Northern Ireland Assembly

Committee for Health, Social Services & Public Safety

Review of Workforce Planning in the Context of Transforming Your Care

NIA 268/11-16

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Committee powers and membership

The Committee for Health, Social Services and Public Safety is a Statutory Departmental Committee established in accordance with paragraphs 8 and 9 of the Belfast Agreement, section 29 of the Northern Ireland Act 1998 and under Standing Order 48. The Committee has power to:

- Consider and advise on Departmental budgets and annual plans in the context of the overall budget allocation;
- Consider relevant secondary legislation and take the Committee stage of primary legislation;
- Call for persons and papers;
- Initiate inquiries and make reports; and
- Consider and advise on any matters brought to the Committee by the Minister for Health, Social Services and Public Safety.

<u>Membership</u>

The Committee has 11 members including a Chairperson and Deputy Chairperson and a quorum of 5.

The current membership of the Committee is as follows:

Ms Maeve McLaughlin (Chairperson)
Mr Alex Easton (Deputy Chairperson)
Mrs Pam Cameron MLA
Mrs Jo-Anne Dobson MLA
Mr Paul Givan MLA
Mr Kieran McCarthy MLA
Ms Rosie McCorley MLA
Mr Michael McGimpsey MLA

Mr Daithí McKay MLA

Mr Fearghal McKinney MLA

Mr George Robinson MLA

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Terms of Reference

The Committee agreed the following terms of reference:

1. To assess progress to date on workforce planning in support of the implementation of Transforming Your Care, to include:
   a) Progress made on evidence based workforce modelling at regional and Trust level;
   b) Investment made in training/re-training of staff to achieve appropriate skills mix; and
   c) Investment in leadership and capability development.

2. To ascertain the extent to which the impact on the workforce of shifting £83 million from hospital based services to primary/community based services has been modelled and planned for, and the impact on staff to date of money shifted in accordance with this aspect of Transforming Your Care.

3. To examine the extent to which workforce planning in support of the implementation of Transforming Your Care is taking account of recruitment issues for particular geographical areas, the desirability of seven-day working, and the composition of the workforce in terms of gender mix and the associated work-patterns.

4. To scrutinise the Department's assumption that the implementation of Transforming Your Care will require a reduction in the overall workforce of 3%, and the proposed mechanisms to achieve this objective.

5. To examine the Department's approach to involving staff, professional bodies and staff side organisations on workforce planning in support of the implementation of Transforming Your Care

6. To identify examples of best practice in relation to workforce planning in support of a "shift left" in services, which could be usefully applied to the implementation of Transforming Your Care.

Committee Consideration

7. The Committee held 9 evidence sessions with a range of witnesses, including the Department, who provided information on workforce planning in the health and social care sector.   The Committee heard from:

   - The Regional Workforce Planning Group (chaired by the Department)
   - British Medical Association (BMA) and Royal College of General Practitioners (RCGP)
   - Royal College of Nursing (RCN) and Royal College of Midwives (RCM)
   - Unions (ICTU, NIPSA and UNISON)
   - NI Social Care Council (NISCC) and NI Association of Social Workers (NIASW)
   - Allied Health Professions Federation NI (AHPFNI)
   - Scottish Government
   - 5 Trusts

8. The minutes of evidence of these sessions are at Appendix 1, and the presentations and notes provided by witnesses are at Appendix 2.

9. The Committee also held evidence sessions with Departmental officials on 11 March and 24 June (see Appendix 1) and considered written correspondence from the Department (see Appendix 3).

10. The Committee considered two papers from Assembly Research and Information Service entitled 'Transforming Your Care (TYC – Workforce Planning' and 'Transforming Your Care (TYC) Workforce

Planning 2 – Trends in HSC Staff Numbers'. These can be found at Appendix 4.

List of Recommendations

11. **The vision set out in Transforming Your Care has widespread support across the health and social care sector. However, there is a lack of clarity around the plan and timetable for implementation. The Committee believes that the Department should move to speedily implement Transforming Your Care.**

12. **Communication between the Department and professional and staff side bodies on the status of Transforming Your Care requires improvement. The Committee believes that the Department needs to reiterate to key stakeholders that Transforming Your Care remains the policy driver in terms of the reform of health and social care.**

13. **The development of the service models required to implement Transforming Your Care should be prioritised by the HSCB/PHA, so as to provide a sound basis for workforce planning. The plan for developing these models should be shared widely among key stakeholders, including professional and staff side bodies.**

14. **The Committee welcomes the establishment of the Regional Workforce Planning Group and believes it has a key role in the implementation of Transforming Your Care. However, given that the Group was set up in August 2012, the Committee would have expected the Regional Workforce Planning Framework to have been produced earlier than April 2015.**

15. The Committee welcomes the workforce review of domiciliary care, and awaits with interest its findings. However, the Committee believes that the Regional Workforce Planning Group should be taking a wider-approach to workforce planning at all levels, and making strenuous efforts to avoid "silo-based" approaches which focus primarily on staffing groups rather than meeting the needs of patients.

16. The Committee is concerned that the Regional Workforce Planning Group is not taking sufficient cognisance of the workforce needs within the private/independent sector – particularly in terms of the nursing and social care staff required for nursing and residential homes, day-care and domiciliary care. As a starting point, it should endeavour to capture data on that workforce and engage with the key stakeholders in that sector.

17. The Committee is concerned that while a number of successive reviews have recommended an increase in GP training places, this has not been implemented by the Department. The Committee recommends that the Department implements the recommendation of the most recent review to recruit an additional 15 GP training places.

18. The Committee is concerned that the regional initiatives on normative nurse staffing having not been completed or implemented, and the potential impact this may have on patient safety. The Committee recommends that the Department implements the findings of Phase 1 and progresses the reviews necessary for Phases 2 and 3 on an urgent basis.

19. The Committee recommends that the Department considers how primary care services can be reconfigured across a range of health and social care professionals, to deal with the increasing demands for GP appointments.

20. The Committee welcomes the fact that the Department is not working towards a 3% reduction in staffing as a target required to implement Transforming Your Care, given the increasing growth in demand for services over recent years. However, the Committee finds it somewhat surprising that the Department was not able to advise exactly how and why this figure was ever contained within the public consultation document on Transforming Your Care Review.

21. The Committee recommends that the Department produces an estimation of the percentage increase or decrease in the size of the workforce required to implement Transforming Your Care.

22. The Committee is concerned that proposals for a voluntary exit scheme with the HSC are not being strategically aligned with the proposals being developed by the Regional Workforce Planning Group. The Committee recommends that the Department urgently engages with the Regional Workforce Planning Group on this matter.

23. The Department should review the membership of the Regional Workforce Planning Group, and consider how it can be made more inclusive of staff side and professional bodies. It should also look at other ways of communicating and engaging with staff side and professional bodies to ensure that organisations are aware of the direction of travel for workforce planning at a regional level.

24. The Committee recommends that the Department requires the Health and Social Care Board to produce an annual workforce plan, as part of the annual Commissioning Plan.

25. The Department should consider taking a longer- term approach to workforce planning than the current five-year horizon. It may be helpful for it to engage with other jurisdictions, for example, Scotland, in terms of understanding the merits and challenges involved in taking a longer- term view. The Department also needs to ensure that the timeframes for workforce planning are integrated with the timeframe for the implementation of Transforming Your Care.

26. It is widely acknowledged that recruitment and retention is a problem in certain sectors of the health and social care workforce. While it is welcome that the Department is open to considering innovative approaches to address these issues, it is disappointing that work to produce clear policies had not been advanced further. The Department should make the development of such policies a priority in terms of its approach to workforce planning, and move quickly to produce an action plan with clear timescales.

27. The Committee recommends that the Department engages in discussions with the Scottish Government with a view to learning more about the approach they are taking to renegotiating aspects of GP contracts. The Committee believes that such an approach may have merit in terms of dealing with the problems in relation to the recruitment and retention of GPs in Northern Ireland.

28. The Committee recommends that the Regional Workforce Planning Group examines the use of locum and agency staff, and develops policies to prevent the availability of locum/agency work acting as a barrier to permanent recruitment.

Discussion of Key Issues

The status of TYC and its role in terms of workforce planning

29. The Transforming Your Care (TYC) Review (December 2011) provided a vision of the health and social care services that would be needed to meet the future demands of the people of Northern Ireland. Those demands included:
    - a growing ageing population;
    - an increase in patients with long term conditions;
    - a growing demand for services, with an over reliance on hospital services;
    - an increasing drive for greater productivity and value for money; and
    - the changing profile of the available workforce.

30. As a starting point, Transforming Your Care in its broadest iteration appears to have the general support of the health and social care sector. All of the organisations that the Committee heard from in the course of the review believed that the general principles of TYC were reasonable and provided a sensible direction for how future services would be provided. However, concerns were communicated to the Committee in terms of the implementation of Transforming Your Care, and the communication from the Department regarding that same process.

31. For instance, the Royal College of General Practitioners stated that the: *"failure with TYC is setting the key priorities and performance indicators…there has been no outline of how we get to where we want to be, where we are going to be in two years, where we are going to be in four years and where we are going to be in six years." (Appendix 1)*

32. The trade unions also believed that the problem was about implementation, rather than the vision set out in TYC:

"Fundamentally, it seems that no one disagrees that a shift from acute to community is a bad thing, but it needs to be properly resourced. In relation to TYC – we have been trying to achieve something that we are not funded to achieve." (Appendix 1)

33. Given these concerns, the Committee was keen to establish with the Department the status of TYC in terms of planning the structure and shape of health and social care services going forward.

34. During the evidence session on 24 June 2015, the Department stated in relation to TYC:
"It is the policy driver. Its whole ethos and its objectives are fundamentally the foundation on which we build our work". (Appendix 1)

35. However, later in that session, the Department explained that in their view, TYC is not a "plan" which can ever be completed, but rather is an "ethos" which informs commissioning decisions. When the Health and Social Care Board (HSCB) were questioned about the progress made on developing the new service models required to implement TYC, they made the following point:
"I am not sure that it has a beginning and an end. It is a live issue all the time . . . It is not the case that we have to produce 10 service models, and, when we produce those, the job is done. It is a way of thinking. It is a context for the way in which we think. It is about trying to work from a patient's point of view . . . There is never an end to this". (Appendix 1)

36. When the HSCB was directly asked when the point would be reached when all the service models were in line with the vision set out in TYC the response was:
"I do not think that we ever get there". (Appendix 1)

37. In the Committee's view, this approach to TYC in terms of not working to a measurable, costed plan, raises concerns and questions in terms of monitoring, governance and funding. This approach also appears to have caused confusion at a local level. For example, organisations including the

Allied Health Professions Federation Northern Ireland (AHPFNI) and the Northern Ireland Association of Social Workers (NIASW) told the Committee that they were not aware of whether new service models were being developed for their workforce as part of TYC. In other instances, organisations were not clear on whether a new model operating in one Health and Social Care (HSC) Trust was going to be replicated across all the Trust areas. For example, the AHPFNI told the Committee that under TYC some Trusts have brought in a care pathway whereby paramedics can assess, treat and discharge a person. However, this is not a Northern Ireland wide approach, and they are not aware of whether it is planned to be so in the future.

38. One of the key aspects of Transforming Your Care, which also formed a Programme for Government 2011-2015 commitment, was a proposed shift of £83 million from hospital based services to primary/community based services. The Department had previously advised the Committee that approximately £28 million has already been shifted, the majority of which is in the areas of learning disability and mental health resettlements. However, from correspondence with the Minister dated 20 April 2015, the Committee learned that in 2015/2016 the Department intends to "shift left" further monies through a *"re-direction of new investment into community based transformational services" (Appendix 3).* The Committee noted this change in direction, which appears to be a move away from the notion of altering how monies are allocated across programmes for care on a recurrent basis.

39. When the Committee questioned stakeholders on the "shift left" of monies, and its impact on the workforce, most organisations were unaware of how this had affected staff on the ground, for example in terms of whether they had been required to move roles or location. The trade unions stated:
"Even though we have asked for it three times, we have not yet seen a breakdown of where the £25 million was spent, how it was spent and where it was applied. There is no breakdown yet on what has been spent to date." (Appendix 1)

40. Similarly, the British Medical Association advised that they have no evidence that investment has been shifted from hospital settings to primary care. They pointed out that there has been no additional investment in GP training places, to allow for GPs as a workforce to take on new work that has traditionally been carried out in secondary care settings. The Royal College of Nursing also pointed out that there had been a decline in the number of community nurses over recent years, which similarly seems to be out of step with the direction of "shift left" under TYC.

41. However, when the HSC Trusts were asked about the shifting of these monies, the majority of which (£25 million approximately) was in the programmes of mental health and learning disability resettlements, and what it had meant for staff who had been previously based in hospital settings, they were able to provide concrete details.

    For example, the Southern Trust stated:
    "In the model that we chose, we had one-to-one meetings with all of our staff to try to find out where they wanted to go. Some of them wanted to follow the clients. For instance, quite a number of our staff followed the clients within supported living, which required a great deal of retraining. Others, however, chose to go and work in Bluestone, which is a mental health facility. Home crisis response in the community was again an option that some others decided to go for. Of 220 staff, we had 14 who took voluntary early retirement; all the rest were redeployed within the trust to various roles, not just in mental health, but in the other programmes of care in the trust. That was again done with the agreement of trade union colleagues, particularly UNISON and NIPSA, which were very helpful in that whole process". (Appendix 1)

42. Therefore, it appears in relation to the impact of the "shift left" of monies under TYC, there has been a lack of wider communication across the health and social care sector, particularly with professional and staff side bodies at a regional level.

43. The Committee also identified an issue in terms of who is responsible for developing the new service models under TYC. During the evidence session with the Regional Workforce Planning Group (RWPG) on 24 June 2015, the Department stated that this role belonged to the Public Health Agency (PHA) and the Health and Social Care Board (HSCB) as commissioners:

" . . . it is the Department's responsibility to set the vision; to ensure that a regional approach is taken; to provide regional information and trends; to facilitate capacity building; and to make decisions on the commissioning of pre- and post-registration education and training as a logical conclusion of the workforce planning process. It is the role of the Board and the PHA as commissioners to determine and agree the various models of service delivery, including the outworking of TYC; to challenge the trusts or providers to ensure that they have identified their workforce needs to be able to deliver the commissioned services; and then to flag to the Department where intervention on the supply side is needed, recognising that there is a lead time to making an impact on the workforce through training. It is the role of trusts to ensure that they have an appropriate and skilled workforce in place to develop operational workforce plans, to adapt to what is being required and to makes changes to their own workforces as required". (Appendix 1)

44. However, the HSC Trusts all advised the Committee that in some instances they are taking the initiative for developing new models and then bringing these to the HSCB to bid for them to be funded. The Belfast Trust explained:

"There are local service delivery models that we develop locally and then seek the support of the commissioner to provide funding for. There are also regional service delivery models that are very much led by the Health and Social Care Board, as a commissioner, and influenced by the Department that we would be party to in terms of resolving the impacts that that might have on our workforce. In direct answer to your question, both of us are responsible". (Appendix 1)

45. This suggested to the Committee that the roles and responsibilities in terms of developing the new models required to implement TYC are not quite as clear cut as the Department may have suggested.

Recommendations/findings

46. **The vision set out in Transforming Your Care has widespread support across the health and social care sector. However, there is a lack of clarity around the plan and timetable for implementation. The Committee believes that the Department should move to speedily implement Transforming Your Care.**

47. **Communication between the Department and professional and staff side bodies on the status of Transforming Your Care requires improvement. The Committee believes that the Department needs to reiterate to key stakeholders that Transforming Your Care remains the policy driver in terms of the reform of health and social care.**

48. **The development of the service models required to implement Transforming Your Care should be prioritised by the HSCB/PHA, so as to provide a sound basis for workforce planning. The plan for developing these models should be shared widely among key stakeholders, including professional and staff side bodies.**

Progress made on workforce planning at a regional level

49. According to a Departmental briefing paper dated 5 March 2015, the Regional Workforce Planning Group (RWPG) was established in August 2012 to consider the implications of TYC for the workforce and to ensure that this was appropriately reflected in the workforce planning programme (Appendix 3). The RWPG is chaired by the Department.

50. The specific workforce planning elements within TYC are proposals 79, 95 and 97A:

   i.   Recommendation 79: Make necessary arrangements to ensure critical clinical staff are able to work in a manner which supports the new arrangements;

   ii.   Recommendation 95: development of new workforce skills and roles to support the shift towards prevention, self-care, and integrated care that is well co-ordinated, integrated and at home or close to home; and

   iii. Recommendation 97A: More formal integration of workforce planning into the commissioning process to drive the financial transformation.

51. One of the key outputs of the RWPG is a Regional Workforce Planning Framework which was finalised in April 2015. The Department described the framework as follows:

   "That framework is key to moving forward, as it sets out the respective roles of the Department, of the HSCB and the Public Health Agency (PHA) as commissioners, and of the trusts". (Appendix 1)

52. While the Committee welcomed the publication of the Framework, it was concerned about the time taken for its production, given that the RWPG had been established in August 2012. In response, the Department made the point that during that period, other streams of work had been progressed in parallel:

   "That work started alongside capacity building work and the roll-out of a training programme that also came from the diagnostic report. In

*addition, the regional workforce planning group oversaw the
commissioning of additional uni-professional reviews. That strand of
work was proceeding alongside the other pieces of work." (Appendix 1)*

53. Another key aspect of the work of the RWPG was a decision to
conduct a workforce review in the context of a programme of care,
rather than in a particular profession. This approach is being piloted by
means of a workforce review of domiciliary care for older people. On 24
June 2015, the Department provided the following update on this pilot:
*"A steering group and a project group has been established, drawn
from across the relevant stakeholders, including the trade unions, and
there is a linkage to the independent sector providers. Terms of
reference and time scales have been agreed, so we are aiming to
complete that work by the end of 2015. An initial data-capture analysis
has been performed to assess the size of the workforce, the number of
contract hours provided, expenditure, and so on. That is very much
building on the regional review of domiciliary care led by the board, the
purpose of which was to determine the service models for future
delivery. That is almost complete." (Appendix 1)*

54. The Belfast HSC Trust explained the benefits in its view of this kind of
workforce review:
*"Factoring it around programmes of care is very important, as opposed
to focusing on uni-professional need. There is absolutely no point in
going away and doing a social work workforce plan or a nursing
workforce plan for the provision of older people's services in the
community. What you need to do first and foremost is assess the
demand for older people's services in the community and,
subsequently, look at the uni-professional and multi-professional
requirements that fall out of that. What are the consequences of the
demand that we face for older people's services in the community?
How do we best meet that and work outside the traditional professional
boundaries? It does not necessarily always need to be about the*

recruitment of more nurses or social workers. Really begin to look towards the development of new roles, such as we mentioned in the allied health profession or support role — an opportunity to modernise and innovate, as opposed to continuing to deliver the service in the traditional means by which it has always been delivered". (Appendix 1)

55. In addition to undertaking this programme of care workforce review, the Department is pursuing a range of uni-professional workforce reviews. An update was provided on these reviews on 24 June 2015:

"Last time, I mentioned that a rolling programme of medical specialty reviews was ongoing, led by the PHA. That works continues. Paediatrics was completed in September 2014, and no additional trainees were recommended. General practice was completed, as you know, in October 2014. The initial interim report, which you will have seen, has been confirmed as final, with a recommendation for a phased introduction of a minimum of 15 additional trainees by next year to meet the current ratio of trainees to population in England.

For radiology, radiography and medical physics, workforce data has been completed and submitted to the Department as part of its regional review of imaging services. The aim of that wider review is to produce recommendations on service configuration, skills mix and optimal use of skills to best address future demand, all of which will inform the development of an associated workforce plan. Shortly to be completed are reviews of occupational medicine, trauma and orthopaedics, and emergency medicine. A further tranche of reviews will encompass geriatric medicine, anaesthetics, intensive care medicine, acute medicine, urology and haematology. In fact, the plan continues from July to December 2015. Other specialties identified include neurology, ophthalmology, psychiatry and dermatology . . .

In addition to the work on medical specialties, separate work on a general medical workforce review that is focused on informing the number of medical undergraduates is continuing. The regional workforce planning group met on Monday of this week, 22 June, and considered the emerging need for workforce reviews relating to allied health professions, paramedics and the range of dental professionals. They will be scoped and built into our programme of work. However, we need to be absolutely clear that we will looking at them through both a professional and a programme-of-care approach, informed by the domiciliary care experience, all with a view to progressing and furthering the aims of TYC. For completeness, I should mention that a comprehensive and robust workforce review of nursing and midwifery has been completed. Work continues on implementing the various phases of normative nursing . . ." (Appendix 1)

56. While the Department stated that the RWPG was attempting to combine both a professional and programme of care approach to workforce reviews, some organisations expressed concerns that it was still taking too much of a silo-based approach. For example, the Allied Health Professions Federation NI (AHPFNI) took the view that the Department needs to be more innovative in terms of developing different models of care. The organisation stated that currently approximately 30% of GP appointments are for musculoskeletal issues. If self – referral was brought in across Northern Ireland, these patients could be dealt with directly by a physiotherapist, hence freeing up GP time. Logically, this could mean that the same/fewer number of GPs would be required. In terms of workforce planning, this requires more physiotherapists to deal with the pressure on GP services, rather than providing more GPs through more GP training places. However, the AHPFNI pointed out that this would require a real transformation in terms of how care is delivered, which they do not see as happening at the moment.

57. In a similar vein, the Northern Ireland Association of Social Workers (NIASW) advised that at present social workers are carrying excessive caseloads. Additional capacity could be found, not through necessarily more social workers, but by freeing up social workers' time by providing more administrative staff to deal with the required paperwork. Again, the requires a strategic approach to service delivery which looks beyond just social workers and considers the number and type of administrative staff needed as part of the service model.

58. However, the Committee did acknowledge that the Department could provide examples were workforce solutions were being considered beyond traditional professional boundaries. At the evidence session on 24 June 2015 the Department advised:

   " . . . the Belfast Trust will utilise some resources that would otherwise have been used to pay for locum cover to pilot a small number of PAs [physicians associate] in the emergency department setting. We have also discussed with the Northern Ireland General Practitioners Committee (NIGPC) how we can test the added value of such a role in the primary care setting in Northern Ireland to help address the workforce issues that have been flagged up by the GP workforce review. Alongside that, we are seeking to expand the number of advanced nurse practitioners, as a further opportunity for those who want to develop their skills and expertise, while at the same time helping to address areas that have been traditionally hard to fill".
   (Appendix 1)

59. In relation to the Department's general approach to workforce planning, the Committee was concerned that it appears to be heavily focused on the staff employed by the HSC Trusts, and on GPs as doctors, and less focused on the private/independent sector in terms of nursing and residential homes, day-care, domiciliary care and the support staff in GP practices. This is despite the

fact that the Trusts often rely heavily on such services. The Royal College of Nursing (RCN) made the point that a third of their members work in the independent sector. However, in their view workforce planning in this sector is inadequate:

"We live in an integrated health and social care system where the statutory sector coexists with the independent and nursing home sector, GP practices, private clinics and voluntary organisations, to provide health and social care services for the people of Northern Ireland. These areas of practice do not exist in parallel universes. They are simply part of the same system. Workforce planning for nursing must address, in particular, the needs of the nursing-home sector and GP practices, as well as those of our hospitals, health centres and community services." (Appendix 1)

60. The RCN advised that there are significant nursing vacancies in private nursing homes, and issues of staff being "poached" from this sector by the Trusts, who can offer better terms and conditions. Therefore, in terms of the nursing workforce, at this stage the Department's workforce planning approach does not appear to go beyond those nurses employed by the Trusts.

61. Similar concerns were expressed in terms of General Practice. The British Medical Association (BMA) and the Royal College of General Practitioners (RCGP) highlighted their concern over the number of GPs working in Northern Ireland, and the provision of GP training places. The RCGP stated:
"In Northern Ireland, we have the lowest number of GPs per head of the population in the United Kingdom at 6·4 per 10,000; the oldest GP workforce, with 24% of our GPs over the age of 55; and an ageing practice nurse population. Insufficient numbers of young doctors are being trained as general practitioners, and, in addition, we have real problems in the retention of GPs. There have been three workforce reviews since 2006, with each highlighting the need to increase the number of GPs. It is with dismay that the college notes that there has been no action taken on the recommendation in these reviews. Each one has highlighted the urgent need to increase the number of general practitioners in the workforce." (Appendix 1)

62. Unlike the nursing workforce within the private sector, the Department has taken a more pro-active approach to workforce planning for GPs, and numerous workforce reviews have been commissioned and published over the years. The latest review has resulted in an interim report recommending that the number of GP training places be increased to 111 phased over 4 years, with an initial target to increase the number by 15 by August 2015. However, in a letter dated 29 April 2015, the Department advised that it has not taken a decision on this issue, pending clarity on the financial situation for 2015/2016 (Appendix 3). A subsequent letter dated 12 August 2015 stated that a bid for 15 additional GP places had been made under the June monitoring round, the outcome of which is not yet known (Appendix 3).

63. In terms of social care, there are over 500 different employers across Northern Ireland – the Trusts, private providers and the voluntary sector. The Northern Ireland Social Care Council (NISCC) was asked by the Committee who was responsible for ensuring an adequate supply of social care workers in the independent sectors. The NISCC did not own responsibility for this and explained that their focus was on the regulation of the workforce. The Committee acknowledges that the RWPG has included representatives from the independent sector on the project group for the workforce review of domiciliary care. However, it is not apparent whether the Department routinely collects data on the social care and indeed nursing workforce based in the private sector.

64. In relation to the size of the overall nursing workforce, the Royal College of Nursing advised the Committee that current staff shortages meant that patient safety was at risk. Representatives explained:

"There is certainly evidence of real concerns that patient safety is at risk. We hear that very often. Whether it is to do with staffing levels in wards, or even in community settings, we see in reports, particularly in the community, that caseloads are increasing significantly. The acuity — the dependency and needs of the patient — has increased significantly in the community. Nurses

are rushing in and out of patients' houses to make sure that they can see all of their patients. They identify that as a major risk" (Appendix 1).

65. The Royal College of Nursing was critical of the fact that regional initiatives to establish normative nurse staffing ranges, driven by the Department and the Chief Nursing Officer, were not being taken forward in 2015-2016 as envisioned, because the funding had not been allocated to this work. Representatives stated:

"Phase 1 is to find safe nurse staffing ranges for acute medical and surgical settings. The previous Minister announced the establishment of the framework for these areas of practice in 2014. Phase 2 is intended to cover emergency departments and phase 3, community settings. However, the Northern Ireland Budget 2015-16 paper states that no funding is available to support work on subsequent phases of normative staffing. The RCN believes that this is unacceptable. The development of safe nurse staffing levels across health and social care is not an optional extra to be pursued as and when resources and other priorities permit: it is a matter of fundamental public safety that must be implemented fully and as a matter of urgency" (Appendix 1).

66. The Committee questioned the Royal College of Nursing on the actions required to address staff shortages, and it was told:

"One of the first things that needs to be done is that the number of pre-registration places needs to be increased. In particular, we certainly need significant investment in post-registration education support for nursing staff to undertake these programmes, whether they are in specialist practice or other advanced practice programmes, to allow for some of these changes to take place. We absolutely need normative staffing, or safe staffing, levels implemented as soon as possible. We need phases 2 and 3 of that to be carried out and supported. It must be not just a paper exercise; we need the funding to follow. The nursing profession is saying, very clearly, that a certain level of staffing is required to provide safe and effective care for patients, so there is an obligation to fund and resource that need. We appreciate that it will not

happen overnight, but we want a commitment that it will happen".
(Appendix 1)

Recommendations/findings

67. **The Committee welcomes the establishment of the Regional Workforce Planning Group and believes it has a key role in the implementation of Transforming Your Care. However, given that the Group was set up in August 2012, the Committee would have expected the Regional Workforce Planning Framework to have been produced earlier than April 2015.**

68. **The Committee welcomes the workforce review of domiciliary care, and awaits with interest its findings. However, the Committee believes that the Regional Workforce Planning Group should be taking a wider-approach to workforce planning at all levels, and making strenuous efforts to avoid "silo-based" approaches which focus primarily on staffing groups rather than meeting the needs of patients.**

69. **The Committee is concerned that the Regional Workforce Planning Group is not taking sufficient cognisance of the workforce needs within the private/independent sector – particularly in terms of the nursing and social care staff required for nursing and residential homes, day-care and domiciliary care. As a starting point, it should endeavour to capture data on that workforce and engage with the key stakeholders in that sector.**

70. **The Committee is concerned that while a number of successive reviews have recommended an increase in GP training places, this has not been implemented by the Department. The Committee recommends that the Department implements the recommendation of the most recent review to recruit an additional 15 GP training places.**

71. **The Committee recommends that the Department considers how primary care services can be reconfigured across a range of health and social care professionals, to deal with the increasing demands for GP appointments.**

72. **The Committee is concerned that the regional initiatives on normative nurse staffing having not been completed or implemented, and the potential impact this may have on patient safety. The Committee recommends that the Department implements the findings of Phase 1 and progresses the reviews necessary for Phases 2 and 3 on an urgent basis.**

Projected size of the workforce

73. The public consultation document on Transforming Your Care had stated that a reduction of 3% of the workforce, representing 1,620 staff would be required for implementation. However, during the evidence session with the Department on 24 March 2015, the Regional Workforce Planning Group (RWPG) advised the Committee that the 3% had only been a working assumption at that time. It had been produced by the Health and Social Care Board (HSCB), however, the Department could not provide details of how the figure had ever been calculated. The Committee further wrote to the Department on two occasions to ask how the 3% figure had been arrived at. The response dated 29 April 2015 stated:

In the public consultation paper, published in 2012, on the proposed service changes following consideration of the proposals set out in the TYC report published in 2011, a working assumption was included on the possible impact to the directly employed workforce. As the Committee has been previously advised, this was not a target and was subject to change. It was based on calculations and assumptions in relation to Voluntary Redundancy and Voluntary Early Retirement as a result of potential changes to the required skills mix and services models, as well as taking account of natural wastage

*over the period. The document also said that it was likely that there would be a
growth of employment in the non-statutory sector. Going forward, no overall
target for either an increase or decrease is being set for the HSC workforce as
that would be arbitrary and would serve no useful purpose. (Appendix 3)*

74. The Committee also questioned the RWPG on the same issue during the
evidence session on 24 June 2015 and the HSCB stated then that the 3%
assumption was perhaps:

*"Straightforwardly, I do not know where the figure of 3% came from. I think that
perhaps . . . it was intended to signal a direction of travel that our default
position going forward has to be that, where it is appropriate, safe and cost-
effective to deliver care near to someone's home, that is exactly what we do.
Where it is appropriate, safe and cost-effective to deliver care in an
ambulatory setting rather than admitting someone to hospital that is what we
do. To give a flavour of what that might look like, the figure of 3% was arrived
at." (Appendix 1)*

75. When the Committee posed the question of whether a 3% reduction of the
workforce was feasible or realistic to the professional bodies which gave
evidence as part of the review, the unanimous opinion was that it was neither.
For example, the trade unions stated:

*"You [the Committee] quoted the −3% staffing figure. We support the PHA
view that the growth in demand is exponential and that, therefore, that figure
cannot be credible. In particular, I highlight mental health and the King's Fund
analysis that shows 50% underfunding. The latest figures that we have seen
show a 25% higher presentation rate than in England. With figures like that,
the original quoted cost of −3% in staffing numbers cannot be achieved. The
best you can do is to try to contain growth." (Appendix 1)*

76. In relation to a voluntary exit scheme, the Committee has heard very little
evidence as to how such a scheme would fit in with workforce planning. The
Committee wrote to the Department to query this issue. The Department
advised in a letter dated 29 April 2014:

"In common with all other parts of the public sector, work is ongoing to develop a voluntary exit scheme (VES) specifically for the HSC in order to contribute to the delivery of organisational savings plans and a bid for funding will be made to the Public Sector Transformation Fund. It is expected that the impact on front line staff will be minimal." (Appendix 3)

77. In the Committee's view this provides little clarity on if and how any voluntary exit scheme will be managed so that it is aligned with the shape of the workforce required to implement Transforming Your Care.

