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NHS
Ayrshire
& Arran

Workforce Plan

2019/20 – 2021/22

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1. Context

1.1 Why do we need a workforce plan?

At its most basic level workforce planning is about ensuring as an organisation that we have **'the right staff, with the right skills and competencies in the right place at the right time managed effectively and efficiently to provide quality services'.**

Given approximately 50% of our annual spend is on our workforce it is essential that we ensure our staff are deployed effectively and efficiently to fulfil our corporate objective of:

'Working together to...attract, develop, support and retain skilled, committed, adaptable and healthy staff and ensure our workforce is affordable and sustainable'.

Our staff are intrinsic to service delivery therefore as such it is critical that workforce planning is undertaken in conjunction with service and financial planning.

The requirement for NHS Boards to workforce plan set out in CEL32 (2011) – Revised workforce planning guidance sets the requirement for all NHS Boards to produce an annual workforce plan. It is anticipated that the updated guidance, superseding CEL32(2011) will be issued, by Scottish Government Health & Social Care Directorates, at the end of summer 2019 in conjunction with the release of the Integrated Health & Social Care Workforce Plan for Scotland.

Significantly the new guidance will look towards a longer planning horizon, changing from annual to three year plans, and formally set out the requirement for Health & Social Care Partnerships (H&SCPs) / Integrated Joint Boards to produce workforce plans (given the current guidance pre-dates their establishment).

1.2 What are the questions we are trying to answer?

The workforce plan is a key enabling plan to support delivery of the NHS Ayrshire &Arran Health & Care Delivery Plan illustrates there is significant service activity, and planned transformation, underway across functional areas, specific specialties and clinical pathways. The size, scope and stage of development (in terms of articulation of impact and plans for delivery) is variable across these discreet portfolios of work and as such it is impossible for this workforce plan to be all encompassing and comprehensive at this stage. Against this backdrop the workforce plan cannot remain static and will need to be a live document on an ongoing basis as constituent and complimentary plans of work start to mature and associated workforce intelligence, i.e. the impact upon the workforce, becomes more accurately detailed.

That said there are three fundamental questions we are seeking to answer with this initial three year workforce plan:

- What aspects of current business as usual activity could we do better, effectively **'fix activity'**, that would have a positive contribution on achieving our vision?
- What is the workforce impact of the planned service redesign / service transformation, effectively **'reform activity'**, and what steps do we need to take to ensure we can deliver?
- What workforce risks do we face as an organisation that may arise from either '**fix**' or **'reform'** activity?

1.2 What are our key workforce planning activities?

Our key workforce planning activities are set out in section 1.6 - Workforce Plan on a page which follows and details:

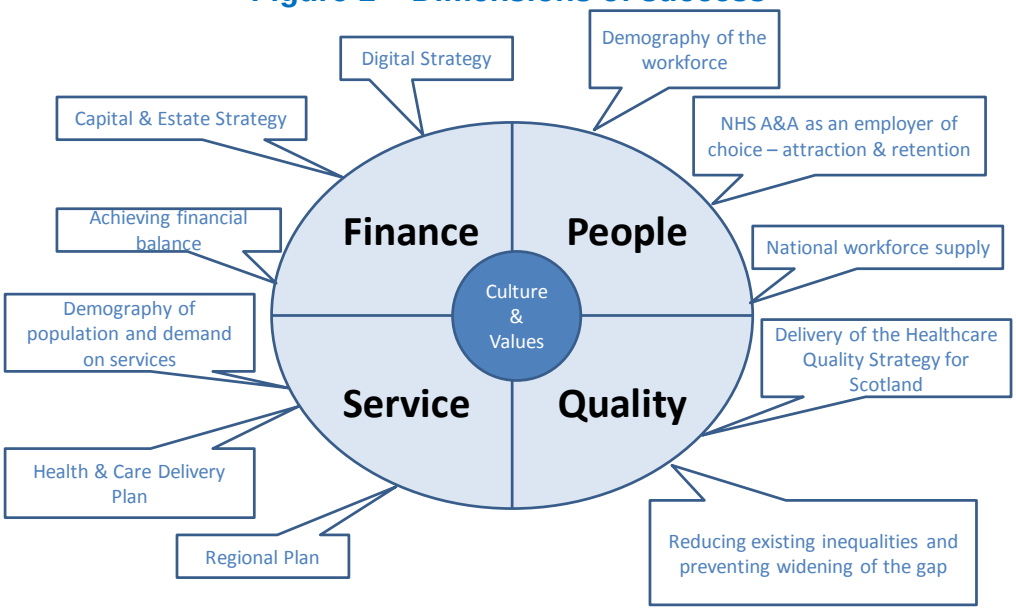
- Our objectives;
- How these will be delivered; and
- What we would deem as success criteria.

Our objectives are ambitious and are likely to take more than a single year to achieve which is congruent with the move to a three year planning horizon.

1.4 How will these activities be delivered?

Fundamentally to deliver on our ambition we need to make workforce planning everybody's business and facilitate a step change away from the perception it is a standalone activity, rather it has parity with the other pillars of success as illustrated below:

Figure 1 – Dimensions of success



The four dimensions of success are intrinsically dependent upon each other, therefore whilst the workforce plan is predominantly about people this cannot be taken in isolation from the other dimensions which will exert influence on the overall configuration of our workforce in terms of shape, size and skills required to deliver services.

Both the Workforce Scrutiny Group (WSG) and the Workforce Planning Group (WPG) will have distinct roles in delivering the workforce plan. The WPG has a distinct NHS focus to its work however this plan intentionally covers the entire system albeit some distinct areas of workforce impact will be encompassed within the workforce plans of our three H&SCPs in North, South and East Ayrshire.

- The **Workforce Scrutiny Group,** will have a distinct **operational focus** upon ensuring our **workforce is affordable**.

- The **Workforce Planning Group** will have a distinct **strategic focus** upon ensuring our **workforce is sustainable**.

Whilst WSG and WPG both have roles in the assurance of workforce planning with NHS Ayrshire & Arran it is incumbent upon all mangers and leaders within the organisation to ensure they robustly consider their workforce in the context of business as usual delivery or service redesign and transformation.

1.5 Plans which are complementary to the workforce plan

As highlighted throughout this section there is interdependency between the workforce plan and a wider suite of local plans which will inform and influence both its delivery and iterative development.

- Health & Care Delivery Plan for Ayrshire – and constituent component plans including the workforce plan:
    - Service Plan;
    - Infrastructure Plan;
    - Quality & Safety Plan;
    - Public Health Plan; and
    - Revenue Plan.
- People Strategy;
- People Plan;
- Health Safety & Wellbeing Strategy; and
- Health & Social Care Partnership Strategic Plans and Workforce Plans.

1.6 Workforce Plan on a page

The plan on a page, shown below, is detailed within the NHS Ayrshire & Arran Health & Care Delivery Plan, and sets out the three overarching vision and deliverables for the workforce which complements the service, infrastructure, quality & safety, public health and revenue plans.

Table 1 – Workforce plan on a page

Vision: Attract, develop, support and retain skilled, committed, adaptable and healthy staff and ensure our workforce is affordable and sustainable

Objective:	Delivered through:	Success criteria ~ we will:
Objective One Deliver a robust, quantifiable and iterative Workforce Plan that articulates and plans how we will deliver our future affordable and sustainable workforce (workforce numbers, roles, skill mix and competencies) that services have identified from our key service redesign and transformational change programmes, as well as addressing changes in workforce demography and supply	• Ensuring programmes of system redesign and reform robustly consider workforce impact and articulate this with a supporting workforce plan • Fixing and improving aspects of our workforce management business as usual processes and activities • Running a voluntary redundancy programme for displaced staff in the redeployment pool • Enabling and ensuring organisational spread and benefit of good workforce management practice, workforce design and workforce planning • Ensuring that robust performance and workforce data and metrics drive action and decisions • The People Managers Skills Suite and development programme, enabling managers to be confident and capable people managers • Improving external advertising and branding of the Board as an employer • Implementing our new Health, Safety and Wellbeing Strategy 2019-2022 and promoting and maximising attendance at work	• Ensure that each service redesign / transformational change programme develops its own workforce plan that articulates the workforce implications and the plan to address these the outcomes of which will iteratively feed into the Board's workforce plan • Consider future skills and competencies and proactively plan for these and new roles within the workforce so there is sufficient lead in time and reactive measures to address and minimise workforce risk • Assess the risk arising from the age profile of our workforce and how we may seek to address this • Deliver a masterclass programme for all nurse managers focussed on effective budgeting, rostering and management of sickness and promoting attendance, to reframe the approach and provide support to nurse managers to operate within their staffing budgets • Routinely utilise, consider and plan upon the outputs from application of the nursing and midwifery workforce and workload planning tools, effectively connecting this to service change/redesign • Effectively manage programmes of change and the redeployment process • Scrutinise the utilisation of supplemental staffing solutions to ensure there is sufficient grip and control in use • Utilise nurse eRostering to and consultant job planning systems to ensure we are optimising the deployment of our staff and that this is cost effective and continues to provide quality services • Be an employer of choice and have sufficient supply for our vacancies and specifically be able to recruit to long standing consultant vacancies thus reducing the requirement for agency use • Drive a focussed, intentional and targeted approach to managing sickness absence with the priority focus being nursing workforce levels, with long term intent to achieve level of 4%, and in the short term seeking to stabilise and reduce the organisational rate
Objective Two Through improved business processes and operational performance and grip ensure optimal and cost effective utilisation and deployment of our workforce, in addition to effectively managing and reducing our reliance on supplemental staffing solutions, whilst ensuring we continue to provide quality services		
Objective Three Deliver our People Strategy Attract objective to improve our marketing and recruitment so as NHS Ayrshire & Arran becomes and employer of choice		
Objective Four Deliver our People Strategy Support objective enabling our staff to be healthy and well at work		

