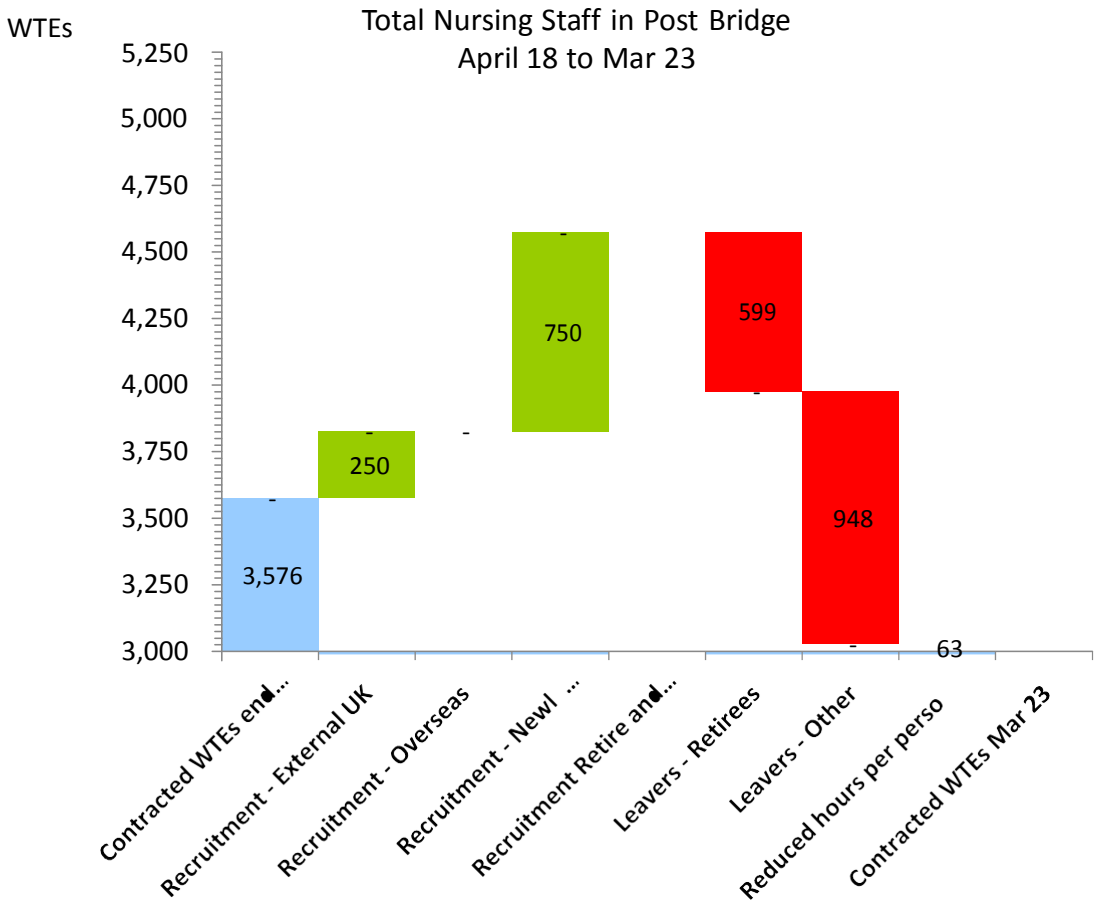
Band 5 Nursing Sickness 4.61%

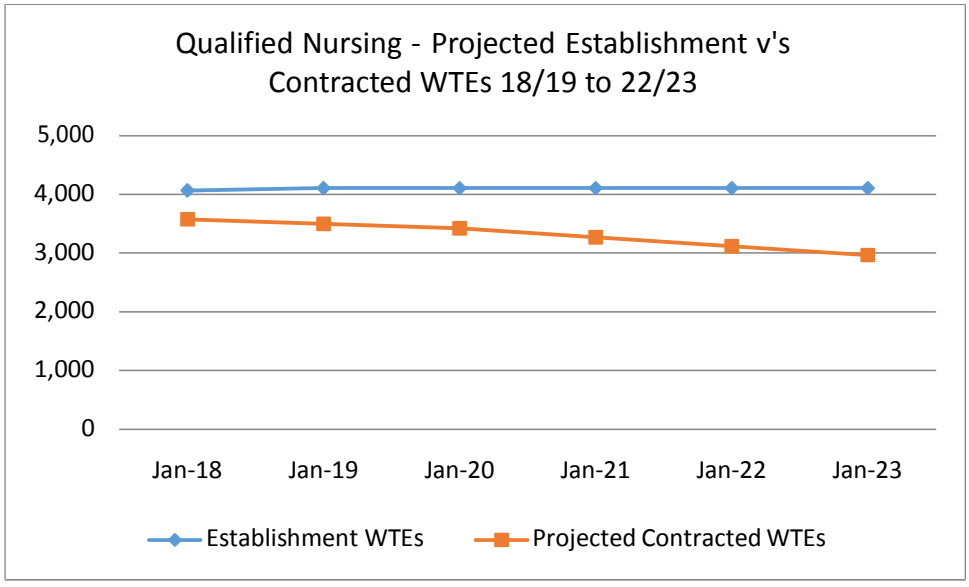
Compare to Trust average of 4.08%

TURNOVER End

2017/18 6.14%

The following nursing workforce bridge shows what would happen to our nursing numbers in a 'do nothing' scenario, and takes into account that there could be accelerated retirements given our age profile:





