Workforce Plan Update

Author: Louise Gallagher Sponsor: Louise Tibbert Date: 7 April 2016 Trust Board paper J

Executive Summary

Context

To deliver an ambitious reconfiguration plan linked to 'Better Care Together', the Organisational Development Plan and Five Year Workforce Plan 2014-2019 sets out our plans in relation to workforce. There are six pillars to the workforce plan relating to reduction in dependency on non contracted workforce, safe staffing, review of urgent and emergency care, impact of seven day services, shift of activity into community settings and increased specialised services where appropriate. Addressing this plan requires ambitious interventions around recruitment, retention and redesign of the workforce supported by a programme of work to support cultural and behavioural change.

Questions

1. Does this update demonstrate the right priorities are being addressed?
2. Does this update demonstrate that sufficient progress is being made?
3. What further actions are required?

Conclusion

Against a number of priority areas we have set out what the challenges are and how we are addressing these challenges. We have also confirmed how we have remodelled the workforce and OD input into the Better Care Together Programme and internal Reconfiguration Schemes to ensure we enable transformational change.

We have a range of dashboards in place for reporting vacancies and performance in relation to non contracted pay spend. Delivery is also measured against operational plans and the Organisational Health Dashboard.

A number of separate reports are provided to update on specific elements in more detail, as referred to in this report.

Input Sought

The Trust Board is asked to note progress with and comment on the implementation of the priorities of the Workforce Plan particularly recognising the impact of apprenticeships.

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

2. This matter relates to the following governance initiatives:

Organisational Risk Register	[Not applicable]
Board Assurance Framework	[Yes]

3. Related Patient and Public Involvement actions taken, or to be taken: Patient representatives involved in key OD initiatives / intervention

4. Results of any Equality Impact Assessment, relating to this matter: [Insert here]

5. Scheduled date for the next paper on this topic: [March 2016]

6. Executive Summaries should not exceed 1 page. [My paper does comply]

7. Papers should not exceed 7 pages. [My paper does not comply]

University Hospitals of Leicester NHS Trust

REPORT TO:	**Trust Board**
DATE:	**07 April 2016**
REPORT FROM:	**Louise Tibbert Director of Workforce and Organisational Development**
REPORT BY:	**Louise Gallagher, Workforce Development Manager, Bina Kotecha, Deputy Director of Learning and Organisational Development**
SUBJECT:	**OD and Workforce Plan Update**

BACKGROUND

1.0 Organisational Development Plan

1.1 We define Organisational Development (OD) as the 'planned and systematic approach to enabling sustained organisational performance through the involvement of its people'.

As previously reported to the Trust Board we have been working on refreshing the Trust's OD Plan in consultation with key stakeholders and the updated plan will be further worked up by the Trust Board at the June Thinking Day.

1.2 In updating the OD Plan we are currently focussing on the Trust's progression and reconfiguration requirements towards achieving the UHL Five Year Plan (2015-20). A desire and willingness to embrace new ways of working, engagement and collaboration are key to future-proofing our change capability and ensuring that the challenges UHL faces over the next few years can increasingly be met with confidence and experience (see separate UHL Way Report dated 7 April 2016).

1.3 As part of the Reconfiguration Programme Business Planning Process, it has been agreed that each business case will include plans and capacity for OD interventions across the project and system. Where this is appropriate, this will ensure that the delivery of the changes are properly developed and implemented. OD capacity should be included from the conception right through to after go-live.

1.4 The Trust's Reconfiguration Board will be responsible for ensuring the appropriate level of rigour in delivering the Reconfiguration elements of the OD Plan and ensuring that robust governance and programme delivery arrangements are in place. The Reconfiguration Board will receive progress updates at quarterly intervals via the Director of Workforce and Organisational Development or representative.

1.5 We will capture the following against Organisational Development Objectives:-
- What will be different?;
- What will we do to make it different?; and
- How will we know if we are successful?

1.6 We will monitor 'how we are doing' on an on-going basis by adopting the new UHL Pulse Check incorporating key quality measures including Staff Friends and Family Test Results Other key measures that will indicate how we are doing include National Staff Survey Results (see separate Staff Survey Report dated 7 April 2016), in role/extra role performance, Turnover, Corporate/CMG Performance, Patient Safety/Harm and Patient Satisfaction Levels.

1.7 The announcement towards the end of 2015 concerning the availability of capital nationally has impacted on the Reconfiguration Programme and the timescales to implement and achieve the three-to-two Acute Site solution at UHL. Whilst focussing on the re-phased delivery of the Reconfiguration Programme, it is essential that we work through the implications for Organisational Development as a whole.

1.8 Organisational Development and Interdependencies

1.8.1 The Better Care Together programme and the UHL Five Year Strategy articulate a vision for services in LLR in which far more care is provided out of the hospital in primary, community and home care settings, allowing UHL to concentrate on delivering care to complex patients.

1.8.2 Externally there will be engagement and discussions with the BCT Workforce and OD Leads to develop a shared culture as part of the Workforce Implementation Plan led by the Director of Workforce and Organisational Development.

1.8.3 The Organisational Development Plan will compliment and interface with the Trust's Strategic Direction, Clinical Strategy, Vision and Five-year Plan. As part of this there will be necessary interdependencies with cross cutting work-streams from an organisational change perspective. Notable interdependencies are:

- Models of Care / Future Operating Model
- Major Strategic Business Cases
- Cross cutting work-streams – beds, theatres, outpatients and diagnostics
- Estates work streams – major strategic projects, infrastructure, property and annual capital programme
- Finance

2.0 Workforce Plan

2.1 UHL's Five Year Workforce Plan (2014-2019) has six strands of delivery to support the five year plan:

- Reducing our dependency on the non contracted workforce
- Ensuring safe staffing levels
- Seven day service delivery
- Urgent and emergency care
- Increasing community provision
- Increasingly specialised services.

These are managed through a range of workstreams including the Workforce Cross Cutting Board and associated subgroups, the Nursing Executive, the Better Care Together workstreams, the Reconfiguration Business Case workstreams, the Seven Day Services Project Board, the New Roles Group and the Strategic Planning Group. Supporting the delivery of the Workforce Plan is the aforementioned Organisational Development Plan which will ensure we address the cultural and behavioural changes and service improvement methodology needed to deliver the large scale changes through engagement of the workforce, the process for this is described in the OD Plan update paper.