2. Key workforce intelligence

The range of workforce intelligence within this section is intended to give both an overview of key features of the workforce and also provide quantitative context in relation to areas of focus within the 'fix' section which follows. Note that data presented relates to the position as at 31st March 2019 unless otherwise notated and data source is local HR system unless otherwise notated.

2.1 Composition of the workforce

There are eleven distinct job families within the workforce covering a broad scope of clinical and non-clinical roles:

Table 2 – Job families

Job Family	Roles / professions
Administrative services	Various roles across areas such as, but not exhaustively, Health records; medical secretaries; clinical team support roles; information technology services; finance; and human resources
Allied Health Professions	Arts therapists; dieticians; occupational therapy; orthoptists; physiotherapy; podiatry; radiography; and speech and language therapy
Healthcare Science	50 various roles across the job sub families of of life sciences; physiological sciences and physical sciences
Medical & Dental	All grades of doctors and dentists (including those in training)
Medical & Dental Support	Including dental nurses and dental technicians, and operating department practitioners in theatre services
Nursing & Midwifery	Across all five branches: adult; children; learning disability; maternity; and mental health
Other Therapeutic	Optometry; pharmacy; play specialists and psychology
Personal & Social Care	Health promotion staff
Support Services	Catering; domestics; estates and maintenance; and portering

Figure 1 – Workforce by job family

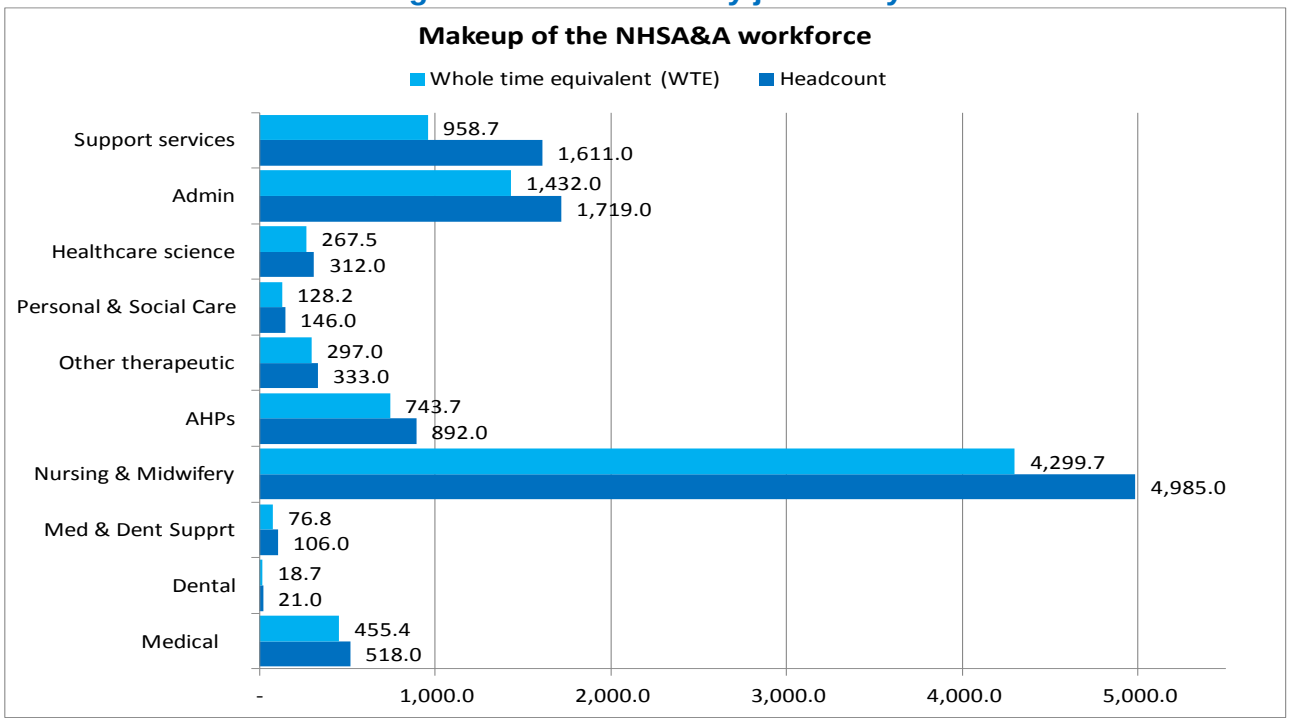
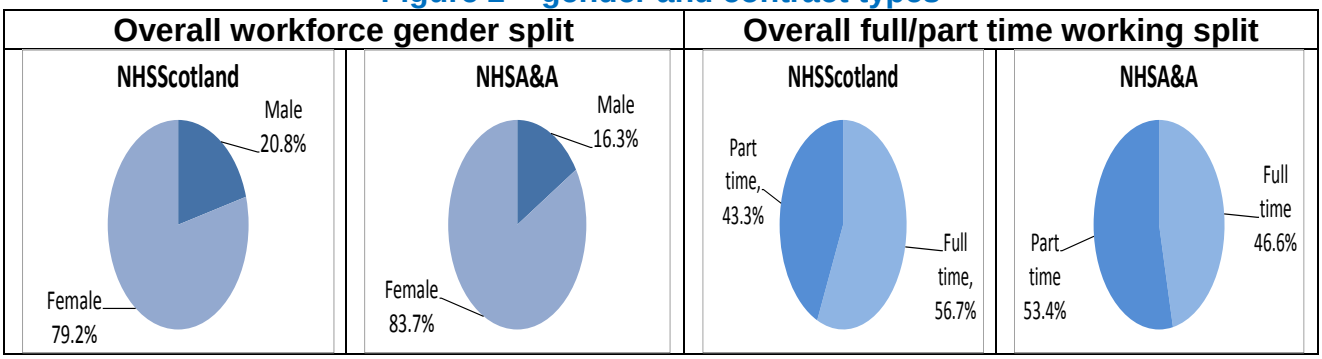


Figure 1 illustrates both the headcount and whole time equivalent for each job family in the workforce. The largest job families in the workforce are nursing and midwifery (49.5%), administrative (16.5%), support services (11%) and allied health professions (AHPs) (8.6%).

2.2 Gender and Full time/part time split

As shown below, in figure 2, there are notable differences in both the gender and part/time full time working split when compared to the NHSScotland average. NHS Ayrshire & Arran has a higher proportion of females in the workforce (+4.5%) and a higher proportion of part time workers (+10.1%).