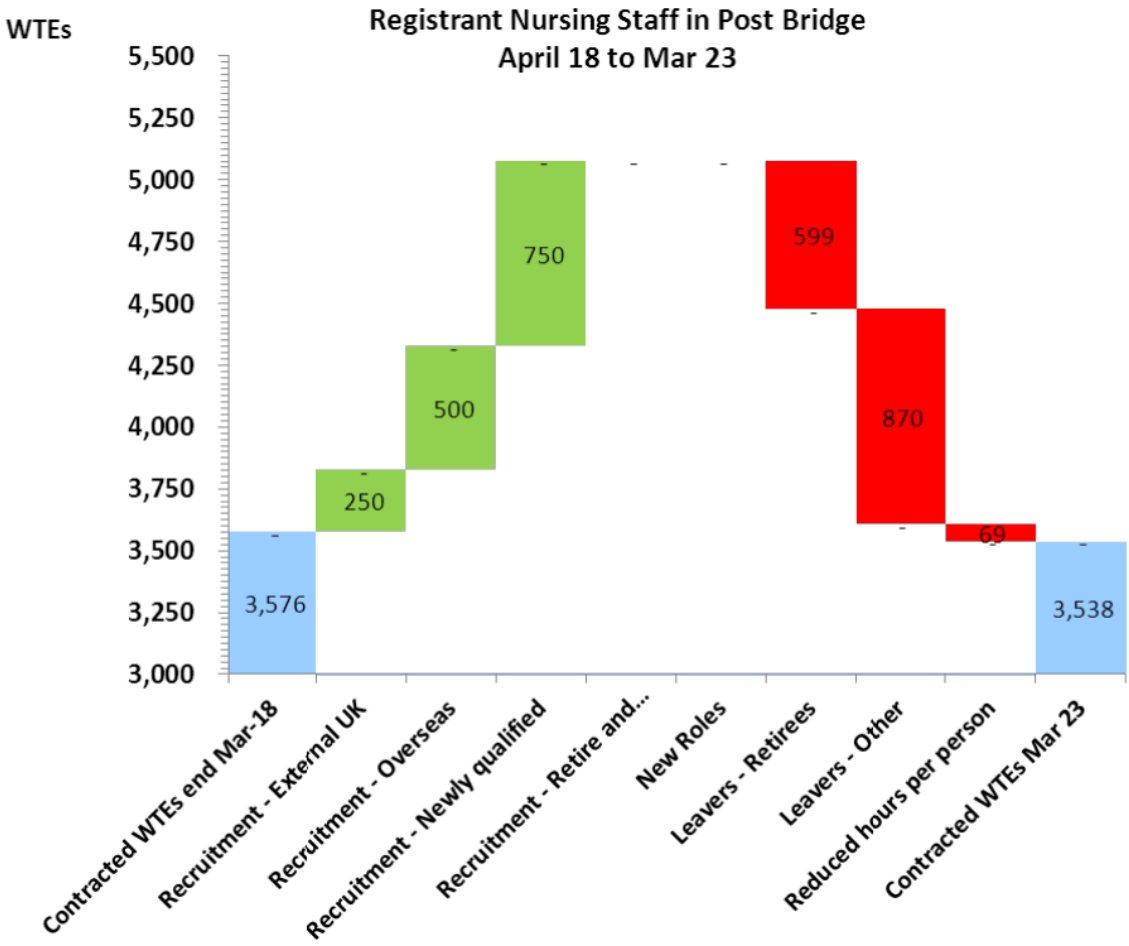
The graphs show what would happen if we assumed our establishment numbers continued increased from 4097 to 4108 registered nurses and continued to recruit using traditional methods of external recruitment and newly qualified routes and experienced a rise in the number of retirements (modelled above as 75 per annum for 2 years and 150 for the 3 years thereafter. After a period of five years, this would increase our registered nursing vacancies from 491 (12%) to 1142 (28%)

Recruitment and Retention Strategies

The Nursing Professional Group have a number of initiatives which could contribute to a closure of the gap between supply and demand.

Overseas Recruitment

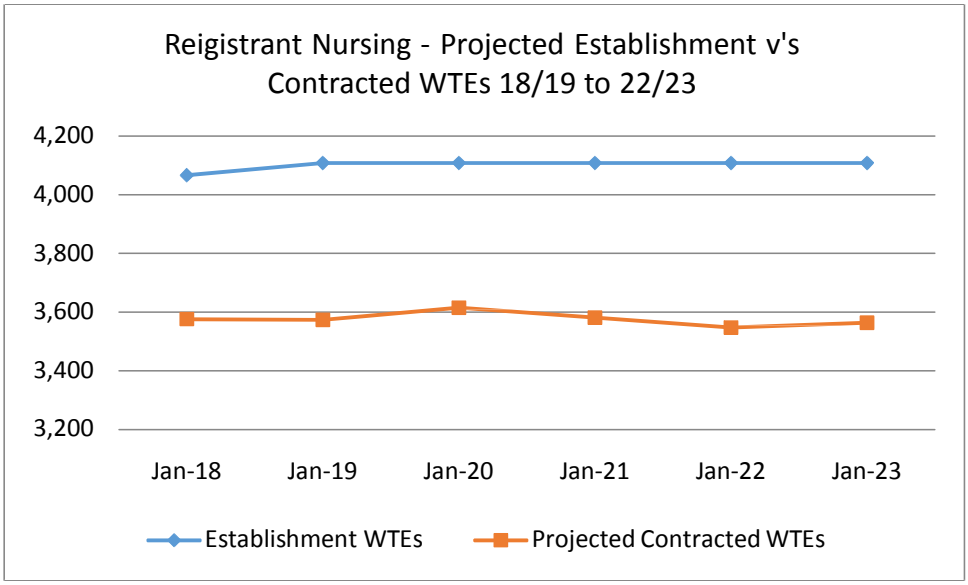
Following an increase in turnover and the diminishing ability to recruit from Europe, recruitment campaigns in India and the Philippines have led to the appointment of 55 overseas nurses commencing in 2018 and there are a further 92 in the pipeline. There are a number of barriers to rapid recruitment via this route including challenging ILETS tests, increasing competition for overseas nursing and lengthy time period to complete all of the required governance and due diligence checks. In an upside scenario, the graph below shows how the gap between supply and demand will close if we recruit via this method and assume 75 in 2018/19 and 100 additional overseas recruits per year thereafter:



In this upside scenario vacancies would be 594 or 14.5% compared to the do nothing of 28%.