78. During the evidence session on 24 June 2015 with the RWPG, the Committee further questioned whether a voluntary redundancy scheme is being factored into workforce planning. The Department answered:

"The Minister has approved a voluntary exit scheme for HSC, and a bid for funding has been submitted to the public sector transformation fund. Being able to proceed with that, however, will be entirely dependent on securing funding. The trusts have carried out modelling of who may be able to avail themselves of the scheme in parallel with, and in order to implement, their savings plans. They have looked at areas where savings are required, and they will offer the opportunity for voluntary exit in those areas, if funding is secured . . . Workforce planning, in the round, has to take account of that, but that will proceed in relation to implementing their savings plans." (Appendix 1)

79. Again this response appears to take little account of workforce planning in a strategic context, and very much focuses on making changes to the workforce by means of voluntary exit in order to meet financial targets.

Recommendations/findings

80. **The Committee welcomes the fact that the Department is not working towards a 3% reduction in staffing as a target required to**

**implement Transforming Your Care, given the increasing growth
in demand for services over recent years. However, the
Committee finds it somewhat surprising that the Department was
not able to advise exactly how and why this figure was ever
contained within the public consultation document on
Transforming Your Care Review.**

81. **The Committee recommends that the Department produces an
estimation of the percentage increase or decrease in the size of
the workforce required to implement Transforming Your Care.**

82. **The Committee is concerned that proposals for a voluntary exit
scheme with the HSC are not being strategically aligned with the
proposals being developed by the Regional Workforce Planning
Group. The Committee recommends that the Department urgently
engages with the Regional Workforce Planning Group on this
matter.**

The role of the Regional Workforce Planning Group and its engagement with key stakeholders

83. One of the aims of the Committee's review was to examine the Department's
approach to involving staff, professional bodies and staff side organisations on
workforce planning in support of the implementation of Transforming Your
Care (TYC).

84. As stated earlier, the Regional Workforce Planning Group (RWPG) was
established in August 2012 by the Department, to consider the implications of
TYC for the workforce and ensure that this was appropriately reflected in the
workforce planning programme. The RWPG is chaired by a senior
departmental official and its membership comprises departmental officials, the
HR Directors of the six HSC Trusts and of Business Services Organisation,
and representatives from the Health and Social Care Board, Public Health

Agency, and the Northern Ireland Social Care Council (NISCC) (Ministerial letter dated 13 April 2015, Appendix 3).

85. As the name suggests, the RWPG is responsible for taking forward workforce planning on a regional level. Since its formation is has undertaken a range of work at this level, including commissioning "Skills for Health" to carry out both an assessment of the workforce planning capacity and capability across the HSC, and a training programme for HSC staff to raise awareness of workforce planning. The RWPG has also developed a Regional Workforce Planning Framework to define the roles and responsibilities for each of the HSC stakeholders in the workforce planning process. Other work streams under the auspices of the RWPG include overseeing a range of uni-professional workforce reviews, as well as the pilot project to undertake a review of the workforce required to provide domiciliary care for older people.

86. During the course of the review the Committee took evidence from a range of professional bodies. Only one of these bodies – the NISCC – was represented on the RWPG. The remainder of the professional bodies have not been included on the RWPG to date, and they all expressed disappointment at that fact. For example, the Allied Health Professions Federation Northern Ireland told the Committee:

"We, representing the professional bodies of the third largest clinical workforce, which is what AHPs are, really want to be part of that support and engagement in the strategic workforce planning. We have the data on our members. We have the innovation from across not only the UK but the world. We can share best practice and the evidence in order to speed up some of this innovation. The issue is that we are not looking at something that is going to happen in the future and that we can start planning for and take our time with. This is happening now, and we have solutions now, if the professional bodies could be engaged". (Appendix 1)

87. The Royal College of Nursing made a similar point:

"The RCN is surprised and disappointed that a group of that nature, which specifically purports to include membership from across the wider HSC, could exclude the organisation representing the largest professional group within the HSC". (Appendix 1)

88. The trade unions expressed their disappointment at being excluded from the RWPG in the following terms:

"We have serious concerns about the process for the workforce planning developments to date. Some two years ago, we raised the issue of workforce planning and were advised by the Department of Health, Social Services and Public Safety (DHSSPS) that the only workforce planning taking place was as part of Transforming Your Care (TYC). We were then informed a little later that there was an initiative at departmental level to do with workforce planning structure that would address the tools required for workforce planning and that there was no space or opportunity for us to be involved. We were advised that it was not relevant to us. We have arrived at a point at which a workforce planning structure has been established: the regional workforce planning group (RWPG). We have not been invited. We have had sight of some paperwork. There was a consultation document in September, and we had sight of the evidence presented to you in March this year, but we have not been invited in". (Appendix 1)

89. The Committee subsequently raised the concerns of the professional bodies and the trade unions with the Department. The Department advised that it believed it was important to keep the membership of the RWPG to a smaller number in order for its meetings to be manageable, but that there was room was a wider range of stakeholders to become involved in particular workforce reviews:

"We had a conversation about the membership of that group when we completed the work on the framework. We felt that we needed to make sure that we had an inclusive process, because we absolutely recognise the value of those stakeholders in the workforce planning process. However, we need a system and a structure that is manageable and in which we can, in practical terms, facilitate meetings that are meaningful. That in itself provides an inherent tension.

At the minute, the proposal is that we have a fairly tightly subscribed regional workforce planning group but a wider stakeholder engagement group . . . The structure that we envisage involves key stakeholders who have a direct interest in particular workforce reviews and are very closely involved in the steering of those workforce reviews". (Appendix 1)

90. However, the Department did recognise that its approach to the membership of the RWPG may need to be reviewed at a later date:

"That is the model that we are working through. If that model does not work, and people feel that they do not have the level of engagement that they want, I am quite happy to review it and to look at how best we can engage people, but my priority is to have a model that is manageable, fit for purpose and does the job" (Appendix 1)

91. While the Committee accepts that the membership of the RWPG may have originally been drawn up with the pragmatics of conducting meetings in mind, it is clear that the absence of the professional bodies and the trade unions has resulted in these organisations feeling excluded from workforce planning at a regional level. It has also meant that these organisations, representing a vast number of staff within the HSC, are not fully aware of the direction which workforce planning is taking in terms of the implementation of TYC. For example, the trade unions expressed this view:

" . . . in reality, workforce planning is very much focussed on the immediate needs of the Trusts and maybe dealing with issues like vacancy control rather than strategic overview planning for the medium to long term." (Appendix 1)

92. This ties in with a finding of the "Skills for Health" report commissioned by the RWPG, which identified that workforce planning is seen by those who work in the service as being reactive, short-term and focused on efficiencies and savings, rather than on future service development. Given that the RWPG were made aware of this perception, in the Committee's view it is disappointing that they have not done more to ensure that key stakeholders are aware of the strategic and regional approach they are aiming to take to workforce planning.

93. The Committee also considered the issue of the profile of the RWPG and the priority which workforce planning is accorded within the Department. It was clear from the evidence received from the Scottish Government, that workforce planning has a significant status within the health service. The Director of Health Workforce advised the Committee:

"The profile is extremely high. It is demonstrating Government's commitment to sustainable health services, so it comes in for a great deal of public scrutiny, media scrutiny and so on, as well. It runs alongside certain other of our commitments about supporting our workforce in an appropriate way to adapt to change and making sure that they are invested in in the appropriate ways through training. Workforce planning is as high profile as it gets. As the director for workforce, which is everything from how many people we allow into med school in the first place to paying for pensions and everything else, including uniforms and standards of conduct, I would certainly put workforce planning at the top of my job description in terms of the things that we absolutely have to get right". (Appendix 1)

94. The Committee also learned that in Scotland, the Department requires the 22 Boards to produce a local delivery plan on an annual basis. This has been a

statutory requirement since 2005, and the annual plan must cover workforce planning. Scottish officials advised:

"In the course of that local delivery process, which includes workforce planning, we will go through with the board all of the issues of concern that they may have, development plans and, essentially, their plan for ensuring the sustainability and the delivery of that service . . . Regarding the practice around that, it is mandatory that boards have to provide us with workforce plans. That has been mandatory for around 10 years now . . . We play a monitoring role within the Scottish Government in terms of our requirements on boards to provide workforce plans, and also three-year projections. Part of that is around the local service planning process, which they are required to fulfil by the Scottish Government. Workforce planning is integral to all of that". (Appendix 1)

95. The Committee asked the Department whether the Health and Social Care Board (HSCB) was required to produce an annual workforce plan as part of the annual commissioning plan. The Department stated that this was not a requirement and added:

"It is an interesting idea. With the extent to which the work is developing, and as service models are changing all the time, an annual workforce plan would be just a snapshot of what is required at that particular time. Again, it is questionable whether the work to invest in describing what is happening is worth it". (Appendix 1)

96. While the Committee accepts that the production of an annual workforce plan by the HSCB would require additional time and effort, the fact that it is not required may point to the relatively low status which workforce planning has traditionally been accorded within the HSC.

97. The Committee also noted the difference in approach between the Scottish Government and the RWPG in Northern Ireland, in terms of the length of their

planning frameworks. Scottish officials advised that they tended to approach workforce planning from a 15- 20 year perspective:

"Essentially, we are planting the seeds for the whole of Scotland to harvest. We have not necessarily relied on boards anticipating some of these things. Government has a legitimate place in the 15-year or 20-year planning time frames for that workforce. It is probably a place that only government can have . . . On occasions, we have looked at the information we are getting from our profiling and have said that the boards are not looking far enough ahead. For example, we have seen a significant expansion in consultancy in emergency medicine in Scotland. We have been able to do that because, essentially, we took a view a few years ago that we were going to need more consultants in emergency medicine". (Appendix 1)

98. In contrast the RWPG told the Committee that its planning is limited to a five year window:

"Any of the workforce reviews that we do, such as that on domiciliary care, will have a five-year horizon. We look to a five-year plan, because we think that one for any longer than that is looking too far in advance to be able to plan for. What might the demography and the situation at the time be? . . . Five years tends to be the optimum period in which to create the opportunity for lead-in times and for training to be able to impact on the workforce. It does need to be done over that horizon". (Appendix 1)

99. While the health and social care sectors may be organised differently in Northern Ireland and Scotland, it is of concern that the Department is not looking further than five years ahead in terms of workforce planning. The Committee believes that projections around population needs can be modelled across a longer time period. Furthermore, given that some health professionals, including doctors, take significantly longer than five years to complete their training, it would seem sensible to look at workforce planning across a longer period, in the way that happens in Scotland.

Recommendations/findings

100.   The Department should review the membership of the Regional Workforce Planning Group, and consider how it can be made more inclusive of staff side and professional bodies. It should also look at other ways of communicating and engaging with staff side and professional bodies to ensure that organisations are aware of the direction of travel for workforce planning at a regional level.

101.   The Committee recommends that the Department requires the Health and Social Care Board to produce an annual workforce plan, as part of the annual Commissioning Plan.

102.   The Department should consider taking a longer-term approach to workforce planning than the current five-year horizon. It may be helpful for it to engage with other jurisdictions, for example, Scotland, in terms of understanding the merits and challenges involved in taking a longer- term view. The Department also needs to ensure that the timeframes for workforce planning are integrated with the timeframe for the implementation of Transforming Your Care.

Strategic approach to recruitment and retention

103.   Many of the organisations from whom the Committee received evidence were of the view that the recruitment and retention of staff is an issue across the health and social care sector in Northern Ireland. Some professions or specialities and some geographical areas experience more difficulties than others.

104.   One area where recruitment and retention seems to be of major concern is in General Practice. During their evidence session on 15 April, the RCGP and BMA stated:

"As you are aware, we have a serious crisis emerging in the GP workforce that can no longer be ignored. Morale is at an all-time low. In Northern Ireland, we have the lowest number of GPs per head of the population in the United Kingdom at 6·4 per 10,000; the oldest GP workforce, with 24% of our GPs over the age of 55; and an ageing practice nurse population. Insufficient numbers of young doctors are being trained as general practitioners, and, in addition, we have real problems in the retention of GPs." (Appendix 1)

105. There are also problems in terms of recruiting staff to particular medical specialities in the hospital environment. The Western HSC Trust told the Committee:

"One of our biggest challenges is our medical workforce, and the Department is very aware of the issues that we have there". (Appendix 1)

106. Similarly the Belfast Trust stated:
"We have a number of medical posts that, probably in common with all five provider trusts, are hard to fill; for example, consultants in emergency medicine or consultant surgeons. Particularly with specialisation now, it is no longer just a general surgeon that you are looking for but a breast surgeon, gastroenterologist, radiologist, urologist or dermatologist". (Appendix 1)

107. The Royal College of Nursing also highlighted recruitment and retention issues in the nursing profession and stated that 20-30% of student nurses who qualify in Northern Ireland do not end up working here. However, they also made an interesting point that culturally, it has

become the norm for young nurses and doctors to work abroad for a number of years and then return to Northern Ireland. In their view, this needs to be considered in the broader approach to workforce planning.

108. The Committee wished to explore the options for both recruiting staff in the first place, and retaining those staff once they were in post.

109. It was the unanimous view amongst organisations that penalties should not be used to solve recruitment and retention issues - for example, tying someone to a work contract and enforcing penalties if the contract is broken. The HSC Trusts also stated that contracts banning someone from leaving a job can be very difficult to enforce. The Western Trust stated:

"We had that type of contract for clinical psychologists a number of years ago. The difficulty is that it is quite hard to enforce. These people have gone through specialist training, and if their life circumstance change, if they marry someone and that person, through their job, has to live in a different country, it is very hard for any employer to say that they need to stay here. Legally, it is hard to enforce. Even if you had that condition, it may be hard to make it stick". (Appendix 1)

110. However, there was openness to the idea of the use of incentives. The Belfast Trust provided an example of circumstances in which they had used financial incentives on a short-term basis to recruit in a particular speciality:

"I can quote an example that we used some years ago where we had real difficulty in a specialty in the Belfast Trust. We introduced a very highly specialised service, unique only to the Belfast Trust, and we brought forward a requirement for recruitment and retention premia. A case was made to the Department, which was ultimately approved by the Department of Finance and Personnel. For a time-limited period,

we were able to offer those premia to attract the right people to the service and to retain them. That meant that stability was brought to a service that was so unique that it was going to have to stop being provided by the National Health Service". (Appendix 1)

111. However, the Trusts did recognise that recruitment and retention was not just about financial packages. The Belfast Trust explained:

". . . the solutions are multifactorial; sometimes, it is not simply all about money. We need to do better to package what we have in Northern Ireland and the educational facilities that we have, through Queen's University, to offer research facilities. Sometimes, it is not just about adding more money but about being able to put together a better package to sell the idea of coming to work and live in Northern Ireland". (Appendix 4)

112. The BMA and RCGPs suggested that debt-relief for student loans should be considered as a possible incentive for hard to fill medical posts. The RCGPs advised:

"Medical students now come out of university with very substantial loans — £60,000 plus — and if there were some measure of debt forgiveness then, to me, that would seem to be a very positive thing. There are things you could do that are not restraints but are positive and would help the situation . . . If incentives were to be used — golden handshakes, handcuffs or whatever — we should look at areas that are under-doctored and where there are real problems. One of the areas to highlight is rural general practice. That is true throughout the United Kingdom and Ireland where rural areas tend to be un-doctored, and there are other areas where there are high levels of health inequality. I think that incentivising young doctors into areas where there is a lack of doctors or where there is a high degree of need may be of benefit" (Appendix 1).

113. One of the consequences of an inability to recruit and retain staff is over-reliance on the use of locum and agency staff. The use of such staff is associated with high costs, and in some instances, a lack of stability in a particular work area. The British Medical Association told the Committee:

"It is easy to see the consequences of ineffective workforce planning. Members will be well aware of, and have commented on, the resources that have been spent on locums in secondary care to fill gaps. The BMA believes that an over-reliance on locums is a very clear consequence of the failures of planning and implementation to date. That money could and should be more effectively spent on training a sufficient number of doctors in necessary specialties" (Appendix 1).

114. The Committee also explored the issues of recruitment and retention during its evidence session with officials from the Scottish Government. In Scotland the approach is focused on making the working environment in the healthcare system attractive so that people want to work there, rather than using monetary incentives to attract healthcare workers. Some other interesting ways in which Scotland has addressed specific recruitment problems include the use of a salaried GP model to in rural areas, and "fellowship programmes" whereby a doctor works between a rural hospital and a centre of excellence attached to one of the universities or a large urban hospital.

115. The fellowship programmes developed because the Scottish Government was having difficulties finding hospital specialists willing to work in district area hospitals. While there were doctors who wanted to be in a rural setting, they did not want to lose the experience and other links that come with working in a large hospital. Therefore, a model of mentoring and educational/fellowship links was developed in these

circumstances, which has been successful in terms of recruiting doctors to rural hospitals.

116. The Committee also learned that in Scotland, they have begun a process to look at how GP contracts can be more closely aligned to meet their specific needs, rather than being a general contract across four jurisdictions.

Officials from the Scottish Government advised:

"The Scottish Government have a slightly different position on GP contracts, in that they were negotiated with a view that there would be a two-year window to allow us to look at and review service redesign. My colleagues in primary care work very closely with the GPs and I am just in the foothills of starting to think about what a GP contract in Scotland might look like . . . We have tried to get ourselves into a position where we are having some very positive early discussions about how a GP contract needs to reflect the reality of how GP services are delivered in Scotland. That is not the same as the way that they are delivered in Westminster, Kensington or wherever. We have to have a contract that reflects the nature of the practice here" (Appendix 1).

117. The Committee was keen to establish what the DHSSPS's approach to retention and recruitment was, and whether they have developed any regional policies, over and above the work which HSC Trusts are doing at a local level.

118. The Department advised at the evidence session on 24 June 2015 that it had commissioned work internally to consider the issues:

"However, we have recently been discussing what we can do to address our "leaky bucket" situation, which is how the chief executive of Health Education England (HEE) described the situation whereby

the NHS, or Health and Social Care (HSC) in our case, trains people at huge expense only to lose them to other countries. We commissioned some work internally that looked at how other countries incentivise the recruitment and retention of medical staff. The work looked at issues such as work-life balance and the possibility of introducing more downtime between shifts and providing childcare discounts. It looked at work-related incentives; for example, enhanced periods of study leave or extended leave to undertake further training after a period of time, such as five years. It also looked at staff recognition incentives, such as mentoring or the awarding of extra leave for a completed project; regional incentives, such as bonding schemes, whereby fees are paid off for every year worked in the health service; and recruit-and-retain initiatives, including finding ways in which to support spouses or partners to find work, childcare or schools and strengthening urban and rural links to minimise rural isolation. We now need to consider those ideas and decide what we can apply or adapt for use here. Of course, although our initial focus has been on the hard-to-fill medical posts, there is nothing to stop us applying the same principles to any and all disciplines". (Appendix 1)

119. The Committee asked the Department whether it intended to apply any of the approaches taken to recruitment and retention which other countries, such as Scotland, have used. The Department advised:

"We have been looking more generally at hard-to-fill medical posts to see what other countries are doing to attract and keep people. This is a problem the world over, so it is not unique to Northern Ireland, but other countries have come up with other ways that are connected not to salary levels but to other things. By and large, those crystallise around additional leave. What highly qualified and skilled people in stressful jobs probably want most of all is time. They want extra time between shifts, extra leave and extra-long service leave if, for example, they have worked for a long time. We have gathered that from the

information.

A European study that looked at this issue is about to publish later this month or early next month. We await with interest what it recommends as successful mechanisms to be able to retain and recruit staff. We are very keen to look at it.

There is a cost, so we have to be mindful of that. Even if we are saying that this is not about increasing salary levels, there is a cost to everything that we would do, including giving people time off; that time has to be filled in some way. It will not be easy, but it must be better than the current situation in which we have vacancies and locum spend. It is about the better use of that money." (Appendix 1)

120. In terms of the specific suggestion around debt-relief for hard-to-fill medical posts, the Department's position was:

"That is like a bonding scheme. That approach is certainly being looked at in other areas. We are open to looking at it as a way of helping to prevent people who have been trained here from leaving. Obviously, we cannot ever prevent people leaving — there is free movement; people have to be able to leave — but we can incentivise them by saying that we will start to pay off student debt for every year that they stay. We need to explore that proposal alongside a range of other things and come to a view" (Appendix 1).

121. While the Department stated that it was "open" to considering a range of initiatives and policies which have been used in other countries, it did not seem to have developed a clear view on which approaches might work best in Northern Ireland. Furthermore, there was no mention of any timescale or plan for implementing any of these measures, even as pilots.

Recommendations/findings

122. **It is widely acknowledged that recruitment and retention is a problem in certain sectors of the health and social care workforce. While it is welcome that the Department is open to considering innovative approaches to address these issues, it is disappointing that work to produce a clear policies had not been advanced further. The Department should make the development of such policies a priority in terms of its approach to workforce planning, and move quickly to produce an action plan with clear timescales.**

123. **The Committee recommends that the Department engages in discussions with the Scottish Government with a view to learning more about the approach they are taking to renegotiating aspects of GP contracts. The Committee believes that such an approach may have merit in terms of dealing with the problems in relation to the recruitment and retention of GPs in Northern Ireland.**

124. **The Committee recommends that the Regional Workforce Planning Group examines the use of locum and agency staff, and develops policies to prevent the availability of locum/agency work acting as a barrier to permanent recruitment.**

APPENDIX 1

MINUTES OF EVIDENCE

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Transforming Your Care: Regional Workforce Planning Group

11 March 2015

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Transforming Your Care: Regional Workforce Planning Group

11 March 2015

Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Ms Paula Bradley (Deputy Chairperson)
Mr Mickey Brady
Mrs Pam Cameron
Mrs Jo-Anne Dobson
Mr Paul Givan
Mr Kieran McCarthy
Ms Rosaleen McCorley
Mr Fearghal McKinney
Mr George Robinson

Witnesses:
Mr Damian McAlister	Belfast Health and Social Care Trust
Ms Heather Stevens	Department of Health, Social Services and Public Safety
Dr Carolyn Harper	Public Health Agency

The Chairperson (Ms Maeve McLaughlin): There was some confusion about timescales, so we will get straight into it. In the interests of time, I ask members and witnesses to keep the evidence as concise as possible.

With us are Heather Stevens, the director of workforce policy and chair of the regional workforce planning group at the Department of Health, Social Services and Public Safety (DHSSPS); Dr Carolyn Harper, a member of the regional workforce planning group at the Public Health Agency (PHA); and Mr Damian McAlister, a member of the regional workforce planning group at the Belfast Health and Social Care Trust. I hand over to you to make a presentation, and I will then open it up to members.

Ms Heather Stevens (Department of Health, Social Services and Public Safety): Thank you, Chair, and good afternoon. We are grateful for the opportunity to provide evidence to assist your review of workforce planning across Health and Social Care (HSC) in the context of Transforming Your Care (TYC). I propose to highlight very briefly a few issues from the briefing paper that was provided to give you an overview of the approach that has been taken to workforce planning across the HSC.

TYC clearly has to be and, indeed, is a major driver of workforce planning. By the same token, workforce planning is essential to the successful implementation of TYC. In recognition of that, three TYC recommendations — 79, 95 and 97 — specifically relate to workforce planning. They deal with ensuring that critical clinical staff are able to work in a way that supports the new arrangements, the development of new workforce skills and roles to support the shift towards primary care and a more

formal integration of workforce planning into the commissioning process to drive the financial transformation.

In 2012, a regional workforce planning group was established, with members drawn from the board, the PHA, the trusts, departmental professional leads and statisticians and others to take that work forward. Initially, the work focused on a diagnostic exercise and the sector skills council, Skills for Health, was commissioned to carry out an assessment of the capacity across the HSC to do workforce planning. That resulted in a training programme being rolled out and a programme to raise awareness of workforce planning issues. The diagnostic report, which was published in November 2013, also recommended the development of an overarching framework that would clearly set out the roles and responsibilities of each of the HSC stakeholders in the workforce planning process. Since taking up my post last year, I have worked with colleagues to achieve a common understanding of what is meant by an integrated approach and to process planning for a future workforce that not only maintains safe staffing but supports the service transformation that is envisaged by TYC as necessary to improving quality of care.

We are finalising the regional workforce planning framework, which sets out the relative roles of the Department, the Health and Social Care Board (HSCB), the PHA and the trusts for the approval of the respective organisations. In short, the draft framework establishes that it is the Department's responsibility to set the vision; to ensure that a regional approach is taken; to provide regional information and trends; to facilitate capacity building; and, crucially, to make decisions on the commissioning of pre- and post-registration education and training as a logical conclusion to the workforce planning process. It is the role of the board and the PHA as commissioners to determine and agree the various models of service delivery, including the outworking of TYC; to challenge the trusts and providers to ensure that they have identified their workforce needs to be able to deliver the commissioned services; and to flag to the Department when intervention is needed on the supply side, recognising, of course, that there is a lead time to making an impact on the workforce through training. It is the role of the trusts to ensure that they have an appropriately skilled workforce in place; to develop operational workforce plans to adapt to what is being required; and to make changes to their workforce as required.

The framework is not just a paper exercise. We are determined that it will drive the practical implementation of workforce planning at all levels across the HSC. We now want to test it. Traditionally, the Department has commissioned or carried out a series of workforce reviews on a uni-professional basis that looked at the dental workforce, the nursing workforce, the medical workforce and so on. Whilst those are still tremendously valuable in informing education commissioning decisions, and will be into the future, they understandably focus on the profession rather than the patient. TYC rightly demands that the needs of patients should be at the centre of our planning process, so we have decided to pilot a workforce review within a programme-of-care approach. The initial focus will be on the domiciliary care service area in the older people programme of care. That will enable us to look right across the range of roles and professions involved in delivering that service and ensure that, on a regional level, we are looking at issues such as skills mix, training needs and the numbers required to cope with a growing demographic. That work is just beginning to be scoped, and an approach as to how it will be taken forward will be discussed at the next meeting of the regional workforce planning group, which is due later this month. In the meantime, a number of uni-professional workforce reviews are well advanced or are under way, some of which have been separately commissioned such as those relating to medical specialties being led by Dr Harper, whilst others are being taken forward as strands of other reviews — for example, the Department's imaging review.

The uni-professional reviews are providing vital information and knowledge on the current size and composition of the workforce, as well as projections to deliver the required services and to further the implementation of TYC. The interim report we recently received on the workforce review of GPs, for example, has given us a real insight into the workforce issues in that area, which is, of course, at the heart of primary care.

My final point is that workforce planning is usually defined as the process of placing the right number of people with the right skills, experiences and competencies in the right job at the right time. For the HSC, with a workforce of approximately 62,500 individuals, that is a challenge, as it is for many organisations, and it is an art as much as a science. Our aim is to match supply with demand closely, but that is technically difficult, given the wide range of factors that can influence forecasting and the complexity of changing the way in which services are delivered. We believe, however, that an approach that provides absolute clarity about our respective roles and that combines uni-professional

regional reviews with a programme-of-care approach will help us to do that better, and we are committed to doing that.

Chair, I hope that that is helpful by way of context. My colleagues and I are happy to expand further and answer questions.

The Chairperson (Ms Maeve McLaughlin): Thank you, Heather. By way of context, how many reviews are taking place?

Ms Stevens: We have a number of reviews. We have a general medical workforce review, which is looking at the entirety of the medical workforce — specialisms and general medicine. That has a longer horizon, and it is very much based on scenario planning. It is being taken forward by the Centre for Workforce Intelligence, and its findings are expected later this year. We also have six medical specialty workforce reviews under way, and we have findings from four of them already. We have a nursing and midwifery review, which has reached the stage of being costed and will go to public consultation. There is a workforce strand in unscheduled care, which is looking at a series of issues to improve workforce planning in unscheduled care. Finally, we are about to start domiciliary care and take forward an approach there, but that work has not begun; we are at the initial stages.

The Chairperson (Ms Maeve McLaughlin): So there are 10 reviews.

Ms Stevens: Yes, and a further series is planned on the medical speciality field over the next 12 to 18 months.

The Chairperson (Ms Maeve McLaughlin): So there are 10 reviews. I am trying to be positive about this, but how much do they cost?

Ms Stevens: The general medical review that we commissioned from the Centre for Workforce Intelligence is costing us £35,000, but the rest are being taken forward internally or by using a partnership approach with other organisations.

The Chairperson (Ms Maeve McLaughlin): So there are 10 reviews, and one of them is costing £35,000. Reviews take time, which means money.

Ms Stevens: Absolutely, but it is resource in terms of people's capacity in the organisations that are involved in that process.

The Chairperson (Ms Maeve McLaughlin): With specialisms, are you convinced that that is the correct approach?

Ms Stevens: There is a balance. In making hard decisions about how much we need to provide to the Northern Ireland Medical and Dental Training Agency (NIMDTA) to train, for example, a consultant radiologist, we need to know how many we need to train, because that is an expensive process. Those uni-professional reviews are very valuable in helping us to make such commissioning decisions.

The Chairperson (Ms Maeve McLaughlin): When did the first of the 10 reviews start?

Ms Stevens: Some of them started before I arrived in post. The nursing and midwifery review had certainly started, as had the general medical workforce review. That was the middle of last year.

The Chairperson (Ms Maeve McLaughlin): Did any of them predate Transforming Your Care?

Ms Stevens: In this set of reviews, no. I understand, however, that, previously, from 2001, the Department funded some 29 workforce reviews, and they will have certainly preceded Transforming Your Care. There has been a history of uni-professional reviews from that point. The ones that I just mentioned are all since TYC.

The Chairperson (Ms Maeve McLaughlin): If there were 29 workforce reviews prior to TYC, it would be useful to get a sense of the impact or the recommendations that were taken forward as a result of any of them.

Ms Stevens: They will have influenced decisions at that time, but they will have dated from 2001 and will have needed to be refreshed for an up-to-date picture of the service. If you remember, I said that the initial point is to determine the model for service delivery, and the staffing structure follows that. As service models change, the need for a workforce review changes.

The Chairperson (Ms Maeve McLaughlin): Do you not accept that your biggest service model change was to have been Transforming Your Care?

Ms Stevens: Yes, absolutely.

The Chairperson (Ms Maeve McLaughlin): At that point, your focus, in advance of TYC being implemented, should have been in place.

Ms Stevens: Sorry, I do not understand. We have information on what the workforce was in 2011.

The Chairperson (Ms Maeve McLaughlin): Do you have information about what the workforce should be?

Ms Stevens: We have a series of reviews to tell us, and, as we get the information, we can act on it.

The Chairperson (Ms Maeve McLaughlin): Can you say, three years into the process, that we need x amount of staff in x amount of sectors to implement TYC fully?

Ms Stevens: It is more complex than that because TYC is a very fluid arrangement. As services are being considered and new services are developed that focus more on the community and on care being provided at home, given that demand is growing, we cannot immediately turn off the tap on services that are provided elsewhere. We can see that we have a growing demographic and a growing need, so we have to look at it. You can take a workforce review as a snapshot in time.