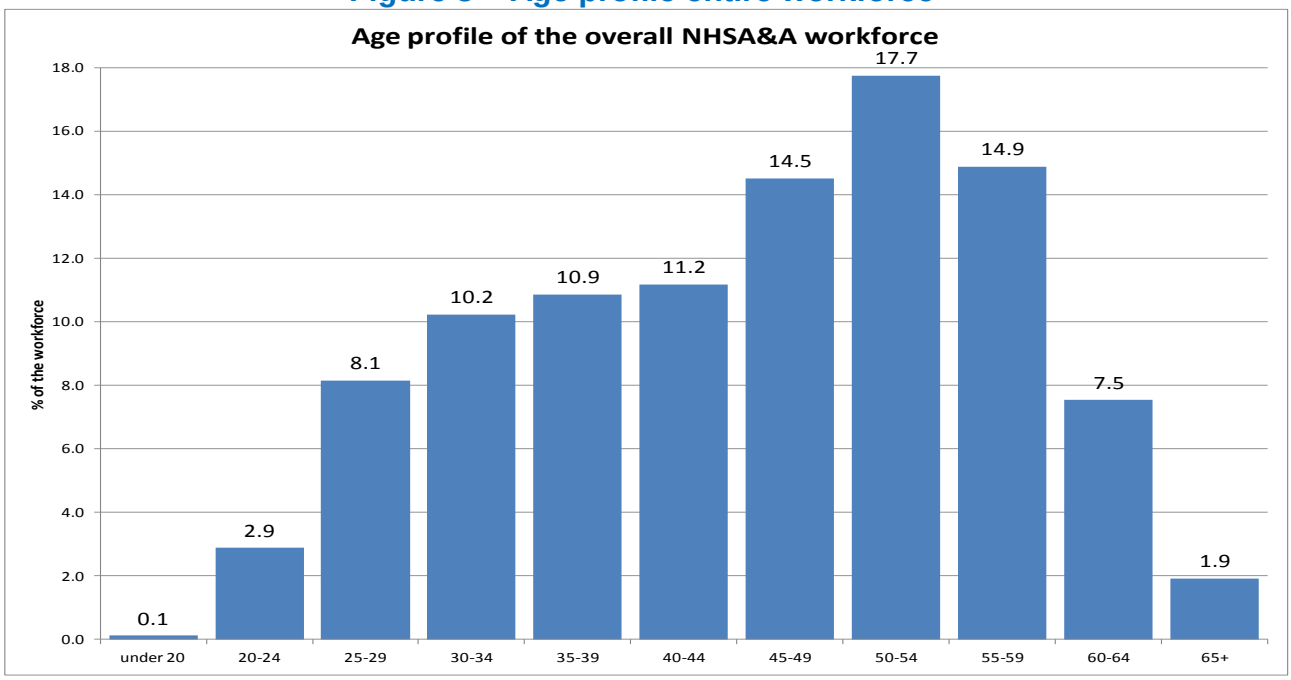
Figure 2 – gender and contract types



2.3 Age of the workforce

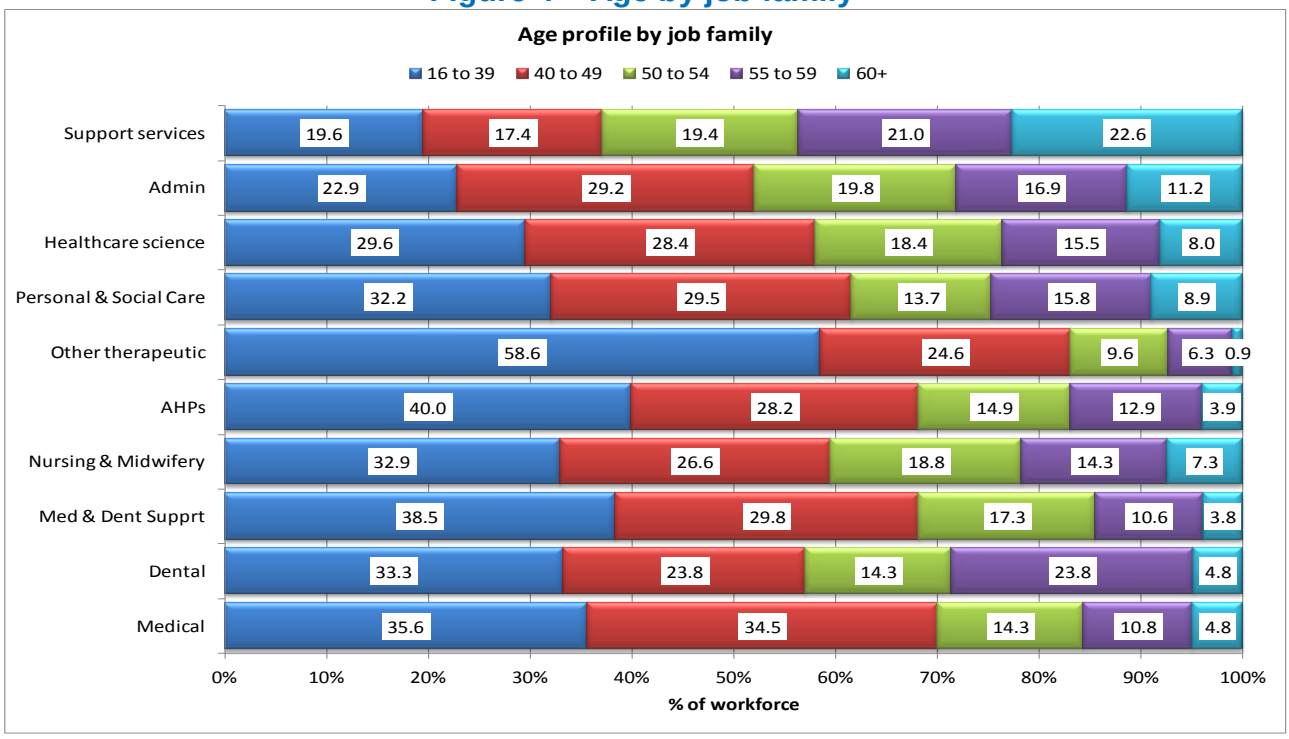
The age of the workforce when allied to supply for some clinical staff groups presents a significant and common challenge not only for NHSA&A but wider NHSScotland. Figure 3, below, shows the global age profile across the workforce within NHS Ayrshire & Arran and it is notable that 42% of our workforce is aged 50+.

Figure 3 – Age profile entire workforce



Ensuring robust succession planning for the 50+ age group will be a key organisational consideration albeit this will require to be countered against national legislation. Up to 70% of the workforce will now have a pension age of between 65 and 68 depending on their date of birth. Figure 4 shows the age profile for each job family:

Figure 4 – Age by job family



As illustrated in table 3, below, the average organisational retirement age if 61, albeit there is variation in average retirement ages by specific job families.

Table 3 – Average retirement ages

Job family	Average retiral age
Administrative	63
Allied Health Profession	61
Medical	61
Nursing & Midwifery	59
Support Services	65
All job families	**61**

Table 4 – Potential retirees

Job family	61 to 65	65+	Total
Admin	130	31	161
AHP	24	5	29
Dental	1		1
Dental Support	2		2
H/care Science	18	3	21
Medical	18	7	25
Medical Support	1		1
Nursing & M/wfry	253	26	279
Other Therap.	2	1	3
Pers & Soc Care	13		13
Support Services	237	84	321
Total	**699**	**157**	**856**

Using the average retirement age the potential retirement profile is approximately 8% of the workforce i.e. 856 individuals may potentially retire at any time – as illustrated in table 4 above. The greatest area of concern is within the support services cohort whereby, using retirement age of 61, the potential retiree size is 19%, or using the average retiral age for this job family, of 65, this reduces to 5%. Note that some members of the clinical workforce have 'special status' and can potentially opt to retire at age 55.

Ensuring the health needs of our ageing workforce is critical, not least in recognising that some roles, e.g. nursing and support services have a substantial physical element and may become more onerous.

Younger age profiles also need to be considered carefully, for Allied Health Professions and Other Therapeutic (which includes pharmacy and psychology staff) job families there is a direct correlation between the gender (predominantly female) and age (a younger age profile compared to the organisation average) and associated maternity leave rates. The organisational maternity leave rate for 2018/19 was 1.7% however the rates for AHPs was 3.4% and for other therapeutic 2.9%.

2.4 Turnover

It is important to note that both local and national turnover reporting is based on leavers i.e. individuals that have exited the payroll and as such internal staff movements to another role are not reflected within turnover detail.

Figure 5 illustrates the turnover rate for NHS Ayrshire & Arran compared to NHSScotland. 2018/19 is the first time in 5 years that the rate locally has exceeded the national rate, albeit the overall rate of turnover remains stable. Whilst the stability of our workforce can be viewed as beneficial we are not complacent with this position and as described in the People Strategy we will continue to refine our approaches to attracting and retaining our staff.

The low turnover rate for the organisation is a significant factor as natural turnover often provides the leverage to enable services to redesign roles and alter skill mix albeit the volume of internal staff movement also provides scope however this is not technically classed as turnover.