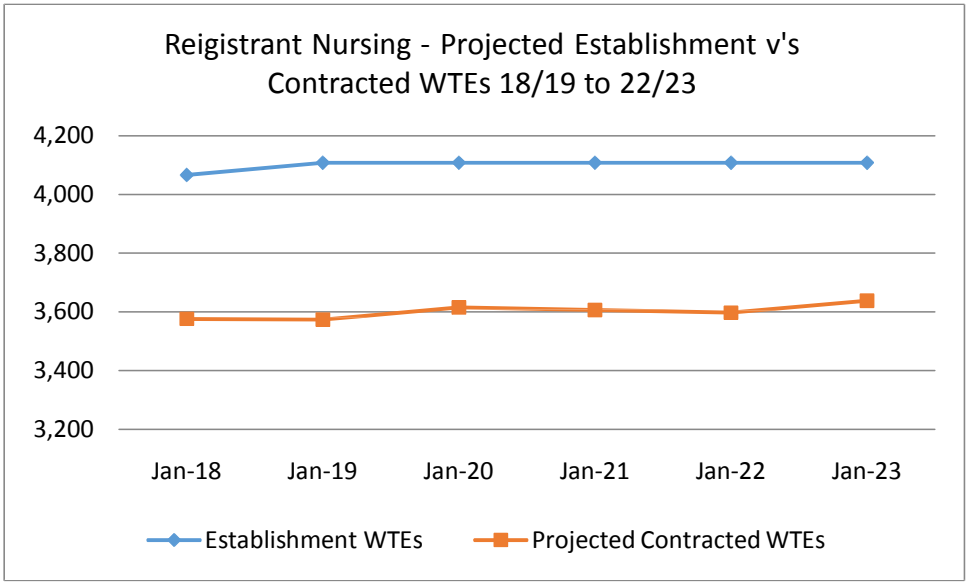
Improve numbers of level one registered nurses

The new programme at University of Leicester presents an opportunity to grow workforce by 50 (upside estimate) after 4 years undergraduate study. We are also reviewing attrition rates of pre-registration nursing cohorts and would work in partnership with universities to maintain attrition at 10% or less per cohort (adult and child). This will improve the forecasted vacancy position to 12.3%.



Improve Retention via Retire and Return

As part of an overall retention plan, plans are being developed to support nurses in such roles as career coaches and support for our newly registered nurses and HCAs. If we can stem the loss of retirees by -25 from year 3 the gap is reduced to 10.5%:



Introduction of New Roles to Reduce our Dependency on Agency Nursing

A functional mapping exercise has been undertaken to review potential skill mixes on wards where it is safe to do so and in line with specified patient cohorts. This mirrors the work undertaken in the Medical Step Down ward. The majority of our workforce gaps are covered by agency nurses or bank nurses and these new roles would be preferable to non contracted workforce. A full report has been developed identifying how new roles could be inserted into a specified medical ward setting by reviewing the tasks involved in core function and what level of staff could be deployed to undertake those roles. A pictorial summary of a new model of staffing is shown below identifying the ideal workforce, the current workforce make up with non contracted staff and what a new workforce

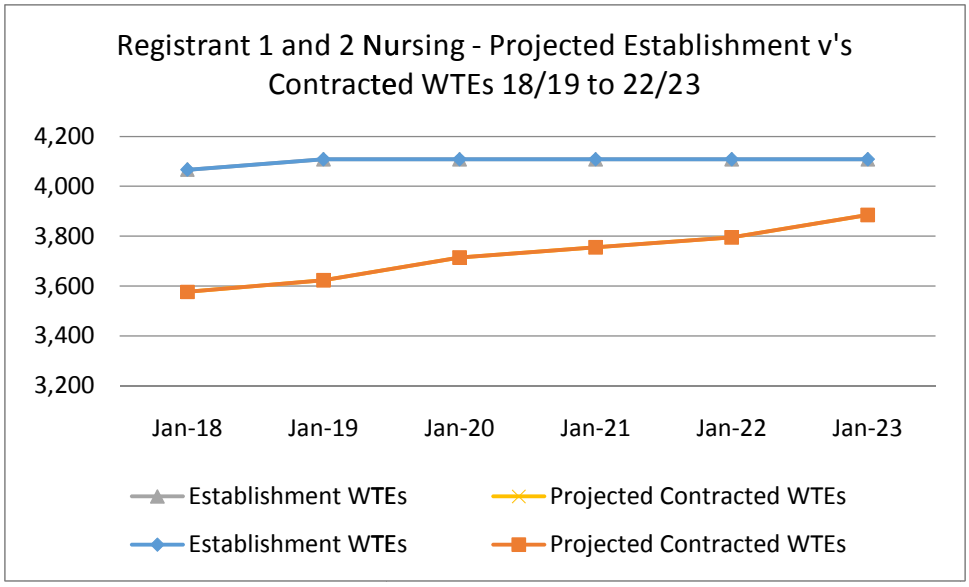
Establishment		Current Practice		Preferred Model	
	Total / band		Total / band		Total / band
B2	11	B2	11	B2	12
B3	0	B3	0	B3	2
B4	0	B4	1	B4	2
B5	10	B5	4	B5	7
B6+	2	B6+	2	B6+	2
Agency B5	0	Agency B5	3	Agency B5	0
Total people per shift	23	Total people per shift	21	Total people per shift	25

model might look like.