The Chairperson (Ms Maeve McLaughlin): I do not accept that TYC is fluid. TYC was the policy context that we all signed up to, as was the shift of the £83 million. I suggest, therefore, that it would not have been rocket science, when TYC was only an idea, to do your workforce planning and ask what we needed to do to shift the £83 million and to shift the focus from acute care to community or primary care and what front-line staff, GPs and consultants we need. We should not be doing it two years into a process.

Ms Stevens: Carolyn wants to come in. The starting point is to determine what your models for service delivery are. That process is under way through the establishment of integrated care partnerships (ICPs) and the work to determine what elements of care can be transferred. The workforce then flows from that. Until you have models of care, you cannot determine what your workforce is.

The Chairperson (Ms Maeve McLaughlin): We had 29 reviews, and you are suggesting that they should have informed that.

Ms Stevens: We had 29 reviews including a workforce review in 2001 and another review of the dental workforce. There will have been one review in 2001, another in 2004 or 2005 and maybe another in 2008. They have to be refreshed. There may have been 29, but they will be outdated. At least one third of them will have been superseded by subsequent workforce reviews.

The Chairperson (Ms Maeve McLaughlin): Are we learning from them?

Ms Stevens: Yes, all the time.

The Chairperson (Ms Maeve McLaughlin): You referred to Skills for Health. What is that?

Ms Stevens: Skills for Health is the sector skills council for the health and social care sector. Its remit is to look at the skills needs of the various occupations and roles that make up the health workforce. It is a UK-wide organisation, so we can approach it to do specific work for us. We have a service level agreement with it and are talking to it about capacity building for workforce planning. It helped us in the initial stages of devising our framework.

The Chairperson (Ms Maeve McLaughlin): So Skills for Health published a diagnostic report in November 2013.

Ms Stevens: Yes; it was on capacity building.

The Chairperson (Ms Maeve McLaughlin): For clarification: where was that report published? Was it circulated? Who was it circulated to? How much did it cost?

Ms Stevens: I would need to get the information on that.

The Chairperson (Ms Maeve McLaughlin): Was it published?

Ms Stevens: It will have been published.

The Chairperson (Ms Maeve McLaughlin): Was it on the Department's website?

Ms Stevens: I would need to check, but the document is certainly available for public scrutiny.

The Chairperson (Ms Maeve McLaughlin): Will you clarify that, Heather, and come back to me?

Ms Stevens: Yes.

The Chairperson (Ms Maeve McLaughlin): The paper also states that the framework is now at its final draft stage. Just so that I am clear, does that mean that it took 16 months from the publication of the report to come up with a framework? Is that a good rate to be progressing at?

Ms Stevens: That work started alongside capacity building work and the roll-out of a training programme that also came from the diagnostic report. In addition, the regional workforce planning group oversaw the commissioning of additional uni-professional reviews. That strand of work was proceeding alongside the other pieces of work. It started before I arrived in post, so that would have been before the summer of last year.

The Chairperson (Ms Maeve McLaughlin): Do we now have a timeline for that framework?

Ms Stevens: It is at final draft stage. We are testing it now.

The Chairperson (Ms Maeve McLaughlin): When will we have an opportunity to feed into it?

Ms Stevens: We will get it approved in the Department, and we can send it to you.

The Chairperson (Ms Maeve McLaughlin): Are we talking months? Are we talking weeks?

Ms Stevens: Weeks.

The Chairperson (Ms Maeve McLaughlin): It will come to the —

Ms Stevens: It needs to be tested. We consider it to be a living document, and we want to test it as we take forward the domiciliary workforce review on a programme-of-care basis. That is a new approach, so it may require the framework to be refined.

The Chairperson (Ms Maeve McLaughlin): So we are talking weeks, and it will be shared with the Committee.

Transforming Your Care very clearly stated that a reduction of 3% of the workforce — 1,620 staff, to be exact — would be required for implementation. How was that 3% figure reached?

Ms Stevens: I cannot give you a clear answer to that. It is not a departmental assumption; the assumption was made by the Health and Social Care Board, which was developing Transforming Your Care. As a best estimate, it will have been developed as a result of looking at the amount of money

that was intended to be shifted, and a calculation was then done on the pay bill. That is my estimation of it; I have no information on it.

The Chairperson (Ms Maeve McLaughlin): Can we get that information? It is critical. That was a key objective. I assume that it remains your objective.

Ms Stevens: I asked for that information. It was a working assumption as TYC rolls out. A more nuanced approach is probably needed as opposed to having a blanket figure of 3%. I keep going back to the process that we have all signed up to, which is that you look at the model of service delivery and make your workforce fit that model. We should not be shoehorning ourselves into a particular percentage reduction. The TYC 'Vision to Action' document acknowledges that you might need growth in the workforce in the community setting.

The Chairperson (Ms Maeve McLaughlin): It concerns me, Heather, that, three years into a process, we hear that it was a working assumption.

Ms Stevens: That is what the document says.

The Chairperson (Ms Maeve McLaughlin): You have answered my question: you cannot shoehorn. You look at what you need to provide the service and what policy shift is required, and you analyse the workforce needs accordingly. We are now being told, however, that the 3% reduction in staff to implement TYC was a working assumption.

Ms Stevens: That is what the document says. I am happy to ask the board for further information. I did ask the board, but I am happy to go back again to ask for it.

The Chairperson (Ms Maeve McLaughlin): I suggest that we need absolute clarity on that. Are we still working towards 3%?

Dr Carolyn Harper (Public Health Agency): I will give you our experience in medical workforce planning. The approach that we have taken is what you have suggested: you look at the needs of the patients, the demand and the new standards. TYC is one driver, but there are a number of professional documents, new National Institute for Health and Care Excellence (NICE) guidance or new professional standards that are setting new standards for medical cover, for example. There is a move to seven-day services. We want to move to seven-day services, and we took account of all that in approaching the calculations on how many medical staff are required. While it is primarily focused on medical staff, we have also taken into account opportunities for new roles and a skills mix, particularly roles for advanced nurse practitioners in paediatric and emergency medicine specialties. We involved nursing colleagues, and there are clear opportunities by looking elsewhere to develop that role, so they are not purely uni-professional. It is very much about looking at the needs of patients and clients and at trends and demands and making calculations on that basis.

The Chairperson (Ms Maeve McLaughlin): I will rephrase: as it stands today, to implement Transforming Your Care fully, are we talking about a 3% reduction in staff? What reduction are we talking about?

Dr Harper: I will have a go at that. The overall population is increasing in total numbers, and, in relative terms, it is also ageing. While all the good things such as TYC, better preventative medicine, better self-management and earlier intervention will help — we have already seen increases in the number of years that people live, disease-free and disability-free — as the population ages, there will be continued demand for acute hospital care, acute care in the home and so on. There will be patients with increasingly complex needs. On that first principle that there will be a bigger and older population, we will continue to need more staff, not fewer staff, as the years go by.

The Chairperson (Ms Maeve McLaughlin): So is it not now a reduction of 3%? All I am asking for is a figure. I get the context. I am asking for a figure.

Dr Harper: I do not think that any of us at the table is working to an assumption of a 3% reduction in staff.

The Chairperson (Ms Maeve McLaughlin): So we are not working towards a 3% reduction in staff. Is it less than that? Is it greater than that? Can you give us any indication?

Mr Damian McAlister (Belfast Health and Social Care Trust): From a trust perspective, I can comment and say that demand is growing. We are trying to provide many more services in a community setting rather than having people in hospitals, and, even for those in hospitals, we would rather provide their care on an ambulatory basis so that they do not require to be an inpatient. That still requires a growth in services, both in the acute hospital and community setting, so we are not experiencing the reduction in the demand that TYC predicted.

The Chairperson (Ms Maeve McLaughlin): I am going to labour this point. If you are carrying out workforce planning, there must be a target figure somewhere that you are working towards.

Ms Stevens: It is not a reduction.

The Chairperson (Ms Maeve McLaughlin): Is it an increase?

Ms Stevens: We are working to make sure that there is a workforce that is fit to deliver the service models that are agreed as they are agreed.

The Chairperson (Ms Maeve McLaughlin): So that is likely to be an increase in staff employed to deliver TYC as opposed to a 3% reduction.

Ms Stevens: Undoubtedly. Over the last three years, the number of staff in the whole HSC has increased by over 4%. That is reflective of the growing population and growing demand.

The Chairperson (Ms Maeve McLaughlin): I am labouring this because I think that it is important. Can you share with us, if not today then as soon as possible, what we are talking about in terms of the staff requirement to implement Transforming Your Care? If it is not now a 3% decrease, it is an increase. What type of an increase do we need and in what sectors?

Dr Harper: I am not sure that you could come back with a figure as definitive as that, Chair. You have to look at each specialty area or service area. It is not an exact science. It is based on a number of assumptions and trends over time and so on. It is not as straightforward as saying that it will go from x to y, with y being exactly what you need to implement TYC. Implementing TYC, Making Life Better, the Quality 2020 strategy, the maternity strategy or the paediatric review when it comes out are all factors. It is continuous and fluid, which I think was Heather's point. The situation is fluid in that we have to adjust the plans constantly. It is not about going from one fixed point to another.

The Chairperson (Ms Maeve McLaughlin): I accept that, but are we now saying that the target in the policy direction was wrong?

Dr Harper: I do not think that it was a target that the Department set.

The Chairperson (Ms Maeve McLaughlin): It was clearly in the Transforming Your Care strategy. A 3% staff reduction is clearly there in black and white.

Ms Stevens: It is there as a working assumption, which is how it is described. It is not a target. It does not take into account the fact that, for many of the changes that TYC envisages, it is not about recruiting new staff but changing the role of existing staff. All that has to be factored in, so it is not a straightforward case of x new services equating to y new staff.

The Chairperson (Ms Maeve McLaughlin): I again go back to the point that, if it has now changed from being a 3% reduction, we want to be informed as that figure is being developed.

There were reports and reviews into general practice in 2006, 2010 and 2014. Why were those recommendations not acted on?

Ms Stevens: Is that to do with increasing the number of GPs who are trained? At the time, the decision would have been based on available resources. That is the climate that we still find ourselves in.

The Chairperson (Ms Maeve McLaughlin): So it is to do with available resources. Despite the fact that this goes back to 2006, when the potential crisis in general practice was highlighted, with clear recommendations about the number of training places we needed in the North, nothing was done.

Ms Stevens: As I understand it, the training places that have been commissioned have been 65 a year for some time. There are concerns about the length of time it takes GPs to complete their training. Many are taking longer than the three years that we want to see. We are also conscious that we are losing quite a few GPs who train in Northern Ireland and are paid for to train in Northern Ireland to elsewhere. We want to address those serious issues. An increase in training numbers is one part of a bigger review on how we increase the number of GPs currently practising in Northern Ireland. We know that we are under-supplied with GPs.

The Chairperson (Ms Maeve McLaughlin): Of course we are. There is the final 2010 report, and there was also one in 2006. The 2010 report clearly stated that urgent action was needed to increase the number of training places from 65 to 80. I have a copy of the interim report here, and I think that it is worth quoting. The interim report — the figures are very recent — looked at the period from 1 January 2014 to 24 September. The Department has this report. It looked at the number of occasions on which GPs had to close: Kilkeel, 43 times; Armagh, 86 times.

Ms Stevens: We completely —

The Chairperson (Ms Maeve McLaughlin): No, I am sorry Heather. Two very clear recommendations go back to 2006, stating that GP training places were at crisis point and needed to be shifted. One recommendation is to increase GP training places to 111 annually, phased over four years.

Ms Stevens: I completely accept that that recommendation was made. We have built in a requirement to increase such training places as a pressure in our budget, but, as you are aware, that is competing with other significant budget pressures in the 2015-16 discussion.

The Chairperson (Ms Maeve McLaughlin): Are you saying that you have built an increase for GP training into the 2015-16 budget?

Ms Stevens: It is for consideration as part of the 2015-16 budget. The Minister has not yet approved that.

The Chairperson (Ms Maeve McLaughlin): Is it a fair criticism that, given that this goes back to 2006 and that there is a considerable amount of data on it, the recommendations in three reports were not followed through?

Ms Stevens: I cannot argue: the recommendations were not implemented.

The Chairperson (Ms Maeve McLaughlin): This is at a time when there is the potential for the system to burst in a number of sectors, particularly in primary care.

Ms Stevens: That is why we are keen to make sure that the training places that we fund produce GPs who will work in the Northern Ireland system. It is a very expensive process, and we do not want to train them and have them lost to the system.

The Chairperson (Ms Maeve McLaughlin): I know that Fearghal wants to come in on this. You have the report: it is £90,000 per training place.

Dr Harper: That was one of the medical specialty plans that was agreed through and approved by the regional workforce planning group, which Heather chairs.

For clarification, the 2014 report is still working through the process. Heather mentioned that it is factored into the budget for 2015-16, subject to the overall pressures and position. We do not yet know whether the 2014 recommendations will be fully accepted, but we have certainly made the case. The evidence is there.

The Chairperson (Ms Maeve McLaughlin): Are we likely to see an increase in training places, given the recommendations?

Ms Stevens: It will be for the Minister to decide, Chair. In terms of all the other —

The Chairperson (Ms Maeve McLaughlin): Given the policy direction of the need to refocus on primary.

Ms Stevens: The Minister has that information, and he will make his decision in terms of the 2015-16 budget.

Mr McKinney: There is a big pattern in the figures. Of the roughly £27 million available for Sunday and training etc, £23 million of that, last year, went to the Belfast Trust and hospital provision. Fully cognisant that we are short of GPs, how can you justify that level of budget going into hospital training and not into GPs?

Ms Stevens: That is for undergraduate medical and dental training, so it relates to the placements of the students who are going through Queen's and doing their basic medical degree. At that point, they have not decided what specialty they want to pursue.

Mr McKinney: Yes, but if they are not going to GPs for more than about four weeks in their training, how are we going to encourage them into GP-land?

Ms Stevens: We do not have any difficulty in encouraging GPs. GP placements are oversubscribed. We have roughly double the number of people applying who can be accepted by NIMDTA to train as a GP.

Mr McKinney: They are not getting training in GP surgeries to the extent that they are getting training in consultant or hospital roles.

Ms Stevens: Do you mean as part of their undergraduate experience?

Mr McKinney: Yes.

Ms Stevens: At the minute, that is right. We are perfectly happy to —

Mr McKinney: Is that consistent with trying to get people to be GPs?

Ms Stevens: It has not hampered them; we are still oversubscribed with the number who want to apply. That is not to say that we should not be discussing the composition of the undergraduate degree and the placement programme anyway. What you said is very valid. We need to give more doctors experience of primary care in any case. However, it is not an inhibiting factor in attracting people to train as GPs. We are oversubscribed.

Mr McKinney: Is that consistent with what the BMA found in its report about general practice here, with the shortage of doctors, the number retiring and the gap in the market?

Ms Stevens: The constraining factor is the number of places that we can fund, not the placement. The placement is a good idea anyway, but that is not the constraining factor; it is the number of places that the Department can fund.

Mr McKinney: It is one of the constraining factors.

Ms Stevens: I do not agree. It is a good idea to do it, but it is not a constraining factor in terms of the number of GPs who can go through.

The Chairperson (Ms Maeve McLaughlin): The first recommendation in the interim report is that the training places should be increased to 111 annually. Are you likely to support that? Did that recommendation come from you?

Dr Harper: We are all members of the regional workforce planning group that approved that report. I lead the particular work strand to develop the plan, so I absolutely support it.

Mr McCarthy: Following on from that — correct me if I am wrong — you mentioned the figures for the students who want to go into general practice. You are satisfied with the numbers. Only last week, I think that Dr Tom Black told the community that there was going to be a shortage of GPs; the ones who are there are retiring. You are saying that that is not correct.

Ms Stevens: No, I am not saying that at all. It is correct. We have a number of people — over 100 — who want to apply to be GPs, but we cannot, at the moment, fund the places; we can fund only 65. Tom Black would argue that 65 is not sufficient for us to fund in order to meet the fact that a large number of GPs are going to retire. The lack of funding for the training places is our barrier.

Mr McCarthy: Surely that must be an urgent action or work on somebody's behalf to ensure that the required number of GPs will be available as GPs retire.

Ms Stevens: That is why it is built in for the Minister's consideration, but only he can make the decision as to what his priorities are for 2015-16. The arguments are certainly there. Apologies for repeating this, but he will also want us to make sure that the number of GPs whom we fund are encouraged to stay in Northern Ireland and deliver the service here. We are concerned at the number who come through that process and go elsewhere, because that is a loss to the HSC in Northern Ireland.

Mr McCarthy: I come to the roles and responsibilities set out in the draft framework at paragraph 7 of your paper. One of the roles of the board is to ensure that independent practitioners identify their workforce needs for service delivery. Given that GPs are independent contractors, what power does the board have to make sure that they carry out workforce planning, so that they have enough GPs, treatment room staff, nurses and receptionists to keep their surgeries functional?

Dr Harper: GPs were certainly part of the work that we did to develop the GP workforce plan. Indeed, they were more than a part: they were the main leaders and drivers of the plan. The Royal College of General Practitioners was included in that work as well. Any of the workforce plans involve all those who have a direct stake in the service.

Mr McCarthy: We all know that GPs play and will play a very important role in the implementation of Transforming Your Care and are crucial to workforce planning. However, I understand that the Department does not currently compile data on GP practices, such as the number of treatment room or practice nurses. How can the Department truly understand the GP workforce if no data is collected?

Ms Stevens: The HSCB is working on a business case for a data warehouse facility that will capture exactly that information. Obviously, that will be subject to resources, as is everything in the current climate. We are conscious, however, that it would be extremely helpful, if not essential, to have information on GPs. What we have at the moment is what we can glean from the returns that GPs make to claim their funding under the general medical services (GMS) contract. We are constrained by that.

Mr McCarthy: Do you not think that this work should have been done long ago?

Ms Stevens: The need for it has been identified, and it has taken some time. Obviously, because independent practitioners are just that, it is for them and the BMA working with us to agree it. We do not have the power to require them to do it.

Mr McCarthy: Finally, is the Department carrying out any workforce planning for other independent contractors, such as pharmacists or, indeed, opticians?

Ms Stevens: We are certainly aware of the need to do a pharmacy workforce review. It is on our list, if you like, together with allied health professionals. The immediate priority, however, is domiciliary care, which is of course delivered through a mixed economy, with some statutory sector and some independent sector provision. We will get a good sense of what the workforce needs are in that area to begin with.

Mr McCarthy: The sooner that is done the better, surely.

Ms Stevens: Absolutely.

Mrs Dobson: The paper provides some information on workforce modelling at trust level relating to the Belfast Trust. Have any other trusts undertaken workforce modelling yet?

Mr McAlister: Maybe I should clarify my role. I am here as a representative of the regional workforce planning group. I happen to work for the Belfast Trust, and that is why the figures relate only to it. Yes, all trusts provide and analyse their workforce statistics and carry out modelling based on service demand. Then, when a commissioned need is identified, we work with the HSCB as the lead commissioner to secure the resources to meet that demand as identified.

Mrs Dobson: Trusts are currently facing unprecedented pressures on nursing staff. My trust, the Southern Trust, has told me of unprecedented spikes in activity in acute hospitals across Northern Ireland. I appreciate the need to plan ahead; it is essential for changing roles. Surely, however, the challenges in our hospitals are currently happening. What are you doing now to help the trusts to address those problems?

Mr McAlister: Our trust, like all organisations in the health and social care sector in Northern Ireland, is facing unprecedented demand; it has been that way since just before Christmas and continues. We have been flexing up our nursing workforce insofar as we can, both by offering our existing staff additional hours and looking to bank and agency staff to augment our existing workforce to meet the unprecedented demand. When the current surge abates, we plan to look at the demand over this winter and, indeed, over previous winters with a view to scheduling our workforce in such a way as to meet the demand when it is at its greatest. I know that each organisation is doing the same. The problem is that, when a nursing workforce is faced with significant demand and that demand outstrips capacity, it creates a workforce gap. That is maybe what some areas are experiencing at present.

Mrs Dobson: I met senior management at the Southern Trust last week, and they are under considerable pressure. I note that you said, Damian, that you are offering existing staff extra hours to alleviate the pressure. I am somewhat concerned that too much pressure is put on staff while the Department is not helping to resolve the issue. Staff are coming off long shifts and are being asked to come in for extra hours. They are so dedicated; but I do not like them being put under pressure, and many have told me that they feel under considerable pressure. How, then, will the regional workforce planning group help trusts, with existing staff, to keep pace with the pressure on the services? We cannot go on like this. Staff can only cover additional hours at weekends or whatever. They cannot continue to do this, and so many are going off sick.

Mr McAlister: Maybe Heather would like to answer that. From the point of view of my organisation, the professionalism of our staff is tremendous; what they do every day is fantastic. I hope that they are not being put under duress or pressured.

Mrs Dobson: They feel that they are. They are outstanding in the work that they do, but —

Mr McAlister: Of course. Certainly, the management team in our organisation is acutely aware of the pressure that our staff are under. We are working, through the management team and with the staff, to alleviate that as much as possible and to make sure that staff are not put in a position where their own health and safety is compromised. The regional workforce planning group —

Mrs Dobson: Certainly, I am concerned based on what I have heard from staff who do not want to be identified for fear of their jobs. They are so dedicated and committed, as we all know. This cannot continue, however. What sort of time frame are we looking at?

Mr McAlister: It cannot, I agree. That is what I mean by taking stock of what has occurred and starting to plan for the future. That is the nub of workforce planning. Looking back, past performance is the best predictor of future performance. The demand over winter 2014-15 will influence our approach in winter 2015-16.

Mrs Dobson: You do need to plan ahead, but these issues are evident now. I am really concerned. They are not being addressed now, when staff are demoralised and at breaking point. How then can you continue to future-proof, when they need the help now?

Ms Stevens: I think so, and if I may, I would like to add that I completely support what Damian has said. Patient safety is an absolute priority, as is the health and well-being of staff. We rely on them to do the job that they do. When it comes to grossing up, if you like, our workforce requirement at regional level, we have to be realistic about what we are asking people to do. Currently, we have 62,500 staff, or 54,000 whole-time equivalents, but does that count the extra time that staff put in, thereby masking the fact that we should actually have a higher number? My concern is that we get a really accurate fix on the workforce requirement; one that does not take into account the goodwill of people who are trying to do a lot because they care.

Mrs Dobson: It is alarming. The staff are tremendous, but when they are under so much pressure, that needs to be addressed as a matter of urgency, before we plan.

Ms Stevens: It does. One of the vehicles that we have to try to capture that is a staff survey, which is usually done biannually. We are working with the trusts now to plan the new survey, and I would like to think that we will capture that sort of information, so that we get a sense from people of where the pressures are and to what extent they are working above and beyond the call.

Mrs Dobson: Certainly, I was very concerned about the pressures following my meeting.

To be clear: you are saying that the Belfast Trust will publish its first workforce plan in March 2015. Is that correct?

Mr McAlister: Since TYC, we have been taking forward workforce planning in our adult social and primary care services, which covers mental health, learning disability and older people services. It is quite a broad area of service delivery in the organisation. We are confident that, by the end of the month, we will have published a workforce plan, which will then in turn inform our commission bid to the HSCB, as the commissioners, for the additional resources to maintain those services. It does take time to develop them, because the first step in any workforce plan is identifying the service need, and we have been considering in mental health, for instance, how we move away from inpatient treatment to treatment at home. So, from that perspective, it is a service reconfiguration, and it might just mean a reskilling of some staff; for example, psychiatric nurses who previously worked on a ward to work as community psychiatric nurses. That is workforce planning at its sharpest edge, and we are confident that, by the end of this month —

Mrs Dobson: It is a ticking clock for time.

Mr McAlister: It is, and the sooner it is published, the sooner we can engage in discussions in the workforce planning cycle with the board as the commissioner and then ultimately with the Department, if there is identification that there are additional training places required, for example.

Mrs Dobson: So it is going to be later than March 2015.

Mr McAlister: No, for adult social and primary care, we will have a workforce plan for the Belfast Trust for those services by the end of this month.

Mrs Dobson: In a couple of weeks' time, you will have that.

Mr McAlister: Yes, that is the intention.

Mrs Dobson: In relation to the workforce planning being carried out at Department, board and trust level, how will you ensure that the plans complement one another other and that people do not end up working in silos? Who has overall responsibility for monitoring workforce planning? Is it you?

Mr McAlister: In the Belfast Trust, I am responsible for the monitoring of workforce planning within our organisation —

Mrs Dobson: But what about over all the trusts?

Mr McAlister: For all the trusts, it would probably be the responsibility of the directors of HR and the directors of planning. That is why we have the regional workforce planning group. It is through it that we organisationally present our programmes of care workforce planning, and it is about marrying

those with the uni-professional workforce plans that are being developed, for example, down the medical line, to make sure that we do not end up working in silos, where one profession says that it needs x, y or z nurses and another says that, from a programme of care perspective, it wants to move away from a nursing-led model towards more of a multidisciplinary team model that involves nurses, social workers and allied health professions.

Mrs Dobson: How regularly do you meet the chief executives of the trusts? I can speak only from the example of my Southern Trust. Is it weekly?

Ms Stevens: How often does the regional workforce planning group meet? It has been meeting monthly recently, and it is due to meet again on 30 March.

Mrs Dobson: How often do you talk to the chief executives of the trusts?

Ms Stevens: It would be the HR directors —

Mrs Dobson: If I can spend two hours talking and seeing the problems quite quickly, surely you are doing the same.

Ms Stevens: We work with the HR directors who would obviously communicate the views of the chief executives.

Mrs Dobson: You are not actually meeting with the chief executives.

Mr McAlister: We are there as the representatives of the organisations through the regional workforce planning group. So I represent the views of the Belfast Trust chief executive and interact with the chief executive on workforce planning issues, as I would with other service directors within the organisation.

Mrs Dobson: But are you meeting face-to-face with the chief executive of the Southern Trust, for example?

Mr McAlister: I cannot comment on the Southern Trust, sorry.

Mrs Dobson: You are not meeting directly with the chief executives; it is just HR directors.

Ms Stevens: I meet with HR directors, but the chief executives of all the trusts will meet our permanent secretary on a regular basis. There are other avenues.

Mrs Dobson: How regular is regular, given the crisis now?

Ms Stevens: I think that it is pretty regular, but I am not familiar with the schedule.

Mrs Dobson: It would be useful, Chair, to find out how regular is regular, given the crisis that there is now, and how that is defined.

Dr Harper: I think that it is fair to say that no one within the group — no one on any senior management team across HSC organisations — could be in any doubt as to the pressures, the needs and the strategic direction. It reflects the approach that we have taken to date. Firstly, it is patient/client need. Secondly, what is the service model that we need? That is the integrated teams that Damian and Heather have mentioned. Thirdly, what are the workforce needs to put those in place? The move from five-day services to seven-day services will, undoubtedly, help to remove some of the pressure that staff feel on that Monday to Friday concertinaed effort. Undoubtedly, that means that we need additional workforce, because you are covering an extra two days of the week —

Mrs Dobson: They are telling you that three staff members in a particular area will be off that weekend, and they really need that coverage, and they know that on a Thursday for a Friday.

Dr Harper: Yes. You are absolutely right: it is not sustainable. I echo the comments that others have made about the commitment and the professionalism in nursing, medicine and social work, right

across the disciplines, to make sure and provide the service for patients. Specifically on the nursing, there has been extensive work to look at nurse staffing levels; it is called the normative nursing exercise. It has been completed in some aspects of acute care, and there are further phases looking at community nursing, health visiting and so on. Again, the results of the first phase of that are factored into the financial planning for 2015-16, so we have started to put in place the recurrent additional staffing that is required to give us that sustainability and take the pressure off staff.

Mrs Dobson: There is nothing like sitting across the desk with a chief executive —

Dr Harper: Absolutely.

Mrs Dobson: — or the head of a department to find out exactly what pressures there are. In relation to investment and retraining of staff, for those who have time to do it, to achieve the appropriate skills mix, I note that your paper provides examples from the Belfast Trust. However, the majority of those examples seem to be about simply providing training opportunities for staff rather than retraining. Is this a fair assessment?

Mr McAlister: Are you relating retraining to moving from working in one sector to another to meet a shift in services? I think that it is fair to say that, given the demand that there has been on our hospital services over the last three years, there probably has not been the movement from hospital settings to community settings that would involve a retraining of staff. There has probably been some around individual programmes of care, maybe in respect of how diabetes is treated or respiratory illnesses that have been supported with funding from the Health and Social Care Board. What is presented here is predominantly how we are trying to upskill staff in those settings at present to continue to meet the demand in the way that it is coming through our front door. So, yes, in answer to your question.

Ms Stevens: There are a few other examples. For example, in the Ambulance Service, paramedics are being upskilled at the moment to do more of the see, treat and leave as an alternative pathway to help to divert more people away from emergency departments. Carolyn mentioned that there is a move to upskill nurses into advanced nurse practitioner status so that they can start to take on some of the roles that more traditionally have been done by junior doctors. We, in the Department, have a small budget to support health care support workers. Those are people who are working in the HSC at lower levels, bands 2 and 3, but who are very committed and want to upskill and perhaps want to take advantage of open access through the Open University to do, for example, a nursing degree. We are able to provide some support for that. There is a range of ways in which we are trying to upskill staff.

Mrs Dobson: Is that aspirational, given that we seem to be firefighting to get the cover for a shortage of nurses?

Ms Stevens: Yes, and that is reflected by the number of people who can currently go through. Absolutely.

Mr McAlister: I draw your attention to the generic support worker post that we have created across allied health professions in the community. I think that it is an important one. That is a worker who now works across occupational therapy and physiotherapy. Previously, particularly from a client perspective, clients will have had visits from individual workers representing both programmes, so they will have had an occupational therapy support worker and then a physiotherapy support worker. Now, we have upskilled 95 of our staff to be able to cover both disciplines, and it means that the client is getting one face to see and that it is a better service. In terms of upskilling, that is one example of where we have been able to reskill, because that has an element of reskilling where they have had to learn across what was two separate professions previously.

Mrs Dobson: Finally, can the Department quantify how much has been spent across the trusts on retraining staff to meet the shift left requirements since TYC was published?

Ms Stevens: I cannot give that figure today. We can commission that. We can ask for that information and provide it.

Mrs Dobson: It would be useful, Chair.

I am really concerned about the pressure put on the front-line staff, and I have nothing but admiration for the work that they do, but there is only so much pressure that they can take as well, and it is urgent that you deal with that before you get to tackle future planning.

Mr McAlister: I could not agree more with you.

Ms McCorley: Go raibh maith agat, a Chathaoirligh. Thanks for the presentation. It has been referred to a bit by Jo-Anne, but I want to ask about the £25 million shift out of the £83 million for Transforming Your Care and the actual impact of that. The paper does not talk about the impact of that on staff working in mental health and disability. Why would that not have been referenced in the report?

Ms Stevens: We are still working through what the workforce implication is of the resettlement of the £27 million for mental health and learning disability services, so we need to get that information from the board in terms of TYC. I do have more information in relation to the new services that are being commissioned for primary and community care going forward. By 2015-16, an additional £16 million will have gone in, and that will include some recruitment, for example of reablement teams, additional foster carers, staff in dementia services and 40 additional nurses. I can quantify that more easily for you. I need to go back to the board and get more information on the resettlement.

Ms McCorley: When you say recruitment of staff, is that going to be completely new staff or would it be staff coming from other places?

Ms Stevens: It is recruitment of completely new staff.