Figure 5 – Organisational turnover

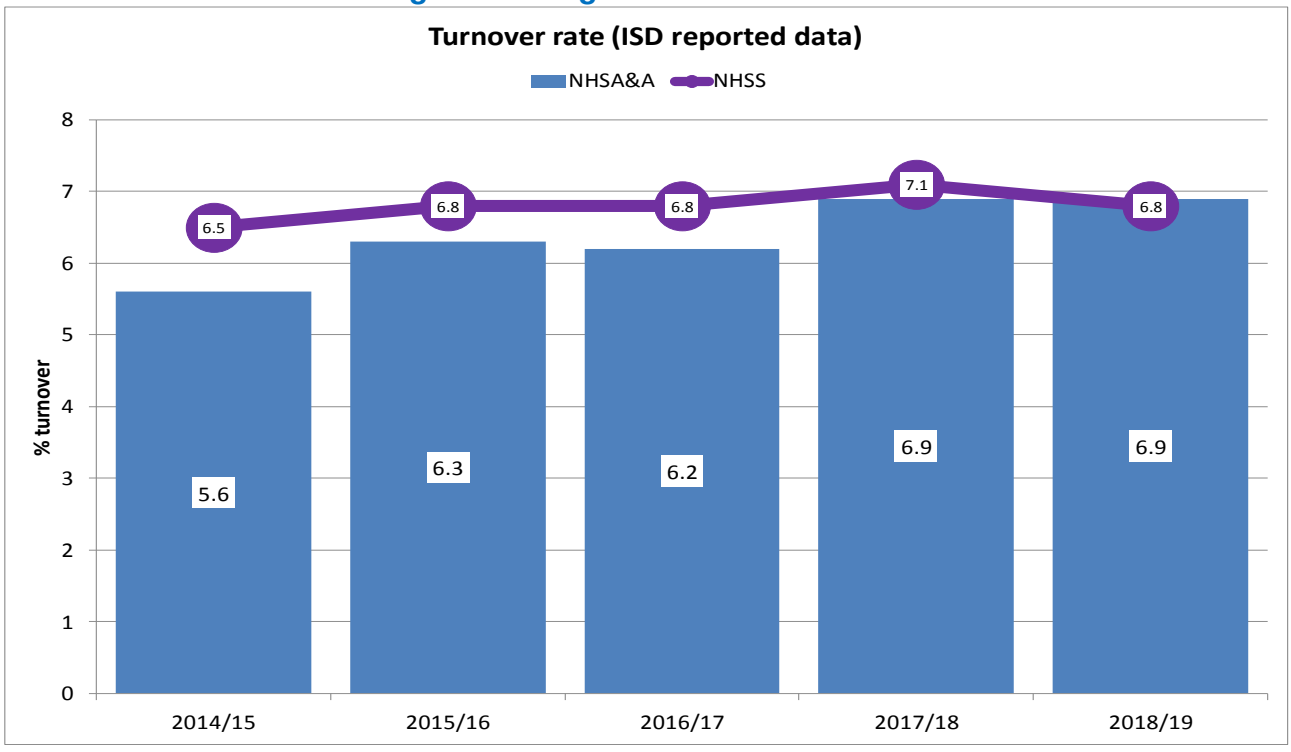
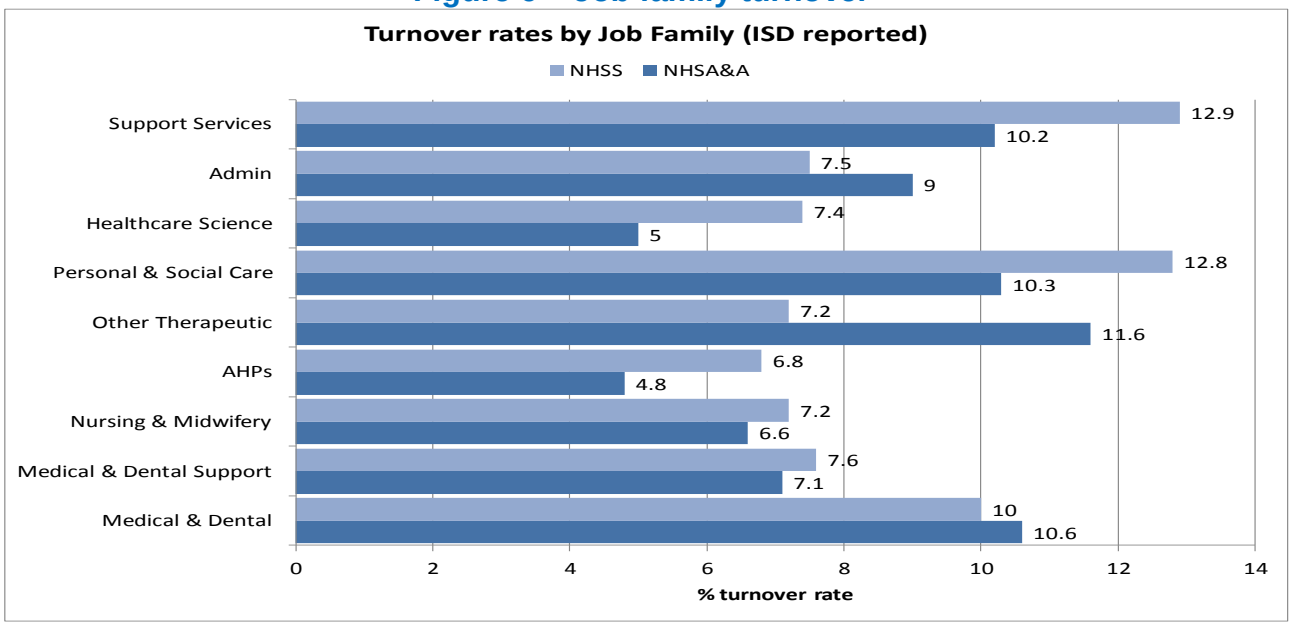


Figure 6 provides more granular detail on turnover by job family compared to the averages for NHSScotland. Two particular areas that stand out are the higher levels of turnover within NHS Ayrshire & Arran within the medical and dental job family (0.6% higher than NHSScotland rate) and other therapeutic – pharmacy and psychology (4.4% higher than NHSScotland rate). Reasons for leaving are multi-factorial however some issues detailed in section 2.6, hard to fill posts / long term vacancies, may be applicable to these specific job families e.g. both medical and psychology posts are recognised nationally, both in Scotland and on a UK basis as being hard to fill. In terms of pharmacy there is increased demand for pharmacists and pharmacy technicians associated with implementation of Primary Care Improvement Plans by all Boards across NHSScotland.

Figure 6 – Job family turnover



2.5 Sickness absence

Figure 7 shows the organisational absence level compared to the NHSScotland rate and the national standard of a 4% absence level.