2.2 Since the last Trust Board update on the Workforce Plan, Clinical Management Groups and Corporate Services have been focused on developing Operational Workforce Plans to support delivery plans for 2016/17. This has been a fully integrated process with activity and capacity planning. At the same time plans need to align to evolving business cases linked to service transformation and the LLR Better Care Together Programmes. In addition, plans have needed to take into consideration supply challenges as these impact on the ability to create capacity for the

delivery of services and projections for agency expenditure. The majority of this paper will describe these challenges and the Trust's workforce planning and development response with specific reference to:

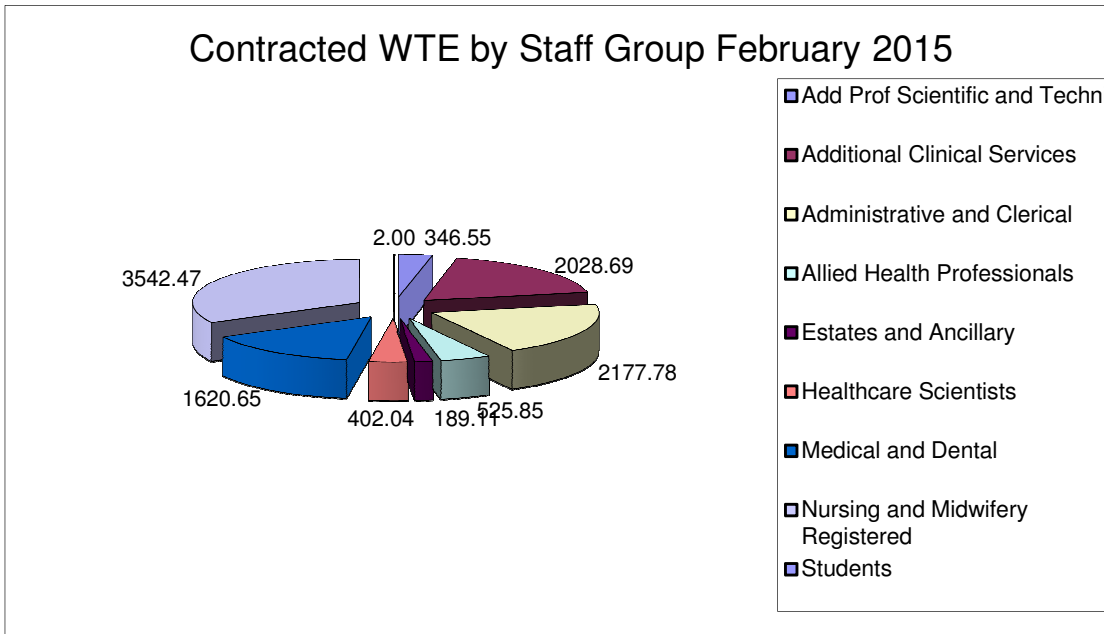
- The Medical Workforce
- The Nursing Workforce
- Non-Medical/Other Clinical Roles
- Better Care Together
- Internal Reconfiguration
- New Roles
- CIP and Paybill

The paper will also describe the internal HR and workforce response to enable the changes to take place as initiated by the September Board Thinking Day, launch of the UHL Way and the potential launch of an LLR Way.

3.0 THE CURRENT WORKFORCE POSITION

3.1 A comparison of the workforce profile in February 2016 compared to February 2015 is shown in Figure One below. Figure Two is a bridge diagram showing the relative growth in each workforce category by whole time equivalent (WTE) to reach our current position – please note that there is a slight variation in numbers as finance systems utilise different staffing categories to ESR for example nursing qualified and non qualified are aggregated. An analysis of administration and clerical role growth has been undertaken which demonstrates increases are resulting from investment in coding, waiting list coordination and flow coordinator posts which improve the patient experience. Nursing and Midwifery overall shows 37 less staff contracted compared to February 2015 although this is mainly accounted for in a reduction in numbers of unqualified nurses (68 WTEs) compared to an increase in qualified nursing and midwifery staff of 31 WTE.

Figure One: Staff Group Change Comparison (source ESR)



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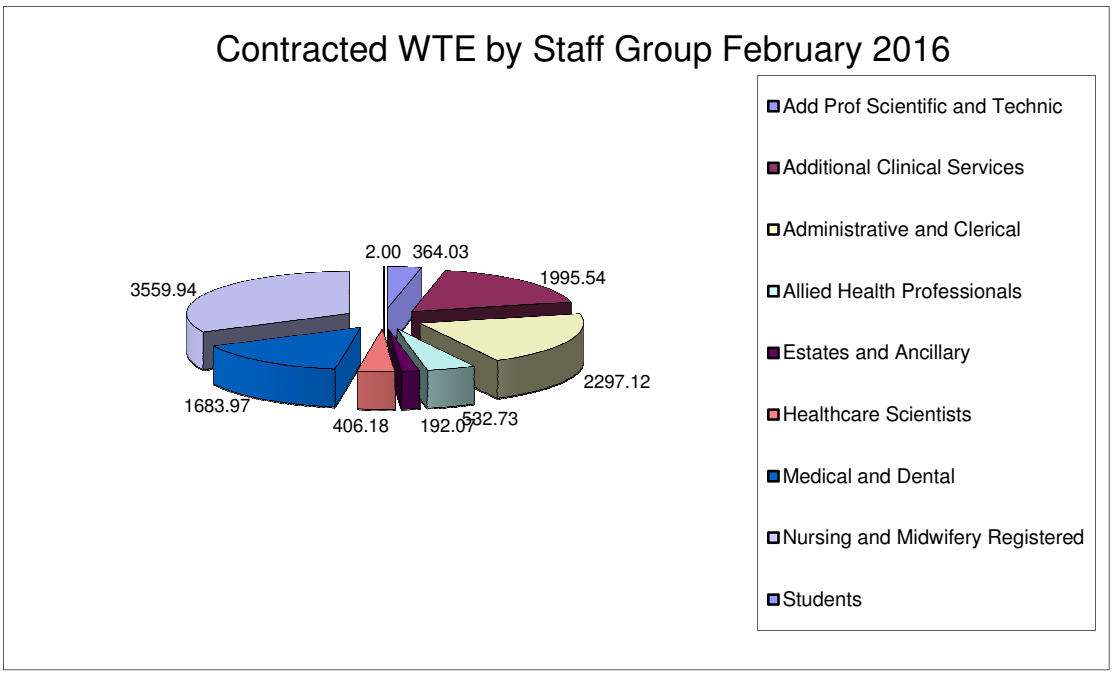
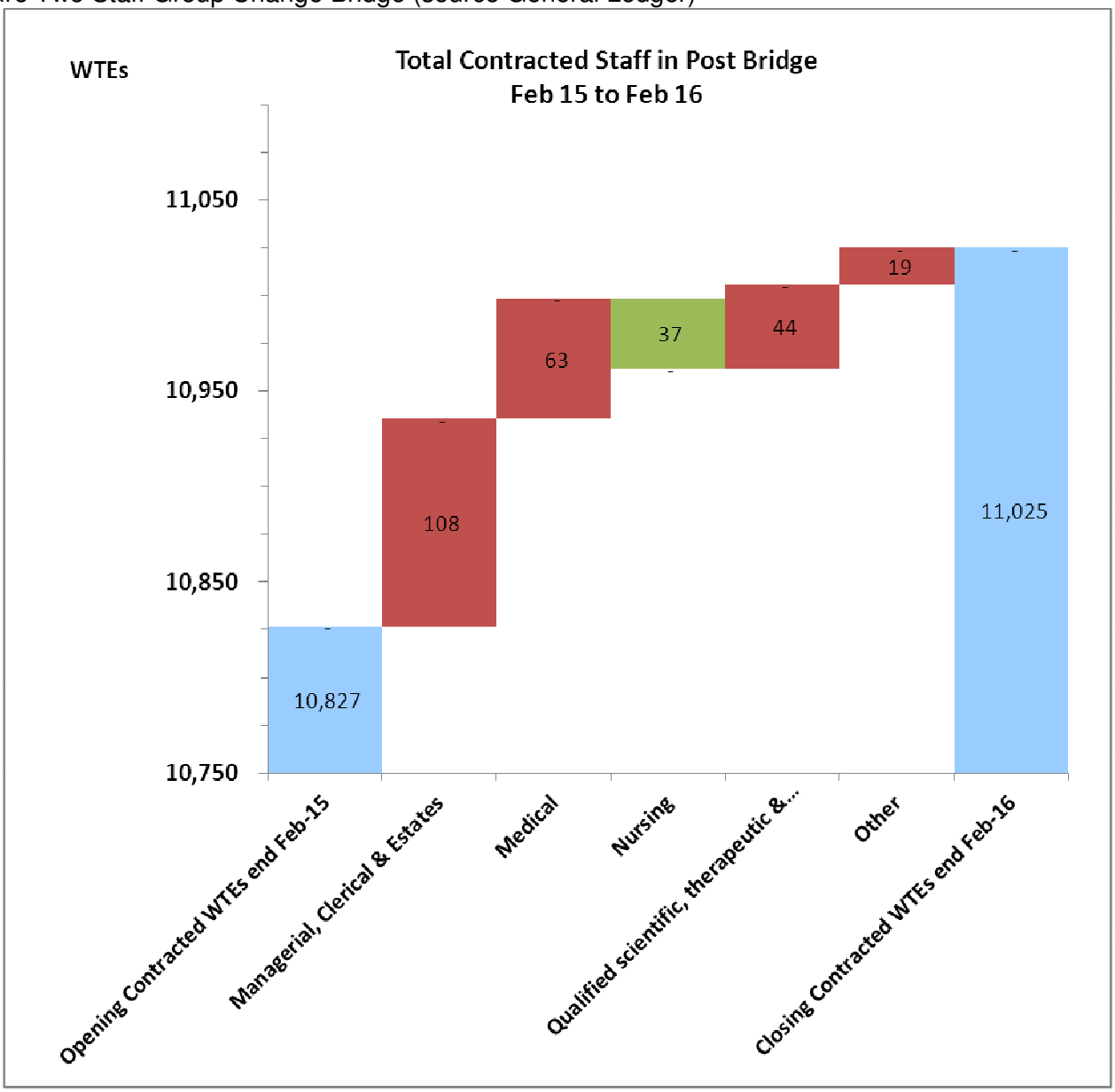