Ms McCorley: OK. Have any of the existing staff in institutions dealing with mental health issues and disability been transferred?

Mr McAlister: Yes. Where we have reconfigured services to take people out of what you describe as institutions and into supported living programmes and whatever, staff who previously supported people in those institutions have transferred or been redeployed. No staff in our trust have lost employment as a result of a reconfiguration of services.

Ms McCorley: Are staff who are moving to accommodate, maybe, facilitating or providing services for people in a different setting being retrained?

Mr McAlister: Where retraining is appropriate, there would be an element of that, but it is mostly about the institution as opposed to the direct care that is being provided. The care tends to be quite similar, so it is more about the change in the infrastructure of the institution.

Ms McCorley: When will you have the information about the impacts of that on staff?

Ms Stevens: I will commission that.

Ms McCorley: When will it be available?

Ms Stevens: I can get that information to you in a few weeks.

Mr McCarthy: May I come in on the back of that to ask about Muckamore Abbey Hospital? Your comments worried me a bit. I would have thought that this is about patients and people rather than other resources. What is the up-to-date position in Muckamore? I know that the deadline for the Muckamore patients to be resettled was March 2015.

Mr McAlister: I will need to come back to you on that. I do not have the figures to hand, but I know that the programme is continuing and that we are resettling patients from Muckamore.

Mr McCarthy: Are they being resettled where they want to be? My concern, which is shared by others, is that there was a push on to get people out wherever they go and that is not on.

Mr McAlister: That is not my understanding, but I will provide the figures.

The Chairperson (Ms Maeve McLaughlin): Is there somebody from the board on the regional workforce planning group?

Ms Stevens: Yes.

The Chairperson (Ms Maeve McLaughlin): Who is it?

Ms Stevens: There is membership on the commissioning side and on TYC. They have not attended recently because we have been focusing very much on the framework, but they are core members as the group was originally set up.

Mr G Robinson: The Committee had asked you to provide information on how workforce planning is taking account of recruitment issues in particular geographical areas. However, the briefing paper provides no information. Are the Department and the board looking at that issue? Can you give me an answer on that, please?

Ms Stevens: We are very aware of gender issues and working pattern issues, and they are part and parcel of workforce reviews as they go forward. For example, we know as a result of the GP workforce reviews that that is a predominantly female specialty. We know that lots of female GPs want to work part-time. So we get that information through the workforce reviews. We are looking at seven-day services, and we have asked the two pay review bodies — the NHS pay review body and the doctors and dentists' pay review body — to make recommendations, or rather observations in relation to the enablers for and barriers to seven-day services, because, again, that impacts on flexible working patterns. We are very conscious of it, and it is being dealt with through a number of channels.

Mr G Robinson: Is that seven days for doctors, did you say?

Ms Stevens: It is about seven-day services across the piece, recognising that some parts of the system already work over seven days. Nursing care is provided over seven days already and, increasingly, laboratory services are being provided over seven days. In many areas, physiotherapists are being provided over seven days.

Mr McAlister: I will answer your question about geographical areas. From a workforce planning perspective, it is the responsibility of the local trust to identify any geographical concerns that are prohibiting recruitment. In the workforce planning cycle, that would be through the regional workforce planning group fed back through to commissioners and, ultimately, to the Department to try to address.

Mr G Robinson: Does that take in all trust areas?

Mr McAlister: Yes. All the trusts are represented on the regional workforce planning group; that is our responsibility.

Ms Stevens: If there were shortages in, perhaps, the Western Trust, we would be aware of that in the context of attracting middle-grade doctors into those areas. We are aware of it. There is not always a training solution for that; sometimes it is about recruitment and retention, which is very much an issue for the employers to sort out.

Mr McKinney: In your report, you talk about doing workforce planning on programmes of care or on staff groups. In the end you decided, by and large, on staff groups. Why?

Ms Stevens: Traditionally, that is the approach that has been taken for some time. We are now moving towards a programme-of-care approach, recognising that the patient needs to be at the heart of it. That is very much driven by TYC. We think that that is a better way to allow us to look at the skills mix so that we can start to look at different roles that different professions play.

Mr McKinney: Why did you decide to do it on staff groups?

Ms Stevens: We already had those under way when we reached the conclusion that we wanted to pilot a programme-of-care approach. However, I argue that, in any case, they are very valuable, if not

essential, in allowing us to make decisions about how many doctors and nurses we need to train. You get that only by looking across the profession.

Mr McAlister: I think there is a need for a blended approach, whereby both can coexist. The programme of care readily identifies how the demand can be met and by what professional group. I think that there is then a responsibility to take that into a uni-professional workforce plan, because you might commission the education. Nursing education is commissioned through a different provider than medical, AHP and social work education. You almost need to have an overarching programme-of-care workforce plan that you then split into the uni-professional workforce plans.

Mr McKinney: Yes, but which is the most important? I think you are saying that it is the programme-of-care work, which is then to be supplemented by the staff. So, we have not done the programme-of-care work.

Ms Stevens: No, no one has. It has not been done in England either. Traditionally, workforce planning is done on a uni-professional basis. We are working through a process now, and we have decided to focus on domiciliary care as a key area that has not been looked at to date but is an area where we see there might be a need for growth. We want to test the approach in that.

Mr McKinney: I welcome that, but it is four years late, because TYC had at its heart the concept of a growing, ageing population, long-term conditions and, clearly, the need for more care. Why are you coming to look at that only now?

Mr McAlister: Work has been done on older people's services. Re-enablement was a concept that was introduced on the back of TYC.

Mr McKinney: That is a specific programme; it has not taken account of an overall assessment of what older people need.

Mr McAlister: I accept that.

Ms Stevens: I do not have a straightforward answer for you, but it might be that it is very difficult. There were perhaps concerns that it could not be done properly. As we have become more confident about looking at the skills mix, challenging ourselves and considering whether a particular profession has to do a particular job, that has now opened us up to thinking that we just need to look at it differently. It has perhaps taken a while for that thinking to come to fruition, but we are there now. We want to test this.

Mr McKinney: But you are not there yet, because —

Ms Stevens: We want to test —

Mr McKinney: — you are at the point of scoping out. You are not at the point that you say you are.

Ms Stevens: No, we are there by having made the commitment to do it.

Mr McKinney: Sorry, now you are making a commitment to do it?

Ms Stevens: Yes, we have decided that we are going to focus on the domiciliary care.

Mr McKinney: You are beginning to scope this review.

Ms Stevens: What needs to be scoped is the consideration of the services that are provided within that domiciliary care service area, for example. We need to scope it out, look at what different professions are involved and look at the population that we are trying to serve.

Mr McKinney: Do you see how I am asking these questions? My jaw is dropping, because, if the first point of principle of TYC was recognising the growing ageing population, surely the first job in the whole thing was to assess the need for that growing older population. That means not the staff need but the patient need and all the needs of that growing demographic.

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Dr Harper: You can cut it both ways. If you look at an older person, you can see they may have needs that their general practitioner or community pharmacist can meet. Some others will have needs that can be met in only a critical care unit or by an interventional radiologist in a tertiary-level centre.

Either way you cut it, you need to understand that from both perspectives. For designing training, you certainly need to know how many radiologists we need to train.

Mr McKinney: I understand that, and I get and welcome that you are now, four years late, coming to this as a concept. Does that mean that what we have in place now is not satisfactory? I am talking about, for example, limited 15-minute domiciliary care packages.

Ms Stevens: We cannot comment on that until we do the review. We need to do the review, look at the services that are provided and at the population needs and then make determinations about what the size, composition and skills of the workforce need to be so that we can deliver the service that we all agree should be delivered.

That is part of that process. Then we need to look at the models to see whether it involves statutory provision or independent sector provision, and we then need to look at the skill levels. That is all part of that work.

Mr McKinney: But in the absence of that considered information, I can reasonably question the value and quality of the care that is provided.

Mr McAlister: Care is provided on an assessed-need and individual case-by-case basis, so not everybody gets 15 minutes. The workforce plan is about trying to identify the resource that is required to provide the growing demand that older people are experiencing. As it stands, each case is assessed on an individual basis.

Mr McKinney: Just to broaden it out a bit, is it right simply to look at the domiciliary care side of this? Consistent with the overall TYC plan, with a view to reducing that demand on the expensive side of the service, a much bigger scoping exercise should surely be done on the overall needs of that growing population, which we all recognise is going to put increased demand on the service.

Ms Stevens: I think that will come, but we were conscious that we did not want to bite off more than we could chew by looking at this in a different way. We want to focus on that one area, and then we can roll it out.

Mr McKinney: Typically, how long does a review like this take?

Ms Stevens: It depends. We have not done one like this before. That will be part of the scoping exercise. That work is going on to see how quickly we can get the information together and where it is. So, I cannot give you an answer to that at the moment. The regional workforce planning group will have an idea at the end of the month when that scoping work has been done.

Mr McKinney: Do you accept that there is a reasonable cause for incredulity, given that this work has not been done, given what TYC set out?

Dr Harper: I think your question, Fearghal, implies that other work is not going on. I mentioned the normative nursing work, and Heather mentioned the 4% increase in staffing overall across the HSC.

Mr McKinney: That is OK, but that is from the staffing point of view; you are now coming to the view that this needs to be done around programmes of care.

Dr Harper: No, I said that the driver of the staffing needs is, first, the patient/client need, then the service model and integrated teams, and —

Mr McKinney: But we have not established the specifics or the generality of that patient/client need.

Dr Harper: The general practice report, for example, is very much based on the trends in demand for general practice from patients and their needs. It is calculating on a straightforward basis the

workload trends and, from that, the number of GPs, so it is very much driven by patient needs. That is the approach we have taken. It is the same with the normative nursing levels. They look at —

Mr McKinney: It is my understanding — maybe this point was raised earlier — that you do not keep the data on the staff in the GP services.

Dr Harper: We know the numbers. I am talking about the GPs themselves and the number of training posts you need in general practice to meet the need. The report sets out the expansion that is required. It is based on that style of information.

Mr McKinney: I think we are on record as saying that we are very concerned about how domiciliary care is provided here and how inequalities are provoked by individual trusts taking individual decisions consistent with their financial bottom line. That inequality is increasing. Also, Damian, it is clear that some people are not getting care packages and that only those with higher conditions are getting them. That is also flying in the face of TYC. The recent story about 14 frozen meals being delivered once a fortnight is a new low in the service for and care of our older people. I urge that this review work be done as quickly and as comprehensively as possible and that we, as a society, start to actually look after older people, rather than seeing them as a cost and a burden.

The Chairperson (Ms Maeve McLaughlin): No other members have indicated that they wish to speak. I thank you for your time today. By way of conclusion, I think that a number of questions remain to be answered. It was quite enlightening to hear today that we are not working towards a 3% reduction in staff to implement TYC. That is certainly news to the Committee. As I said, I stress that we want to get a sense of what the figure will be. Somebody somewhere calculated that initial figure for Transforming Your Care. It is also critical, Heather, that we get a sense of the recommendations for primary care, in particular GPs, and for those in the report that I referred to for the 111 training places that are required and were costed at £1·35 million. That does not seem to be an insurmountable amount of money when you look at the effort that should be made on the front line and to keep people out of hospital. I suggest that you come back to us on how that is being progressed. Generally, you are indicating today that the framework will be available in a few weeks and that it will be shared with us.

Ms Stevens: Yes.

The Chairperson (Ms Maeve McLaughlin): I will go back to the point that a lot of this work has been ongoing. The 29 reviews and the 10 reviews that are in the system should have scoped out the need and the demand. We are three and a half years into a process and only now are we starting to grapple with that concept. That is of concern to us all. Thank you for your time today.

Northern Ireland
Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Workforce Planning in the Context of Transforming Your Care: British Medical Association and Royal College of General Practitioners

15 April 2015

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Workforce Planning in the Context of Transforming Your Care: British Medical Association and Royal College of General Practitioners

15 April 2015

Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Ms Paula Bradley (Deputy Chairperson)
Mrs Pam Cameron
Mrs Jo-Anne Dobson
Mr Kieran McCarthy
Ms Rosaleen McCorley
Mr Michael McGimpsey
Mr Fearghal McKinney
Mr George Robinson

Witnesses:

Dr Tom Black	British Medical Association
Dr John Woods	British Medical Association
Dr Shauna Fannin	Royal College of General Practitioners
Dr John O'Kelly	Royal College of General Practitioners

The Chairperson (Ms Maeve McLaughlin): I welcome Dr John O'Kelly, who is chair of the college of GPs; Shauna Fannin, who is deputy chair; Dr John Woods, who is the BMA council's chair; and Dr Tom Black, who is the council's deputy chair and chair of the BMA NI GP committee. I ask each of the representatives to make an opening presentation, after which I will open the meeting to comments and questions.

Dr John O'Kelly (Royal College of General Practitioners): On behalf of the college, I thank you for the invitation to address and give evidence to the Committee this afternoon. We have met several members of the Health Committee on an individual basis on a number of occasions and have very much appreciated the time given by you to listen to our concerns and discuss various issues.

Most of you will be well aware of the issues facing general practice in Northern Ireland. The college is the professional organisation for GPs in the United Kingdom and has approximately 1,300 members in Northern Ireland, which is over 80% of the GP workforce. We have 50,000 members in total in England, Scotland, Wales and Northern Ireland, and we have over 600 members in the Republic of Ireland. General practice faces similar urgent concerns in all these countries, and the Health Departments in England, Scotland and Wales have begun to take action on some of them.

Chair, we have provided you and your colleagues with a briefing document, which, I hope, together with our previous conversations, will offer an insight into the serious crisis that is emerging in general practice.

The college has traditionally focused on the key issues of setting and developing the standards for general practice to deliver the highest possible quality of care for our patients, the training of young GPs, the further education of established GPs and research in general practice. In November 2013, the college launched an unprecedented campaign — Put Patients First: Back General Practice — in response to concerns for the future of general practice and the delivery of care to our patients. The campaign calls for an increase in the percentage of the NHS budget allocated to general practice to 11% to reverse the trend of disinvestment and to allow GPs to continue to deliver high-quality care. That is in the context of the increasing needs of our population, significant rises in consultation numbers, the movement of care to the community and the increasing complexity and number of medical conditions that our ageing population will develop.

As you are aware, we have a serious crisis emerging in the GP workforce that can no longer be ignored. Morale is at an all-time low. In Northern Ireland, we have the lowest number of GPs per head of the population in the United Kingdom at 6·4 per 10,000; the oldest GP workforce, with 24% of our GPs over the age of 55; and an ageing practice nurse population. Insufficient numbers of young doctors are being trained as general practitioners, and, in addition, we have real problems in the retention of GPs. There have been three workforce reviews since 2006, with each highlighting the need to increase the number of GPs. It is with dismay that the college notes that there has been no action taken on the recommendation in these reviews. Each one has highlighted the urgent need to increase the number of general practitioners in the workforce. The 2014 interim report on the GP medical workforce said:

> "There is material evidence that a shortage of GPs available to the medical workforce is having a detrimental impact upon the delivery of GMS in NI. There is a further likely consequence in that this will undermine any attempts to deliver a 'shift left' commissioning policy, moving service provision from secondary to primary care."

It recommended that the number of GP training places in Northern Ireland should be increased to 111 annually, phased over four years, with an initial target to increase the number by 15 for commencement by August 2015 but implemented no later than August 2016. The Department of Health has pursued a policy over the last decade akin to the ostrich's head in the sand. It is time to get the head out of the sand and start dealing with the situation. Our concern is that the recommendations of the 2014 report will not be acted on, as happened with the previous reports. If that occurs, be in no doubt that general practice in Northern Ireland will face meltdown in the next few years, with dire consequences for our patients, especially our most vulnerable patients. We already see problems with shifts in GP out-of-hours not being covered, with outlying centres not staffed. This will continue to deteriorate and will have knock-on effects on in-hours care in emergency departments.

As GPs, we want to deliver the best possible care to our patients. Our job is complex, demanding, interesting and professionally rewarding, and we get great enjoyment from it. I know I can speak for Shauna and Tom by saying that we do not want to do anything else, but it is incredibly frustrating when you find that you are being constrained by circumstances outside your control. If we do not address the working environment for GPs in Northern Ireland, we will end up having a brain drain, with our young, brightest doctors emigrating or taking up positions in other parts of the United Kingdom.

The college is calling for a new deal for general practice, with increased investment in infrastructure, support staff, secretarial staff, practice nurses, pharmacists, physical therapists and other allied professionals. We need investment in training, increasing the numbers of GPs in training and extension of GP training to four years. We need retention and returner schemes and a greater emphasis on general practice at the Queen's University undergraduate medical course. With these measures, we believe that we can turn the tide and have a profession that can continue to deliver the highest quality of care to our patients.

Dr John Woods (British Medical Association): Good afternoon. Thank you, Chair, for the opportunity to come from BMA Northern Ireland and give evidence to the Committee about workforce planning in the context of Transforming Your Care (TYC).

Committee members will have received a copy of our briefing paper, and I will address some of the main issues in that. The BMA represents all doctors delivering care to patients in primary and secondary care in Northern Ireland, and we believe that effective medical workforce planning is essential to allow those clinicians to deliver high-quality care and safe care to patients. That is why the BMA has been advocating so actively and contributing to a whole series of medical workforce reviews. Those were done and published in 2004, 2006 and 2010, and we are involved in the current

round. We advocated very strongly for the current round of reviews, and we are involved in those. To date, they have been in paediatrics and in general practice.

Northern Ireland really has a first-class medical workforce, and I think that patients rightly expect to be able to continue to access high-quality care and safe care. We believe that ineffective workforce planning is seriously undermining that goal, and we see the consequences of a lack of effective workforce planning. Crucially, this is increasingly impacting on patient care. Despite work done by the Department to date, we are very concerned and frustrated at the lack of progress that has been made to date.

Implementation of TYC began four years ago, but we have not yet seen the changes that are needed in the workforce to make the TYC vision a reality, being planned and being resourced. We have not seen any work on that to date.

I know you are well aware that there is a major workforce crisis in general practice. Although this is the most obvious example, there are similar gaps in secondary care specialties as well, in emergency medicine and radiology for example.

It is easy to see the consequences of ineffective workforce planning. Members will be well aware of, and have commented on, the resources that have been spent on locums in secondary care to fill gaps. The BMA believes that an over-reliance on locums is a very clear consequence of the failures of planning and implementation to date. That money could and should be more effectively spent on training a sufficient number of doctors in necessary specialties.

There is a pattern of continued failure to recognise and adjust to the changing health needs of the population in Northern Ireland. There are a couple of factors here. First, we have an increasingly ageing population and they have more complicated health needs. I see that in my practice as a hospital consultant. Patients are older, sicker, and their needs are more complex in general. That has led to significant increases in demands for diagnostic imaging, scanning and x-rays, so we now have insufficient radiologists to do those tests, and we have been hearing earlier this afternoon about the problems that that causes. Secondly, as Dr O'Kelly alluded to, with TYC, there is a planned shift of service delivery from being predominantly hospital-based to community-based. That has implications for primary and secondary care. Appropriate workforce planning is integral to this. It must be properly planned, managed and resourced, and we are really concerned that that is not happening currently.

A final factor leading to change is that the composition of the medical workforce is changing. Again, there has been failure to act in response to these changes. Our information about the changing demographics of the medical workforce is on page 8 in our briefing paper, but one clear trend is that there is an increasing proportion of female doctors. The medical workforce is a dynamic situation and there is a range of changing factors, which means that it has to be a continuous, ongoing process.

General practice, as Dr O'Kelly suggested, really stands out as an example of a specialty demonstrating the hazards of failing to respond to those changing circumstances. Due to increasing workload, GPs are increasingly choosing to retire or leave. I think you will have seen the results of our survey, which have been published today, showing that one third of GPs will retire in the next five years.

For general practice, the problems have been recognised but the necessary action has not been taken. There is a whole series of reviews showing what the problem is. The crisis affecting this specialty could have been averted if the recommendations in those reviews had been implemented. One of those is the increase in the number of GP training places.

It is important that action is taken soon because, as I am sure you will appreciate, the lead time for training for these people is very long. From entry to medical school to qualification as a GP, it takes 10 years, and it takes 14 years to train a consultant. If we do not address the problems in workforce planning as a matter of urgency, we think that a similar problem will emerge in secondary care in the very near future. This is something that we care about very strongly. We have been very committed to assisting the Department in that and have contributed actively to the reviews to date, but we really are frustrated at the lack of progress that has been made to date.

We now understand from the evidence given to you in your session on 11 March that the Department is looking at a programme of care perspective for workforce planning, beginning with a pilot programme in domiciliary care. We are concerned about that, because we think that it risks further

delays in resolving that issue. This has been the problem: things have just been pushed back and back and have not been implemented.

Our recommendations are on page 15 in our briefing paper. We really think it is crucial that the current workforce reviews are completed on a speciality by speciality basis as a matter of urgency and that the recommendations made are properly resourced and implemented. Otherwise, the quality of care to patients will be compromised, and that is a situation that none of us want.

Thank you, once again, for the opportunity to give our views to the Committee. Dr Black and I are happy to take questions.

The Chairperson (Ms Maeve McLaughlin): Thank you both. The Committee obviously shares the view that we need to, if you like, refocus our health agenda in relation to primary community care. That does require a refocusing, rebalancing and reprioritisation of the services that are provided by primary community care.

I have a couple of questions. I have met both organisations over a period of time. The issue is much bigger than simply saying that we need an allocation of funding. There are issues of training and retention. I want to ask about the training aspect first. Both reports have a number of figures, and I think that Dr O'Kelly said that 111 places were needed over a four-year period. Was it 80 places by August —

Dr O'Kelly: 2015, or 2016 at the absolute latest.

The Chairperson (Ms Maeve McLaughlin): Is there consensus on that number with the BMA? Is that correct?

Dr Tom Black (British Medical Association): We need 111 in order to stand still, Chair. We thought that, as a first step, it should be increased to 80. We have heard that there will be no increase. This is the third report that has suggested this; nothing about this is new.

It is about priorities. There is limited funding; this is the health service and we deal with priorities. General practice is clearly not a priority for the Department of Health. Why? That is its decision. It has chosen to keep us as the lowest funded and lowest staffed group with the highest workload and the lowest training numbers. This is a perfect storm. The result of this perfect storm is — and we have already seen it — that out-of-hours has collapsed in real time. If you talk to your constituents, they will tell you that they were suffering nine-hour waits for phone backs at the weekend. That is not a service, it is a disservice. The worst thing you can do in the health service is to pretend to have service.

We have a huge recruitment and retention problem. We have a workforce that is inadequate for the needs of patients, and the canary in the mine is the out-of-hours service. That has already collapsed in real time. With the failure to retain older GPs and those we are training over the next couple of years, we will probably lose another 100 GPs. We have 950 whole-time equivalent GPs. There are more than 2,000 patients per whole-time equivalent GP in Northern Ireland now. When I joined my practice, there were 1,500 patents per doctor. We now have more than 2,000. We have had 67% more workload during that time, as you have seen from our strategy document.

We have a perfect storm. The least you would expect is that the Department would prioritise the training of GPs, and it has not done so. That is extraordinary.

The Chairperson (Ms Maeve McLaughlin): I want to refer specifically to page 13 of the BMA briefing paper. NIMDTA is obviously the responsible body, and it made 65 training places available for general practice. Of that number, 33 completed training, which only equated to a whole-time equivalent of 18 GPs.

Dr Black: We have not lost any of those trainees; they are still in the system. They may have reverted to less than full-time training, which is part-time training in our parlance, or they may have taken maternity leave; but, they will come out in time. Two thirds of our young workforce in general practice are female, and it is reasonable if they need maternity leave because they are that age — you cannot defer that time in your life. We should be taking that into account in our workforce planning, but we are not doing so.

This year, we will lose 80 GPs through retirement. We have a survey out today that shows that 35% of GPs will retire in the next five years, and that 79% of those are aged between 55 and 59. So, we will lose 80 this year. If we are bringing in 30, that is a net loss of 50; so, we have gone from 950 to 900. Next year, it will be down to 850. That is collapse time. Within the next two years, we will not be able to maintain daytime general practice.

You sit back and think, "Wow!". Everybody at this table, and Mr McGimpsey referred to it earlier, knows that the crisis in Northern Ireland is the GP workforce. Everybody knows that this is where most of the work goes. It is the foundation of the health service, yet is not a priority. We saw the Minister announce an extra £15 million for general practice; and I smiled, because £10 million was for premises, Michael, which is not current account investment. It is £10 million that we GPs are allowed to borrow now from the Bank of Ireland to build premises, so that leaves £5 million. Of that, £3·1 million is going into out-of-hours. That is excellent; out-of-hours needs that because they are spending less on out-of-hours now than in 2003. We are spending £22 million on out-of-hours now and it was £25 million in 2003.

We are now down to £1·9 million for general medical services, and that is for enhanced services, which will require extra work. The last thing GPs need is a bigger workload. In this very tight financial settlement, not a single penny has been devoted to general practice, despite the fact that we have suffered cuts for eight years in a row.

Chair, it comes down to the basic question, which you asked the previous witnesses, "What are your priorities?" The priorities are clearly not what they said, which is community care, because district nursing has been decimated. The word "decimated" means that you lose 10%, but it is actually about 20% in most areas. Mental health care in the community has been decimated, as has general practice. Three key areas in the community have been disinvested. Not a priority. Extraordinary.

The Chairperson (Ms Maeve McLaughlin): I think in general, yes. That is why the Committee has looked at workforce planning. When you have such a huge policy shift, it would seem logical and sensible that your first key area of work would be to plan your workforce. What are you workforce requirements? That has been a key issue for us.

I want to drill down a wee bit more on cost. Are the 111 places over four years — 80 by August or, at the latest, by August 2016 — still costed at £90,000 per training place?

Dr O'Kelly: That would be £90,000 extra per place, yes; so that would cost, I think, £1·3 million.

The Chairperson (Ms Maeve McLaughlin): Yes, £1·35 million; so, that is what we are talking about in terms of the training ask.

Dr O'Kelly: The other thing is that not all the young GPs we train are necessarily going into general practice. They are not going abroad, but a lot of them are being employed at staff grades by the trusts and we are losing them to general practice. We have to fix the environment in which general practitioners are working. That is absolutely key. We have got to make it a safe environment and one that you would want to work in.

The Chairperson (Ms Maeve McLaughlin): Going back to Dr Black's point; are you saying that the 33 who completed the training are lost to the system?

Dr Black: They are still in the system; they will come out.

The Chairperson (Ms Maeve McLaughlin): OK.

Dr Black: We are not losing them but, as Dr O'Kelly says, they come out and look at the workload. The workload for a GP now is 47 consultations. You all do surgeries when you go back to your constituencies. Would you like to do 47 this Friday, plus 172 prescriptions, 35 lab tests, and all the other stuff we do? That is the standard day's work.

It takes us about 12 hours to get through that, and then you go in at the weekend and catch up on your paperwork. This is the environment that we are trying to entice young doctors into. To be frank, they come into general practice, stay a year or two, and say, "I have no life. I haven't seen my children for three days." They then go back into hospital, and the most extraordinary compliment they

are paying us is that they are going back to A&E posts because they think it is easier. If A&E is easier, we are in trouble.

The Chairperson (Ms Maeve McLaughlin): If my maths are correct, were the other 32 trained and then left?

Dr Black: No, they are still in the system.

The Chairperson (Ms Maeve McLaughlin): The whole 65 are still in the system.

Dr Black: I spoke to the director of the training programme and she is very clear that our attrition rate is only one or two per year. Thirty-three came out and 32 are still in the system and will come out.

The Chairperson (Ms Maeve McLaughlin): Contracts are an issue. I am seeking your views on how, within appropriate processes, you can ensure that we get the maximum number of GPs being able to stay and deliver for constituents in the North of Ireland. Is that feasible? Is it doable? Can something be written into GP contracts? Are we just training GPs up and then they will leave?

Dr O'Kelly: One of the concerns is that you cannot legally stop them working anywhere in the EU. If a young doctor is trained in general practice in Northern Ireland, and England, Scotland and Wales are producing a better environment, then they are going to work there. I talked about the brain drain. We need to fix the environment in which general practitioners are working. I feel confident that, if we can do that, there is enough to keep people here.

The Chairperson (Ms Maeve McLaughlin): A number of members have indicated that they wish to ask a question. Both of your briefing papers are, obviously, very frank and strong, and correctly so, in my view. I noted in the BMA's briefing paper on page 11

> "BMA... is now calling into question the competency of the Department to effectively plan for the medical workforce."

That is quite a strong statement.

Dr Black: We have had three reports, and there has been no action from any. You have already had departmental officials in front of you. I was told that the video was better, but I read the transcripts. You were testing them, quite rightly. It comes back to my previous statement. It is extraordinary that this has not been actioned.

I will give you a history lesson, Chair. This happened in 1966, and they had to bring in a new deal for general practice; it happened in 1990, and they brought in a new deal; it happened in 2004, and they brought in a new deal. Simon Stevens, the chief executive of NHS England, is explicit in saying, "We have underfunded general practice for 10 years; there will be a new deal". He needs a new Government in, and he will present a new deal for general practice. He will save general practice in England. Scotland is much better funded because they like their GPs. Northern Ireland would be very grateful if its Department copied what they are going to do in England and Scotland. Wales is in trouble too, admittedly.

Ms P Bradley: Thank you. Like the Chair, I have met both organisations over a period of time. It is sad that we have reached this stage and that no resolution has been found. You said that out-of-hours has all but collapsed. If we do not have this increase, and we see one third of GPs retiring within, I think you said, the next five years, what is ready to collapse next? What is going to happen?

Dr O'Kelly: Out-of-hours will go first. That will have a knock-on effect on in-hours general practice. The pressure on that, with GPs going, is that list sizes will increase, which means that patients will find it difficult to get appointments. We will probably be firefighting. You will find that practices may have to close their lists and, as is already happening, as Tom knows, practices will collapse and close. We have already had a practice in Craigavon. Others are under threat; that will have a domino effect. Everybody will then end up in the emergency department.

Ms P Bradley: That is the knock-on effect. We look at our hospitals and at what is going to happen there. That is going to be catastrophic.

Dr Black: The A&E departments in Northern Ireland, in total, see about 600,000 or 650,000 attendances per year; GPs do 12·7 million consultations. You would need something like another 90 A&E departments. It just cannot happen. The Department is very well sighted on this problem but has failed to make it a priority. When it is just about to collapse, the Department will make it a priority, because it has to, as there is no alternative.

Ms P Bradley: The information you have given us is that there has to be this upload and increase in training because of the length of time that the training takes. It should have been started some time ago, as you say. It is firefighting now, and it has got to the stage where this is the limit. We cannot go any further. This has to happen, and that is exactly where we are now.

I want to follow up on a few points that the Chair made. We know about the brain drain across lots of different professions, and I listened to that again on the radio this morning. Lots of our young people are being trained, and they are leaving. My daughter works in China. Our children are leaving and are taking their expertise to other countries.

With regard to training our GPs and doctors in general — and I know what happens within other disciplines where we invest a large amount of money — should we look at having something written in the contracts to say that they should remain in Northern Ireland? I am being controversial, but what are your views on that?

Dr Woods: I do not think so. As John said, we have to look at the environment here and find out why people are not choosing to stay. I think that people are often very reluctant to leave Northern Ireland, and they would like to work here if it were possible. However, when they look at the opportunities elsewhere, those appear so much better, and that is why they leave. It is much better to try to incentivise people to stay, rather than attempt to put handcuffs or restraints on them. That will not work. People will find a way round it. It has to be that the working environment improves so that it is attractive to work.