The preferred model has more people covering the three shifts (see box below) with a change in skill mix in the preferred model. This change is augmented by the following additional staff:

- B2 x 1 – Ward Clerk - late shift
- B3 x 2 – Meaningful Activity Coordinator (early & late shifts)
- B4 x 2 – Early shifts TAP (discharge management) & Pharmacy Technician (TTOs)

The preferred model is cost neutral but has a different skills mix and greater opportunity to recruit to vacant posts. This type of modelling in terms of process could be extrapolated to other areas to enable the numbers of required qualified nurses to be reviewed. If we assume this could impact by having a combination of Registrant 1 and 2 nurses in the contracted figure, the total number of vacancies could reduce to 5.2%



The nursing workforce overview clearly shows that it is number of multiple actions that will lead to a closure in supply and demand that require transformative and innovative thinking.

THE MEDICAL WORKFORCE

Key Headline Datasets

Figure one below shows our total medical paybill has increased from £178m in 2015/16 to £198m in 2017/18. Our average costs per WAU are also excessive as seen in step two of this plan- mapping the service change.

Figure one

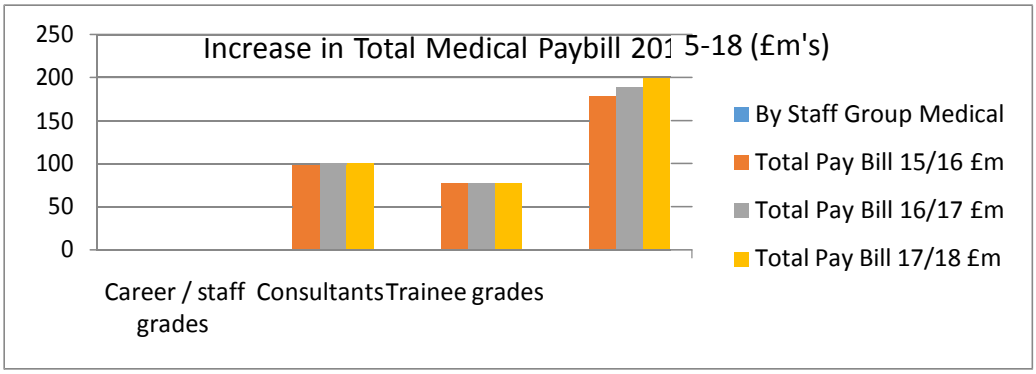


Figure two below shows our total paybill on medical agency has reduced from £16.7m in 2015/16 to £8.9m following rigorous approaches to rate reduction and recruitment as covered in our Medical Workforce Strategy 2014-2016.

Figure two

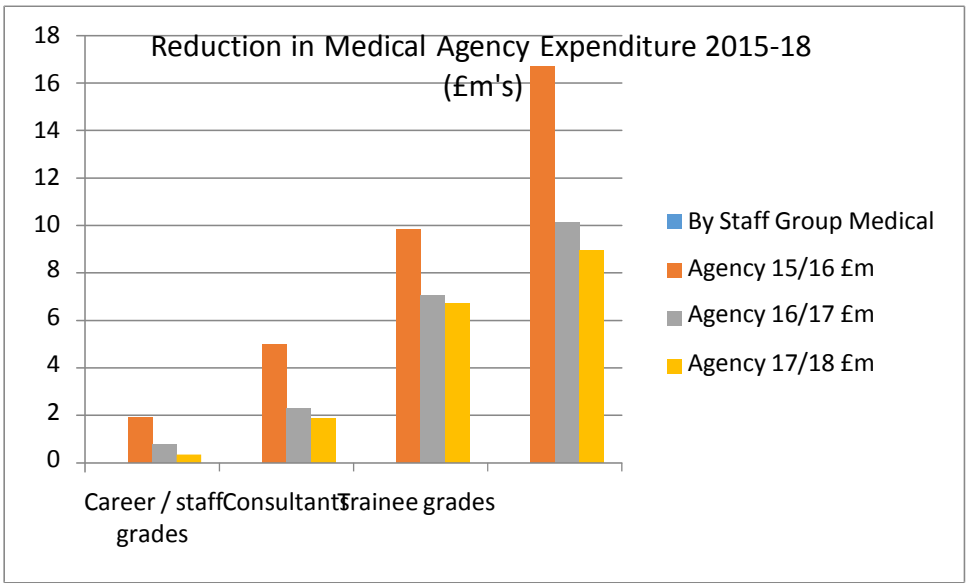


Figure three below shows some reduction in medical agency can be linked to increasing use of internal locums which gives greater continuity and is a better cost per hour than agency.