Figure 7 – Absence rates

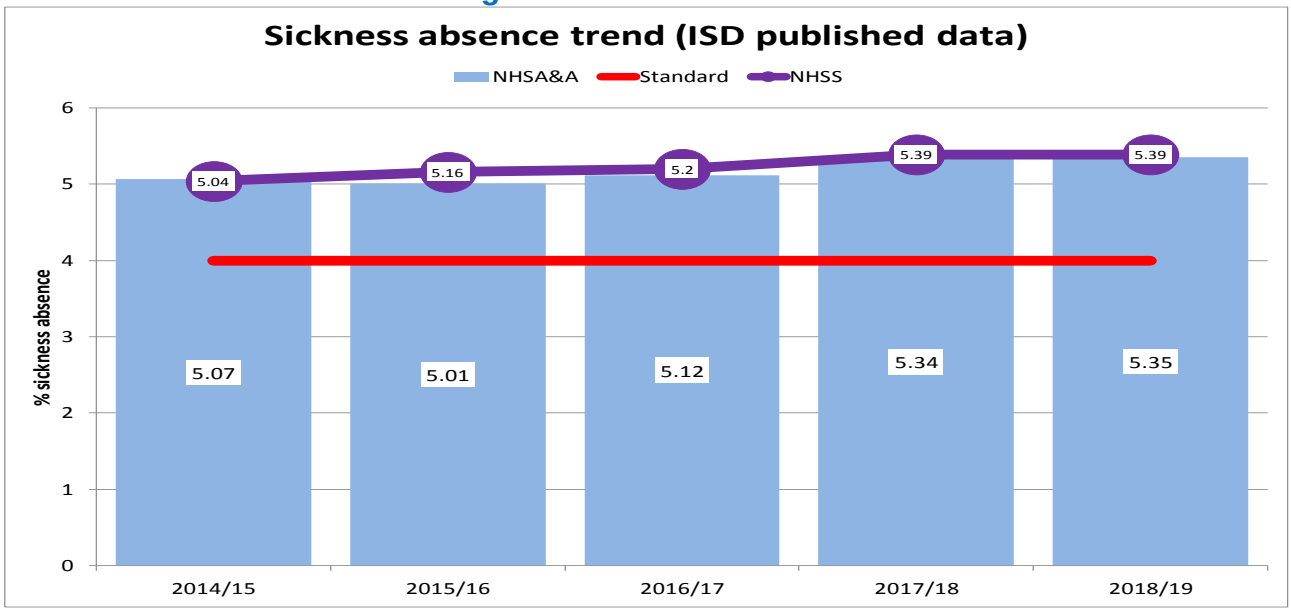
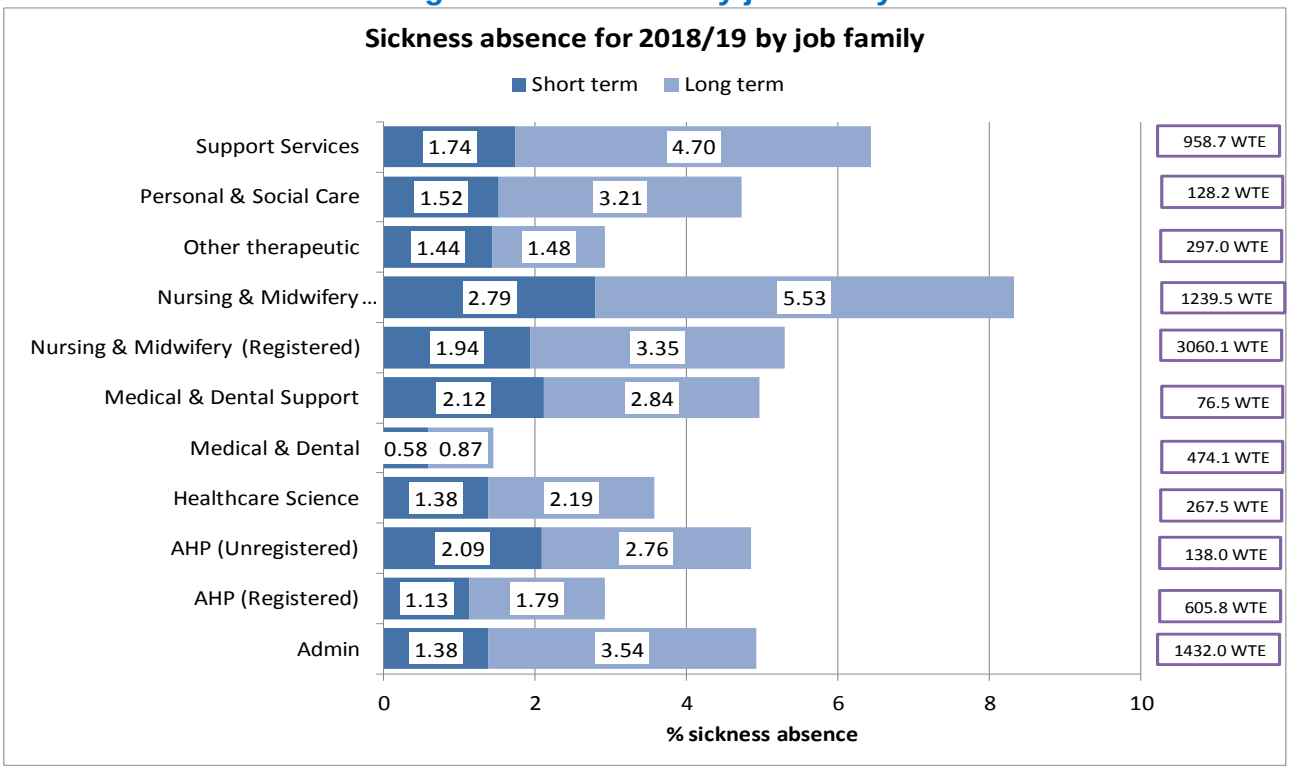


Figure 8 provides more granular detail on levels of absence by job families, and illustrates the variation between staff groups:

Figure 8 – Absence by job family

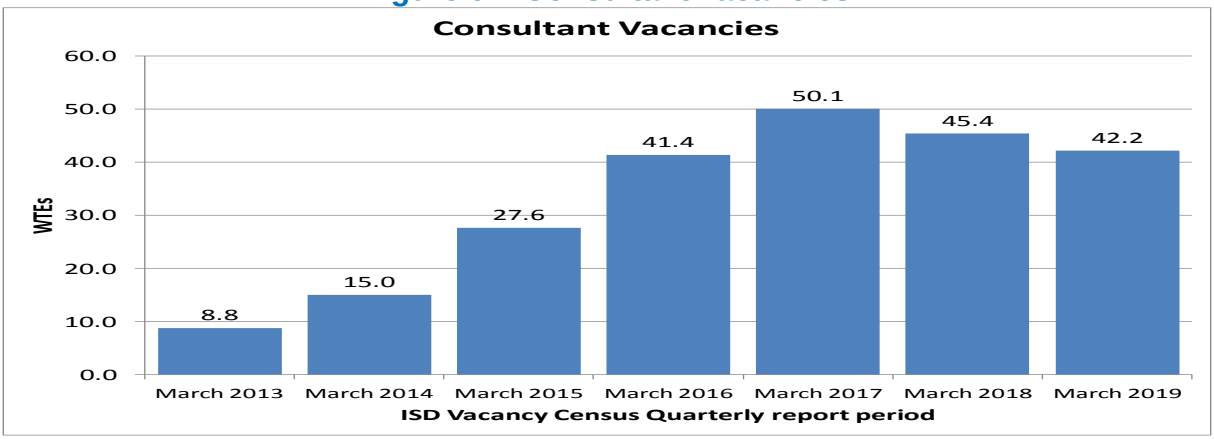


Reasons for absence are multi-factorial. The age profile of our workforce, set out earlier at section 2.3, could be one significant contributory factor in terms in terms of the proportion of our workforce aged 50+. The Health & Safety Executive (HSE: Diversity in the workforce – Age) found there are marked differences in the sickness absence patterns between younger and older workers. Typically younger workers tend to be absent more often, but for shorter periods of time, whereas older workers are likely to be absent less frequently but are more likely to have a longer period of absence.

2.6 Hard to fill posts / long term vacancies

Vacancies within consultant medical roles, presents one of the most acute pressure points for the organisation as the chart below illustrates:

Figure 9 – Consultant vacancies



Whilst there has been some improvement compared to the position in March 2017 the mismatch between demand and supply, and resultant inability to recruit, exerts pressure on both clinical teams and the organisation (as explored in the following section in relation to supplemental staffing usage). The specific specialties with vacancies include:

Table 5 – Consultant vacancies by specialty

Specialty	Vacancy WTEs	Specialty	Vacancy WTEs
Anaesthetics	5.0	Geriatrics	3.0
Radiology	4.0	Dermatology	2.8
General Psychiatry	4.0	Gastroenterology	2.0
Acute Medicine	3.0	Histopathology	2.0
General Surgery	3.0	Neurology	1.8

The Workforce Planning Group undertook work in late 2018 to identify particular workforce hot-spots in terms of recruitment to inform our response to the Migration Advisory Committee full review of shortage occupation lists i.e. those high skilled occupations whereby a Tier 2 visa can be granted to recruit non European Economic Area migrants.

The Migration Advisory Committee collects evidence to make recommendations on which occupations should appear on the shortage list, at its most basic level the criteria which must be met being:

- Skilled – are the jobs skilled to the right level?
- Shortage – is the job in shortage?
- Sensible – Is it sensible to fill these shortages through migration?

In addition to a range of medical specialities NHS Ayrshire & Arran requested the consideration of audiology and physiology (cardiac and respiratory) at bands 5, 6, and 7 for inclusion. In putting forward these areas the Workforce Planning Group were taking cognisance of issues recruitment issues at a macro level whereby there are known / emergent issues in terms of national supply.

That said there is recognition of more localised issues which impact across both clinical and non-clinical roles within the organisation and can make recruitment challenging e.g.:

- Geographic factors such as provision of services to island communities;
- Demographic factors such as the age profile and skills within the existing workforce;
- Remuneration compared to the private sector;
- Non-recurring national allocations of funding necessitating use of fixed term contracts; and
- Insufficient national supply as all NHS Boards are accessing the same ‘pool’ to respond to national policy directives e.g. health visiting, psychology etc.