Ms P Bradley: So, that is definitely not an option in your opinion. I know that it happens in other disciplines within health and social care, and I know that it happens in social work. If you are investing that money, you expect a return.

Dr Woods: Yes; not a pure restraint, but there are things you can look at. Medical students now come out of university with very substantial loans — £60,000 plus — and if there were some measure of debt forgiveness then, to me, that would seem to be a very positive thing. There are things you could do that are not restraints but are positive and would help the situation. However, a pure restraint will not work.

Dr O'Kelly: If incentives were to be used — golden handshakes, handcuffs or whatever — we should look at areas that are under-doctored and where there are real problems. One of the areas to highlight is rural general practice. That is true throughout the United Kingdom and Ireland where rural areas tend to be undoctored, and there are other areas where there are high levels of health inequality. I think that incentivising young doctors into areas where there is a lack of doctors or where there is a high degree of need may be of benefit.

Mr G Robinson: Thank you for coming today. In my opinion, it has been very useful and helpful to hear your views. Are GPs doing any work to carry out their own workforce planning to ensure that they have enough nurses and receptionists to keep their surgeries functioning?

Dr Black: Mr Robinson, the funding for general practice has decreased every year for the last eight years. When I hire an extra receptionist, as I did a couple of weeks ago, it comes out of my bottom line. When I hire an extra nurse, it comes out of my bottom line. If you keep cutting the funding, as they have done every year for eight years, it becomes difficult. The problem then is that if I advertise a job, which is so badly paid that people would have to take a pay cut to take it, that creates another problem for me in terms of recruitment. I advertised a job in my nice practice in the Bogside in Derry before Christmas, and I got zero applicants. There are 40,000-odd GPs in the United Kingdom. I offered a full share of profits etc, and I got zero applicants. Why did I get zero applicants? It was not so much the money, to be frank, although any locum who might have taken the job would have had to take a pay cut of probably 25% or 30%; I did not get any applicants because they knew what the workload is like, and they will not take a job as a partner because they will not see their children. Everything comes back to workload.

Dr O'Kelly: As I said, we need the increased support of the practice team. We need pharmacists working with us, we need physiotherapists working with us and we need our practice nurses. We need them. When we talk about investment, it is not just purely with GPs; it is investment in the GP workforce and the wider community workforce. Tom talked about the destruction of district nursing and health visiting.

Mr G Robinson: From a personal point of view, we are now starting to see effects on the out-of-hours practice where I live in the Limavady area. It should be there from about 6.00 pm until 11.00 pm. Recently, that has been cut back. On some nights, from about 10.00 pm onwards, there is no doctor because they have to be railroaded to Altnagelvin for the out-of-hours service there. It leaves wee rural areas like Limavady without an out-of-hours practice.

Dr Black: I asked the four local medical committees to do a survey of the empty shifts in the out-of-hours services. Limavady, as you say, Mr Robinson, is showing up as an area. The whole southern area has shown up, as has the south-east and Belfast. Pretty much all the out-of-hours services in Northern Ireland have huge gaps in their rotas. I have asked for commentary on that from the LMCs, and tomorrow I will submit the evidence to the Department and the health board. GP out-of-hours services in Northern Ireland are now broken, and I want to ask the Department and the board what they are going to do. They have promised an increase in funding of £3·1 million on top of the £22 million that they spend, but we spent £25 million on GP out-of-hours services in 2003. Health inflation, as you know, is 6%. That means that they should be spending £50 million now. If they were to spend the same as Scotland, they would be spending £50 million. Is a general practice out-of-hours service a priority? Not for the Department.

Mr G Robinson: To be fair to the trust, in my area, you just cannot get the doctors.

Dr Black: It is Western Urgent Care. John will remember that I was one of the founding members of Western Urgent Care back in 1995. We set that company up. It was the best out-of-hours service, as you will remember. In Limavady in particular, it was a great service from the local GPs. That work is now so high-risk and so demanding that, if you walk into one of those out-of-hours shifts, you will be told, "There are 100 phone calls behind time, a queue of people 35 or 40 long and 10 house calls. What would you like to start on, Dr Robinson?". The young doctors are saying, "I am not doing that".

Mr G Robinson: Exactly. The trust suggested to us that we could write to the local doctors to ask whether anyone would volunteer. We did not get one reply, and that was understandable.

Dr Shauna Fannin (Royal College of General Practitioners): Of course, the same doctors often work in hours and out of hours, and, if your workload is unmanageable during the day, you are very glad to be able to get home at night and spend some time with your family. The likelihood of that doctor wanting to work in the evening and overnight is very slim.

Mr G Robinson: To be fair, I am not knocking those doctors. They do a tremendous job.

Dr Black: The day job now finishes at about 7.30 pm or 8.00 pm, plus you go in at the weekend and catch up. The out-of-hours shift starts at 6.00 pm. So, I cannot commit to a 6.00 pm out-of-hours shift when I am not finishing until 7.30 pm or 8.00 pm; it cannot be done.

Mr G Robinson: It might be seven days a week.

Dr Black: Yes.

Mr McCarthy: Thank you very much, gentlemen and lady, for your presentation and briefing. I must say I have been sitting in this room for two and a half hours, and it is the most depressing two and a half hours that I have ever spent in this room. You people were sitting at the back, and I am sure you must be disgusted also. I do not know how long it will take us to complete this, but I want to say that I support 100% your campaign to put patients first and back general practice. I am sure that all the members in the room are the same.

I have two or three questions. Dr Black, I listened to what you said and have heard you on the airwaves on many occasions, and I agree entirely with what you are saying. You have criticised the Department, and rightly so. There have been changes in the Department in recent times. You said that there were, I think, three reviews that came up with recommendations and that there were four

recommendations from the last review. What do you think your chances are of having those recommendations implemented, given the changes in the Department now?

Dr Black: The Minister and the permanent secretary have a very difficult job. I would not want that job. The criticism that I have of them is not that they do not understand or do not have the knowledge; they clearly do. I have spoken to both, and I think they are both well able, yet my criticism is that they have chosen not to make general practice a priority; they have chosen other areas. That is where my criticism is because if this is the foundation of the health service and the service cannot work without GPs, we are in the worst crisis in my 25-odd years in general practice. This is much worse than 1990 or 2004. This is the back to the worst that we have ever seen in general practice. So, my criticism, Mr McCarthy, is that they have failed to make it a priority.

Mr McCarthy: Given what you said, Transforming Your Care, in my opinion, was based solely on the GP and primary level care, and it is not going to happen. Again, in my opinion, I think that Transforming Your Care is dead in the water. Given what you are saying, you are convincing me more that that is the case, unfortunately, because we supported Transforming Your Care as a vision for the future, but it is gone.

Dr O'Kelly: What has been a failure with Transforming Your Care is setting the key priorities and performance indicators. Nobody could argue with the vision of Transforming Your Care. We were very supportive of it, and I am sure that the BMA has been as well, but there has been no outline of how we get to where we want to be, where we are going to be in two years, where we are going to be in four years and where we are going to be in six years. It has been muddling along. You say that it is dead in the water; I think that it is in neutral.

Mr McCarthy: That is not very encouraging either, given the aspects of where we thought it was going.

I have three questions briefly. I have the letter here. The Health Minister recently announced a £15 million investment in GP services, and Dr Black spoke about it. Within that, £300,000 is to recruit and retain GPs. Your recommendation is for 80 young doctors to be trained. Is that £300,000 going to do that?

Dr Black: No, they are looking to use the £300,000 for innovative schemes to retain and recruit, so, as Dr O'Kelly described, it will be to bring doctors into under-doctored areas, to bring doctors back from foreign parts or to retain older GPs who are about to retire. What they are suggesting is not the wrong thing. I think that success will be very difficult to achieve though, given the environment of the workload.

Mr McCarthy: So, it is not going to happen, really.

Dr Black: If you were 59 and three quarters and you were about to retire on what is a good pension in the health service, could I persuade you to stay on and do 47 consultations and 172 scripts?

Mr McCarthy: I do not think so.

Dr Black: I do not think that you are going to stay on; you are going to go.

Mr McCarthy: Anyway, let us stick to the £15 million. You mentioned £10 million to extend your premises if that is what you wanted, but it says that there will be up to £3·1 million of investment in out-of-hours service. You said that it is up the tubes now, too. Is the £15 million going to be blown away like other millions and we are not going to see the benefit of it?

Dr Black: Well, the £15 million is really £5 million because £10 million is for premises; it is a capital sum. The £3·1 million is recognition from the Department that out of hours is in severe bother. Despite the fact that we have such a constrained budget, they are taking £3·1 million and giving it to GP out of hours. However, to reiterate the point, in 2003, when GPs were running out- of-hours services, we spent £25 million on it. It is £22 million this year, plus £3·1 million, which is £25 million. It should be about £50 million if they had maintained the 6% increase every year that they should have done, but they did not. You cannot get doctors to work because there is one doctor on instead of three. There should be three doctors to run the phone, see the patients and deal with the house calls, but one goes in and says, "Where do I start?".

Mr McCarthy: Again on that £15 million, £1·2 million of investment is to help GPs meet demand for blood tests and other diagnostic work. Do you welcome that?

Dr Black: Yes, that is the enhanced service. It will obviously mean that we will take on work to earn that money, so what we are hoping to do is bring in phlebotomists to do that. Again, it is part of TYC. We are doing an awful lot of hospital bloods at the minute. My treatment room is bunged. I do not have capacity to take on more hospital bloods, but it is obviously better for patients, when they are going in before their cancer treatment, to get their bloods done locally in their GP practice. Getting phlebotomists or nurses to provide that service would be a good idea; not extra money.

Dr O'Kelly: The move to recognise pharmacists in general practice is to be welcomed and will be extremely useful. Certainly, the college strongly supports the pharmacists working closely with GPs in practice — actually embedded into practice — because they can offer an awful lot of support and take an awful lot workload off us. We would strongly support any further developments in that regard, and I think the BMA would be —

Dr Black: Yes, there is a good story there, Mr McCarthy. The Health and Social Care Board is working with us on a pilot to bring forward pharmacists in GP practices. There are 39 million prescriptions. Two hours of my working day in which I should be seeing patients is instead spent producing scripts. A pharmacist placed in a practice could do that work. The board is going to invest in that this year with a rolling programme to increase up to, hopefully, a pharmacist in every practice; about 300 pharmacists in total. That is still fewer than the 400 pharmacists in the trusts, but I would have to make that point, would I not?

Mr McCarthy: Yes, of course you would. In your paper, you state that the percentage of GPs working part-time is not known. Why is that data not available?

Dr Black: What is full-time? Some practices tell me that it is nine sessions a week in face-to-face consultations, some say it is eight, and then the rest of the time is audit, paperwork, education etc. That is a much higher proportion of face-to-face clinical time than you will find in any other health environment. Every practice does its own thing, so you would have to go in and interrogate and check. I have a part-time partner who seems to work every day of the week now. Why? Because we have strong-armed her into coming into the practice more. So, is she part-time or full-time? She works full-time but would like to be part-time.

Mr McCarthy: Your paper also states that they are:

> "unaware of any visible and positive impact of the £25m already shifted from hospital services to community/primary services in the areas of learning disability and mental health resettlements."

Somebody already mentioned learning disability. Can you give us any more detail on that issue?

Dr Black: My memory of TYC was that there was £86 million going to community, of which £23 million would go to general practice; I do not think I have seen a penny. I will hone it right down to the investment per patient. In 2009 in Northern Ireland, we spent £124 per patient per year. That is what general practice costs. We spend something like £2,300 on health care per patient per year. So, £125 — 6% of the budget — goes on general practice: £124 in 2009, and this year it will be £125. That is a 0·8% increase in six years. During that time, the total health-care budget has increased by 35%. So, that is a 35% increase in the health-care budget, and in general practice the increase is 0·8%. That is a cut of 34% in real terms. That is the sort of thing we are dealing with.

Mr McCarthy: Finally, it is a concern that professional bodies are not represented on the regional workforce planning group. How is that group engaging with the professional bodies?

Dr O'Kelly: We had input to the interim report that I alluded to earlier, and we had representation on the interim GP workforce group, but not on the overall group.

Mr McCarthy: That must be very disappointing.

Dr Woods: It is, and there is a pattern to this. We are involved in each of the individual specialty streams. We are asked to be part of that, but we are not part of the overarching group. It was the same thing in the group that looked at unscheduled care recently. Tom and I advocated for positions on the central group. I think there is a pattern of the Health Department operating in this manner.

Mr McCarthy: So, in fact, they do not appreciate the experience of you people and your input to such a very important aspect of the health service.

Dr Woods: I am not sure why. Clearly, the professionals have an important role to play to bring their experience and their patients' experience to that forum.

Mr McCarthy: Finally, finally, can you give us any encouragement that there is light at the end of the tunnel? We are all affected. We all have to see the GP at some stage or another and —

Dr Black: The light at the end of the tunnel is GP federations. In England, we have Simon Stevens, who is a very bright person with a clear idea. His plan is outlined in the 'Five Year Forward View'. If you want really good reading on health care, read that by NHS England.

We actually moved ahead of him. We anticipated this problem and set up GP federations, with 13 out of the 17 already incorporated as not-for-profit community interest corporations. Through the federations, we will hopefully be able to implement changes: TYC; the transforming of the system; and the shift left into the community. We have persuaded the board to invest in federations through these pharmacists, and the big advantage — this is why we set them up as not-for-profits — is that when they invest in a GP federation they are not paying GPs any more money. They seem to have a real problem with that, which is fine. There is now a forum in the community where they can invest and develop services. You have seen the strategy document. We sent you a copy — you have got it under your pillow, I am sure — and there is a whole section on the federations in that. It is hope for the future.

Mr McCarthy: That is hope for the future.

Dr O'Kelly: The federation model is one that the college has been putting forward from a document in 2007, and we are strongly supportive of it. It is basically collections of GPs and practices getting together, pooling resources and delivering. I remain optimistic. I am one of the two thirds that will not be retiring within the next five years, I assure you. If we are given the tools to do the job, I have confidence in my colleagues delivering. We can deliver. It is not a total solution, but federations offer us a real way forward.

Mr McCarthy: So, you are not as despondent as the people who sat in those chairs previously. They were totally of the mind that, unless millions of pounds come from heaven, we are going to be stuck in zero land.

Dr Black: They have to fix general practice, and they will fix it. It is inevitable. It happened four times before in the National Health Service. Which is more important: the National Health Service or general practice? The NHS does not exist without general practice.

Dr Fannin: In general practice, if you are doing 90% of contracts as a whole in the NHS, you have to take seriously the problems we have with workforce recruitment, retention and returners. All those things are extremely important in order to beef up the clinical workforce. There has been the ostrich, head-in-the-sand approach, not appreciating that we are going to have a major demand/supply imbalance in the workforce, compounded by the things we have talked about.

Mr McCarthy: Thank you very much. I wish you all well.

Mrs Cameron: Thank you very much for your time today, and apologies I did not hear the presentation from the start. I have to say from the outset that I have had the privilege a couple of times of going to a local GP surgery to see the work that they do. I was blown away on the first visit and equally so on the second visit, apart from my own experience as an ordinary punter going to my own doctor's elsewhere. I have much respect and appreciation for the work that you do. It is a challenging role for you and, given that we talk daily about early diagnosis, there is much pressure on you, as doctors, to do the best for us. I just want to say from the outset that I really appreciate the work that you do.

Dr O'Kelly, the BMA paper states that demands on GPs mean that young doctors are choosing not to enter general practice. However, the Committee heard that the GP training places are oversubscribed and that we do not have a problem getting young people to choose general practice. Can you clarify which is the accurate scenario?

Dr O'Kelly: What we have is an incredibly low number of GPs being trained in Northern Ireland: 65. There is no doubt that, if we increase to the 111, we will have problems filling all those. In England, about one in eight training places are not being filled, and they have had to go through two, three or four recruitment exercises to try to fill those. At the minute, it is false in that we are training so few, 65, when we need to be up at 111. Health Education England and the Department of Health in London have stated that we need approximately half of all undergraduates in medicine to be training in general practice in order to deliver the doctors we need for 2020 and 2030.

Queen's has in the order of 230 or 240 graduates every year, so the maths are obvious there. We get 65 because the numbers are quite low. One of the other problems, then, if we train them, was illustrated when I was talking to a young, trained GP recently who told me that he is working in orthopaedics as a sessional doctor on a hospital ward. Again, it was for the reasons that it provided regular hours and because he could not take the stresses and strains of working long hours in general practice. So, one problem when we get them trained is about how we keep them in general practice. I come back to the working environment.

Dr Fannin: We need undergraduates to have much more experience in general practice. A lot of undergraduates make up their mind as to whether they want to be GPs even before they qualify. In Northern Ireland, undergraduate medical students are spending only around 5% of their entire curriculum in general practice, so they are getting very limited exposure. As John said earlier, we are the third lowest in terms of time spent in general practice in the whole of the UK. Students in universities like Keele in England spend over 30% of the time in general practice and, not surprisingly, a very high percentage of Keele's students want to become GPs.

As a college, we are also calling for the overhaul of the supplement for undergraduate medical and dental education (SUMDE) funding so that more time can be spent by our undergraduates out in general practice getting first-hand experience. Of course, they have to be able to see a workload that is manageable, but we feel very strongly and we are all passionate about general practice. We want young doctors to come into our profession, so that is something that we would want as well.

Mrs Cameron: That was raised with me locally on my visit, so I am aware of that. I know that part-time working is an issue as well. We always talk about women going off to have babies, and that is grand, but I noticed in the practice that I went to that there was an awful lot of part-time male doctors of all ages.

Dr Fannin: Yes. As a college, we, of course, are very glad that the gender imbalance that there was in previous decades is now being rectified. We think that it makes for a much more balanced GP population if we have 50:50 in terms of the doctors in general practice. We are moving from a very male-dominated profession two decades ago to a point where more than 50% of trainees in general practice are women. In England, I think that around 65% of GP trainees are women. Currently, around 47% of the workforce of GPs are women. These women are, of course, taking longer to train, often because they are taking time off to have babies and have maternity leave. They are sometimes having part-time training, which is taking longer, but we are not losing those individuals; they are getting their full qualification in general practice. The problem is, then, about creating a flexible working life for them. Most female GPs will not want to work full-time for all their working life; they will want some flexibility with that. Increasingly, however, our male colleagues want that flexibility, too, because they are finding that, in general, the stress of general practice every day, full-time, is just too much.

Dr O'Kelly: A lot of the time, they are doing almost like a portfolio; their basic job is in the general practice, which they do part time, but they are working in other areas. You may find a GP who has a special interest in ophthalmology is working in genito-urinary clinics or is maybe doing some work for commissioning or the trusts. You get that. One of my partners who was full time has gone down to two days a week, but he is working for the Northern Trust in dermatology, doing minor surgery. He made a conscious decision that he needed to do that to keep himself sane. That is probably a trend that we cannot reverse. That has to be taken into account. The models for how we work as general practitioners and how we relate to our hospital colleagues will be changing over the next 10 or 15

years. That has great challenges for us as general practitioners, but I think that we are adaptable and that we can do that and still deliver.

Dr Woods: The BMA is equally positive about women in medicine; they bring very positive things. Part-time working by female doctors seems to be largely unique to general practice. Participation by women in hospital medicine is much greater. Although I suspect that they probably work fewer hours, the majority of them work full time. In fact, one of our members had a grievance case about four or five years ago against the Belfast Trust, the basis of which was that more women work part time. In fact, the converse proved to be the case: men, among consultants, were more likely to work part time. It is a characteristic of doctors who choose to enter general practice.

Mrs Cameron: The whole subject of part-time working is very interesting. It is a very good thing. I understand that it costs a lot of money to train up doctors, but you are still human. If you go off to have children, whether you are male or female, there is no point in having them if you never see them. There is a balance to be struck. Thank you.

Ms McCorley: Go raibh maith agat, a Chathaoirligh. Thanks very much. It has been really interesting to listen to what everybody has said. Are you aware of whether the Department is seriously addressing the issue of workforce composition in terms of gender mix? How does that impact on the workforce?

Dr Woods: We do not think that it has been to date. That is one of the reasons why this crisis has developed in general practice. As we said, there is much greater participation by women doctors in general practice, but that really has not been taken into account. I think that the evidence that we presented referred to 33 people coming out of the programme at the end. That is one cohort that has travelled through. I suspect that 65 went in, but 33 came out. Effectively, that is because many female doctors are choosing to train on a part-time basis, and, ultimately, when they go into the workforce, they are more likely to work part time. That has been clear. The trend did not develop overnight; this has been happening for a decade or more. I suspect that it is outlined in the prior reviews that were done, and it should have been acted on.

Dr Fannin: It has been clear for some time that women are choosing to become GPs. The fact is that more women are applying to become doctors and joining medical courses. This has not just happened suddenly; it has been a rolling progress, but there should have been the foresight that it would be an issue and that you would have to have more training places to keep the workforce demand/supply balance.

Ms McCorley: Taking all of that on board, you do not really think that they are seriously looking at this as an issue.

Dr Fannin: They cannot be if they are not increasing the number of training places.

Dr O'Kelly: It also has had a knock-on effect on NIMDTA. If you do not have the numbers that you are expecting coming out and the students are still in the system, they have to find practices for them to train in. The expense goes up as well, and NIMDTA's GP budget certainly has not increased to allow for that. The blunt answer to you is that I totally agree with you: no, they have not taken it into account.

Ms McCorley: That is another depressing aspect to add to the list that we have heard today. Do you have any views on how to encourage female doctors to work full time?

Dr Fannin: I started off as a full-time GP. Like so many, I now work more part-time hours, but I have a portfolio career, like John, where we do other things. I am a Macmillan GP facilitator involved in the education of GPs in cancer and palliative care. I find that very useful for my own work and I also enjoy it greatly. I think that it is difficult to encourage people to be full-time GPs for the whole of their careers. Some may wish to work part time while their children are small, and some may wish to remain part time all of their working lives. I think that it is difficult to be prescriptive about that.

Dr Black: John Humphrys of Radio 4 visited his GP, Sarah Jarvis, who is quite famous in our community as a high-profile GP. She is leaving general practice because she cannot cope with the workload. He went and spent the day with her, just as you were saying, Mrs Cameron. She was going home at 4.00 pm, and he said, "What kind of a job is this? I thought you said that you worked

hard". She said, "I am on a half day today. I am part time". You get to go at 4.00 pm if you are part time.

Young female doctors tell me that they bring their children in to see them at lunchtime because they have not seen them for two or three days. I know of one who brought her child in to see her on Friday at lunchtime because she had not seen the child since Tuesday. You will look at me and ask why anyone would put up with a job like that. You then have to ask yourself why the spouse would put up with someone working those hours. It keeps coming back to workload. Young female doctors work part time because part time is nearly like full time. If you want to make the job more attractive, we have to manage the workload, and the best way to do that is to have more doctors there to do it. It is a circular argument. It is so obvious, yet it clearly is not obvious in certain quarters.

Ms McCorley: I want to echo what everybody is saying about the importance and the central foundational place of GPs in the health system. It is the first port of call, and your GP is part of your life. Given all of the stresses and pressures that you have outlined, it is hard to believe how people function like that. A burning question that I have is this: how are GPs meant to find the time to stay ahead of medical advances? Where do you get the time to do that?

Dr O'Kelly: That is a good question. We are all appraised annually. We have to do audits, and we have to attend education and demonstrate that every year. Like all doctors, we now have revalidation every five years. We are doing that in the wee hours. Sometimes, if we can catch a lunchtime, we do lunchtime meetings. Each practice does it slightly differently. We do evening sessions where we work until 6.00 pm or 6.30 pm and then get a pizza or Chinese takeaway or something and work through that. That is what you do. You have to stay ahead of it.

Mr G Robinson: Healthy eating.

Dr O'Kelly: I know, I know. Do as I say, not as I do.

Ms McCorley: It is hardly conducive to effective learning. It is not the best way to be doing it. I have a couple of other questions. Do you feel that the trusts have made available adequate training or retraining programmes for the medical workforce to meet the shift of the TYC requirements?

Dr Woods: That is a difficult question. Part of the problem is that it is not really clear yet what that will look like, so I think the managers are somewhat in the dark about what will be required, but I think that it will be a gradual process. Work in the community will be done both in general practice and by secondary care doctors. I think that home intravenous antibiotics are a good example of the kind of thing that secondary care doctors are doing. There is a cohort of people who, in the past, have been in hospital because they have some condition like a bone infection, which means that they need a very long, prolonged course of antibiotics. It is now possible to deliver that at home using the district nurses service, supervised by a consultant infectious disease physician. That is an example of the kind of innovative programme that fits entirely with TYC, but I think that those types of projects need to be developed organically, and it will differ from specialty to specialty.

I am a consultant in kidney disease. We have a day-case unit where we have patients come and, increasingly, we try to do as much for them as an outpatient using the facilities in the ward that would historically have been used as inpatient beds. We have converted inpatient beds to day-case facilities. I think it really will differ from specialty to specialty, and that is the kind of organic development coming from the front-line clinical staff that will lead to a shift of care into the community.

Dr O'Kelly: Communication between general practitioners and our hospital colleagues is so important in that. I chaired the western region's multidisciplinary respiratory group for very many years. On that, we had our hospital respiratory colleagues, physiotherapists and the nurses, and we were trying to come up with a strategy for how to improve respiratory care in the west. We did manage to put in pulmonary rehabilitation. We also worked with the British Lung Foundation and the Old Library Trust. Chair, you are probably aware of it and the work that it does up in the Gasyard. We did make progress.

Where you have health professionals interacting, coming up with and sharing ideas, it does work. Unfortunately, there were barriers put in place by — how can I put it — the organisation, and following the rules of the organisation. I would say to all politicians, yes, we have to show our outcomes and how we spend the money, but allow us to innovate. Do not be afraid of letting us innovate. The chair of the college's quality committee is working with some renal specialists to look at a care flow for acute

kidney injury, so there is work that can be done. We as GPs may see our hospital specialists coming a little bit more into the community. We could think of paediatrics, for instance, or dermatology. Why does dermatology need to be a hospital-based specialty? That is where we can work together.

Ms McCorley: Finally, both of your organisations addressed the issue of the health service's reliance on locum doctors. Are the proposals to reduce the need for locum doctors coming from either the regional workforce planning group or the trusts?

Dr Black: What is a locum? There are none in the west and none in the south. There are a few GP locums in Belfast. The locums have all gone to Canada, New Zealand and Australia. They Snapchat me: "Bondi Beach, 5.15 pm. Day's work done". That cheers me up. There are locums for hospitals, I am sure.

The Chairperson (Ms Maeve McLaughlin): There are hospital locum doctors.

Dr Black: Yes, but not in general practice.

Dr Woods: There will always be a need for some locums, because people fall sick unexpectedly and there are shifts that have to be filled. We are seeking to work with the Department to do that on a regional basis. We are having some difficulty with that for junior doctors, but we are seeking to make it cost-effective for them. As you correctly identified, locum payments are where there are long-term gaps, often for junior doctors or when a consultant retires, for example. When those posts are not filled immediately, a locum is put in place, which is often a much more expensive proposition than had there been proper succession planning and proper workforce planning to make sure that there were enough people in that specialty.

Mr McGimpsey: Thanks for the presentation. I have been listening carefully. You heard the previous presentation and the issues raised, and we cannot bury our heads in the sand about them: they have to be addressed. I am, basically, asking you the same question, because I am hearing things about primary care collapse, inadequate workforce, workforce retention, retirements, a perfect storm and out-of-hours services being broken. So, it is fair to say that we are in an emergency situation here. The issue is stabilising the situation; how do we stabilise the situation here and now?

In terms of the workforce, we increased the throughput of the medical school from 170 to roughly 250 in 2008. That cohort started to reach the workplace in the last couple of years, yet we discover that 50 young doctors went off to Australia and Canada last year. Clearly, if we are increasing the workforce throughput in training by 80 or 100 and losing half of them to Australia and Canada, using the simple maths that you talked about, that is just not sustainable. That urgently needs to be addressed.

You talked about golden handcuffs and what is meant by that. You also talked about persuading retired doctors back and so on. There has to be some sort of emergency plan. We are in an emergency situation and we need an emergency response. What are the steps, and what is the budget? Have you guys done that? The issue of the budget keeps coming up. A pharmacist in every practice is another proposal. As you know, there has been investment in pharmacists in hospitals, which is a good idea. We cannot go on, as you say, Tom, until primary care collapses. This has got to be fixed. We have got ourselves in an emergency situation, emergency steps have to be taken now and, after that, or at the same time, we need to work on the medium term.

Dr Black: Mr McGimpsey brings us to the big picture and how to solve it. Thank you, Michael. The first short step is getting pharmacists in practice, because if the board, bless them, can find the funding to put a pharmacist in every practice, it saves each GP two hours and suddenly underpins the workload issue.

The five-year forward view in England is very clear that the shift left needs to take place because hospitals are expensive, hospital doctors are really busy and we should retain them for the most acutely ill. The five-year forward view talks about more than half of all outpatient appointments taking place outside trusts with providers in the community. Those providers will be made up of GPs, hospital specialists, nurse specialists etc. That is where the five-year forward view is moving: they call them multi-specialty community providers; we are calling them GP federations.

You and I know that the really big picture in Northern Ireland is our obsession with buildings and maintaining them. You are most sensitive to this, because you are the people who have to put yourselves forward and ask voters to vote for you. That is a local thing, and all politics is local. Who is

going to close the 10 acute hospitals that we have? Do we need 10 acute hospitals? If we maintain 10 acute hospitals and the rotas within them that my hospital colleagues have to maintain, we are spreading our resources too thinly across buildings. We have had the Hayes review. Do you remember that? We have also had the Donaldson review and, in between, we had TYC. They are all very clear that, if we take our limited resource, spread it across too many buildings, call each one an acute hospital and then try to establish rotas within them, we will not have enough resource to do the job right, and that is where we are.

I know that Donaldson said — it is a great compliment to the politicians of Northern Ireland — that he wanted an external international group brought in to say: "This is what you have to do, sign there and do as you are told." I have been doing this job for 20 years and I appreciate how difficult it is. When we went into the Hayes review, we had 17 hospitals; we now have 10. How many should we have? Five or six hospitals and three or four networks, probably. That is the big-picture solution.

Mr McGimpsey: That is the big picture, but it is the here and now that I am interested in: today, tomorrow, this year and next. If you are heading for collapse, by the time you get a consensus to start dealing with the issues that you are talking about, it will be too late. Hayes talked about the "golden six", plus three. It began as the golden six, then it became the golden six, plus three, plus, and they are all still sitting there in some shape or form.

It is the here and now that matters. If you are talking about things like primary care collapse and out-of-hours collapse, it is emergency stuff. It is about this year and next. It is the same as the issue we talked about earlier: the waits and all those patients, thousands and thousands of them, sitting in pain and distress. They have to be dealt with and we have to stabilise the situation now. I think that everybody understands what needs to be done. I have to say that, as the Health Minister in those days, there is no way that I would have been able to do that next stage. I was able to do the reorganisation and got, as you know, huge abuse all round. The next stage needs a different type of approach, and it certainly ain't me, thank goodness, and I am not sitting there now, thank goodness.

We need to do something about the emergency now. We are training an extra 80 doctors a year so that we are now putting 250 through the medical school, but you are getting such a low number into GP practice. We are losing so many to overseas. Yes, you can say that that is the environment, but it is just catastrophic for us.