Workforce Plan Update

Figure Two Staff Group Change Bridge (source General Ledger)



3.2 Figure Three below is an extract from the workforce plan submission to the TDA and shows how we are performing against our revised plan for this year. This shows that we are approximately on target in respect of our relative prediction of substantive staff in post with the exception of nursing where we are 126 substantive WTEs behind plan for 2015/16 (excluding a clearing house intake of approximately 40 qualified nursing staff) and therefore utilising more bank and agency nursing than our original plan(further detail is provided in 4.4 below). Overall we are utilising 126 WTE more staff than plan which is largely driven by the inclusion of the Urgent Care Centre in our staffing numbers. Figure Four shows our turnover compared to the same month last year and there is a slight decrease in overall levels but higher levels for qualified nursing and additional clinical services which will include healthcare assistants. We are increasingly focused on retention through more detailed thematic analysis of exit interview data, with a relaunch of the latter planned for April.

Figure Three TDA Workforce Plan Submission (source Finance Ledger)

	ACTUAL			
	Substantive Actual in Post WTE	Bank WTE	Agency WTE	Total WTEs WTE
Managerial, Clerical & Estates	2,233.0	38.6	13.0	**2,284.6**
Medical	1,687.0	0.0	69.5	**1,756.5**
Nursing	5,110.7	217.2	178.4	**5,506.3**
Qualified scientific, therapeutic & technical staff	1,247.9	12.2	32.4	**1,292.5**
Other	746.3	0.0	0.0	**746.3**
TOTAL ACTUAL WTEs	**11,025.0**	**268.0**	**293.3**	**11,586.2**

	REVISED NTDA PLAN			
	Substantive Actual in Post WTE	Bank WTE	Agency WTE	Total WTE
Managerial, Clerical & Estates	2,204.0	24.0	9.0	**2,237.0**
Medical	1,685.0	0.0	57.0	**1,742.0**
Nursing	5,236.0	149.0	106.0	**5,491.0**
Qualified scientific, therapeutic & technical staff	1,222.0	10.0	12.0	**1,244.0**
Other	746.0	0.0	0.0	**746.0**
TOTAL PLAN	**11,093.0**	**183.0**	**184.0**	**11,460.0**

	VARIANCE TO PLAN			
	Substantive Actual in Post WTE	Bank WTE	Agency WTE	Total WTEs WTE
Managerial, Clerical & Estates	-29.0	-14.6	-4.0	**-47.6**
Medical	-2.0	0.0	-12.5	**-14.5**
Nursing	125.3	-68.2	-72.4	**-15.3**
Qualified scientific, therapeutic & technical staff	-25.9	-2.2	-20.4	**-48.5**
Other	-0.3	0.0	0.0	**-0.3**
TOTAL VARIANCE	**68.0**	**-85.0**	**-109.3**	**-126.2**

Figure Four Changing Turnover Levels (excl Junior Doctors) (source ESR)

	Feb 2015	Feb 2016
Staff Group		
Add Prof Scientific and Technic	11.55	11.35
Additional Clinical Services	10.60	10.92
Administrative and Clerical	11.34	10.45
Allied Health Professionals	11.86	10.33
Estates and Ancillary	9.36	10.04
Healthcare Scientists	9.26	8.89
Medical and Dental	9.93	9.75
Nursing and Midwifery Registered	9.02	9.12
UHL	10.17	9.99

3.3 Figure Five below shows our vacancy levels (difference between the budgeted establishment and staff in post on ESR):

Vacancy WTEs	Feb 2016	Jan 2016	Dec 2015
Managerial, Clerical & Estates			
Admin & estates staff	99.3	105.2	109.0
Managers & senior managers	20.3	21.5	19.7
	119.7	126.8	128.7
Medical			
Career / staff grades	1.5	-0.0	1.1
Consultants	48.1	50.5	59.8
Trainee grades	44.4	56.6	58.7
	94.0	107.1	119.6
Nursing			
Qualified nursing	328.2	314.6	317.7
Support to nursing staff	149.2	138.8	127.1
	477.4	453.4	444.7
Qualified scientific, therapeutic & technical staff			
Allied Health Professionals	38.8	40.5	38.3
Healthcare Scientists	-8.3	-5.3	-2.8
Other ST&T	40	43.2	47.4
	70.4	78.4	83.0
Other			
Other Infrastructure & Support Staff	14.1	14.5	16.1
Other support to clinical staff	19.3	14.0	10.0
Reserves		0.0	0.0
Turnover factor	53.5	-53.9	-53.9
	20.5	-25.5	-27.9
Grand Total	740.9	740.2	748.1

Generally we are closing the gaps on vacancies and further work is in place to provide more transparent reporting of progress against defined recruitment campaigns including data on key performance indicators for recruitment.