The Migration Advisory Committee published its review report at the end of May 2019 and has recommended the following health specific roles for inclusion (across all registered grades and specialties/branches of specialism):

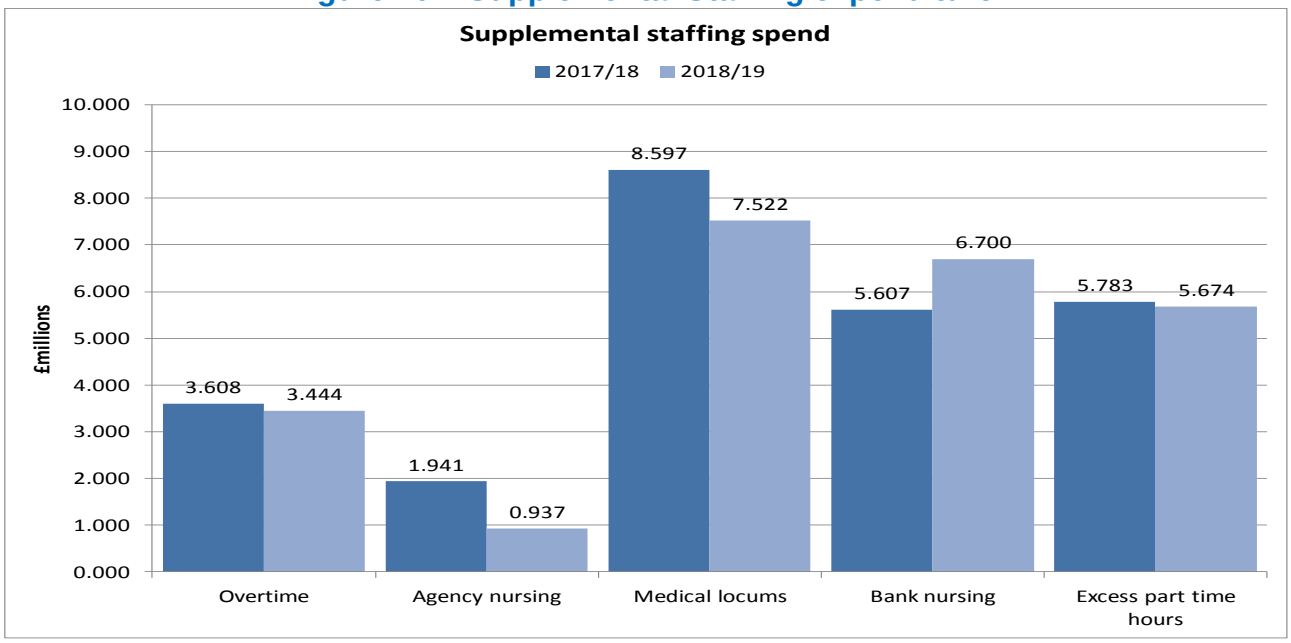
- Medical Practitioners;
- Psychologists;
- Medical Radiographers;
- Occupational Therapists;
- Speech & language therapists; and
- Nurses.

The proposal to include all registered grades and specialties / branches of specialism is welcome as it recognises the challenges health systems across the UK are facing in being able to recruit to some roles, which is a step change from the previous iteration of the list which detailed specific specialties or specialisms.

2.7 Supplemental staffing usage

In order to minimise service disruption and to ensure service standards are maintained NHS Ayrshire & Arran utilises a range of supplementary staffing solutions for the following main reasons: staff absence; patient acuity; patient observation; or alternatively in the case of medical staff to provide cover for hard to fill vacancies in the short to medium term, the duration of cover being variable dependant on circumstances. The preceding two sections, on sickness absence and hard to fill posts, clearly have a material impact as drivers for our utilisation of supplemental staffing as Figure 10 illustrates:

Figure 10 – Supplemental Staffing expenditure



Links between the use of supplementary staff and patient outcomes was demonstrated in the report into Mid-Staffordshire NHS Trust, therefore it is the organisation's ambition to reduce to the lowest possible level the use of bank, locum and agency staff usage.

The Medical Workforce Spend Group and the Nursing & Midwifery Workforce Delivery Group respectively review of supplemental staffing expenditure and progress towards reducing agency costs as per agreed targets and Workforce Scrutiny Group has overall oversight.

3. Fix Activity

The eight fix activities detailed in this action constitute the broad workforce action plan. Delivering these activities is anticipated to be both positive for our workforce but also enabling in the delivery of our reform activity.

These areas of focus are material levers, and need to provide a stable foundation, upon which the portfolio of reform activity can progress. Whilst some areas may have a very distinct O&HRD focus they will not ultimately succeed unless there is collaborative ownership with operational colleagues. As is apparent in the detail provided the fix activities are not mutually exclusive and there is crossover between some activities in terms of cause and effect.

Fix activity: (i) Address the organisational sickness absence rate

Where are we now?

- Section 2.5, Figure 7 & 8, show current absence levels
- Annual rate typically above 5%
- Backfill of absence impacts on fix activities (ii) nursing budgets and (v) supplemental staffing costs

Where do we want to be?

- National expectation that 4% absence standard is achieved within 3 years by March 2022
- Sustainable reduction in absence rate, particularly in those Directorates and job families where rate is in excess of 4%, thus ensuring healthy available staff at work
- In reducing the rate of absence there should be a realised financial benefit of not having to pay for supplemental staffing solutions to backfill

How are we going to get there?

- Implement the staff health improvement approach described in the Health, Safety & Wellbeing Strategy
- Clear targets and performance trajectories against which WSG can monitor delivery
- Concerted focus upon the Acute Services Directorate which proportionally accounts for approximately 45% of organisational absence
- Investment in promoting attendance team to enable the focused work with Acute Services
- Continued collaborative work with all managers to ensure adherence with the extant promoting attendance procedures and policy
- Workforce Scrutiny Group monitoring of sickness absence on a monthly basis

Fix activity: (ii) Operate within nursing budgets

Where are we now?

- Overspend in a number of nursing staffing budgets at end of 2018/19, and some of those areas have had annual overspends for a number of years which is contributory to the organisational overspend – nursing is the largest constituent job family in the organisation (see section 2.1, figure 1)
- Links with fix activities (i) sickness absence and (v) supplemental staffing costs which are directly contributory to overspend position

Where do we want to be?

- Nurse managers able to operate, i.e. spend, up to their budget level on both substantive staffing costs and the use of supplemental staffing solutions therefore ensuring balanced budget outturn at year end

- Systematic and routine scrutiny of budgets and factors which influence this – e.g. rostering and attendance management – on an ongoing basis by senior charge nurses / team leaders in community settings, clinical nurse managers and general managers

How are we going to get there?

- Masterclasses for all senior nursing staff to ensure all nursing management acutely aware of their role and the expectations upon them in terms of managing their budget
- Ensure nursing managers are aware of and routinely utilise nursing dashboard to assist in monitoring use of supplemental staff, absence rates, application of predicated absence allowance etc
- Implementation of the new national eRostering system is likely to make a positive impact
- Workforce Scrutiny Group monitoring nursing spend profile on a quarterly basis

Fix activity: (iii) Understand and effectively plan for the staff age and retiral profiles

Where are we now?

- Section 2.3, figures 3 and 4, and tables 3 and 4 set out the age profile of the workforce and potential retirees risk to the organisation. 3% of our workforce is under 24 (links to fix activities iv- recruitment and marketing and ix – employability) and 42% of our workforce is over 50 (links to fix activity i – sickness absence)

Where do we want to be?

- Proactively plan for both an ageing workforce, to enable our employees to productively contribute in roles that support their health and wellbeing
- Encourage younger people to pursue careers within the NHS
- Ensure there is succession planning for more specialist roles so as to avoid potential detriment to service delivery

How are we going to get there?

- Working Longer Group to drill into age profile and look at best practice approaches that could potentially be utilised in Ayrshire
- All Directorates encouraged to consider the age profile of their workforce to so as to proactively, as opposed to reactively, consider succession planning mechanisms
- Workforce Planning Group to have an overview of work looking at staff profiles

Fix activity: (iv) Design and implement an improved recruitment and marketing strategy

Where are we now?

- With the exception of some distinct alternative approaches (for Primary Care Improvement Plan posts and trainee doctors) we still utilise a very traditional advertising and recruitment method
- There are a number of areas where we have hard to fill posts / long term vacancies – see section 2.6, figure 9 and table 5, and given some of these areas are related to national supply issues we are not necessarily standing out from other employers recruiting from the same labour pool – links with fix activities (iii) age profile, (v) supplemental costs and (viii) employability

Where do we want to be?

- NHS Ayrshire & Arran viewed as an employer of choice
- Moving away from traditional recruitment methods to better exploit and utilise both technological (e.g. social media) and personalised recruitment marketing and messaging (e.g. staff conveying what they like about NHS Ayrshire & Arran as an employer)

- Applicants able to easily apply for posts in Ayrshire and lead in time from preferred candidate stage to 'feet on floor' optimised to be as timely as possible

How are we going to get there?

- We need to take steps to have a clear description of NHS Ayrshire & Arran and use this effectively to market and brand
- Innovation and improvement in how to sell NHS Ayrshire & Arran as employer of choice on an ongoing basis, maximising use of social media, and apply this to posts during the recruitment process
- Implementing the JobTrain recruitment system to improve applicant experience

Fix activity: (v) Improve operational grip and control of supplemental staffing costs

Where are we now?

- Section 2.7, figure 10, sets out the range of supplemental staffing expenditure which totals approximately £24 million annually
- Links with fix activities (i) sickness absence, (ii) operate within nursing budgets, (v) supplemental staffing costs which are directly contributory to overspend position and (iv) recruitment and marketing

Where do we want to be?