Dr Woods: I think that, in terms of the workforce, we know what to do. The reviews have told us what is required for general practice and we just need to implement that. As my colleagues were saying, we need increased numbers. There are shortages in specialties in secondary care. We are beginning workforce reviews for them, but we need to do those rapidly. That is paediatrics, radiology and emergency medicine — subjects like that. We need to look at the workforce, and that is clearly a substantial issue for general practice. Why is the workload so high and what can we do to reduce it? And we need to look at the working environment and incentives for people to stay. How can we make these jobs attractive?

Mr McGimpsey: It is the bit about young doctors going into training. When they come out, they do not want to do general practice. How do you fix that? That is the wee bit that I am just not catching at the minute. You say that you need more people but you are getting very few, as I understand it, actually signing on for general practice. Yes, there is an argument about Queen's getting more experience for the students as they go through, getting them out to GP practices and all that. That would be an important step, no doubt, but how are you going to get to that?

Dr Fannin: The RCGP UK is promoting general practice. It is doing a big professional marketing campaign to encourage young doctors to become GPs. There is a variety of different moves. Obviously, if you want to increase your workforce, it is going to take some years before you are going to get those extra doctors trained. Even if they decided to start increasing the numbers this year, which is really not going to happen —

Mr McGimpsey: Well, we did that in 2008. We increased the numbers and it has not worked out, you tell me, because 50 went off last year to Canada and —

Dr Fannin: Well, 50 left the performers list. I am not sure whether we know the exact statistics for who left for Bondi Beach or how many, as John says, are working in hospitals because they find the working conditions better. There is the issue of retention and of refresher and induction training for getting people back who may have left general practice for whatever reason. Maybe they have gone

to have a child and then are outside of general practice for more than two years. Are you going to them and saying, "Look, we could refresh and induct you back into general practice"? Are you offering retainer schemes to keep doctors who may want to work only four or fewer sessions a week in the system and keep their professional standards and education going? Those are things that you can do immediately to start to build the workforce.

You have to increase attractiveness, possibly by bringing other support workers into general practice. We talked about increasing the numbers of practice nurses. We have an ageing practice nurse workforce, so we could possibly skill up people as advanced nurse practitioners in general practice, use pharmacists, as John said, increase the number of support staff, and have community navigators. We have patients coming to us who do not need medical care. Patients come to general practice as the first port of call with everything. They need a letter to get a postal vote. They need a letter because they were sick and could not go for an exam. Whatever it is, everything comes to general practice. A lot of what we do is not actually in our remit. A community navigator post of some sort would help that. There is a variety of things that we could be doing that would —

Mr McGimpsey: Sorry, just finally, how many practices do you see being in each GP federation?

Dr Black: There are 20 practices in each federation, looking after a population of about 100,000. There will be 17 in Northern Ireland and 13 are already incorporated as not-for-profit community interest corporations. The last four will come in over the next couple of months. We have managed to —

Mr McGimpsey: Are all your GPs signing up to this?

Dr Black: Every single one — except this one guy, but I will talk to him. Every practice has signed up, to be clear. What they will hopefully do in the first instance, Michael, is start providing the phlebotomy service so that people do not have to go to hospitals. The key short-term solution to the workload issue is to get the pharmacists in. We spend literally about two hours a day on acute and repeat prescriptions. If my four doctors had a pharmacist doing that, we would suddenly have two hours a day of extra time to see patients and maybe get home, making the job more attractive.

Medical students are staying away from general practice for one very clear reason: they are the most highly informed; they go everywhere and see everything. They say to themselves, "I am not doing that. I wouldn't get to go home." You have to create a narrative so that people hear that the system has recognised that general practice is in trouble and is starting to apply resource and staff. Once you create that narrative, you have solved it. We have done this three times before, in 1966, 1990 and 2004. To be frank, I thought that 2015 was the year. I went up to the Department and they went, "Nah. Not yet, son." But it will be soon.

Dr O'Kelly: General practitioners are resourceful. That is the nature of the business. You deal with the unexpected and you have to adapt. I mentioned in my presentation that morale is at an all-time low, and it is. It is at rock bottom. However, if we as GPs can see that people accept that there is a problem and, more than that, are starting to do something about it, we will work as hard as we can to make it right, and you may just stop that flow of GPs out of Northern Ireland and out of the profession.

Mr McGimpsey: We may even get some of them to come back with their experience.

Mr G Robinson: You mentioned the help that pharmacists could provide. Would prescription charges deter pharmacists from giving you that type of help?

Dr Black: No. The pharmacists will come in as employees of the federation, working in the practice. They will work for patients, dealing with acute prescriptions, repeat prescriptions, chronic disease management, diabetes, chronic lung disease, yellow and amber drugs — that type of thing. I do not think that the prescription charge will impinge on that. We, as the BMA, will naturally respond that we want to see everything free at the point of need, universal and funded by taxation, but you have heard that one before; I think that it was Aneurin Bevan who first said that. I do not think that prescription charges would affect the help that we are bringing in.

Ms P Bradley: I want to go back to a point that Rosie made earlier about the medical workforce and the shift left to meet the requirements of TYC. Both Johns used the word "innovation". I have said many times in the Committee and the Chamber that, even for someone in my own household, we had

an innovative consultant in infectious diseases in the Royal who showed great forward thinking and planning. She looked at not only the needs of the patient but the needs of the service and saved the trust very many pounds through home treatment. I know that that happens in lots of disciplines in our hospital services. That is the way forward, and it all fits in beautifully with TYC. How are those innovative consultants being supported? Are they being supported by the trusts, the boards and the Department? Is that being brushed away, or is the support there for it?

Dr Woods: Consultants say to us that they often feel that they have very innovative ideas but it is difficult to get trusts to take those forward. Trust managers often have competing priorities, and that is part of the problem. People definitely feel that they have innovative ideas but have difficulty in getting those recognised. I think that trusts are getting better, but we clearly have a significant way to go.

Ms P Bradley: I know from personal experience and you all know of the savings that can be made, whether it is in bed days etc. It is all moving in line with TYC and the patient experience. We all see how important that is. You see that. At the end of the day, if we are all going to be quite clinical about it and look at the financial savings that we so desperately need to make in our health service, we need to look at that a bit more closely.

The Chairperson (Ms Maeve McLaughlin): OK. I have a final point in relation to workforce planning in general. The original target suggested a 3% reduction in staff. When the departmental officials were in front of us a number of weeks ago, they indicated that that was just a working assumption. Do you have views on the reduction or increase in our medical workforce that is required to implement TYC?

Dr Black: In the next decade, the number of over-85s will increase by 84% and the number of over-65s by 46%. Those are rough figures, but we are in deep trouble. The last thing that we need is fewer health-care workers. Forget about consumerism, convenience and all of that, if we are just to look after our old people with complex comorbidities, we are going to need more health care.

The Chairperson (Ms Maeve McLaughlin): It is certainly not a 3% reduction that is required.

Dr Black: In the next 10 years, history will give us a real lesson in terms of the ageing population and their needs.

The Chairperson (Ms Maeve McLaughlin): OK. Thank you all. This has been very frank, open, honest and informative. We are conducting this work because we feel strongly that TYC is the right vision and policy direction. However, it feels as if the system has not responded accordingly by redirecting the focus towards primary community care. I could say that for any number of sectors. It is a conversation that we have continually across health generally. We will be looking closely at the four recommendations that you have made. We will take them forward and look for responses from the Minister and the Department. Thank you very much for your time. Please continue to have this communication with us.

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Transforming Your Care — Review of Workforce Planning: Royal College of Nursing and the Royal College of Midwives

22 April 2015

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

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22 April 2015

Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Ms Paula Bradley (Deputy Chairperson)
Mrs Pam Cameron
Mr Paul Givan
Mr Kieran McCarthy
Ms Rosaleen McCorley
Mr Michael McGimpsey
Mr Fearghal McKinney
Mr George Robinson

Witnesses:
Ms Breedagh Hughes	Royal College of Midwives
Ms Rita Devlin	Royal College of Nursing
Ms Maureen Dolan	Royal College of Nursing
Mr Garrett Martin	Royal College of Nursing

The Chairperson (Ms Maeve McLaughlin): Representatives from the Royal College of Nursing (RCN) and the Royal College of Midwives are here to brief members on workforce planning in the context of Transforming Your Care. Folks, you are very welcome. We have present Garrett Martin, deputy director of the Royal College of Nursing; Rita Devlin, head of professional development at the Royal College of Nursing; Maureen Dolan, vice chair of the RCN board; and Breedagh Hughes, director of the Royal College of Midwives. I invite both organisations to make a presentation, and then we will open the meeting to members' questions, comments and observations.

Mr Garrett Martin (Royal College of Nursing): Thank you, Madam Chair. The RCN thanks the Committee for the invitation to submit evidence in relation to workforce planning in the context of Transforming Your Care (TYC). I hope that members of the Committee have received our briefing paper, which, I hope, should have been helpful in preparing the ground for today's session and informing the work of the Committee on this issue.

In the briefing paper, we have endeavoured to address specific issues that were raised with the RCN in the invitation to attend. It also introduces some additional themes that we feel are important for the Committee to consider. The briefing paper provides some background information in relation to the workforce planning process for nursing and midwifery in Northern Ireland. It explains how, in July 2013, the RCN presented to former Health Minister Edwin Poots a detailed analysis of the nursing workforce in Northern Ireland, highlighting the challenges that needed to be addressed in order to help

build a nursing workforce that would be fit for purpose in addressing the significant healthcare challenges confronting Northern Ireland in the years ahead.

We note, at paragraph 12 of the Committee briefing paper, our specific concerns about a recent document from the Department entitled 'A Workforce Plan for Nursing and Midwifery in Northern Ireland (2015 to 2025)'. The RCN is particularly concerned about the growing number of nurses who are leaving Northern Ireland to work elsewhere; the increasing staff-vacancy levels in nursing reported in the DHSSPS vacancy survey; the growing number of entries on Health and Social Care (HSC) trust risk registers, detailing the risks associated with nursing staff shortages; the increasing use of bank and agency staff and associated escalating agency costs; and the fact that there are insufficient financial resources to meet demand for the specialist and advanced nursing roles required to support the medical workforce, resulting in a further depletion of an already overstretched nursing workforce.

The paper highlights the impact of inadequate or non-existent workforce planning on the nursing-home sector and GP services. We live in an integrated health and social care system where the statutory sector coexists with the independent and nursing home sector, GP practices, private clinics and voluntary organisations, to provide health and social care services for the people of Northern Ireland. These areas of practice do not exist in parallel universes. They are simply part of the same system. Workforce planning for nursing must address, in particular, the needs of the nursing-home sector and GP practices, as well as those of our hospitals, health centres and community services.

We note that the Committee recently received oral evidence from the regional workforce planning group (RWPG) in relation to Transforming Your Care. The Committee specifically asked the RCN to confirm whether it has representation on the RWPG, and the answer to that question, as we explain in our briefing paper, is that we do not. The RCN is surprised and disappointed that a group of that nature, which specifically purports to include membership from across the wider HSC, could exclude the organisation representing the largest professional group within the HSC.

The ultimate benchmark for the success of TYC is, or should be, its impact on emergency department admissions. However, between December 2013 and December 2014, the total number of attendances at the major acute hospital emergency departments in Northern Ireland actually increased by 6%. Across all emergency departments, the increase was 3%. If TYC was designed as a means to keep people out of hospital and ensure that they are able to access health services in their own homes and communities, by that criterion it has singularly failed.

The community nursing workforce in Northern Ireland faces many significant challenges. They include: high workloads and demands on the service; an excessive burden of paperwork; poor or non-existent technology; and a fear of letting patients down, due to cuts in service and workforce. The demands on community nursing services have also affected the work/life balance of nurses, with many nurses working longer, unpaid hours because that is the only way to make sure that patients receive the care to which they are entitled.

A summary analysis of the community nursing workforce is presented in the briefing paper. It illustrates the numerical decline in the community nursing workforce over the last four years, at precisely the time when the workforce should have developed in order to deliver TYC. Secondly, the figures demonstrate the ageing demographic profile of the community-nursing workforce, particularly in relation to school nursing and treatment-room practice nursing.

There is a further point to be made with specific reference to the district-nursing workforce. As table 2 on pages 12 and 13 demonstrates, many of the nurses who are categorised as district nurses by the DHSSPS are not employed as district nurses at all but as registered nurses who are deployed to work in the community. District nurses are nurses who have undertaken a specialist programme subsequent to their initial registration to equip them with the high levels of skills and expertise that are needed to lead and deliver the provision of specialist care to people with complex conditions. In simple terms, two out of every three nurses whom the Department categorises as district nurses are actually not district nurses at all.

The paper also stresses that we need to make sure, in our integrated health and social care system, that we are not trying to deliver nursing care within a domiciliary care model. The RCN is concerned about current consultation on a proposed outline for domiciliary care services. This definition of domiciliary care services includes programmes of care for older people, physical and sensory disability, mental health and learning disability. It goes on to claim that domiciliary care includes meeting:

"a service user's health needs (eg managing medication)".

This is unacceptable and potentially dangerous in the RCN's view. Meeting the health needs of patients and clients requires skilled professional nursing care that is prescribed, directed, supervised and delivered by registered nurses who have been trained to provide that care and who are accountable for the quality of the care that is provided and the experience of the patient or client.

The Committee has sought views from the RCN on the number of registered nurses who are required to implement TYC. As the briefing paper points out, commissioning involves assessing health and social care needs and then planning and designing services to meet those needs. Workforce planning is or should be an integral part of this process. It is equally a commissioning responsibility to seek assurances about staffing in the context of patient safety, quality and experience within the services commissioned. The RCN has been involved in a regional initiative to establish a framework for safe or normative nurse staffing ranges to support person-centred care in Northern Ireland. This work is currently being undertaken in phases. Phase 1 is to find safe nurse staffing ranges for acute medical and surgical settings. The previous Minister announced the establishment of the framework for these areas of practice in 2014. Phase 2 is intended to cover emergency departments and phase 3, community settings. However, the Northern Ireland Budget 2015-16 paper states that no funding is available to support work on subsequent phases of normative staffing. The RCN believes that this is unacceptable. The development of safe nurse staffing levels across health and social care is not an optional extra to be pursued as and when resources and other priorities permit: it is a matter of fundamental public safety that must be implemented fully and as a matter of urgency.

The RCN believes therefore that the answer to the Committee's question as to how many nurses are required to implement TYC lies in developing robust commissioning and workforce planning processes that are supported and underpinned by the implementation of safe staffing levels across all healthcare settings, including community healthcare settings.

At the end of the briefing paper, we draw to the Committee's attention the statement that is made in the executive summary of the 'Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry', with which I am sure that you are familiar. In particular it states that:

"The report has identified numerous warning signs which cumulatively, or in some cases singly, could and should have alerted the system to the problems developing".

I will not read those out, as they are in your briefing paper.

RCN believes that these warning signs are present in Northern Ireland's health and social care service today and that they can no longer be ignored. Last year, the RCN told the Committee that TYC is "a vision without action". We now need to reassess that conclusion. The Northern Ireland Executive's Budget paper for 2015-16 states that:

"The Department's budget does not allow for the funding of new service developments in 2015-16, across a number of areas including ... Transforming your Care (TYC) transitional funding".

Knowing that alternatives to acute hospital admissions are being closed, with more and more patients being funnelled into emergency departments because they are the only viable points of access to the health system, the RCN believes that we are entitled to ask whether TYC remains, in any meaningful respect, a viable strategy.

We note that, earlier today, the permanent secretary of the Health Department was scheduled to deliver a presentation at the annual conference of the Northern Ireland Confederation for Health and Social Care (NICON). It was entitled 'Beyond Transforming Your Care'. If TYC is not now the blueprint for the modernisation of the health and social care service, we ask this question: what is? Where is the new strategic direction or vision? Are we living in a system where the only mantra is that there is no money, so we will all have to muddle through as best we can? This is not leadership: it is a dereliction of duty.

I hope that this presentation, in association with our briefing paper, has been helpful to the Committee. Thank you for inviting the RCN to your meeting today. I hope that our evidence has been helpful.

Ms Breedagh Hughes (Royal College of Midwives): Thanks very much for the invitation to come and meet the Committee. Apologies for the very late tabling of what I am about to say. We have been otherwise engaged over the last few days. Sorry.

The issues in midwifery are in many ways very different from those in nursing. For example, there is no private sector for midwifery in Northern Ireland, nor are there any agency midwives, although, across the sector, we do have quite a high reliance on the use of bank midwives.

I have looked at the terms of reference for the Committee's ongoing piece of work and, in particular, the challenges that Transforming Your Care identified for maternity services going into the future. These were about giving women a realistic choice of birth location; the need for more continuity of care throughout pregnancy; the need to reduce unnecessary interventions; dealing with public health issues that face women of childbearing age to reduce ill health and disability of both mother and child; support the expectant mother in her antenatal care and connecting that support to the early years of parenthood. Transforming Your Care went on to say that it expects change to follow the pattern that is set out in the forthcoming maternity strategy from preconception through pregnancy, birth and the postnatal period. In addition, it recommends a specific regional plan for supporting the small number of mothers with serious psychiatric conditions.

At the time that Transforming Your Care was written, the Department of Health, Social Services and Public Safety was working with the royal colleges, service providers, commissioners and indeed with women themselves to develop the strategy for maternity care. I think that Mr McGimpsey was Minister when it was published. It clearly accepted the recommendations that were outlined in Transforming Your Care and has, for midwives, clearly identified the vision and the future direction of maternity services in Northern Ireland. It addresses women's choice, accessibility of services and who is best placed to be the lead maternity professional. I think that, for us, it is a unique document in that it is a maternity services strategy. It cuts right across all of the professional groupings. It applies equally to our medical colleagues, general practitioners, midwives and nurses who work in such places as neonatal intensive care units. It is a service strategy and not a uni-professional strategy. It is supported and, in fact, driven forward by our colleagues in the Public Health Agency. There is a very robust maternity strategy implementation group, which, each year, puts in place annual targets to be met by the end of the year to move the strategy forward. It is not a strategy that sits on a shelf somewhere; it is very much a living and evolving document. It spans both the acute and primary care sectors.

The premise of maternity care is that every woman needs a midwife and some will need a doctor as well. In fact, some will need more than one doctor. They may need a very highly skilled team of doctors to provide them with that wrap-around care. In Northern Ireland, the service developments in maternity care are in line with the maternity strategy. There has been robust implementation of the strategy since 2013, with women now having a wider choice of birth location; more continuity of care throughout their pregnancy; and fewer unnecessary interventions, including non-medically indicated caesarean sections. That issue was addressed by the Northern Ireland Audit Office, probably at the request of the Committee. Those are being reduced. Midwives are at the forefront in discussing public health issues, including drug and alcohol abuse, smoking, nutrition and exercise with pregnant women, who are actually very well disposed to receiving public health messages during their pregnancies for themselves, their unborn baby and other members of their family.

The only recommendation from Transforming Your Care that is still to be implemented fully is the development of the specific regional plan to support women with serious psychiatric conditions. That work is, in fact, ongoing. There is a perinatal mental health working group in Northern Ireland which has, so far, developed very robust training to identify women at risk. It has put in place an algorithm or flow chart for midwives to follow when they identify a woman at risk of perinatal mental health problems. Our difficulty is that there is not a dedicated resource for those women once they have been identified. We still do not have a mother-and-baby bed that women who are seriously unwell can be admitted to with their baby, so any woman with a mental health problem in Northern Ireland will be separated from her baby if she requires admission to a psychiatric unit, but we are campaigning on that one. We will keep going, and I am quite sure that we will get it eventually.

There is an evolving role for midwives in decreasing social complexity and enhancing parenting skills. It is a massive transition to make, as anybody who is a parent will know, from having a bump one day to having a baby — a real, live human being — the next day. We are beginning to see midwives moving to work outside the health-care system in Sure Start schemes, the early intervention transformation programme that the Public Health Agency is about to start and the family nurse

practitioner scheme. Midwives are reaching out to those who are most vulnerable in the community and working with them to help them to make that transition from pregnancy to parenthood.

Whilst there has been an increase right across Northern Ireland in the number of women choosing to have midwifery-led care throughout their pregnancy, there has also been an increase at the other end of the spectrum in the number of women with complex needs who require to have their care provided by an extensive team of health-care professionals. That is to do with women delaying having their first baby until they are older or women presenting for pregnancy with other ongoing diseases, particularly things like diabetes, epilepsy, renal disease, cardiac disease and respiratory disease.

The midwifery workforce in Northern Ireland is predominantly female: only two of our 1,300 midwives are male. It is an ageing workforce. Almost 60% are aged over 45, and, indeed, 22% of them are aged 55 and over. It is a part-time workforce, with almost 70% of midwives working part-time. At any given time, up to 5% of the workforce may be on maternity leave, so that means that, at any given time, 65 midwives are off on maternity leave in addition to any midwives who may be off on sick leave.

Midwives work flexibly across hospital and community boundaries. That is incorporated into their pre-registration training and carries through into clinical practice. In order to keep them fit for practice at any point in their career, ongoing professional development is crucial as the service develops to meet women's needs and wishes. Ongoing professional development is provided, some of it in-house, some of it by the Clinical Education Centre and some of it by the universities, but it is all unfunded, and many midwives undertake their own continuous professional development (CPD) in their own time and at their own expense.

The midwifery workforce is reviewed annually in conjunction with the Department of Health. It is a group led by the Chief Nursing Officer. We work with service commissioners and providers, the higher educational institutes and the professional organisations, which include both the RCM and the RCN. Like Garrett, I echo our concern that there is no midwife on the regional workforce planning group. We were completely unaware, for example, of the Skills for Health workforce planning diagnostic report that was provided to the Department in November 2013, so I thank the Assistant Clerk for giving me a copy of that.

The 2013 report highlighted several workforce planning issues that it might be worth the Committee taking some cognisance of: for example, that workforce planning is seen by those who work in the service as being reactive, short-term and focused on efficiencies and savings, not on future service development. It asks how you translate a service change into a workforce change and who really owns workforce planning: is it HR, or should it be the people working in the service?

By using the maternity service strategy as our framework for the development of midwifery workforce planning, we are taking service developments and looking at the midwives we currently have in place, at how the service is evolving, at where those midwives need to be and what they need to be doing, and their skills are updated constantly and reviewed throughout their career. There are midwives in places like Lagan Valley who worked in a hospital environment for 30 years and, when it became a midwife-led unit, started working in the community as well as the hospital. They are doing home births and rotate back and forth to the Ulster Hospital to update their critical skills. They are working in many different ways — more ways than anybody ever envisaged. It is still an enormously popular career, however. There were 534 applications to Queen's University this year for the three-year midwifery course and 75 for the shortened 18-month course, which is open to those who already have a nursing qualification. So, it is still a very attractive career option.

The introduction of maternity support workers to the maternity workforce has provided support to midwives and added value to the care that women receive. We have, working with the Business Services Organisation (BSO), developed a single training scheme in Northern Ireland that is adapted by each trust to meet their service needs. In some places, maternity support workers work in theatres; in other places they work in the community; in still other places they support breastfeeding women. It is about tailoring their use to meet local service need.

The major threat to midwifery is that an ageing workforce, many of whom have the ability to retire at 55, may, in today's difficult environment, choose to exercise that right. That would leave us, if they all went in the next couple of years, with an immediate 22% depletion of the workforce. It is, therefore, in everyone's interests to keep our midwives at work, happy and motivated. We are happy to add to that by answering any questions.

The Chairperson (Ms Maeve McLaughlin): Thank you for very clear briefings from both organisations. Just by way of opening up the conversation, I want to say that the daily work of your organisations and their many staff is vital to the delivery of our health service and to our wider society. I hope that you hear that genuine message from us.

I picked up on a few points of Garrett's. The reason for our doing this piece of work is that we view workforce planning as integral. Personally speaking, to promote a strategy but not to engage in workforce planning until a number of years down the line is certainly not foolproof. The first port of call should have been looking at workforce needs and planning accordingly. That is the message from this Committee, and that is why we have undertaken this work.

We are uncovering a lot of the same patterns, suffice it to say. We are looking at in the region of 29 reviews of aspects of the workforce, with a number of reports — we heard from the GPs last week — that have not been actioned. There is a real challenge in the system, if we are serious about the shift left. That leads me on to a very direct question to both colleges. The College of Nursing, at a previous meeting, talked about TYC as a vision without action. I note that you say now that you are entitled to ask whether it remains a viable strategy. My question is this: in your view, is Transforming Your Care dead?

Mr Martin: The college's response is this: what options do we have? Very few things in health care get the consensus that TYC got three years ago. Very few people said that it was a bad thing. It absolutely is the right thing to do. The problem that we, and patients, see, day in and day out, is that it is not being delivered. Look at some of the figures that we provided, and not just for emergency department waits. Another statistic that I heard recently, which is quite damning of TYC, was the increase in delayed complex discharges. That in itself indicates something about the process for getting patients out of an acute hospital in a timely and safe fashion. The community services have to be in place to facilitate that, and there has been a 30% increase. At an unscheduled care workshop a number of weeks ago, it was presented that there has been a 30% increase in the number of delayed complex discharges, which involve patients who are older or vulnerable people who need packages of care. That is an indicator that services in the community are not there. You have the figures in front of you for district nursing. I think that most patients and members of the public understand that the district nurse is the cornerstone in coordinating patient care in the community. They are the people who liaise with the different services and make sense of services for patients in the community. That 6% reduction over the last four years, a time when the figure should have been increasing, shows that, if the figures and the workforce do not change, TYC cannot be delivered.

The Chairperson (Ms Maeve McLaughlin): Can it be fixed?

Mr Martin: I would not be as pessimistic as to say that it cannot be fixed, but we are starting way beyond when we should have. This should have started not just three years ago when TYC was published; it should have started long before that. Community care and care in the community is not a new concept. TYC was not the first strategy document to identify community care as the right way to go. It requires funding in the right place and commissioning to work better in transferring that resource from the acute sector to community. It certainly needs a major overhaul of how things are being done.

The Chairperson (Ms Maeve McLaughlin): What about from your point of view, Breedagh?

Ms Hughes: We were starting from a different place. There had already been a very strong move driven by service users — the women themselves — to de-medicalise maternity care where possible. When Transforming Your Care was being developed, the maternity strategy was being developed in tandem. It looked at how to keep care locally accessible for women. You have to make a difference between the women who are low risk, and for whom that is an option, and the women who have high-risk pregnancies and need complex teams caring for them, but you do not treat every single woman as a medical disaster waiting to happen. That groundswell was already being driven forward by women and the maternity services liaison committees attached to each of the trusts.

Maternity services started much further back. We already had that move to decentralise, to keep things locally accessible, to centralise the services that needed to be centralised and to make everything else as locally accessible as we could: for example, by the time TYC was published, plans were well under way to open a midwifery-led unit in Downpatrick. That was closely followed by one in Lagan Valley, and there is also one now in the Mater. The service has evolved and continues to do so, but that process started before TYC was issued as a strategy document. In fact, we often

wondered whether they copied our maternity strategy when they were writing TYC, because it embodies many of the same principles.

The issues were very different, and we started from a different place. It is also the case that, when looking at only one discrete service, such as maternity services, you can make those changes more easily. There are fewer groups of people involved, and, generally, you do not have very ill people. It was easier for us to accomplish. It is much more difficult, as Garrett highlighted, when there is any sort of dissonance between the acute sector and the community sector. People get stuck in the system. Women and midwives now flow in and out of maternity hospitals. If a woman is completely low-risk and delivers in a midwife-led unit, whether it is a free-standing one or an alongside one in one of the bigger units, she has her baby and goes home in six to 12 hours. There is then a seamless pickup by the community midwifery service. In fact, the midwife who delivered her might also be the midwife who sees her at home. Our issues were different, and we were in a different place at the point at which the process was starting.We share the concerns about the funding, particularly because, although the service has changed, the funding structure remains the same. It is calculated on an old formula that just takes the number of births in each trust and gives the funding according to that number. It does not look at the complexity of need of some women and their babies. Some women will have very complex needs and have a very expensive birth; others will not see a doctor at any point during their pregnancy, the birth or afterwards, so they do not have complex needs and do not cost a lot of money.

Simply looking at the total number of births and then allocating the funding is not helpful, because it means that we do not have the flexibility to redirect some of those resources into the community. Why, for example, does every woman have to queue in a hospital for two or three hours to have a scan to be told that they are definitely pregnant? We would love that to be done in the community by community midwives, but they have to buy handheld scanners, and they are expensive. It is about redirecting some of the resources currently concentrated in the acute sector to the community sector in order to allow that element of care also to be transferred out into the community and keep services locally accessible for women and their families.

Ms Rita Devlin (Royal College of Nursing): In the context of TYC, workforce planning has two strands: the numbers; and the knowledge, skills and expertise. Northern Ireland is the only one of the four countries that will not increase student nurse levels this year. The education budget for post-registration nursing education and development to help nurses to keep up their skills has also been reduced, so we have a potential reduction in the number coming in and a reduction in the budget to keep them trained and developed to bring forward new ways of working and transformation.

The Chairperson (Ms Maeve McLaughlin): Given that both colleges have outlined the pressure in the system — we have seen that reflected in the last 24 hours in your decision on industrial action — is nursing safe? Is midwifery safe?

Ms Devlin: Should we not ask whether patients are safe?

Ms Hughes: As long as organisations like ours have access to those who make decisions, I am personally confident that we can get the ear of the relevant person and raise concerns directly. I think that we are probably in a better position here in Northern Ireland than our colleagues in England in particular, because there are so many hoops to jump through over there when you wish to raise a concern. However, it depends on what action is taken as a consequence of those concerns being made known.

The Chairperson (Ms Maeve McLaughlin): What about from a nursing point of view?

Mr Martin: There is certainly evidence of real concerns that patient safety is at risk. We hear that very often. Whether it is to do with staffing levels in wards, or even in community settings, we see in reports, particularly in the community, that caseloads are increasing significantly. The acuity — the dependency and needs of the patient — has increased significantly in the community. Nurses are rushing in and out of patients' houses to make sure that they can see all of their patients. They identify that as a major risk

Also, as Rita pointed out, it is not just about numbers; it is about the skill mix of the staff who care for patients. Very experienced staff have left emergency departments because they cannot take it any more. They have had enough and are burnt out. We heard of one department recently that 12 experienced staff left within a short space of time. That is a massive chunk of experienced and skilled

staff to leave a department. You may, if you are lucky, be able to backfill with new staff, but new staff take time to orientate, induct and develop to a level at which they are competent. So, absolutely, there are real safety concerns, and nurses struggle with that daily, but they do their best. They go beyond the call of duty, as you know, to try to make sure that patients are as safe as they can possibly be.

Ms Hughes: We share the concerns about the skill mix. With 22% of midwives aged over 55 and feeling the pressure sometimes, it is like a domino effect. If one person retires from a department, he or she comes in and tells everybody how wonderful retirement is. Within the next six months, half the department has gone — they can go and they do. Our nightmare is that we would be left trying to fill that gap. Even if we managed to recruit and train midwives, they are, at the end of their three-year course, very inexperienced. It takes them a number of years to reach a high level of competency, whether in nursing or midwifery, in any particular arena. We have a huge concern about that as well.

The Chairperson (Ms Maeve McLaughlin): Obviously, it is of concern to us all that patient safety may be at risk in areas where people are delivering a life-or-death service on behalf of both organisations. What is the urgent action that is required? In the last number of weeks and months, I have listened carefully to you, Breedagh, and others talking about the hard decisions and the genuine dialogue, based not just on budgets and money in the system. If somebody asked you what needed to happen urgently — A, B and C — what would they be?