4.0 WORKFORCE PLANNING AND DEVELOPMENT

4.1 Planning our future workforce is a complex process as we need to envisage and predict different models of care for the long term planning horizon (the next 3-10 years) and plan education and development interventions now to deliver these changes. This needs to occur in the context of managing current workforce pressures such as changes in the supply of workforce and changes in the relative dependency on a non contracted workforce. Appendix One summarises our current challenges, how we are managing and governing these changes and some key outputs to date for each of the workstreams outlined in 2.1.

4.2 The Trust is currently concluding operational plans for 2016/17 which show how Clinical Management Groups are translating changes in activity into capacity requirements and consequently workforce. Once a final establishment figure is agreed, CMGs will indicate the relative balance of non contracted and contracted workforce to meet this demand based on best predictions of the supply market. Plans details the drivers for workforce changes which include volume growth, service changes, seven day services, efficiency etc.

4.3 The Medical Workforce

A detailed Medical Workforce Strategy action plan is in progress and the principle highlights are summarised below. These highlights reflect our current short term plans to increase Trust Grade capacity and flexible deployment as we redefine, and educate an alternative team around the patient.

4.3.1 Recruitment

4.3.1.1 A focus on Trust Grade capacity increase, supported by international recruitment is addressing the dual objectives of the Workforce Plan to reduce dependency on the non contracted workforce and ensure safe staffing. Detailed recruitment plans are now in place at specialty level for trust grades to support any predicted gaps from August 2016.

4.3.1.2 The Trust is actively participating in Medical Training Initiatives and British Council Led recruitment campaigns to attract workforce to UHL.

4.3.1.3 It is acknowledged that further work is required to increase the numbers of applicants for consultant posts within the Trust and this will form part of an overall attraction strategy. A number of specialties have participated in events to encourage applications from higher level trainees.

4.3.2 Retention

4.3.2.1 HEEM funds continue to support our investment in Trust Grade Clinical Supervision and development and the introduction of rotational posts will further enhance the ability to retain this workforce.

4.3.2.2 The impact of the new junior contract is not yet known but will be closely monitored.

4.3.3 Redesign

4.3.3.1 The Trust is currently engaging teams in how to construct different ‘teams around the patient’. Work undertaken in Cardiology has identified the scope to increase the numbers of Advanced Practitioners who are also supporting the quality of training for our junior doctors.

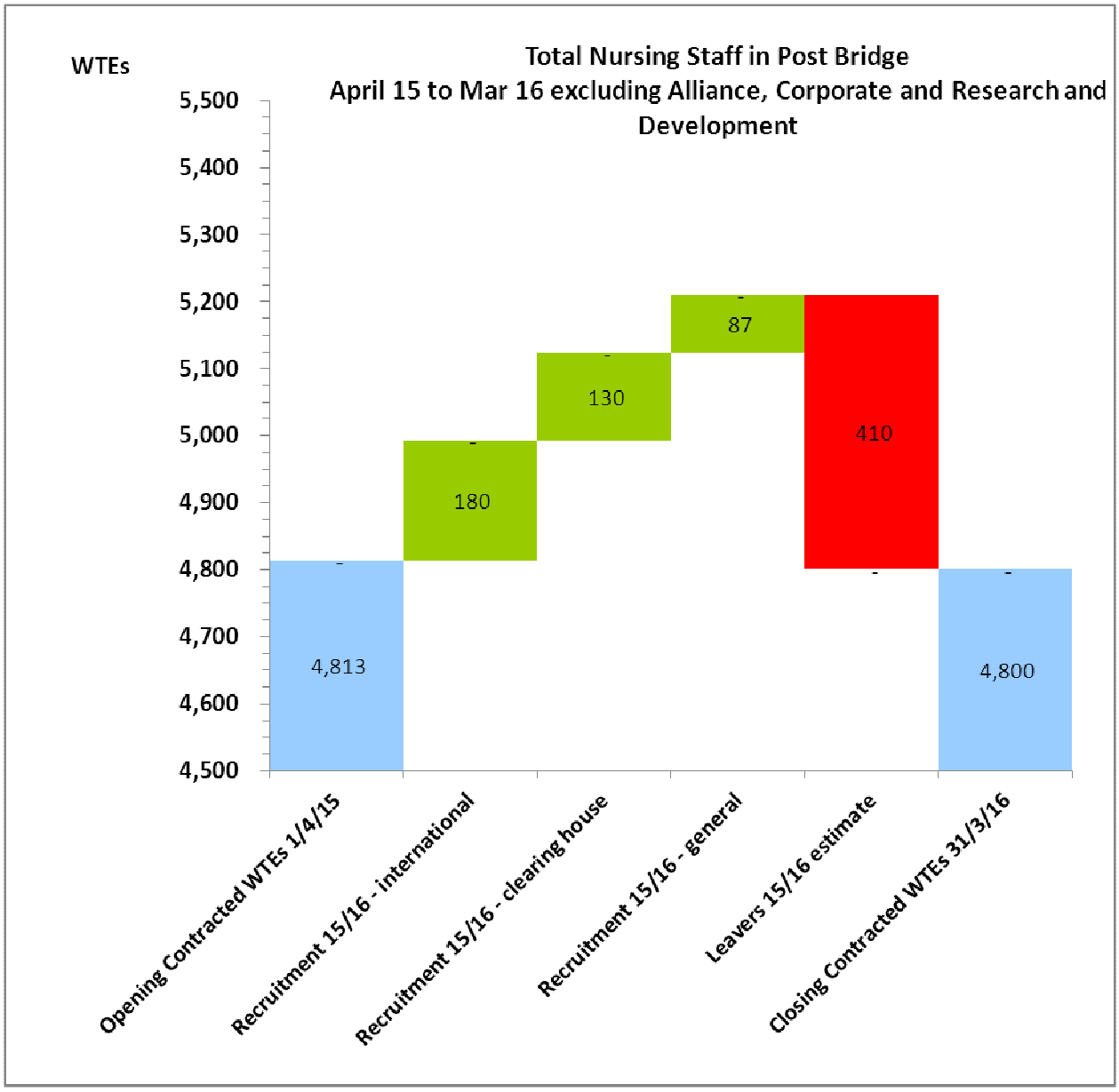
4.3.3.2 The Physician Associate (PA) National Expansion Programme has led to the appointment of six Physician Associates from the United States who will provide support in Orthopaedics, Urology, Gastroenterology and Paediatrics. A comprehensive support programme is being developed to ensure these postholders experience a high quality on boarding programme.

4.3.3.3 Deep dive analysis of consultant job plans is currently underway in a number of specialties to ensure we are maximising the efficiency and effectiveness of job planning. This work is consistent with the outcomes of the Carter Review.

4.4 The Nursing Workforce

The vacancy position for registered nurse and healthcare assistants continues to be closely monitored together with relative turnover trends. The turnover for International Nurses has increased to 21.43% and Emergency Department Nurses has increased to 24.27%, this is contributing to an overall increase in turnover. As at February 2016, the current vacancy position is c9% of 477 whole time equivalents (wte), 328 wte registered nurses & 149 wte unqualified. Figure Six is a bridge of the qualified and unqualified nursing recruitment trajectory (excluding Alliance, Corporate Nursing and Research and Development) from the starting position in April 2015 to the closing position in March 2016. This shows the numbers to be recruited from three recruitment campaigns – international, clearing house and generic advertising. These numbers are offset against total turnover which is around 410 whole time equivalents. The net position is a reduction in overall nursing of 13 whole time equivalents. In April 2016 we are expecting a further intake of international nurses which will not be included in the workforce bridge shown below.