- Employing the right workforce therefore negating/minimising the need for supplementary staffing
- Building on the work that has already taken place to drive down agency expenditure as far as practicably possible to a minimum
- Ensuring supplemental staffing is the exception and not the norm by ensuring appropriate deployment / rostering of our substantive staff resource
- Reduced sickness absence level drives down demand for supplemental staffing solutions

How are we going to get there?

- Ensuring the processes and authorisation for use of supplemental staffing are consistently applied and adhered to
- Managers at all levels consistently monitoring their workforce spend against budget and specifically for nursing manager applying learning from masterclasses
- Successfully recruiting to vacant medical posts negating the need for agency locums
- Medical Workforce Spend Group and Nursing & Midwifery Workforce Group to monitor respective supplemental spend and Workforce Scrutiny Group to monitor on a monthly basis

Fix activity: (vi) Improve consultant job planning

Where are we now?

- Current job planning process is paper based which presents a number of issues:
  - Clinical resource to undertake the planning process and complete relevant paperwork
  - Ability to systematically produce and interrogate job planning intelligence readily
  - Inconsistency of approach

Where do we want to be?

- Through implementing an eJob planning solution improve the transparency and efficiency of job planning and match job plans to service delivery requirements and organisational objectives in a consistent manner as well as:
  - Reducing time involved in managing consultant contract
  - Improving the job planning process and consultants satisfaction

- Ensuring standardisation
- Improving data quality and reporting
- Improving financial planning related to job plans

How are we going to get there?

- Implement an electronic job planning solution, Allocate, which is in keeping with the approach of other NHS Boards in the West Region

Fix activity: (vii) Improve workforce planning at service level

Where are we now?

- Workforce planning is not a robust as it could/should be and the and assurance that it is taking place needs to be strengthened with requisite support provided to managers to enable this

Where do we want to be?

- All transformation programmes have an associated workforce plan that details workforce impact
- Managers are equipped / aware of how to access workforce data and methodology to undertake workforce planning
- Systematic and routine identification of workforce risks the organisation faces
- Clear 'routing' for new and developed roles
- Effective horizon scanning

How are we going to get there?

- Workforce Planning Group will take a lead in role in determining interventions to improve workforce planning which may include training and support
- Transformation leads to present the workforce plan associated with their programme to WPG to improve visibility, understanding and identification of potential cross cutting impact (e.g. on other services, professions etc)

Fix activity: (viii) Ensure cross-site working in Acute Services

Where are we now?

- There is some variation in practice and pathways within Acute services which is site specific
- There are particular consultant staffing issues within University Hospital Ayr

Where do we want to be?

- Common patient pathways regardless of hospital site
- Mutuality of support and cover for both acute sites

How are we going to get there?

- Ensuring whole system planning that takes account of both Acute sites, University Hospital Crosshouse and Ayr, and does not differentiate due to geographic location
- Encouraging closer working between specialty teams on both acute sites

Fix activity: (ix) Develop an employability strategy to maximise potential of apprenticeships, working with schools and F/HEIs

Where are we now?

- We currently undertake a range of employability schemes however these are not at significant scale
- The gender and age profiles of our workforce would suggest that we may not be capitalising fully in diversifying our workforce and encouraging young people particularly to undertake careers in the NHS
- Links with fix activity (iv) recruitment and marketing

Where do we want to be?

- Utilising employability schemes more deliberately and systematically to meet our workforce demand
- Positively contributing to the shared aim with our Community Planning Partners to promote employability
- Effectively promoting the career opportunities the NHS offers across the diverse range of professions available and the 'career ladder' that is available
- A more diverse workforce in terms of age, multi-generational, and gender, mix

How are we going to get there?

- Initial step will be an Event to scope organisation needs and requirements for employability
- Engagement with local authority colleagues to improve our understanding of the employability agenda
- The Workforce Planning Group will have an overview of his agenda as it develops

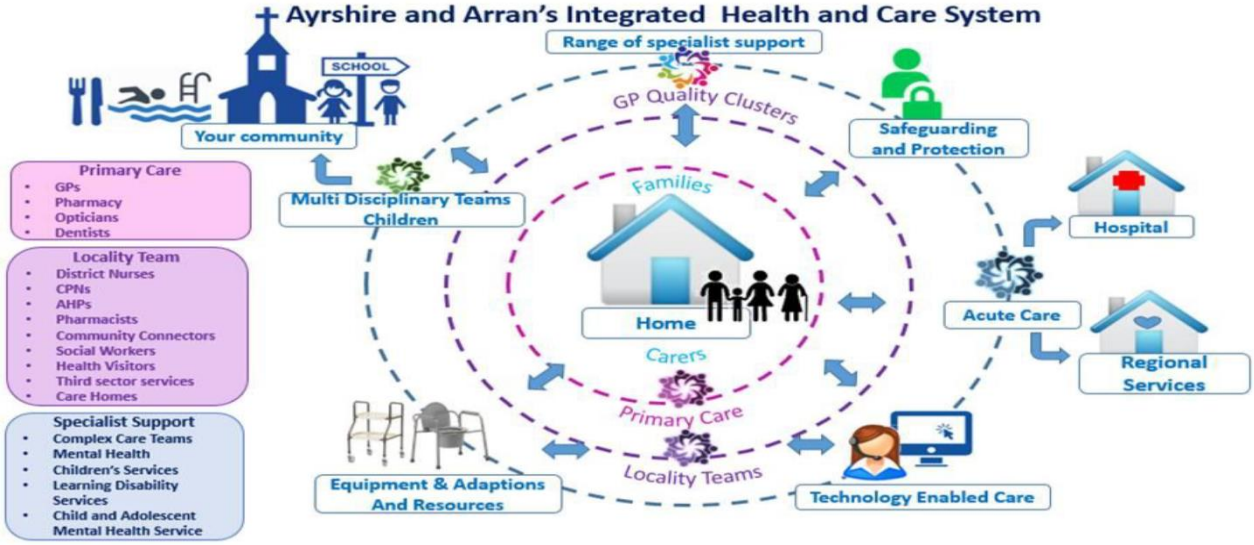
4. Reform activity

Transformation *is a deliberate planned process that sets out a high aspiration to make a dramatic improvement and irreversible change to how care is delivered, what staff do (and how they behave) and the role of patients that results in sustainable, measureable improvement in outcomes, patient and staff experience and financial sustainability.*

Health Foundation

NHS Ayrshire & Arran set out its significant transformational change programme in September 2016, and this is set against the national policy and strategic context provided by the Health & Social Care Delivery Plan whilst acknowledging the intention to deliver a regional approach moving forward. Figure 11 shows the model developed collaboratively by NHS Ayrshire & Arran and the three Health & Social Care Partnerships to deliver an integrated health hand care system.

Figure 11 – Integrated Health & Care model



Further specific detail on the model is provided within the Health and Care Delivery Plan. Key enablers to this vision will be our digital and estate infrastructure and the planning horizon, to repurpose and re-provide facilities in Ayrshire (at primary, community,

community hospital and district general hospital level) is anticipated to take 10 years. As already alluded to within this plan areas of reform are at varying stages of progress with some being at early stages of commencing and others underway. The impacts upon the workforce will vary by programme and will include changes in skill mix, new and developed roles and 'shunting' of skills and tasks in response to improvements in treatment and management of patients. Additionally in the case of some service, in response to critical mass and/or availability of specialist staffing resource and resultant service sustainability it may be more practical to provide some distinct aspects of service at a regional centre, within another West of Scotland Board, with due adjustment and development to our local workforce profile to deliver the regional service plan.

The areas of regional focus include:

- Major trauma – Emergency departments and rehabilitation services;
- Cardiac Services;
- Ear, nose & throat services;
- Ophthalmology services;
- Cancer services (including provision of systemic anti cancer treatments (SACT));
- Urology services;
- Pelvic prolapsed services;
- Vascular services;
- Child & Adolescent Mental Health Services including forensic provision;
- Sexual assault and rape services; and
- Laboratory medicine;

In all of these services there is a distinct medical workforce impact however as some of the programmes mature there is also emergent proposed models of complementary workforce roles such as advanced nurse practitioners undertaking a wider range and volume of clinical activity in response to changing clinical demand.

There is natural crossover of regional workstreams with those being undertaken locally given that Boards will be reviewing and adapting in accordance with agreed service models.

Our aspiration going forward, as already detailed within our fix activity, is to more robustly and comprehensively articulate the workforce impacts arising from, with a specific emphasis on quantitative impact on the workforce, facilitated through all reform programmes having a workforce plan and/or assessment of workforce impact. To this end work will take place during the remainder of this calendar year to compile an addendum to this plan which sets out workforce impact associated with each transformation programme e.g. quantitative impact, role development / skill mix change, supply/demand issues, specific areas of risk. The detail from the addendum will inform necessary revision to this plan going forward.