Figure three

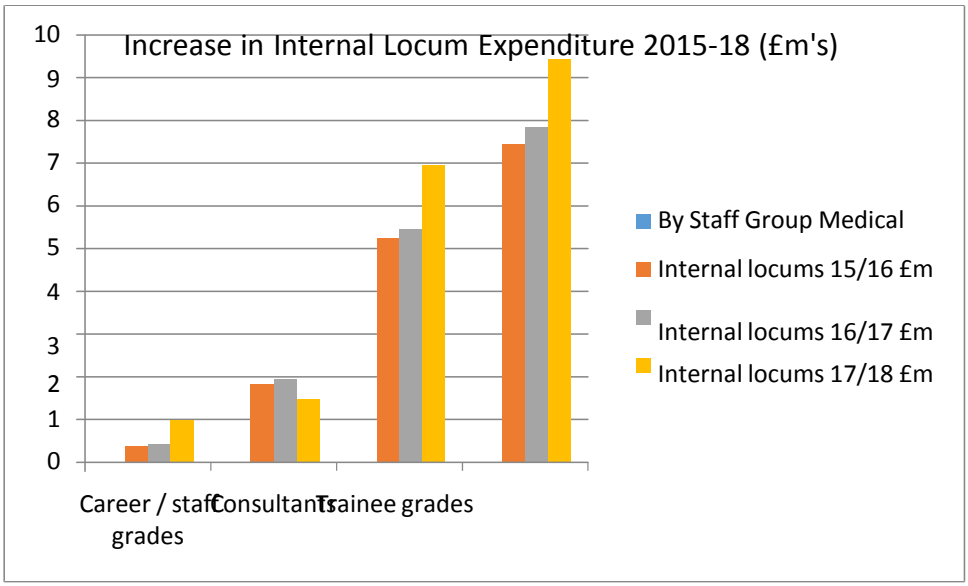
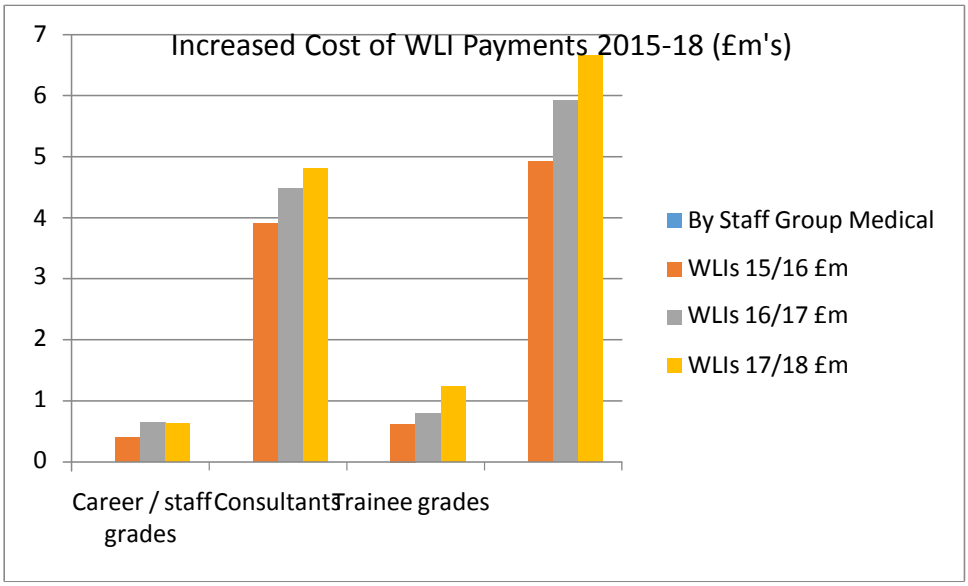


Figure four below shows how WLI expenditure has increased over the last three years:

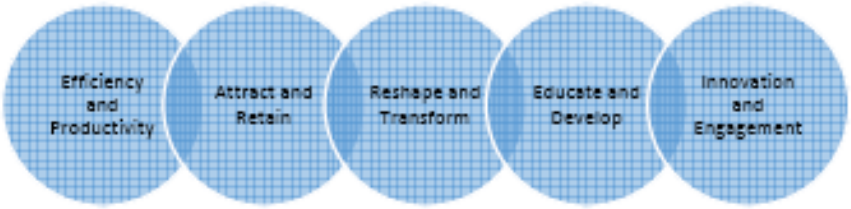
Figure four



In the period 2015-18 we have seen our contracted workforce grow by 55 consultants and 30 trainee doctors. Much of this is attributable to business cases eg Vascular, Emergency floor, radiology increases as a result of a focus on the cancer pathway.

Much of our issues are driven by variable vacancy levels which range from 50-100 vacant junior doctor posts. At a consultant level, although the gap on vacancies has improved, we still see low number of applicants for specific specialties such as emergency and specialty medicine (particularly geriatrics), respiratory medicine, oncology, cancer and haematology, genetics and sub specialties in anaesthetics and paediatrics and intensive care.

As a result of these issues we have refreshed our Medical Workforce Strategy which is themed around five core workstreams:



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Our pressures on junior doctor supply and the relative attraction of our consultant posts are impacted on by our three site configuration. Our pool of doctors frequently have to provide rotas over three sites, increasing on call intensity. Resources are stretched, increasing pressure on our workforce.

Model Hospital and Getting it Right First Time data suggests we are an outlier in terms of the relative productivity of our workforce and although this requires further understanding at the time of writing this strategy, it is recognised that much of this arises from our physical configuration. A new configuration which supports a split of emergency and elective care gives the opportunity to review a number of our processes and the way we carry out care functions for example concentration of outpatients in a single site not only gives economies of scale but also opportunities to maximise the benefits of digitalisation such as virtual clinics.

Work Stream 1: Efficient and Productive Medical Workforce

Desired Outcomes

To ensure we are no longer an outlier in respect of model hospital and that our workforce is wrapped around processes which reduce clinical variability.

To ensure we have the optimum workforce to enable learning and development to be of the highest quality

Work Stream 2: Recruit and Retain A High Quality Medical Workforce Proactively

Desired Outcomes

To ensure all roles attract sufficient high calibre applicants to ensure excellence in clinical skills is complimented by behaviours that support the Trust values and a commitment to work effectively in multidisciplinary teams.

To ensure we have the optimum workforce to enable learning and development to be of the highest quality

Work Stream 3: Shape a Medical Workforce to be Focused on Quality and Continuity adopting non- medical models where appropriate

Desired Outcomes

Respond to the key workforce gaps identified by our CMGs within UHL and develop innovative solutions based on new and extended roles, address the capacity gaps with workforce solutions that may be non-medical or multi-professional and support the development for all training and career grade doctors that support safe and sustainable rotas.

Work Stream 4: Develop a Learning Organisation Approach to Education and Training and Enhance Our Reputation as a Teaching Trust

Desired Outcomes

To deliver the objectives identified with the Medical Education Strategy ie:-

- Enhance the recruitment and retention of staff through the provision of excellent training for both medical students and postgraduate doctors
- Ensure UHL remains an accredited centre for training based on the experiences of trainees
- Ensure the Trust has the appropriate estate and facilities to deliver excellence in training provision
- Working in partnership with the University develop a programme for improving the quality and capacity of education provision
- Capitalise on our reputation in relation to research and development
- Maintain learning programmes which incorporate community and acute experiences
- Sustain multiprofessional approaches to education based on the model developed in the Emergency Department
- Fully utilise technology

Work Stream 5: Establish a Culture of Engagement and Innovation

Desired Outcomes

We will systematically engage Doctors in decisions that affect them and enable a culture of innovation in order that, as leaders of their clinical services, they have the opportunity to develop and enhance their services

We will create opportunities to develop service improvement techniques and encourage a culture of testing and trying new initiatives in partnership with the wider health and social care community where it is safe and appropriate to do so.