Figure Six : Nursing Bridge



4.4.1 **Recruitment**

4.4.1.1 International nurse recruitment has been very successful with 413 recruited since the start of international recruitment. UHL has lost 80 international nurses in total. In April 2016 we will have 30 additional qualified nurses joining the workforce.

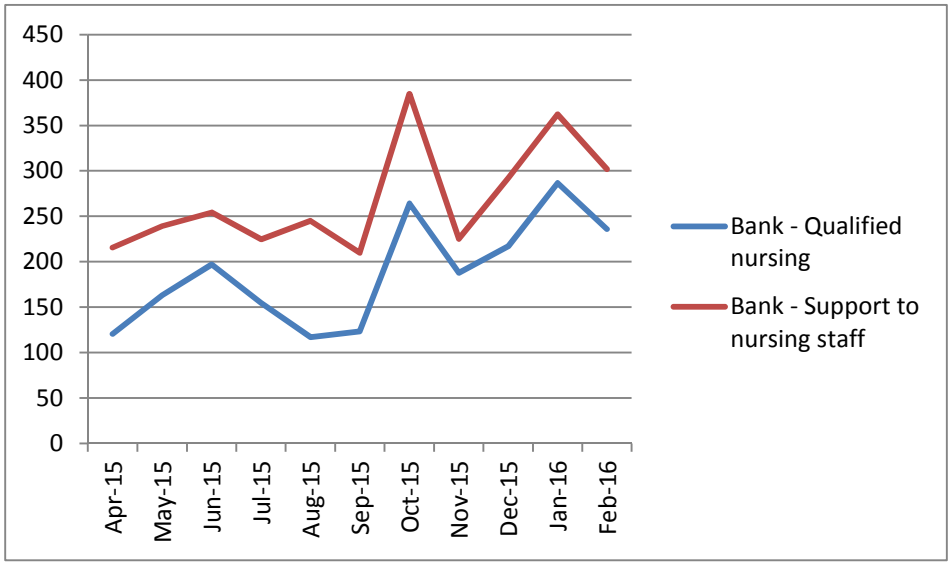
4.4.1.2 A further Clearing House intake commenced in March of approximately 40 nurses (numbers will be reflected in the Bridge) and agreement has been reached with DMU that in the future there will be two cohorts of paediatric nursing in order to maintain more balanced staffing levels throughout the year. Commencing in 2017, in addition to moving the current January intake of adult nurses to March in line with other HEIs (again from 2017). Following the changes to nursing commissions announced in the Comprehensive Spending Review, the Trust has put forward a bid to Health Education East Midlands for funding to support a range of initiatives to support Access to Nursing students enter nurse training at DMU and to support LLR readiness for the changes in the student bursary.

4.4.1.3 In addition to risks within children's, other areas of significant risk remain medicine and theatres. Medicine, together with ED and Children's have local recruitment and retention premia in place.

Within Medicine, the Trust has put in place a joint preceptorship scheme with LPT to attract newly qualified staff into developing skills across both care settings.

4.4.1.4 Following the introduction of scrutiny in relation to use of non framework nursing agencies and a requirement to reach the agency cap level of 3% by April 2016, more emphasis has been placed in increasing the bank. The introduction of bank weekly pay and improved pay and conditions has led to a significant increase in the use of bank staff to fill non contracted workforce requirements. Figure Seven below shows the increase in WTE bank usage through the current financial year:

Figure Seven: Bank Usage Qualified and Unqualified Nursing



4.4.1.5 The Trust has embraced Revalidation and the Care Certificate as an opportunity develop first class education and support programmes to attract qualified and Non-registered staff to UHL. The Care Certificate has also provided the opportunity to raise the bar on selection standards for health care assistants which has resulted in better appointments and improved retention although the numbers successfully recruited at each recruitment campaign has reduced. Work is underway to provide improved support for the acquisition of maths and English skills at the required level.

4.4.1.6 As part of the overall attraction and resourcing strategy, the Trust will be reviewing its approach to the support of Return to Practice Nurses (in collaboration with LPT and HEEM) commencing in May 2016, the recruitment of healthcare assistants including developing methodology to tap into new recruitment sources and increasing the number of intakes.

4.4.2 Retention

4.4.2.1 Nursing into Action teams have fully embraced the principles of Listening into Action to engage and motivate staff to develop local innovation to improve both patient and staff experience.

4.4.2.2 Within ESM and ITAPs a retention survey has been implemented to identify key reasons why individuals would remain in UHL employment. This will enable the design of proactive retention schemes.

4.4.3 Redesign

4.4.3.1 The two principle redesign initiatives in the nursing workforce are Advanced and Assistant Practitioners. An advanced practice unit is now well established (supported by HEEM). This unit

has put in place robust governance arrangements for quality assuring the practices, academic levels and competencies of this workforce. There are 23 advanced practitioners participating in development programmes and the Trust intends to fill the new cohort for September 2016 and a number of advanced practice roles are identified in workforce plans for this year.

4.4.3.2 Assistant Practitioners are able to undertake a range of tasks traditionally undertaken by nurses but do not require registration. The approach replicates in the advanced model as it is a 'grow your own' model and emphasises learning in the workplace at QCF level 5. There are approximately 40 assistant practitioners participating in training programmes. UHL also is the preferred provider for LPTs assistant practitioner training which enables a level of consistency across the LLR community. The Trust is currently reviewing how these roles may be supplemented with the proposed introduction of Nursing Associate. UHL have responded positively to the proposal for these new roles and if accepted as a national pilot site, training will commence almost immediately.

4.4.3.3 Within the Emergency Department, Band 1 roles have been introduced which are designed to reduce administrative burdens on qualified staff and will release time to care.

4.5 Non Medical/Other Clinical Roles

This group embraces allied health professionals, pharmacists and health care scientists for whom there have traditionally been fewer risks to supply.

4.5.1 Recruitment and Retention

4.5.1.1 Sonographers have always been a recruitment risk and the Trust has invested in international recruitment programmes to redress shortages in supply. In addition, the Trust has an internal development programme to 'grow our own' sonography workforce. The introduction of agency caps has led to some reduction in the cost of sonographers although there are still breaches of national caps.

4.5.1.2 Imaging are continuing to pursue the international recruitment market in order to bridge gaps in the supply of qualified staff. This will include promoting roles at the Greece Recruitment Fair in June 2016. Other professional groups such as biomedical scientists are reviewing the requirements of registration bodies in order to determine whether Greece offers a viable recruitment market.

4.5.1.3 A number of Occupational Therapy staff have been seconded to LPT to support the Integrated Care Service model of care which is a virtual bed model of care supported by a multidisciplinary team of therapists and nursing staff. This is undergoing evaluation during March and April to ensure we continue to recruit the right skills and effectively use this initiative to develop career opportunities.

4.5.2 Redesign

4.5.2.1 Through the redesign group some healthcare scientists and pharmacists are looking to develop clearer routes to bridge the gap between unqualified and qualified staff through advanced apprenticeship courses and locally designed training.