Mr Martin: It is very difficult to say what would need to happen "urgently", because it takes time to train people. One of the first things that needs to be done is that the number of pre-registration places needs to be increased. In particular, we certainly need significant investment in post-registration education support for nursing staff to undertake these programmes, whether they are in specialist practice or other advanced practice programmes, to allow for some of these changes to take place. We absolutely need normative staffing, or safe staffing, levels implemented as soon as possible. We need phases 2 and 3 of that to be carried out and supported. It must be not just a paper exercise; we need the funding to follow. The nursing profession is saying, very clearly, that a certain level of staffing is required to provide safe and effective care for patients, so there is an obligation to fund and resource that need. We appreciate that it will not happen overnight, but we want a commitment that it will happen.

Ms Maureen Dolan (Royal College of Nursing): I concur with what Garrett was saying. As a nurse working on the front line, I find it very difficult — other members would also say how difficult it is — to work with the level of staffing that we have at the moment. It is not just the level of staffing but the experience of the staff who come to help on the wards. They might be agency or bank staff who are not used to the environment. Inexperienced staff are coming into acute services, for instance, where work is done on surgical wards, and that adds to the workload rather than assisting with it. A lot of experienced and valued members of staff are leaving, as Garrett said, not just to take early retirement but to work for private agencies that pay better. There is less incentive for staff, including pre-registration staff, to stay where they are when they know that, if they go to England, America or Canada, they will have incentives to work.

The Chairperson (Ms Maeve McLaughlin): That is useful because that is one of the issues that came up when we were looking at unscheduled care. People often reflect on recruitment, but the debate is about the type of recruitment and the type of staff required.

I want to go back to your point, Garrett, about pre-registration places and programmes. Your briefing paper states:

> "trusts are not commissioning sufficient places on ... Programmes such as district nursing and health visiting."

Why is that happening? Why is that the case?

Mr Martin: There has been a specific issue with health visiting. There was an increase in the number of commissioned health visiting places because of the risk associated with the caseloads in that area. That is, to a certain degree, being addressed. It is to do with funding and pressure. The Department does not provide backfill for a number of these programmes, so the trusts simply say that an individual has to do it in their own time. For professionals to try to develop their career, expertise and skills while working in a very stressful clinical environment is very challenging. Quite often, and more often than not, it is absolutely to do with resources and the lack of backfill to provide cover when staff are out on these programmes.

The Chairperson (Ms Maeve McLaughlin): A number of Members want to come in on this. Your paper, Garrett, refers to staffing shortages in the independent nursing homes sector.

Mr Martin: Absolutely.

The Chairperson (Ms Maeve McLaughlin): That is a serious risk, I suggest, to the viability of those nursing homes.

Mr Martin: Almost a third of our members work in the independent sector. These are, as you all know, nursing homes, and there are 10,000 nursing home beds for our older population. We believe that the service — the Department of Health and HSC as a whole — has a responsibility to ensure that there is a nursing workforce that is able to staff those independent nursing homes, but there are significant staff vacancies. They are finding it very difficult to recruit. One large independent provider had 150 registered nurse vacancies.

They recruit from the EU. There is, as you probably know, a ban on recruitment outside the EU, which is a challenge in itself. There may be some things that could be looked at in relation to that, which may help. Nurses recruited from within the EU spend a period in the private sector — the independent nursing home sector — after which, because we are in a cycle of a lack of supply to meet the demand, trusts are able to employ nurses from other parts of Europe. The independent homes sector cannot compete with the terms and conditions and the pay. Trusts now recruit those nurses because they are reporting large numbers of vacancies in nursing. It is almost a perfect storm in the nursing workforce. We highlighted the risks a couple of years ago. We had the demographic profile of nursing, and the risk was much higher in certain areas — district nursing being one of them.

It was inevitable that the changes to pension arrangements and the reduction in pre-registration nursing programmes would leave a deficit in the supply of the nursing workforce, and that is exactly what has happened. Unfortunately, the warning signs were not listened to, and that is why we are in the situation that we are in. We are playing catch-up. If we do not start picking this up now, in two or three years' time, we will be sitting at this very table, I am sure, in a worse situation than we are at present.

Ms Hughes: Midwifery is slightly different, in that we have a very robust workforce planning tool called Birthrate Plus, which helps us to look at how a service is configured. It is a bit of a guesstimate, but it is pretty much based on a huge amount of data, and we can work out how many midwives are needed, at any particular time and in any particular place, to staff the service safely. That has been backed up more recently by guidance issued by the National Institute for Health and Care Excellence (NICE) on the safe staffing of maternity units. We are in a better position to guess how many we need. That will not help us if the 22% who are over 55 all decide to lift their pension.

From our point of view, probably the single biggest thing that would help to keep workforce planning on everybody's horizon is for both the RCM and RCN to be involved in the regional workforce planning group. I do not see how the HR directorate at the Department of Health can plan for the professional workforce across Northern Ireland without speaking to us.

The Chairperson (Ms Maeve McLaughlin): OK, that is very clear. Finally, before I move on, I noted from your paper, Garrett, that 600 nurses were employed across GP practices. You referred to concerns about terms and conditions.

Ms Devlin: We are looking at practice nurses, and there are a couple of issues. Obviously, they are seen as independent. GPs are independent employers, so there are no standardised terms and conditions for practice nurses. There are a few issues with keeping practice nurses skilled, because it depends on whether GPs are prepared to pay for their education and training. Obviously, good employers pay for that. They are an ageing workforce, too. There is no standardised preparation or acknowledgement of standards of education for a practice nurse post. Some of the issues are about keeping them skilled for the services that TYC expects to be delivered through the GP and practice nurse role and the fact that the practice nurse programme is no longer commissioned by the universities because the employers would not pay for nurses to do it. There is an onus on us to look at what skills and development the practice nurse population needs for the future. TYC and the GPs are the gatekeepers, and the practice nurses do things like health assessments and signposting and try to keep patients out of hospital. It is all nursing, but it all happens in different places and they have

different skill sets. It is about recognition that workforce planning is not just about numbers but about skill sets.

The Chairperson (Ms Maeve McLaughlin): There is an obvious issue in that it may become difficult to recruit and retrain practice nurses if those issues are not resolved.

Ms Devlin: If they do not get the same terms and conditions and supervision, yes. Professional revalidation will come in in the next three years, and they need proper clinical supervision and work to do the revalidation. That could become an issue.

Mr McKinney: Strategically, does the system understand the number of nurses and does it audit the work? Does it know what is happening on this side of the wall in terms of GPs? Does the mainstream system monitor that, assess it and know what the day-to-day work of nurses in GP practices involves?

Ms Devlin: The trusts and the independent sector seem totally different. I do not know anybody, apart from us, who has an overall view of nursing as a whole. I do not know that the Department looks at that either.

Mr McKinney: This might be a leading question: is that a flaw?

Mr Martin: It is fair to say that. Part of the overall workforce planning piece should pull all that together. In fairness, work has started on nursing and midwifery workforce planning through the Chief Nursing Officer. We still have some concerns, and our organisations are certainly involved in that from a uni-professional perspective. That needs to dovetail with the overall regional workforce plan, which is where we are saying that we are not and have not been involved at the level that we absolutely need to be, but, as the paper identifies, there are still some concerns about the work in that group.

Ms McCorley: Go raibh maith agat, a Chathaoirligh. Thanks very much for the presentation and for coming today. One of the terms of reference of the review is to assess progress on workforce planning in support of the implementation of TYC at trust level, and the RCN briefing paper states that you are not aware of any workforce modelling at HSC/trust level. I know that you have discussed all that, but can you elaborate on the implications of that? Do you have anything further to add that has not already been said?

Mr Martin: If the trusts were sitting here, they may argue that they are doing that. We would argue that it is generally under the realms of service reorganisation, and, quite often, that is to do with trying to save money. That might sound like a very cynical view, but we deal with it on a day-to-day basis as services are being reviewed. It is about trying to take out posts to save money and, in some circumstances, to almost re-band or downgrade as a way of trying to save money. That is sometimes put under the realms of workforce planning. That is totally wrong.

Ms McCorley: Are you aware of the trusts making any investment? It seems from what you have said that the opposite is true. Are they making any investment in the training or retraining of staff to achieve the shift left in the skills mix that is needed to implement TYC? You said that they are looking for ways to save money but are probably doing the opposite.

Mr Martin: In fairness to the trusts, they are in very difficult times, and they have to live within their budgets. In relation to that, we see examples where trusts put bids to commissioners, where there may well be good and well-evidenced service reform that is evidence-based around patient care. Sometimes, commissioners are not commissioning on that basis, and we do hear from the trusts where they feel the difficulties with commissioning. From Sir Liam Donaldson's recent report, we know the difficulties and problems that we have with commissioning, and that is certainly something that we do not want to put solely on the responsibility of the trusts. The commissioners have a big, big part to play in relation to this work.

Ms McCorley: Do you feel that the trusts are investing in leadership and capability development in the nursing course?

Ms Devlin: I do a lot of training programmes for senior nurse leadership, and, last year, from our point of view, there were, as far as I know, 120 places on the leadership programme requested and commissioned by the trust, but there was no education budget at the Department to let them carry on.

Ms McCorley: It did not happen then.

Ms Devlin: It did not happen.

Ms McCorley: So, there is no investment in leadership, in reality.

Ms Devlin: Those ones were not commissioned.

Mr Martin: I think that it is fair to say that there are some but not nearly enough to provide for what is required.

Ms Devlin: I think that one of the things that we need to remember is that we are all fishing from a very small pool. We talked about the fact that 65 health visitor places were commissioned this year to meet need, but those are not 65 extra nurses. Those are 65 nurses who have come out of trusts, so everything new that happens, including new district nurses, are coming out of a trust somewhere. It is not that we are making more of them. One of the concerns that we have is that, while we can move on and improve skills and knowledge, it is from the same pool. The independent sector and we are all fishing from the same pool, and that is causing a difficulty.

Ms Hughes: I suppose that the same is true in midwifery, where, although midwives can and do work flexibly across hospital community boundaries, if you are going to move more services into the community, you have to create midwives out there to staff those services. There comes a level beyond which you cannot pull any more out of the acute service either because it needs them. There is a piece of work that we still need to do to look at what commissioning extra midwifery places might mean to get midwives in place to follow through the complete shift into the community for women with low-risk pregnancies. We would very much like to see that.

Ms McCorley: The briefing paper expressed disappointment about you not being included on the regional workforce planning group, which you talked about, and the fact that you have not been made aware of any proposals being developed by the group. How do you assess the Department's approach to involving professional bodies like the RCN and the RCM in the workforce planning that is needed to implement TYC?

Mr Martin: We need to be there, and I think that, recently, the Department and officials at the Department have not particularly been engaging in relation to the involvement of organisations like ours and other trade unions. Recently, we have had correspondence in relation to the partnership forum, as an example. The previous Minister had given a commitment that a review, regionally, will be carried out of the partnership forum. The terms of reference for the new partnership forum were agreed by Minister Poots, and, unfortunately, the permanent secretary has recently communicated to say that he does not believe that we need a partnership forum. His view is that the joint negotiating forum is the forum to discuss these issues. We disagree; we believe that the partnership forum is much greater than a negotiating forum. It is about policy, strategic direction and key stakeholders having conversations like some of the conversations that we are having here today. We are concerned that the current administration and climate is not one where we are being engaged to the level that we should be.

We will be constructive partners in this. Our record speaks for that. We will absolutely challenge, but we will be supportive of directions that are in the interests of patients and for the public in Northern Ireland. That is why we find it staggering that we are not involved to the degree that we believe we should be.

Ms Hughes: We have a huge body of knowledge because of our direct contact with nurses and midwives at the coalface that we could bring to any arena and present those views to the highest levels. At the moment, there is no way for those voices to be heard. We are not, as the Tory Government would have us believe, all in this together. We are not, at the moment, all in this together. Quite often, we do not know what we do not know, which is very worrying. Decisions are being made in isolation and there is no discussion. We were told, however, that we would receive consultation documents in the same way as anybody else, such as members of the public, and that we could respond to consultations and that would be sufficient.

Ms McCorley: It is hard to fathom the logic behind that.

The TYC document stated that a reduction of 3% of the workforce, or 1,620 staff, will be required for implementation. However, the Committee has heard from the Department that that is no longer a target. Has the Department communicated any new target to either of your organisations?

Mr Martin: No.

Ms McCorley: It was a surprise to us that that is no longer a target. It is hard to understand that. You have no knowledge of that, either.

The Chairperson (Ms Maeve McLaughlin): In terms of the regional workforce planning group, the indication to us was almost that the uni-professional reviews would help to shape workforce planning. I assume that you are saying something very different. Are the uni-professional reviews enough?

Ms Hughes: No. A uni-professional review is very helpful. We sit down with the Chief Nursing Officer, who is our professional lead in the Health Department, and discuss what the future looks like for nursing and midwifery, what type of nurses and midwives we need and how many of them we need. However, at some point in time, all the other health service professions need to sit around a table, because I could say, "We will need midwives out in the community doing ultrasound scanning for women, but we will need sonographers to help them with that, to train them or to send the people to for a second opinion. We also need to work with community pharmacists if we're going to send women in that direction". We need to know what workforce planning looks like right across the piece. For that to be seen as purely an HR function is not good enough. The professions are doing their best in the silos that we are forced into. We really need to be round a table at some high level saying, "If you're going to do that, what will the impact be on another group of staff?". We are not having those discussions, and there is no arena for having them.

Mr Martin: We need more than a document and words on a sheet of paper.

Mr McCarthy: Thanks for your presentation. Last week, I said that the three hours that I spent in this room were the worst three hours of my time in Stormont. There were presentations from the BMA and the Royal College of GPs, and they were saying exactly the same as you. I am about to spend another two hours being further depressed by what you have said. I accept that it is the truth as you see it on the ground. I hope that the people who can do something about that are listening to this conversation today. Unless and until something drastic is done to improve the situation, we are all going to suffer the consequences. Having said that, let me put on record my total and absolute admiration for the work of the nursing profession throughout Northern Ireland. It continues to do that work despite what you said about nurses being at breaking point. We understand that.

Do you reckon that the people at the top know what they are doing? We talked about Transforming Your Care last week, and I think that I used the term "dead in the water". There term "viable strategy" has also been used. It seems to me that you people are saying that it is not a viable strategy. It is dead in the water, and where do we go from here? We supported Transforming Your Care, as you said, at the time. Unfortunately, I do not know where the main author of Transforming Your Care has gone. He has left everybody fighting to move it forward. Certainly, from what you are saying, we are not moving it forward at all.

Ms Hughes: I think that this is one for Garrett. Maternity services are very small and discrete, and, as I said, work had started on transforming the maternity service before Transforming Your Care came into being, and that work continues by way of our own mini TYC — the Northern Ireland maternity strategy — which runs until 2018. So, we actually have a pathway that we are on and are following. We are doing it at the moment, absolutely within existing resources. That is not to say that there might not be resource implications further down the line but, in terms of mainstream Transforming Your Care for ill people, that is definitely Garrett's department.

Mr Martin: I think it is fair to say, and we all know, that this is very complex. These are very challenging times financially. We all have a responsibility. Organisations such as ours have a responsibility, and we are very clear about what that is. I think that, if this was easy, it would have been sorted long ago. What we are doing is highlighting the issues and concerns, and they are very serious.

Mr McCarthy: From what you have said, there does not seem to be anybody listening who can do something about it.

Mr Martin: We would like to see more honesty in the system. We would like to see people, at whatever level they are, admit where things are not going to be able to be done. We would like them to be honest with the public and organisations like ours. Absolutely, very difficult decisions have to be made that go to the heart of politics — let us face it — as well as everything else. That is the climate we are in. We owe it to the public of Northern Ireland to show that we all have a responsibility for leadership. We are not here today to engage in scaremongering or raise concerns. We know, absolutely, that there is fantastic work going on in the HSC, day in, day out. We would not want, in any way, to come here and say that everything is doom and gloom. We know that a lot of patients get fantastic care, but the downside, and what we are highlighting here today, is that there are real risks, issues and warning signs, and, if we do not all sit up and listen to them, things are going to get an awful lot worse. We all have to show some leadership.

Mr McCarthy: You mentioned that patients could be at risk because of the situation. That is a critical statement, because nobody wants to see patients put at risk at any time.

Garrett, in your briefing paper, it states that the nursing and midwifery training budgets have been cut by the Department over recent years. Are you aware whether the Department or the regional workforce planning group has any plans to change that in the near future? It seems to be not very optimistic.

Ms Devlin: The nursing education budget, pre- and post-reg, has been eroded over the last number of years. Last year, the education budget was not set.

The Chairperson (Ms Maeve McLaughlin): Apologies for the background noise. I think that somebody's phone is causing it. Can people check their phones? Sorry, Rita, go ahead.

Ms Devlin: The RCN is also a provider of nurse education, and we provide quite a bit of post-registration nurse education. Usually, it is commissioned by the Health Department, and, last year, none of our programmes were commissioned due to the fact that no nurse education budget had been set for pre-reg education. We do not know what the pre-reg nursing education budget is going to be this year yet, and we are in April.

Mr Martin: We are aware that between 20% and 30% of student nurses who qualify in Northern Ireland do not end up working in Northern Ireland. There is a school of thought that that needs to be addressed before we should increase the numbers. We do not believe that is so. We believe that the numbers need to be increased. We need to understand why such high rates of people qualify as nurses and then leave Northern Ireland. We have to absolutely understand the reason for that.

Ms Devlin: I would like to add to that. If you look at young people socially, in all walks of life, it seems to be the recognised norm that they go away for one, two or three years and then come back. That is particularly so among our young doctors and nurses. That might be something that, when we are doing workforce planning, we have to factor in. We may lose them for a couple of years, but we have to make it attractive for them to come back, with the added knowledge and skills that they have gained elsewhere. It is a fact of life that that is what our young people are doing now because the world is so small. Our nurses are very employable. Nurses from Northern Ireland are sought all over the world because of their training. They can get jobs anywhere. They are actively recruited in recruitment fairs in America, Australia and England, in particular, which would take every single nurse we trained, if it could.

Ms Dolan: Again, it is about incentives. Young nurses are leaving for incentives to set up somewhere else. They gain knowledge and experience and then come back again, certainly. However, for the like of me who never left, it can be very difficult when you are working on the ground, on the front line, and you are left with very inexperienced staff.

Mr McCarthy: Thanks very much for that. That was my next question. Is there anything that can be done to retain those highly qualified nurses?

Mr Martin: We certainly have to look at some of the recruitment processes within the trusts and how nurses are being recruited. In terms of the choice of clinical area, the career has been eroded. Ward

sisters used to be able to recruit staff to their own wards, but that too has been eroded. All those processes have been eroded. We also have to look at career pathways and the career options that nurses have when they are qualified and enter their career. So, there are a number of things that need to be done in relation to that, absolutely.

Ms Devlin: One of them is to ensure that, where you work, you have safe numbers of staff. In talking about their concerns, a lot of our nurses mention the risk that there is to their registration.

Mr McCarthy: We heard very recently of situations where nurses cannot leave their work. They stay on for an hour, or an extra hour and half, without pay, to show their dedication to the patient. That is absolutely fantastic, but it is unfair to the nurses who have to do it.

I have a couple of quick questions. Do the regional workforce planning group and the trust have any strategic plans to reduce the use of bank nurses and create more permanent posts?

Mr Martin: That would be part of the normative staffing arrangements, and that work is really just beginning. We have been given some assurance or have an expectation that the first phase of that would be complete or implemented by the end of the first quarter. We think that is optimistic, considering some of the recent communications and things that we are hearing from employers. Certainly, that would be part of it.

Ms Hughes: There is no any agency midwifery in Northern Ireland at all, but there is a heavy reliance on bank midwives. Generally, those midwives already work part-time for a trust and, if a colleague goes off sick, the trust asks all its part-timers to work additional hours to cover those missing shifts, or it asks its full-timers to work overtime. However, they are highly reliant upon the goodwill of their staff to cover any sort of absence, whether it is a planned absence, such as a maternity leave or a long-term sick leave, or an unplanned absence, such as when someone goes off sick, on bereavement leave or something like that. The trusts are highly reliant on the goodwill of their staff to cover.

Mr McCarthy: Finally, you all mentioned rural nursing and the difficulties involved. I think that you use the term "district nursing"; they are the same thing anyway. Is there anything that can be done to provide more of those? What about the use of incentives to recruit district nurses, that is, the nurses who go round the country and the rural areas?

Mr Martin: I think it is back to the point of acceptable levels of staffing, training, having enough places commissioned and supporting people to be released to do that training. Training is the key to that because, as you can see, there has been a reduction in that. Sometimes, the appropriate level of "banding", as we call it, is not given for the skills and qualifications that these nurses have.

Mr McCarthy: Thank you very much. Keep your head up. Do not let them get you down. We are all behind you; you know your job.

Mrs Cameron: Thank you for the presentation. One of the terms of reference for the review is to examine the extent to which workforce planning takes account of recruitment issues for particular geographical areas. Is that an issue for nursing or midwifery? If so, how do you think it can be addressed?

Mr Martin: I will use an example around children's or paediatric nursing, where you find that there are obviously a limited number of places on an annual basis. Because of regional recruitment, you find that Belfast tends to recruit most of those nurses who come out with their paediatric qualification. That can certainly leave some of the hospitals further out of Belfast, particularly in the west, with great difficulty in recruiting. I think the profession needs to be in charge — I think that is the right word to use — of recruitment processes within and for the profession. It should not be based solely on HR processes. We need to have solutions to those situations where we have difficulties recruiting, whether that is in rural areas or in specific specialities. We absolutely need that within any proper workforce planning, and the recruitment process needs to be tightened up to allow that to happen.

Ms Hughes: Midwifery is a popular career option. We do not have the same issues with newly qualified midwives going away. They might go away if there is not a job for them immediately available here in Northern Ireland, but, anecdotally, we know that, within a year, most of them are back in Northern Ireland and stay here. They stay in midwifery until the end of their career. So, we do not have quite the same problems as nursing. Neither do we have a problem recruiting midwives to

work in any particular geographical location. However, we do have a problem when very senior midwives retire. It can be very difficult to get people with enough skills, experience, training and leadership development, as Rita has pointed out, who are willing to step up and take that post. We have one very senior midwifery post in the South West Acute Hospital that has been vacant for two years. It has been advertised nationally three times. So, it is those posts. That post is absolutely needed to provide leadership and strategic direction to the midwives and the maternity service in that hospital. We cannot fill that post. We do not think it is the geographical location, per se; we think it is the fact that it is a post at that very senior level. So, every time I hear that a senior midwife somewhere is going to retire, I feel a bit sick. I think, "Oh Lord, I have to find another one now". That is the bigger challenge for us.

Mr Martin: On that point, we have had the gender statistics for the profession of midwifery, but, in nursing, it is 92% female. Primarily, you have a young, female workforce as well. So, issues relating to the mobility of staff are greatly reduced as well and need to be taken into account when recruiting staff.

Mrs Cameron: I have similar question. Another of the terms of reference is to examine the extent to which the workforce planning takes into account the viability of seven-day working. We know you do seven-day working, but is that an issue for either of you? If so, have you any suggestions as to how it could be addressed?

Ms Hughes: At the minute, it is a 365-days-a year, 24-hours-a-day service, so there certainly is seven-day working. It is incentivised, to some extent. If you work between 8.00 pm and 8.00 am, you will be paid an additional rate for working those unsocial hours, as you will for working on a Saturday or Sunday. I might be wrong on this, but if you are on call, you get about £12 a night. You go on call from 5.00 pm to 9.00 am. You cannot go out, have a drink or let anybody else have your car in case you are called. You get £12 for that.There is, at the moment, some incentive for people to work outwith normal working hours. There are some discussions across the water about doing away with that incentive. If that happened we would not have a health service. No nurse or midwife will provide a seven-day-a-week, 24-hour-a-day service if they are being paid the same rate for working during the day as they are paid for working at nights and weekends.

Mr Martin: From our point of view, it is exactly the same. Obviously there is a lot of empirical evidence around patient safety, and nobody would disagree that if you are admitted to hospital on a Saturday your level of care should be the same as if you are admitted on another day during the week. Nobody disagrees with the concept of having seven-day services. Nurses are used to that. We provide that, and have done so over the years. With any increase, there needs to be a commensurate increase in the workforce required to do that. That should be the same for nursing as it would be for any discipline.

Also, on the point about seniority, sometimes we hear that it is about putting senior doctors on at weekends. We also have an issue about senior nurses at weekends because of the banding issue with nurses. You find that trusts put on band 5s, the most junior nurses in our wards, to staff wards because it is cheaper. We need senior staff, properly remunerated, seven days a week. We also agree with it being rolled out for other professions, but not at the expense of nurses through trying to take away unsocial hours payments from nursing to pay for others to do it. We would find that totally and utterly unacceptable. However, as a principle we are absolutely signed up to it.

Mrs Cameron: Are the incentives for unsociable hours an additional payment, or is that built into the working —

Mr Martin: There is an additional rate for Saturday, Sunday, bank holidays and night work, but that is part of the Agenda for Change contractual terms and conditions.

Mrs Cameron: You are saying that there is an issue with the bands of the nurses that are there at the weekends, when there are also fewer doctors?

Mr Martin: Yes. Most of our wards and departments are staffed with band 5s. They are the most senior people on at weekends in most of our hospitals. We may have one or two band 7s covering a whole hospital.

Ms Hughes: Midwifery is slightly different. Most midwifes are on a band 6, which is a slightly higher band, and it reflects the fact that they are required to work anywhere and everywhere. If you are working in a maternity hospital in a ward with women who have already had their babies, and the labour ward gets busy, they just lift the phone and say "We need you in the labour ward." If you are working in the labour ward and the admissions unit gets busy, they will ring you and say "You need to come down here." They work very flexibly. In fact, if you are working in the community and the labour ward gets busy, you could get a call to come in from the community and work in the labour ward. There is, as I say, a cost to that level of flexibility, and it is about maintaining the goodwill of the staff and recognising the hours and the effort that they put in, especially out of hours, between eight at night and eight in the morning and Saturdays and Sundays.

Mrs Cameron: I suppose that is of vital importance with midwifery because no amount of planning will decide when the baby is going to arrive.

Ms Hughes: No; no amount at all. They come when they are ready, and that is it.

The Chairperson (Ms Maeve McLaughlin): On the point about banding, I note from your paper that the highest percentage of headcount is band 5 across all of the trusts. In the Western Trust, there are no band 6 nurses at all.

Mr Martin: Although there is a higher percentage of band 7s, which we welcome. Some of the trusts have banded district nurses as band 6 who effectively should be band 7s, in our view. There is a discrepancy or an inconsistency around that in the different organisations.

The Chairperson (Ms Maeve McLaughlin): I just picked up on that and wanted to raise it with you.

Mr McGimpsey: Thank you for the presentations. As Kieran has said, we had a couple of presentations last week that were fairly sobering and I have to say, as we look to the future, that your presentations have been equally sobering. Can I begin with the midwives? I know you will correct me if I am wrong, but my memory tells me that your standard used to be 26 babies per midwife. Is that right?

Ms Hughes: It is about 28; one midwife to every 28 babies.

Mr McGimpsey: And that allows you one-to-one in the labour ward.

Ms Hughes: It does.

Mr McGimpsey: Has that standard been maintained?

Ms Hughes: Yes, but it has been maintained at a cost. In order to ensure that every single woman in labour has a midwife with her, the women who have newly delivered are basically seen as the Cinderella service. If you have 20 women and 22 or 23 babies on a postnatal ward — bearing in mind that there are quite often twins in hospital — and you start the day with three midwives and a maternity support worker, you could end the day with one midwife and a maternity support worker, because your other two midwives have been called away to the labour ward to meet that standard of one-to-one care for every woman in labour. That is absolutely crucial, and that is the critical point where that care is needed, but that means that you have 22 mothers and their babies who are being cared for by one midwife and a maternity support worker, and that is not good. For example, we are trying to increase our breastfeeding rates, and women need support. Also, a lot of those women will have been delivered by a caesarean section, and they need the normal post-operative care that anybody needs. The pressure is just shifted somewhere else. Yes, we do still have one-to-one care for women in labour, and we are very proud of that here in Northern Ireland, but the pressure is just being shifted elsewhere.

Mr McGimpsey: You mentioned Downpatrick and Lagan Valley, and there was a concern that a stand-alone outside an obstetrician-led would not be as popular. Has the demand that we anticipated for Lagan Valley and Downpatrick been there, as opposed to Craigavon where you have the obstetrician-led on site?

Ms Hughes: The demand has plateaued in both Downpatrick and Lagan Valley. About 200 to 300 women a year go to Lagan Valley who otherwise would be forced to travel to Belfast. There are only 80 or 100 women a year who go to Downpatrick but, again, that is 80 or 100 women who then do not have to travel to Belfast. They are staffed in different ways. Lagan Valley has a midwife on site 24 hours a day, and during the night there is a midwife and one maternity support worker; that is it. Downpatrick does not have anybody on site at night. It has a midwife there until 8.00 pm and, if a woman rings to say that she is in labour, the midwife who is sitting at home on her £12-a-night rate will come in and meet the woman and deliver her in the unit. The costs of maintaining the service are minimal, because those midwives would be there anyway to provide the antenatal care during pregnancy and postnatal care to women who have already had their babies. If I said to you that 17 whole-time equivalents cover an area that goes from Kilkeel to Carryduff and from Ardglass to Castlewellan, and the 17 whole-time equivalent midwives provide antenatal care to every woman in that area — even if she is not going to deliver in that area, they see her during her pregnancy and when she comes home with her baby — and they deliver the women in both Downpatrick and Lagan Valley as well, you can see the extent of the flexibility of the service that they provide there.

Mr McGimpsey: OK. Thank you for that.

So the workforce is around 1,300. Is there a sense that that is roughly adequate, or do you need more? Also, how do you maintain that workforce when about 25% are liable to retire within the next five years and it takes three years to train through a dedicated degree course, or 18 months with RCN registration, to train? You also have to bear in mind that, when you take that course, you are depleting the nursing workforce. Clearly, you need to be in the planning; that is a given, both for RCN and for midwives. Do you have a sense of what your recruitment needs to be as opposed to where it is now? You work out what the problem is, and after that you work out how you address the problem.

Ms Hughes: At the moment, we think that, by and large, midwives are in the right place doing the right things, because that is important too. They should not be doing clerical jobs; they should not be portering; they should not be stocking up supplies. There are other people who are employed to do that, or should be employed to do that, to free up the midwife to do midwifery. We think that we have just about the right numbers at the minute, and we think that they are mostly doing the right things in the right places. The worry is about the future, and we watch it like a hawk. We meet the Chief Nursing Officer once a year as a nursing and midwifery group to look at education commissioning for the next year. In between times, we also meet the midwifery adviser at the Department of Health and we try to work with the heads of service out there. Every so often we ask them how many of their staff are planning to retire in the next year, so we try to keep ourselves a year ahead, but your point about the length of time that it takes to fill gaps is well made.

We had a situation some years ago in Craigavon where there was not a single unemployed midwife in all of Northern Ireland. They had a domino effect and lots of people retired, and they were left with a huge gap. They had to recruit midwives through an agency from Glasgow for a week at a time, fly them over, give them accommodation and a week's work at agency rates and then fly them back to Glasgow. At that time — I think perhaps you were the Minister at that time — extra money was given to Craigavon and we pushed 12 nurses — sorry, Garrett; we stole them from nursing — through the 18-month education programme to get them trained as quickly as we could, because, although Northern Ireland is an attractive place for people to come and do agency work, it is not all that attractive to people from elsewhere in the UK to come and settle permanently, certainly for midwifery. I am not too sure about nursing. The traffic all seems to be one way the other way.