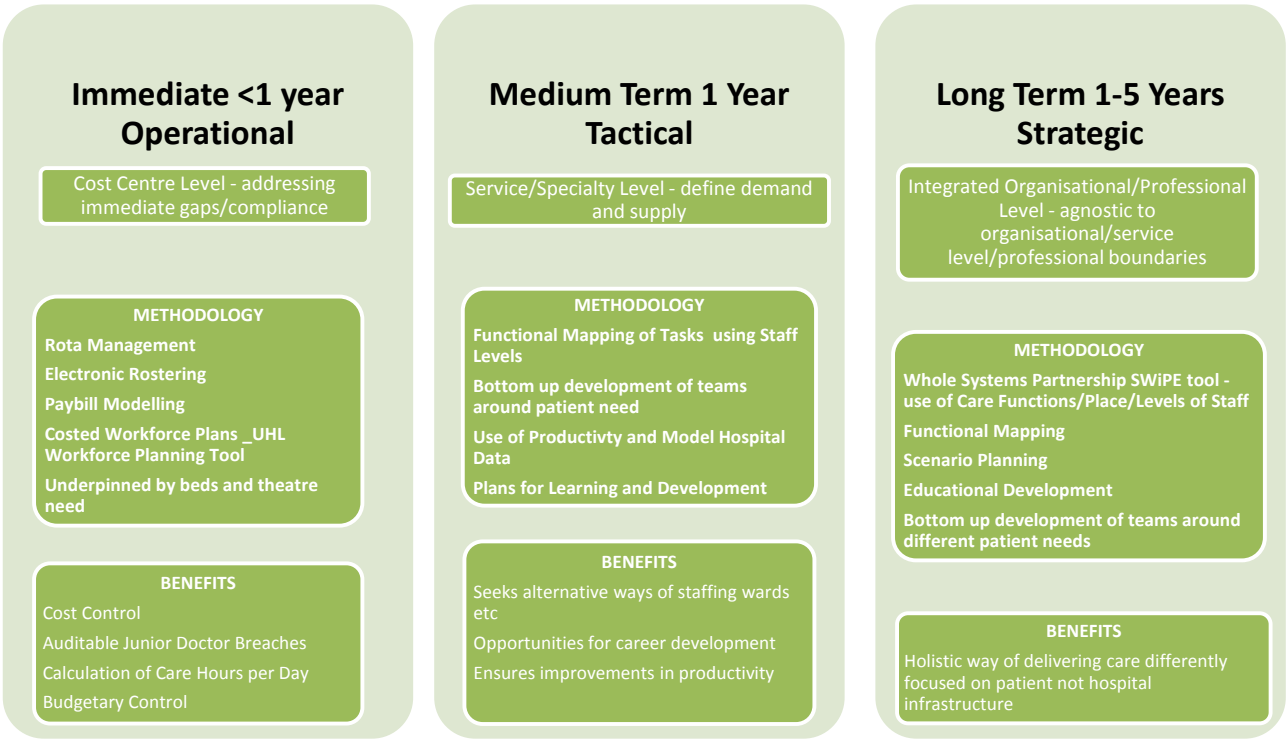
Specific actions across these workstreams are detailed in the Medical Workforce Strategy together with indicators of how we measure success.

CONCLUSIONS

Although this Strategy and Plan is underpinned by a traditional demand and supply model, it is innovative in its approach in that it tries to capture plans in the short medium and long term. The critical component of any workforce plan is to be clear about the definition of the required workforce particularly in terms of skills and competencies rather than who the person is. Our methodology for doing this focuses essentially on skills and competencies although we recognise this is a significant cultural shift in the way that we traditionally undertake planning and our education and training systems are still largely wrapped around traditional professional boundaries.

It is important that this is seen as a live document and as service models and new ways of working emerge, we develop robust plans to ensure we really 'wrap our teams around the patient'.

Appendix 1 Workforce Plan Approach



Appendix 2a Birth Rate Plus

Birth Rate Plus

Birthrate Plus is a national tool available for calculating midwifery staffing levels. It was developed 24 years ago and has now been applied in the majority of NHS Trusts in the UK and Ireland, being modified and developed to reflect changing models of care and working patterns. It has been recommended in all recent DH maternity policy; is endorsed by the Royal College of Midwives and is incorporated within CNST standards issued by the NHS Litigation Authority. Using Birthrate Plus enables individual Trusts to calculate their staffing requirements based on their specific activity, case mix, demographics and skill mix and provides workforce planners with robust data on which to base supply requirements against establishment.

Birth Rate Plus sits outside of internal processes that are in place for monitoring safe midwifery staffing levels.

Methodology

The Birthrate Plus methodology is based on an assessment of clinical risk and the needs of women and their babies during labour, delivery and the immediate post-delivery period, utilising the accepted standard of 1 midwife to 1 woman, in order to determine the total midwife hours, and therefore staffing required, to deliver midwifery care to women across the whole maternity pathway using NICE guidance and acknowledged best practice.

This includes all: • Antenatal outpatient activity including community and hospital based clinics and care in the home, including parent education. • Antenatal inpatient activity and ward attenders. • Delivery in all settings, differentiated by complexity and interventions, including escorted transfers to other units. • All postnatal care in hospital including readmissions and ward attenders, transitional care and neonatal examination of the newborn. • Community based postnatal care until handover to health visiting.