4.5.2.2 In order to meet seven day service standards and reduce dependency on agency staff for specialist skills, imaging have bid to Health Education East Midlands for monies to support the development of advanced practice. Dietetics have also bid for monies to support the education of staff to support more complex caseloads.

4.5.3 Better Care Together (BCT)

4.5.4 An LLR wide Workforce and Organisational Development Group consisting of leads from health and social care has now met on three occasions to review how the workforce agenda will be addressed in an integrated way across the geographical footprint. Building on the findings below, a number of subgroups have been established to deliver clear plans of work:

- The required cultural and behavioural transformation of the workforce
- The required remodelling of the workforce
- The need for joined up approaches to workforce planning and development
- The need for integrated approaches to attraction, resourcing and development
- The need for integrated employment models which enable movement around the system.

The subgroups are organisational development, workforce planning, attraction and retention and staff mobility. Given the risks in the primary care workforce an additional group has been established to address this agenda. All of the subgroups will identify educational requirements which will be progressed through a workforce capability group who will also have a responsibility for oversight of education quality. These will formally report to the LETC Board which progresses the workforce agenda on behalf of the Better Care Together Delivery Board.

4.5.5 The Better Care Together Workforce Strategy which accompanies the pre consultation business case for BCT describes the key outcomes and a draft delivery plan for these workstreams. Summary outcomes are:-

- Capacity – Ensuring the future supply
- Capacity – Ensuring the system can make the capacity shifts required
- Ensuring staff have the right skills and capabilities to perform in the new system
- Ensuring effective management of change and development of the 'system' culture

4.5.6 In terms of progress to date, these subgroups have achieved the following:

- An initial meeting of workforce planners to agree how we will reach an overall workforce plan for the system including the development of consistent templates and language.
- A workshop to review the priorities for system wide workforce planning linked to settings of care. This will commence with urgent care.
- Acquisition of funds to develop an LLR wide attraction strategy.
- Early development of the concept of an LLR Way similar to the UHL Way.
- Guidance on HR policies and processes for rotational posts and secondments currently across healthcare.

4.6 Internal Reconfiguration

4.6.1 Each of the following internal reconfiguration programmes will be supported by a workforce workstream:

- Emergency Floor
- ICU and Vascular Reconfiguration
- Planned Ambulatory Care Hub
- Women's
- Children's Hospital

4.6.2 The purpose of these workstreams is to develop comprehensive multidisciplinary workforce plans to support new models of care arising from reconfiguration. Work has commenced on managing these programmes through programme management methodology to cover all aspects of HR. This approach was approved by the Reconfiguration Board in January and will ensure that critical dependencies between aspects of workforce are planned. Senior confirm and challenge will be introduced at breakpoints in the business case development programme

to confirm and challenge proposed plans and ensure opportunities for quality and efficiency are maximised.

4.6.3 In terms of current progress to date, the following has been achieved:

- Emergency Floor workforce planning workshops to review skill mixes required in terms of specialist, enhanced and foundation skills. This review also needs to take into consideration current workforce challenges arising from the CQC visit. An organisational development plan for the Emergency Floor is currently in progress.
- The ICU plan for workforce is almost finalised subject to a conclusion being reached on middle grade rotas. The vascular workforce plan in terms of numbers is concluded and work is underway on engagement and management of change.
- The Planned Ambulatory Treatment Centre is currently engaging clinicians in new models of care. Workforce are part of these discussions to ensure best practice is adopted in terms of workforce modelling.
- Work is underway to develop an LLR wide Children's Workforce Strategy
- Functional mapping to determine appropriate skill mixes for women's services is underway.

4.7.4 A workforce planning toolkit is almost complete to support managers in developing a range of approaches to workforce planning.

4.7 CIP and Paybill

4.8.1 A new approach to the governance of workforce cost improvement was implemented in March 2016. The Workforce Cross Cutting Workforce Board is now split into a corporate function and and a CMG function. The Corporate meeting is focused on schemes which are managed centrally and include:

- Concluding the Clinical Nurse Specialist Review
- Concluding the ward staffing review including maximising the use of long shifts
- Reviewing the implementation of the job planning methodology
- Ensuring reduction in premium expenditure through full implementation of price capping and control of authorisation and recruitment mitigation plans.

The CMG meeting focuses on CMG led workforce CIP schemes which include skill mix changes and schemes to process higher activity levels with the same level of workforce. CMGs will also report on progress against corporate intiatives such as job plans reviews.

4.8.2 The premium spend workstream continues to meet given the significant importance of reducing our paybill spend and ensuring adequate controls are being implemented. The group reviews the premium spend dashboard which pulls together a number of reporting metrics to give an overview of both expenditure and control. The group also reviews:

- Premium pay reduction action plans and the impact of these on premium spend targets
- Retrospective booking of medical shifts
- The effectiveness of agreements relating to authorisation processes and review of price cap breaches
- Utilisation of the workforce planning tool to predict when recruitment levels will enable significant reductions in premium expenditure.

4.9 New Roles

4.9.1 All of the above sections have made reference to the implementation of new roles which, by their nature, need to reflect multidisciplinary approaches. The New Roles Steering Group,

chaired by the Chief Nurse, is responsible for promoting methods for designing the workforce in different ways and communicating the policies and processes described above.

4.9.2 A key programme of work for the New Roles Steering Group will be to respond to government changes and opportunities presented by the levy on apprenticeships. The Trust is predicting a levy payment of £2.67m bill which will be offset by funding drawn down as apprentices are appointed and receive accredited training. The funding arrangements also enable the Trust to develop our role as a training provider for which we can also draw down funds. This change in government strategy presents us with an opportunity to clearly define how apprentices will form part of our workforce infrastructure and how we can create career pathways into roles at higher bands by offering progressively higher level apprenticeships. This will have a transformational impact on workforce planning and career development in the future.

5.0 HR and Workforce as Enablers

5.1 In order to respond to the significant challenges to reduce pressure in the acute setting and support front line staff in resourcing, developing and engaging workforce, the wider HR team has recognised the need to reform the way in which it operates.

5.2 The HR and Workforce teams are currently progressing a range of strategies to deliver and support this challenging agenda:

- Developing an integrated Trust wide Resourcing and Attraction Strategy
- Review of Recruitment practices and processes designed to significantly reduce the time to hire and supported by a set of robust and transparent KPIs
- Organisational development training for all HR teams in order to better support the change and transformation agenda..

6.0 NEXT STEPS

6.1 Each of the groups described in this paper will continue to deliver the objectives described.

6.2 The Executive Workforce Board and Trust Board will continue to be appraised of progress and risks

6.3 A Board Thinking Day will be held in June 2016 to review progress and refresh priorities

7.0 RECOMMENDATIONS

7.1 The Trust Board is asked to:-

- Be assured of the actions being taken and outcomes to date.