As detailed earlier, at section 1.4, some programmes of work will be distinctly led by colleagues within the three H&SCPs and the workforce impact will be detailed within their respective workforce plans. As this workforce plan is whole system there needs to visibility of these programmes, hence they will necessarily appear in multiple plans.

Key programmes of work identified within the Service Plan for NHS Ayrshire & Arran with a direct workforce impact are:

- Reviewing skillmix with individual Directorates to identify potential opportunities to effect cash releasing efficiency savings which are contributory to the organisation's ambition to achieve financial balance;
- Pain management service development;
- Implementation of best start: 5 year forward plan for maternity and neonatal care in Scotland;
- Laboratory services review;
- Waiting Times improvement Plan;
- Cardiac Services reconfiguration and development;
- Cancer services reconfiguration and development;
- Vascular services development;
- Major trauma / trauma & orthopaedics development;
- Ambulatory emergency care at University Hospital Ayr development;
- Medical day unit at University Hospital Crosshouse development;
- Frailty unit;
- Anaesthetic service review;
- Dementia ward development;
- Implementation of technology enabled care (TEC) programmes and work to improve the digital infrastructure of the organisation;
- Acute and community pathways development for people with complex care accessing health and social care services across all levels of provision;
- Community nursing, including associated out of hours provision, development;
- Modernising the medical workforce;
- Enhanced Intermediate & Rehabilitation Care
- Primary Care Implementation Plan; and
- Mental health redesign programme;

The areas within the Service Plan are wide ranging and touch upon all areas of the workforce. Some of these areas distinctly match the preceding list of regional service areas under consideration and it is incumbent upon the NHS Board to be mindful of, and well cited and prepared for any potential demand and supply issues that could manifest from this work – further detail of this is provided in the risk register section that follows at section 7.

To re-iterate the status, in terms of progress, of the range of local transformation is at varying stages of maturity. Some are at initial investigatory and design stages whereas others, such as the Enhanced Intermediate & Rehabilitation Care model implementation, Primary Care Implementation Plan, and Mental health redesign programme are in well advanced in their multi-year implementation programmes and are actively recruiting and actuating their planned models of care.

5. Enabling our staff to deliver the reform agenda

5.1 Leadership skills

The human response to change is complex, because change is a messy, non-linear process. It is unpredictable and difficult to chart in absolutes or step-by-step project plans with a neat beginning, middle and end.

The King's Fund

To deliver the transformation programme within NHS Ayrshire & Arran we need to ensure that those in leadership roles are adequately equipped with the right skills to successfully convey and implement the vision for a truly integrated health and care system. We have defined three critical areas of focus for clinical and non-clinical leaders:

Creating a sustainable future – redefining both what and how we deliver our integrated services through transformational change

Continuous improvement – Responding to feedback loops and ensuring continuous improvement

Managing today – Continuing to deliver high quality, person centred, sustainable services

We place strong emphasis on ensuring that leaders and managers lead by example and empower teams and individuals to deliver the 20/20 Workforce Vision. The quality of our leaders and managers is critical to the success of the organisation and in recognition of this NHS Ayrshire & Arran has invested in a range of leadership and management development programmes. As the change and transformation agenda impacts on the service in the next few years our leaders and managers will need the knowledge, skills and resilience to provide direction and support to the workforce and it is critical that we build and develop on current programmes going forward.

We will place stronger emphasis on the value of developing effective team working across all services to deliver a range of tools, profiles and approaches and will make these available where appropriate to further improve our transformational change agenda.

Whilst ensuring leadership roles are adequately skilled our organisational imperatives of ensuring all staff fulfil their mandatory and statutory training (MAST) and have annual personal development review and personal development planning remain extant.

5.2 Digitally competent and enabled workforce

We can only provide the best care to all if we can fully exploit the potential of digital and other technologies. We want the health and social care workforce to be fully competent, confident and capable in the use of digital in the workplace in order to be able to provide that best care. Excellent digital capabilities are not just about technical skills but include a positive attitude towards technology and innovation and its potential to improve care and outcomes. *Health Education England*

A digitally competent workforce is wider than our workforce being able to use a PC, we need to think differently about the services provide, how they are provided and the benefits that using technology can bring. Work will take place to scope what we mean by a digitally competent workforce, looking beyond solely agile working, which clearly impacts on our infrastructure plans, but also at the potential wider benefits that could be realised in the medium to long term which enable the vision for health and care in Ayrshire.

6. Health & Care (Staffing) (Scotland) Bill

The Health and Care (Staffing) (Scotland) Bill aims to provide a statutory basis for the for the provision of appropriate staffing in health and care service settings, thereby enabling safe and high quality care and improved outcomes for service users. Once receiving Royal Assent the Bill will become an Act of the Scottish Parliament and enshrined in law.

The legislation does not seek to prescribe a uniform approach to workload, or workforce planning, instead it enables the development of suitable approaches for different settings.

Specific requirements of all NHS Boards are:

- ensure that at all times suitably qualified and competent individuals, from such a range of professional disciplines as necessary, are working in such numbers as appropriate for the health, wellbeing and safety of patients or service users, and the provision of high-quality care.
- have regard to the guiding principles, including when contracting with third party providers for the provision of services.
- have procedures for assessing staffing requirements in real-time, identify and escalate risk across all clinical settings and staff groups.
- seek and have regard to appropriate clinical advice in decisions relating to staffing
- report on high cost agency use
- ensure adequate time and resources are given to all clinical leaders to discharge their leadership role
- ensure employees receive appropriate training to undertake their role
- follow a specified common staffing method where defined workload planning tools exist and ensure the output from the method is used to inform decisions about staffing levels
- train staff in the common staffing method where appropriate
- inform staff of how the common staffing method has been used and the staffing decisions reached
- report annually to Scottish Ministers how they have met the requirements in the legislation
- provide assistance to Healthcare Improvement Scotland (HIS), as required, including providing information, to enable HIS to perform its functions.

Guidelines to assist Boards in fulfilling their duties are currently being developed by Scottish Government and will provide further clarity and detail to inform practical application of the Bill requirements which will materially have an impact upon wider workforce planning processes.

Enactment of the Bill will further strengthen the ongoing application of the suite of Nursing & Midwifery Workforce and Workload Planning Tools that are routinely used within NHS Ayrshire & Arran. It is anticipated that an outcome of the legislative change, in the medium to long term, will be the development of tools on a similar basis to those used within nursing and midwifery for other clinical job families.

7. Workforce Risk Register

The table below is a truncated risk register and gives a high level overview of areas of strategic risk associated with the workforce. These risks will be added to the organisational risk register and monitored via extant processes.

Risk title	Risk description	Impact description	Risk scoring		
			Prob.	Sev.	Score
Insufficient workforce supply	Insufficient workforce supply, to meet demand, for some elements of our workforce	Inability to recruit to some posts which may have an impact on service sustainability. To maintain clinical services the need to high cost agency staff if available e.g. medical staff and/or other supplemental staffing solutions such as overtime, excess part time hours, bank	4	4	16
Age profile of workforce	The age of the workforce in some professions / roles presents a potential risk in terms of service sustainability	Individuals in specialised roles with limited succession planning in place and/or potential for elevated levels of sickness absence due to physical nature of role and/or elevated rates of maternity leave that require back fill and/or requests for more flexible working patterns following maternity leave may be challenging to grant/ fill e.g. part time hours	3	3	9
Non-recurring funding streams for posts	Some national allocations are on a non-recurring basis with confirmation being received on an annual basis as to whether the funding will be extended which presents risk to some services	Staff move to permanent roles when successful due to uncertainty with continuation of funding. Differing approaches across NHS Boards whereby posts linked to an allocation may be filled substantively as opposed to on fixed term basis	4	3	12
New service developments could potentially de-stabilise existing services	Existing employees could apply for new posts arising in new/developed services which could potentially de-stabilise existing service areas.	Local / regional / national developments could create opportunities however there may be insufficient supply to meet demand meaning the potential candidate	3	3	9

		pool is the existing workforce which could potentially de-stabilise existing services			
Silo workforce planning with no cognisance of wider workforce impact	Workforce planning only takes place for immediate service with no cognisance of the impact on wider contributory services	Expansion / development in a service which has a 'knock-on' effect on other services in terms of demand however no associated growth to deal with increased demand	3	3	9
Impact of Brexit	Brexit may have impact on supply within some job families	Uncertainty regarding Brexit may impact upon the substantive workforce (individuals choosing to leave the UK) and /or availability of agency workers particularly medical in both acute and primary care settings	3	3	9

8. Monitoring and review

The Workforce Planning Group and Workforce Scrutiny Group both have distinct roles in delivery of the intent within this plan and both formally report to the Corporate Management Team.

Formal progress associated with fix and reform activity will be reported via established Programme Management Office procedures.