Appendix 2b Safe Staffing

Safe Staffing

The National Quality Board's 2013 guidance, How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability, focused on supporting NHS provider boards to achieve safe nursing and midwifery care staffing. If we are to achieve the Five Year Forward View's ambitions, the principles of safe staffing need to apply to nursing, midwifery staff and the broader multiprofessional workforce in a range of care settings, and do so in a way that optimises productivity and efficiency while maintaining the focus on improving quality. A 'triangulated' approach ('Right Staff, Right Skills, Right Place and Time') to staffing decisions based on patients' needs, acuity and risks, which is monitored from 'ward to board', will enable NHS provider boards to make appropriate judgements about delivering safe, sustainable and productive staffing. CQC supports this triangulated approach to staffing decisions, rather than making judgements based solely on numbers or ratios of staff to patients.

Triangulated approach to staffing decisions

Expectation 1	Expectation 2	Expectation 3
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Implement Care Hours per Patient Day

Develop local quality dashboard for safe sustainable staffing

Measure and Improve
- Patient outcomes, people productivity and financial sustainability -
- Report investigate and act on incidents (including red flags) -
- Patient, carer and staff feedback -

Safe Staffing at UHL

UHL has adopted a comprehensive bi-annual nursing and midwifery establishment review that is compliant with NICE safe staffing and the NQB standards. It forms part of the Trust's systems and processes to seek assurance around safe staffing levels to meet patient care requirements. This process reviews a combination of acuity data, quality outcomes and professional judgement to assess if the set levels of staffing are within the required thresholds.

The importance of 6 monthly establishment reviews is to ensure that the organisation is satisfied that the nursing and midwifery staffing is set at an appropriate level to deliver safe care, and is led by the Chief Nurse.

Appendix 2c Internal Workforce Planning Tool

Our internal Workforce Planning Tool mirrors the NHSI approach to workforce planning which requires us to predict our balance of workforce between substantive and non contracted (including bank and agency). An example of the outputs of this planning are illustrated below:

For each staff group

	Actual / Forecast				Plan											
WTEs	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
	WTEs	WTEs	WTEs	WTEs	WTEs	WTEs	WTEs	WTEs	WTEs	WTEs	WTEs	WTEs	WTEs	WTEs	WTEs	WTEs
Substantive	115.0	117.0	116.0	115.0	115.0	116.0	117.0	118.0	119.0	120.0	121.0	122.0	123.0	124.0	125.0	126.0
Net recruitment					1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Overtime	5.0	4.0	6.0	5.0	4.8	4.7	4.5	4.3	4.2	4.0	3.8	3.7	3.5	3.3	3.2	3.0
Bank	15.0	17.0	14.0	14.0	14.1	14.2	14.3	14.3	14.4	14.5	14.6	14.7	14.8	14.8	14.9	15.0
Agency	6.0	7.0	8.0	5.0	5.9	5.4	5.0	4.5	4.1	3.6	3.2	2.8	2.3	1.9	1.4	1.0
Internal locum																
WLIs																
Total	**141.0**	**145.0**	**144.0**	**139.0**	**140.8**	**141.2**	**141.7**	**142.2**	**142.7**	**143.1**	**143.6**	**144.1**	**144.6**	**145.0**	**145.5**	**146.0**
Establishment					**150.0**	**150.0**	**150.0**	**150.0**	**150.0**	**150.0**	**150.0**	**150.0**	**150.0**	**150.0**	**150.0**	**150.0**

Appendix 2d Whole Systems Partnership (WSP) Integrated Strategic Planning

Care Function Mapping

WSP uses the language of 'care functions' to frame strategic planning and transformation across health and care to meet the needs for local populations. WSP has developed a tool which can be used when considering service re-design and transformation. It links the population cohort needs, the care functions required to meet these needs and the capacity and capability to perform these care functions, typically expressed in terms of skill mix. It enables stakeholders to describe the future in a way that is 'blind' to existing service configuration or professional groups due to its focus on skill levels and care functions. An example of where this has been used is the Cardio-Respiratory Community Integrated Service. It provides a helicopter view which can then be translated into functional mapping (the microscope) or vice versa.

Care Function

A care function is defined as:

'a group of tasks and activities that come together to deliver certain outcomes for a defined group of people'

Advantages to using 'care functions'

- **Common language agnostic to organisation and professional boundaries**
- **Provides a horizontal thread between activity, finance and workforce planning**
- **Opportunity to standardise to enable sharing and learning across the system**

The Care Function Conceptual Framework – 3Cs

A conceptual framework has been developed to reduce the risk of multiple descriptors and varying words which would significantly compromise sharing and comparison.

Cohort

A group of people with similar needs.

1. **Healthy**
2. **Healthy but with the presence of factors that place people at risk of ill health or LTC through lifestyle choices and/or social context**
3. **Single conditions, noting that complex needs or frailty may 'trump' the allocation to the complex or frail cohort**
4. **Complex i.e. having two confounding LTCs or 3 or more conditions**
5. **Being frail, where this is the dominant need irrespective of the number of LTCs present**

Context

Where a care function is undertaken.