Medical Staffing

Appendix

Nursing Staffing

Core Challenges

- Nursing vacancies remain high and gap filling through agencies is costly but necessary to maintain safe staffing levels
- Recruitment pool of international nurses reducing, turnover not likely to be below Trust average
- Concentrated gaps in medicine
- Balance between efficiency and flexible working
- Agency caps and restrictions
- Education levels for Care Certificate and Assistant Practitioners raised will be further impacted by Leicester Labour Market challenges
- Revalidation of nursing and midwifery and preceptorship pressures from Shape of Caring recommendations
- Retirement of long standing nurse leaders
- LLR recruiting from same pool of staff

Trust Response and Governance

- Nursing Workforce Strategy with particular emphasis on international recruitment, Nurse Education Strategy
- New roles identified in form of Assistant Practitioner and Advanced Practitioners to support career framework
- Reporting of Nursing workforce progress through the Nursing Executive Team and EWB
- Board reports on safe staffing and agency usage
- New Roles Steering Group managing implementation of Advanced and Assistant Practitioners
- Nursing/ premium spend strand of Wokforce Cross Cutting Theme

Key Outputs

- International recruitment team to ensure quality and efficiency
- Improved branding and marketing and presence at recruitment events, now promoting through armed forces publications
- Clear career pathways and education programmes for advanced and assistant practitioners and programme of cohorts for 2015/16
- .Strong in house education, training and practice development offering accredited training at degree level. Plan emerging for responding to the removal of commissioned nursing
- Utilising Revalidation as a marketing and branding opportunity
- Introduction of shared rotation and strong partnerships with DMU and LPT
- Improved bank fill rates and demonstrable reduction in agency expenditure

Other Non Medical Clinical Roles

Core Challenges

- Increasing turnover in traditionally easy to recruit services such as therapies, pharmacists and radiography
- Managing internal career development pathways for pharmacy technicians
- Increasing demand in community for therapy services
- Retirement profile in senior healthcare science roles

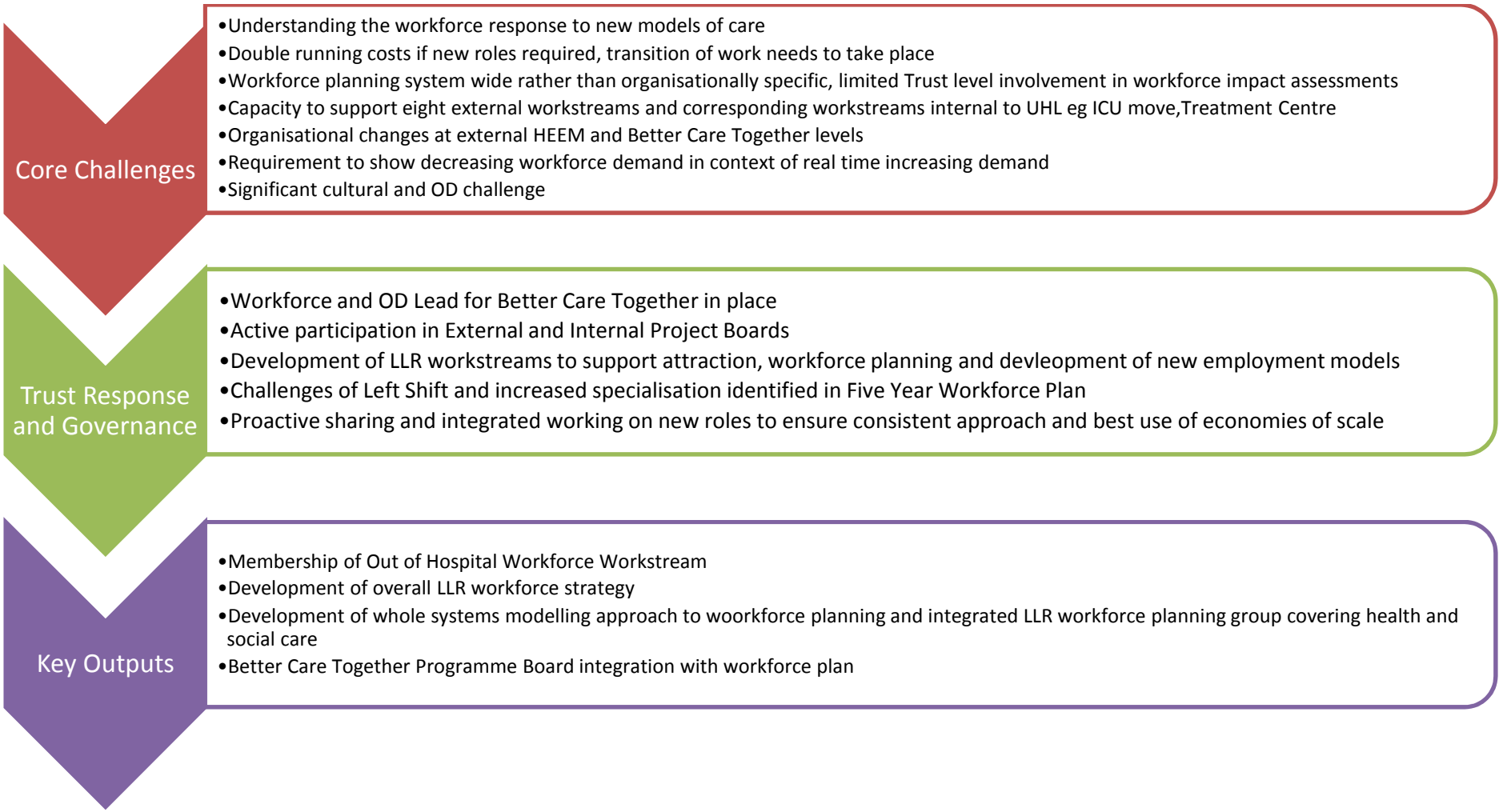
Trust Response and Governance

- Non Medical staff form core component of new roles development governed through New Roles Steering Group
- Engagement in LETG internally and LETC externally
- Engagement in HEEM workforce planning process to predict workforce over five years