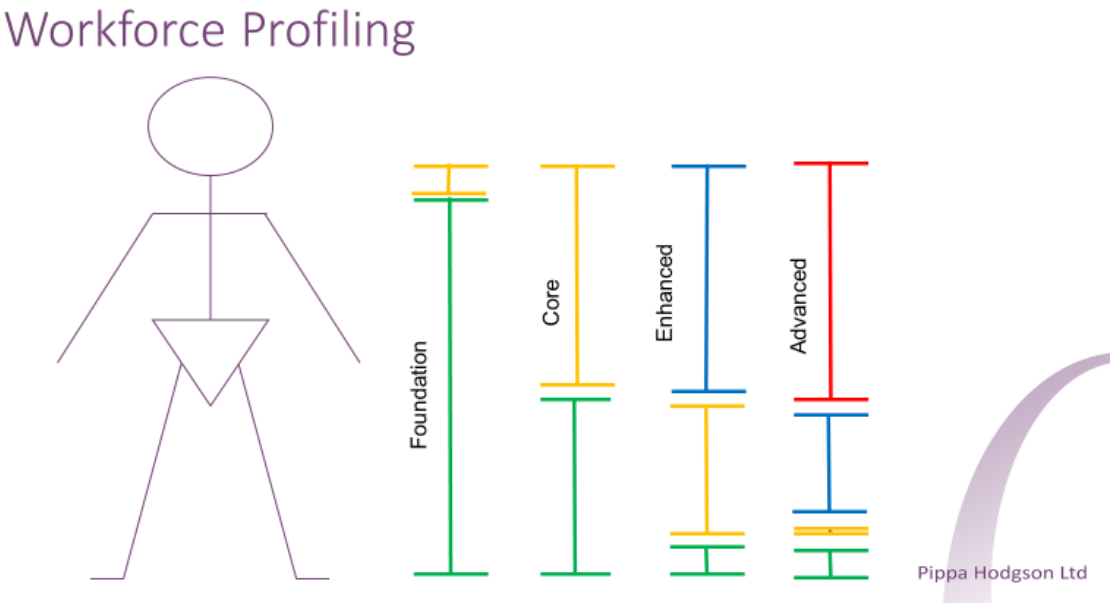
1. **In someone's own home**
2. **In a care or other communal establishment (care home, prisons etc.)**
3. **In an ambulatory community setting (a clinic or other community facility)**
4. **In an ambulatory setting in secondary care (Urgent Care Centre, clinics etc.)**
5. **In a non-acute hospital or similar short term, bed based service**
6. **In an acute hospital as an inpatient**

Care

A high level descriptor for the care delivered.

1. **Prevention with a view to impacting on overall population health and wellbeing**
2. **Assessment or review, including onward referral or sign-posting**
3. **Co-ordination or case management**
4. **On-going support**
5. **Intervention or treatment**
6. **Crisis response beyond that which on-going care can address**
7. **Resolution, rehabilitation and reablement to optimal levels of health and wellbeing**
8. **Transition between different cohorts of need**

Appendix 2e Functional Mapping - Translating High Level Strategic Views into Locally Deliverable Workforce Plans



Functional Mapping / Workforce Profiling

Functional Mapping is a facilitated process with active participation from a range of key clinicians and experts who deliver the clinical services:

Advantages to using Functional Mapping (breaking down healthcare into Functions, Activity & Tasks)

- **Builds on and complements the Whole System Partnership high level (helicopter view)**
- **Focuses on what the individual needs not who provides it (microscope view) and articulates the type and level of roles required (but not the numbers, this intelligence should be used to inform clinicians and service leads to determine their own requirements moving forwards)**
- **Uses national agreed statements taken from a tried and tested "Skills for Health Functional Map" and is delivered via support from Health Education England (Midlands and East) by Pippa Hodgson**
- **Allows roles to be defined and skill mix agreed locally but within a nationally agreed 'map'**
- **Describes the workforce profile in various stages of each clinical pathway into advanced, enhanced, core and foundation**
- **Supports working across boundaries as answers are in skill levels not grades or job titles (i.e. will provide a common currency for acute, primary and social care providers for example)**

Functions

High level groupings of activities and tasks that come together to achieve certain outcomes for the client

Activity

Groups of tasks that combine to deliver discrete episodes of care or support

Tasks

The domain of detailed functional analysis and work-flow type analysis, optimisation at the operational level

Appendix 2f Lord Carter Review
Model Hospital

Background

The NHS is expected to deliver efficiencies of 2-3% per year, effectively setting a 10-15% real terms cost reduction target for achievement by April 2021. Whilst the NHS ranks as the best value healthcare system in the world, we know more could be done to improve quality and efficiency in our hospital so they ca n meet this expectation. Lord Carter undertook a review of productivity and efficiency in English non-specialist acute hospitals, which account for half of the total health budget, using a series of metrics and benchmarks to enable comparison. The review identified unwarranted variation across all the the main resource areas, but also areas of good practice; however, it highlighted that no one hospital is good at everything.

It is estimated that unwarranted variation is worth £5bn in terms of efficiency opportunity. This would create a potential contribution of at least 9% on the £55.6bn spent by our acture hospitals. Lord Carter's report makes 15 recommendations designed to tackle this variation and help trusts improve their performance to match the best.

Unwarranted Variation

A spotlight was used to examine key resource areas including clinical staff, pharmacy and medicines, diagnostics and imaging, procurement, back-office functions, and estates and facilities. Quality was also examined through a clinical specialty lens. Examples of workforce variations include:

Clinical Staff spotlight – in this resource area there was a variation in a range of indicators such as sickness rates and turnover, and policies and practice such as rostering and specialling. There were also variances in the use of medical staff job planning and the deployment of AHPs.

Hospital Pharmacy – the more time that pharmacists spend on clinical services rather than back-office services, the more likely medicines use is optimised. The rate of prescribing pharmacists as a proportion of total hospital pharmacists varies from 2.5 – 71%.

Pathology – the mix of qualified to unqualified staff varied from trust to trust and was inconsistent with trust activity.

Model Hospital

Highlighting variation requires the right metrics with detailed guidance on what good looks like. The adjusted treatment cost (ATC) is one way for trusts to see how they vary in their costs for a given output. The weighted activity unit (WAU) can also be used to compare performance and productivity across trusts. The metrics can be used to create a model hospital which, associated with best practice guidance, will give trusts a single version of the truth on what good looks like from board to ward, to help trusts understand what good looks like. NHS Improvement should continue to develop the model hospital and its underlying metrics, so that there is one source of data, benchmarks and good practice.