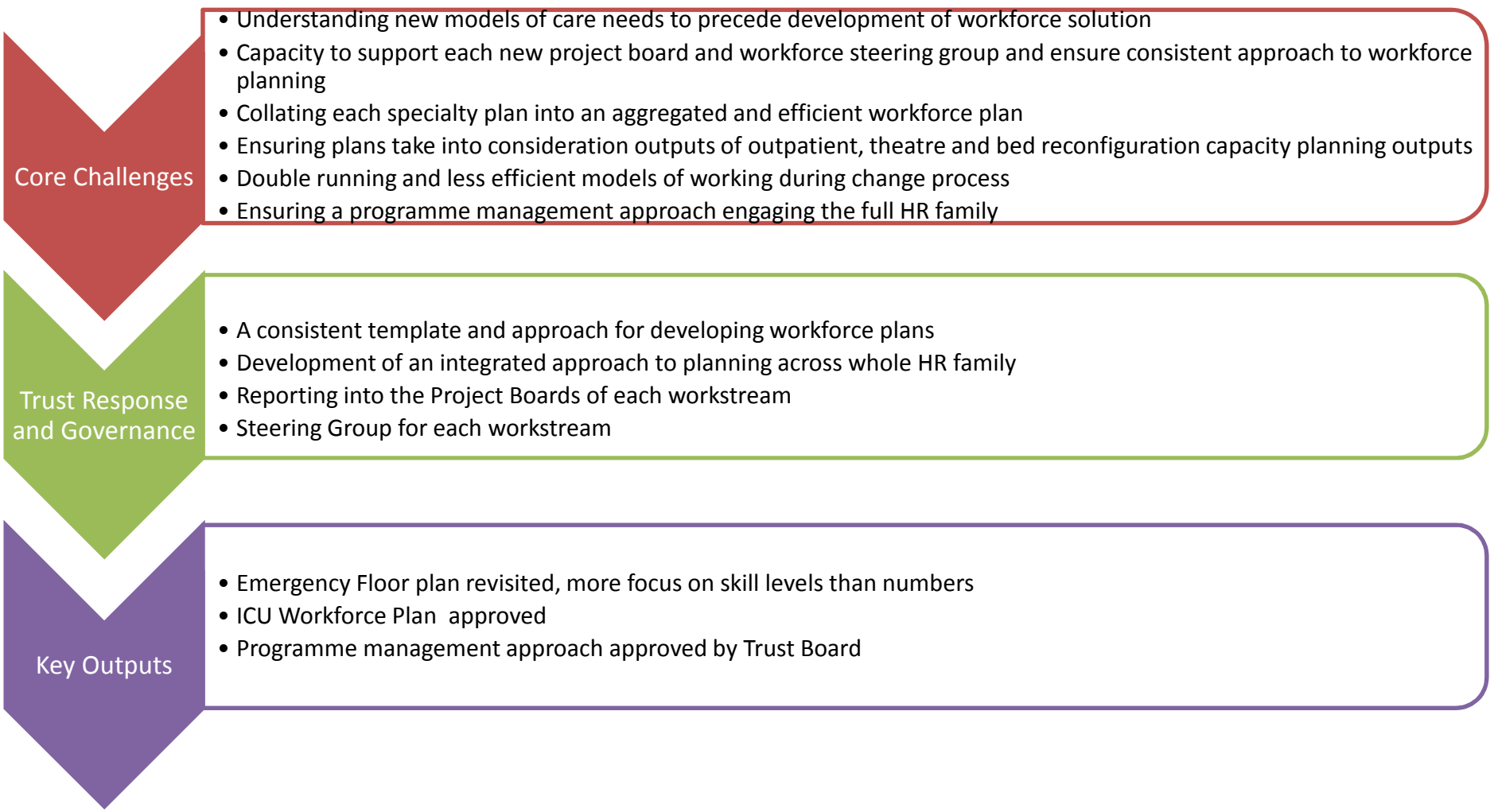
Key Outputs

- More robust workforce return to HEEM outlining core pressures and developments in the Trust
- Wider exploration of how new roles for allied health professionals and healthcare scientists can support medical staffing gaps and new models of care
- Continued international recruitment for radiography posts
- Utilisation of therapy staff to support alternative solution to sonography gaps
- Increased working across organisational boundaries

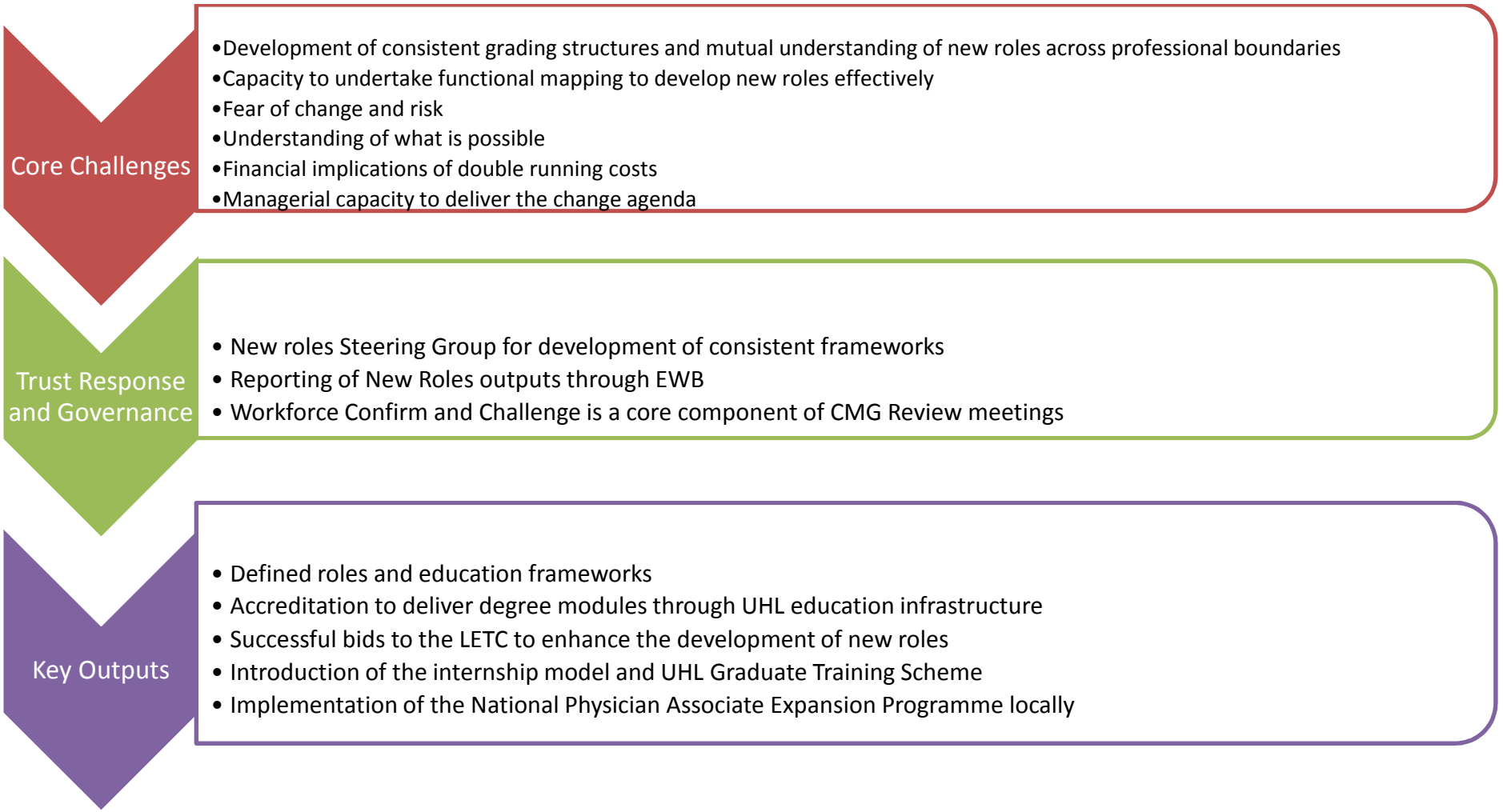
External Better Care Together



Internal Reconfiguration



New Roles


Core Challenges
•Development of consistent grading structures and mutual understanding of new roles across professional boundaries
•Capacity to undertake functional mapping to develop new roles effectively
•Fear of change and risk
•Understanding of what is possible
•Financial implications of double running costs
•Managerial capacity to deliver the change agenda
Trust Response and Governance
• New roles Steering Group for development of consistent frameworks
• Reporting of New Roles outputs through EWB
• Workforce Confirm and Challenge is a core component of CMG Review meetings
Key Outputs
• Defined roles and education frameworks
• Accreditation to deliver degree modules through UHL education infrastructure
• Successful bids to the LETC to enhance the development of new roles
• Introduction of the internship model and UHL Graduate Training Scheme
• Implementation of the National Physician Associate Expansion Programme locally

CIP and Paybill