We have developed the three-year midwifery training programme, which is the route into midwifery for most midwives because it is shorter than doing three years of nursing and then 18 months on top of it, but we also have the 18-month programme so that, if push comes to shove and we need midwives in a hurry, we can rob our nursing colleagues and get them through Queen's that bit quicker.

Mr McGimpsey: OK; thanks for that. As far as nursing is concerned, last week we heard GPs saying that the practice nurse workforce was severely stretched. As they keep getting more and more things to do they need more and more practice nurses, and they are not available. We got that message. We are also getting the message here about TYC and community nursing, and how difficult that is. In fact, TYC has basically stopped, not least because of that difficulty. The nursing workforce is, what, 16,000?

Mr Martin: Roughly, yes.

Mr McGimpsey: In the system. We have heard about nursing staffing levels in wards being at unsafe levels, and that is the main bulk of the workforce. So, effectively we are looking at unsafe levels in places. We cannot ignore that or put our heads in the sand about that, because patients will come to harm. We also have the problems with practice nurses and a problem in community nursing. You say that you are not in the workforce planning group, and it is a given that you should be in there. Do you have a sense of how many nurses we need to recruit, bearing in mind that we offer brilliant degrees for our nurses? I am aware of how attractive they are for the big hospitals in the south-east and other places overseas, and just how keen they are to recruit our nurses because they are so good.

Where do we need to be? If you work out how many nurses you need to recruit each year then it is a simple sum to work out where the money needs to be. My view is that we are in an emergency situation and we need an emergency plan with an emergency fund. It is trying to put all of that together. Where do you think we are? We have roughly 16,000 at the minute, but you have told us here about community, and we know about practice. Putting all of that in the mix, I know that you will have a rough idea.

Mr Martin: I honestly cannot put a figure on it. I am not sure if you can, Rita. I think it would be unfair to even take a guess, to be honest. It is about rolling out the programme for normative staffing and seeing where the deficits and gaps are, but it is also about the future planning. As we have pointed out and indicated in our paper, one of the areas that is neglected here is in the independent and care home sector, where older people are —

Mr McGimpsey: I was setting that to one side, because that is not directly —

Mr Martin: I do not think we can ignore that.

Mr McGimpsey: No, I understand that, but —

Mr Martin: If we do, then we are draining that sector. It is certainly something that needs to be done sooner rather than later. In relation to the community, and also mental health and learning disabilities — sometimes they are areas that are forgotten about — they are areas that require careful plans.

Mr McGimpsey: You say you need more students, and I agree with you, but roughly how many more? Do we have the capacity within the universities to train them? Where are those numbers? Where have they been over the last few years? Are they going down or up?

Mr Martin: They are going down; as we said, the number has been reduced by 9%. The issue of university capacity could be addressed if they were commissioned to take, for example, another 10%. I am sure that they could deal with that but, once again, that is a funding issue and a decision needs to be made by the commissioners and by the Department, which commissions this, to puts the funds to it.

Mr McGimpsey: Absolutely. The 10,000 beds in the independent sector is a stand-alone, but they are heavily dependent on income from the Department, is that right?

Mr Martin: Absolutely.

Mr McGimpsey: A tariff per patient.

Mr Martin: Yes.

Mr McGimpsey: They would say that that tariff per patient has hardly moved in a number of years, so they are finding it very difficult to pay the rates for nurses.

Ms Devlin: Also, patients in the independent sector are much more complex than they were when the tariff was set. A lot of those patients who are being nursed in the independent sector would previously have been nursed in acute medical wards. We did a lot of work with the independent sector home managers, who would say now that it is extremely difficult to give those patients the care that they require, with the complexities that they have and their complex nursing needs. They are not personal care needs; they are nursing needs. They are struggling, with the numbers of nurses that they have,

to give the quality of care that we would expect for older, vulnerable people and also the quality of care that RQIA is inspecting them against.

There are huge issues in that sector around being able to recruit and retain good, high-quality nurses. I spoke to an independent nursing home manager who told me that all seven of her registered nurses were from different countries; they had seven different first languages. You can imagine what that means for older people's cultural needs being met. That is a huge issue. You can imagine trying to develop a team and a vision for your service with seven people for whom English is not their first language and who are trained in totally different ways. That sector has become so reliant particularly on nurses from Europe, because they have the ability to walk in and out of jobs. That brings up huge issues for our older, more vulnerable people. If we do not look at workforce planning for nursing as a whole, our older people will be left to be looked after by people who do not understand their cultural needs.

Mr McGimpsey: Ten thousand beds is a huge population of frail elderly people with, as you say, complex needs. One of the things that community nurses are supposed to deliver is nutrition, and there was a nutrition policy. Where are we with that around ensuring that care in the community through our community nurses?

Ms Devlin: The nutrition strategy is actually a regional strategy across all the professions. It said that all patients, if they are connected in any way with the health service, should have a nutritional assessment. That includes older people who are attending GPs. It uses the malnutrition universal screening tool (MUST). That is not specifically the role of the district nurse; it applies to whatever profession the key worker for that person is.

Mr McGimpsey: Where is that policy?

Ms Devlin: It has been accepted and it is being rolled out. However, again, it is down to whether the resources are available to implement it if a patient is being looked after in their own home and they see a district nurse. In that case, they should do the MUST, but if they are being looked after, for example, by a domiciliary care worker, I cannot guarantee that it is done. The same applies if they are seeing their GP; I do not know whether the GPs have taken it on.

Mr McCarthy: The meals on wheels service has been greatly reduced over a number of years because of different things, which should not be the case.

Ms Devlin: We know that 42% of people who come into hospital come in malnourished, and we know that that has a huge impact on our older people. The nutrition policy was to prevent —

Mr McGimpsey: It is not just meals on wheels; it is diet supplements and so on —

Ms Devlin: It is an acknowledgement of the importance of nutrition for older people.The plan of that policy was to prevent malnutrition, because malnutrition leads people into hospital. I am not 100% sure where we are with the implementation of it, but I know it is across the piece regionally, and it is across all professions.

Mr McGimpsey: Thanks for that, and the best of luck. We will take very much on board what you have told us.

Mr G Robinson: I thank the team for the presentation. I have a question for Breedagh. One of the terms of reference for the review is to examine the extent to which workforce planning takes account of gender mix and the associated work patterns. The majority of the nursing and midwifery workforce is female. Are current approaches taking that into account in respect of part-time contracts or planning for maternity leaves?

Ms Hughes: This is a huge issue for us. There are about 1,300 midwives in Northern Ireland, only two of whom are men. In the region of 70% work part-time. From a trade union point of view, I can say that it is great. We have flexible working across the system, and women are able to achieve some sort of a work/life balance. However, having a service that is 70% part-time brings challenges for somebody who is trying to manage it. If you take the 65 midwives who are pregnant at any given time out of that 1,300 and add sickness absence rates, which vary across trusts from 4% to 8%, you will see that making the number of staff go round is a bit of a stretch.

As I said earlier, we are highly reliant on bank staff to fill the gaps. You will find that a lot of the midwives who work very part-time, less than half the week, will also be on the bank. That means that although they have chosen to work 18 and three quarter hours, for instance, to get a work/life balance, they could be working 35 hours, 36 hours or 37 hours in any given week. This causes stresses on women who have made a conscious decision to try to balance their work life and home life, bearing in mind that at one end of the spectrum they are having babies and at the other end, the over-55s are likely to have caring responsibilities. Making a conscious decision to reduce your working hours, which then gets negated by the need to be at work to cover for somebody else who is off sick, on maternity leave or has been bereaved or whatever or even to cope with an unexpected surge in demand, brings its challenges in managing a service.

I will give credit where credit is due: the HSC is one of those services in which it is possible to work quite flexibly. I am not sure about nursing, but, certainly, in midwifery, there is a high degree of ability to say, "I've been left widowed, or separated. It suits me to work night duty. Can you put me on night duty for six months?" By and large, the service will accommodate that. Or, people will say, "Can you put me on to work all weekends? Then my husband can take care of the children". We can do that as well. So, it makes it a very attractive employer from that point of view.

By and large, over the years, with a lot of cooperation from the trade unions, the health service has moved to this point where it is a very attractive employer for a woman who is trying to balance her work and life. It is also a way of recognising all the investment. We have just heard chat about how long it takes to train as a nurse or a midwife, how much money is invested in that and then developing those skills and experience. It would be a very stupid policy if you were to lose all of that just because you cannot be flexible and accommodate somebody's request to work specific hours.

Mr G Robinson: I have a small supplementary question to one of you in relation to the nurse subscribing situation. Do you think there is enough flexibility for —

Mr Martin: Do you mean nurse prescribing, which is nurses as prescribers? By flexibility do you mean —

Mr G Robinson: When they are training or at university, and so forth, they are maybe being asked to carry on their ordinary job as well.

Mr Martin: Yes, I was an independent nurse prescriber in my clinical practice. It is a recordable qualification within the NMC. It is a one-year part-time programme. It is probably the most demanding academic programme that I ever undertook, and the reward from it is that it allows practitioners to take on roles in relation to prescribing medication that previously would have been carried out by medical staff.

The more support that can be given to individuals undertaking that programme the better. I think that, sometimes, there is an issue about how those individuals are then allowed to practice when they go back into their workplace in that some employers may not have roles for them or may not remunerate them to the level that they should be remunerated to for having undergone such a difficult programme and been successful in getting the qualification. Sometimes, we believe that they are underused in the clinical area, but they must be properly remunerated and facilitated whilst doing the programme and when they have the qualification to be able to practice at that level. It benefits patients. It allows the service to be able to be developed in a way that can free up medical staff to do other things and to provide more timely access for patients to certain services.

Mr G Robinson: When they are doing it, do you think that there is enough flexibility from their bosses?

Mr Martin: I am not sure what you mean by flexibility. Nurse prescribers can come from lots of different areas. It could be somebody who works in an emergency department, or it could be a nurse specialist who works with patients with diabetes. There is a whole gamut of areas where nurses who are independent prescribers work. In terms of flexibility, I am honestly not sure —

Mr G Robinson: They are doing that training and trying to do their own work as well. Are the trusts allowing them enough flexibility?

Mr Martin: I have not heard of anybody coming to us to say that they are not being supported by the employer. I think that the difficulty is that, academically, it is a very difficult programme to do. The more support that can be given the better.

Mr McKinney: I have just one point. A lot of issues have been covered very comprehensively, and thank you very much for your contribution this afternoon. A buzz term in the health service is around the need for innovation. What do you understand innovation to be in that context? Are there other innovations, either through workforce practices or technology, that you would like to see that would assist in your work?

Ms Hughes: I suppose that from the midwifery perspective we can say that innovations are largely led by women, because women will come along and say what it is that they want. The challenge is thrown up to us to develop a service that meets those needs. This has certainly been our biggest driver over the last number of years.

From a trade union perspective, I suppose that innovations are about learning from good practice in other places. If you have a recruitment or retention problem, somebody else will surely have had the same problem. What did they do to tackle it, and can we replicate good practices from anywhere else? I think that this is where we miss the partnership forum so much. Previously, we could have sat down with a group of employers, departmental officials and the trade unions and bounced ideas off one another if we had a particular issue. We did one about tackling violence in the workplace, which was very successful, and we did it in partnership, learned from others and then put that into practice. That was definitely a brilliant innovation.

Ms Devlin: As nurses, we are always innovators because you learn to be a problem solver from the very beginning of your career. Where you see a problem, you identify a solution and you fix it. By their nature, nurses and midwives are innovators. It is very difficult to innovate if you do not teach people the skills of how to get the idea into a change-management programme and into practice. There are skills that can help you to do that. We are back to the whole idea that there are programmes that would help nurses, midwives, doctors or whoever to take a creative solution and bring it forward into practice. However, that again requires skill, education and somebody to get the time out to go and learn how to do it. Those are the bits that are missing.

There are lots of really good ideas out there, but nurses will say, "I do not know how to get my idea into practice". First, nobody asks them. What we would say is that, if you want to know what will work, you should ask the people who work on the front line because they can tell you. They have lots of ideas, but nobody ever asks them. What happens is that somebody else who does not know or understand the service implements a solution that does not work. Nurses and midwives will say, "I do not know why they did that because it is not going to work, and we could have told them that from the beginning".

One the one hand, we are asked to innovate, but nobody asks the questions. We could tell them very clearly. There are also skills that you require to be able to get your idea into practice. We are back to the idea of post-registration education not being commissioned to bring the innovations into practice. I would say that innovations are done to us and not with us. They are done to us, and they do not work.

Mr Martin: We tend to see the culture that we are working in as being very risk averse, and rightly so. Health care is never going to be risk free. There is always going to be an element of risk with it. Sometimes true innovation requires an element of risk-taking, albeit managed. It is all about a culture of leadership in which those innovators can flourish. The Royal College of Nursing is not found wanting in identifying those. Through our Nurse of the Year programme every year, we identify numerous nurses who are working way above the call of duty with innovative solutions.

The frustrating thing we find is that the pieces of work that innovators do are not replicated. Commissioners, or even employers, do not take them forward and roll them out further. We have numerous examples of where there is fantastic work being done in a particular area, but it does not seem to be replicated, for whatever reason. We are asking commissioners and employers to really take on board some of these innovations and start rolling them out as core business and not just being a case of "This is something innovative". A lot of them show real benefits in not just patient outcomes, which of course is what is ultimately important, but cost-effectiveness. They have real efficiencies associated with them and are the things that innovation is all about.

The Chairperson (Ms Maeve McLaughlin): I want clarity on two points before we conclude. One of the terms of reference for our piece of work is the proposed shift left of the £83 million from hospital services to community services and whether that had been modelled and planned for. In the College of Nursing briefing paper, you indicate that progress is very slow. You point out that numbers in community nursing had declined over the last number of years. You may have answered this question but I want to ask it directly: are you aware whether the regional planning working group is even looking at that as an issue?

Mr Martin: I believe that it is looking at that, but I am not aware of the detail.

The Chairperson (Ms Maeve McLaughlin): You referenced the normative staffing work and indicated that that needs to be an action going forward in the next phases. Nursing in community settings is phase 3, behind nursing in acute medical settings and nursing in emergency departments. Put bluntly, is that an example of the Department failing to prioritise community nursing?

Ms Devlin: I sit on the steering group and, to be fair to everybody, the reason it is in phase 3 is because we struggle to know how to do it. We struggle to know how to identify the numbers of district nurses that are needed. Every trust has a different model. Some are called community nurses, others are called acute hospital at home or complex needs case management. There is a different model in every trust, and it was very difficult for us. There is no model that we can look at either in England, Scotland or Wales and say that it is one that we could take forward. Within that work group we have had to almost try to design our own tools to find out how many we need. It is not that the will is not there. It is a difficult service to model against. It used to be a case of one district nurse per numbers of population, but that does not work.

Mr Martin: I will make one additional point. A lot of the information that medical and surgical staffing levels are based on is based on empirical research. There is a much bigger and wider empirical evidence base — publications in 'The Lancet', RN4CAST and European and worldwide research — that links the number of nurses and staffing to patient mortality and morbidity. That is what it is based on; it is empirical research. Unfortunately, there is a deficit in research in terms of community and district nursing services, so it is more difficult to have a framework that can do that. That is why it is probably a little bit down the line.

Mr McKinney: Does that not get right to the heart of this? It links back to Michael's question: if we do not know, how do we provide? If we do not know and do not provide then people are not going through the front door of primary care; they are going straight from home into A&E, malnourished or whatever. For me, this work has to be at the core of it. I am frustrated that, three and a half years after TYC, they are only thinking about maybe doing something about it now

Ms Devlin: To be fair, they have been looking at it. A lot of work is being done by the PHA and the chief nurse in the Department to gather up the information we need. I think that we are nearly there with a model to look at staffing levels in district nursing services, but, again, we have to think about the other models that hang on district nursing and what they look like as well.

Mr McKinney: Yes, and some of that work is only starting to be scoped out.

The Chairperson (Ms Maeve McLaughlin): OK. Thank you all for your attendance, detail and honesty. Obviously, collectively as members, we share the urgency of addressing workforce planning adequately in relation to the delivery of the policy shift and have individually reflected concerns around the delay in processes to do that. We will certainly take on board the recommendations you have made around the normative staffing processes, the pre-registration issues and, indeed, participation in the regional workforce planning group and will reflect on all of that. We will make our own recommendations to the Department. Thank you for your attendance.

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Workforce Planning in the Context of Transforming Your Care: ICTU, NIPSA and UNISON

29 April 2015

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Workforce Planning in the Context of Transforming Your Care:
ICTU, NIPSA and UNISON

29 April 2015

Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Ms Paula Bradley (Deputy Chairperson)
Mrs Pam Cameron
Mrs Jo-Anne Dobson
Mr Paul Givan
Mr Kieran McCarthy
Ms Rosaleen McCorley
Mr Michael McGimpsey
Mr Fearghal McKinney
Mr George Robinson

Witnesses:
Ms Claire Ronald   Irish Congress of Trade Unions
Ms Anne Speed   Irish Congress of Trade Unions
Mr Kevin McCabe   Northern Ireland Public Service Alliance
Mr Jonathan Swallow   UNISON

The Chairperson (Ms Maeve McLaughlin): I welcome Anne Speed, the chair of the Irish Congress of Trade Unions (ICTU) health committee; Claire Ronald, the vice chair of the ICTU health committee, Jonathan Swallow, a UNISON consultant; and Kevin McCabe, the assistant secretary of the Northern Ireland Public Service Alliance (NIPSA). Kevin McAdam could not attend today. We invite you to make your opening statement, after which we will open up to members' questions and comments.

Ms Anne Speed (Irish Congress of Trade Unions): I am Anne Speed from UNISON, but I represent all the affiliates to the Irish Congress of Trade Unions. Good afternoon, everybody, and thank you for the opportunity to give this presentation. First, I will make an opening comment, which is meant with respect to the Committee. We represent between 225,000 and 250,000 people. We are very pleased to be here. We note that the sequence of invitations always seems to start with the medical profession and those who might consider themselves to be the elite. I would like to remind the Committee that, in our own ranks, we have professional and nursing staff, because I notice that the royal colleges, as they are called, were invited separately. We have thousands of members across our organisations in the nursing profession. In the future, perhaps we might be the first in the door, as we represent not only those who work in the service but the users of the service, and our membership and their families have a huge interest in what is happening to the health service.

Secondly, the Irish Congress of Trade Unions has trade unions affiliated to it. Today, I will make observations from a broad strategic or policy approach, but we would like to remind you that, when

UNISON, Unite, NIPSA or the Chartered Society of Physiotherapy (CSP) are mentioned, we have our membership in our affiliates inside the bargaining structures. My colleague Claire represents all the allied health professionals (AHP) in the bargaining body. I represent UNISON in the bargaining body. I remind you of that, because I think that people sometimes get confused and look at NIC-ICTU as being equivalent to UNISON. It is not; it houses all the unions, and we are all part of the general trade union movement.

We have serious concerns about the process for the workforce planning developments to date. Some two years ago, we raised the issue of workforce planning and were advised by the Department of Health, Social Services and Public Safety (DHSSPS) that the only workforce planning taking place was as part of Transforming Your Care (TYC). We were then informed a little later that there was an initiative at departmental level to do with workforce planning structure that would address the tools required for workforce planning and that there was no space or opportunity for us to be involved. We were advised that it was not relevant to us. We have arrived at a point at which a workforce planning structure has been established: the regional workforce planning group (RWPG). We have not been invited. We have had sight of some paperwork. There was a consultation document in September, and we had sight of the evidence presented to you in March this year, but we have not been invited in.

What concerns us in the documentation is that the Department seems to have adopted the conclusion, or certainly a perspective, that we should engage at stakeholder level. We believe that workforce planning requires more engagement than that: we need to be involved as partners. Regrettably, we are dealing with the reality that the Minister — we believe on advice from the Department — closed down the partnership forum. We were not consulted; we were simply told that it was not happening and that anything we had to say could be said in public consultations and in the bargaining forum. The bargaining forum deals with agreements to be made, implemented and overseen. The strategic partnership forum is about vision and planning the future. It is a commitment to that, and we expect to be in there as equal partners. We have not been.

In the Department's evidence to the Committee in March, it said that it is responsible for setting the strategic vision — I refer directly to the report — and that, as far as it is concerned, we have no role in the collapsed partnership. The commissioning body and the Public Health Agency (PHA) say that their role is to agree the models of service delivery. We are now faced with review upon review upon review in which we have not been involved as equal partners, although we may have been invited to engage in conversations. In domiciliary care, I think that there are at least four reviews. The trusts are responsible for ensuring that they have an appropriate and skilled workforce to deliver workforce planning. We have had some involvement across the trusts — it would be wrong to deny that — but it has been slow off the mark, is still in the early stages in some of the trusts, the local involvement at this stage leaves a lot to be desired, and it seems to be entirely connected to the TYC strategy, which is a narrower framework than we think possible or necessary.

As far as we are concerned, workforce planning should start from the needs of the service as a whole, the delivery to patients and the journey that they take rather than amount simply to a strategic approach, for example, to shift left, moving from acute delivery to community delivery, with all that that involves. TYC itself has come under serious review and, certainly for us — maybe even for you — has lost a lot of credibility. I hand over now to my colleague Claire Ronald, who is vice chair of the committee.

Ms Claire Ronald (Irish Congress of Trade Unions): I represent some of the smaller professions in the bargaining forum. One of the problems that we have with workforce planning and with not being involved at the earliest stages is that it is done in silos. Instead of thinking of the patient pathway or journey, we look at workforce planning for GPs, medics and nurses. You took evidence from the British Medical Association (BMA) and the Royal College of General Practitioners, and they were obviously picking up on the crisis in GPs, yet one of the solutions to that crisis is to look outside of GPs. At the moment, about 20% of GP referrals and workload are musculoskeletal conditions, yet the pilot for self-referral for physiotherapy was postponed under TYC and is starting only now, and it is starting as a pilot to evaluate it, when we know that it delivers. We know that it delivers cost savings; we have evidence from Scotland and from the areas in England that have made the change that show that it delivers, but we do not have that joined-up workforce planning. We are planning in silos, and, when you plan in silos, the answer is always going to be that you need more of that profession and are not going to think outside the box. If you truly want to transform delivery, you need to look slightly differently at how you plan your workforce. If, as trade unions and professional bodies, we are not in at the highest level, we cannot influence the decisions that are made.

Ms Speed: I call on Jonathan Swallow from UNISON to present.

Mr Jonathan Swallow (UNISON): I will simply highlight some key elements of the evidence that UNISON has submitted that are relevant to your inquiry. We have pointed to the interesting current context, whereby reshuffles in the Health and Social Care Board (HSCB) seem to slow down the delivery of TYC fundamentally. We have also highlighted the latest figures that show that the shift left in the trusts appears to be blocked. Moreover, new investment of £9 million will hardly buy very much innovation or change. Going back to your discussion on GP numbers, we were amazed to discover that HSCB records do not show the number of GPs and related staff per practice funded. That was admitted by officers at the board. Clearly, planning is difficult in that environment. As indicated, we have highlighted the different reviews of domiciliary care. UNISON is involved in the HSCB review, but we have no involvement in the current workforce planning initiatives and nor do any of the unions.

In answer to the questions you put to us in your invitation, we were particularly disturbed to see that the target in last year's ministerial direction for district and community nursing normative staffing no longer exists in the latest direction. It is also very concerning that a number of targets have now been slackened off, making any performance comparison between this year and last year fundamentally misleading, given that, in just one example, 80% of people and now 65% have to wait 15 to 18 weeks.

I move now to confidence in workforce planning. We remain very disturbed by the statement in the original proposal for integrated care partnerships (ICPs) that there be an evaluation, including conversion of the entire pathway to a social enterprise. That does not create an environment of confidence. Members have asked us whether they are at risk by participating in such a process. That question should not have to be asked.

You quoted the −3% staffing figure. We support the PHA view that the growth in demand is exponential and that, therefore, that figure cannot be credible. In particular, I highlight mental health and the King's Fund analysis that shows 50% underfunding. The latest figures that we have seen show a 25% higher presentation rate than in England. With figures like that, the original quoted cost of −3% in staffing numbers cannot be achieved. The best you can do is to try to contain growth.

As far as your specific question on learning disabilities is concerned, UNISON is actively engaged in a complex, tough workforce planning exercise at facilities such as Muckamore, and we continue to support unconditionally the principle of resettlement. We have absolute unconditional support for that correct concept. We have to deal at workforce level with the consequences.

I move now to day centres. We are looking to take the language of TYC and reinstate the real meaning of "hub" and "spoke" in which the day centre becomes the leading light — the leading source — of care in an area rather than being marginalised and downgraded. That also has major workforce planning issues. Thank you, Chair.

Ms Speed: Finally, Kevin McCabe from NIPSA will address what is happening with social workers and administrative workers, in particular, in the system.

Mr Kevin McCabe (Northern Ireland Public Service Alliance): NIPSA represents various grades and disciplines. I will start with social workers. We want to ensure that there are sufficient numbers of social workers to meet the requirements set out in the 10-year social work strategy, which was launched by Minister Poots. There has been evidence of improved work processes, multidisciplinary working and integrated working across the service, but we think that it is important that proper analysis is carried out on the strategy, which deals with flexible working and 24/7 working. The number of student placements and demand and supply need to be analysed to match the needs of the workforce with the aspirations in the strategy.

The second area relates to admin and clerical staff. They number 3,500 in the Belfast Health and Social Care Trust alone, but it has always been our view that such staff should be considered front-line staff, because we are very clear that, in their absence, clinics would not operate, consultants would not be able to carry out their duties, and, if not properly resourced, there would be a systemic failure in a range of services. There is evidence that shows that they have been crippled by vacancy controls. We ask the Committee to give consideration to my comments that they are the unsung heroes in many ways because of the support that they provide to clinicians and to keeping the service afloat.

Finally, I turn to the social care workforce, from which NIPSA and sister unions have members. We believe that they are being targeted by privatisation and value-for-money audits, which are the twin themes of procurement and privatisation in the 'Vision to Action' TYC consultation document. We have seen reports from the Regulation and Quality Improvement Authority (RQIA) and others, and it is

our view that, where work is being outsourced, it has led to a decline in standards. In some areas, we have seen award-winning, quality-assured professionals replaced by less skilled, less qualified or less experienced staff. That needs to be given due consideration.

The Chairperson (Ms Maeve McLaughlin): Thank you all. There is an increasing sense that TYC is being questioned as a viable strategy. It is called a "vision without action". I certainly have my own views that it was the right policy direction but that it was not validated by any strategic evaluation of investment or an outcome framework for health inequalities. Is it dead or, if it is dying, can it be resuscitated?

Ms Speed: Jonathan, would you like to answer that?

Mr Swallow: I think that it will go through a three- to six-month hiatus, with an internal restructuring of roles in the HSCB. A better look is needed at what the funding has achieved. In particular, I highlight my note on the proposal to produce an update on the original 99 proposals, which could be of great interest to the Committee. I think that the funding environment is now at the cusp of risk to patient safety. The Committee may wish to know that, of the £90 million in cuts that the HSCB demanded of trusts, only £60 million has been taken forward because the remaining £30 million was ruled out by the Public Health Agency as compromising and risking patient safety. We currently have savings plans that rely on the falling price of fuel and the misuse of vacancy control as a low-hanging-fruit saving that compromises performance targets. In that environment, we see the future for the current TYC process as very challenging.

The Chairperson (Ms Maeve McLaughlin): Did you just say that £30 million of those proposed cuts were a risk to patient safety?

Mr Swallow: They were judged by the PHA to compromise or create risk and were, therefore, taken out of the trusts' savings plans. Trusts have put forward £60 million of savings when they were originally asked for £90 million. We found the process very concerning, whereby the situation was so desperate that such proposals had to be brought forward and that the PHA had to say that the trusts should not do it.

The Chairperson (Ms Maeve McLaughlin): That should be of concern to us all when you get an analysis of potential risk.

Mr Swallow: We are seeking the detail of the £30 million that was not taken forward. That has not yet been made available.

Ms Speed: We are seeking the trusts' delivery plans as distinct from their savings plans, post the publication of the commissioning plan by the board. We will have a closer look to see what the practical, on-the-ground implications will be. I think that close scrutiny of those delivery plans should also be the business of the Committee.

The Chairperson (Ms Maeve McLaughlin): We can and should influence that. I am staying with the overall context, because I think that this is the critical part, not only with workforce planning but with Transforming Your Care generally. There seems to be a growing consensus that, at the heart of the problem, the system is flawed in the way that it is currently configured. We see a system that has a lack of clear roles and is overly bureaucratic. There is a lack of transparency. Decisions go in and out through a system, and there does not seem to be a lot of accountability. There is an increasing sense about decision-making processes and good use of public money. As a union representing huge sections of society, is your sense that the system itself, as it is configured, is flawed? If so, what needs to alter to ensure that things like workforce planning can be responded to in terms of need?

Ms Speed: I will ask my colleague Claire to respond to that.

Ms Ronald: I agree with you that, on the ground, we see a flawed system. People do not know how to get into the system. The feeling for us, as trade unions, is that we are being actively excluded from the system, even the regional workforce planning group, despite asking at the earliest opportunity if we could be at the table and involved in those decisions. Suddenly, we are down at stakeholder level and not able to influence to the same extent. When you speak to staff on the ground, many of whom have good ideas, their answer is that they do not know where to take it. Who is accountable? Who do you go to? Is it integrated care partnerships? Is it commissioning groups? As a physio, are you going

through an AHP group? You have so many levels to go through that can reject what you are suggesting. As I said, the self-referral pilot in physio is a classic example. It has been demonstrated that it releases savings elsewhere, but we had to jump through hoops, and it was suddenly withdrawn. The South Eastern Health and Social Care Trust was in the preparation stages and ready to roll it out, and it was suddenly withdrawn. It is no longer in the plan, despite being in the commissioning plan and the DUP manifesto. You feel as though you are running on a treadmill and constantly coming back to the same problems. Things that we highlighted two years ago are now happening. We are back asking about the same things and running on the same treadmill.

The Chairperson (Ms Maeve McLaughlin): In your view, how does commissioning change?

Mr Swallow: Last week, UNISON spoke briefly at the Northern Ireland Confederation for Health and Social Care (NICON) conference. We set out three principles for radical reform: bringing the system back to financial sustainability; ending health inequalities; and raising general performance. We have key principles underlying that, including the end of the commissioning/provider split, which is the legacy of direct rule; single-point leadership and accountability so that somebody has to be responsible; the end of all outsourcing and privatisation; and to go back to previous performance targets, not those sanitised in the latest ministerial direction. I will be happy to arrange for that press release to be circulated to all Committee members.

The Chairperson (Ms Maeve McLaughlin): That would be useful.

Finally, Jonathan, you referred to the 3% reduction in staff that was a component of TYC. It has now been discovered that that was a working assumption. You indicated that you actually need an increase in staffing and the workforce to deliver TYC. Do you have a figure or an estimate for that?

Mr Swallow: Not at this stage. I think that we know that, in every aspect of the service, demand is increasing, so we need to model that increase in demand. I cited the increase in mental health. We have seen the desperate state of statistics for A&E units. We need to move away from the current approach of the Department, which is to state in the commissioning plan that this is what it is doing with the current budget and to go back to the correct approach, which is to model increasing demand and unmet need and then state the answer. We are very concerned about the culture in the Department of simply cutting the coat to fit the cloth rather than looking at unmet need.

Ms Speed: I would like to add two sentences. First, when TYC was first published, we said that the 3% was financial, was not based on an estimate of how the service would change and that there was nothing behind it. We have been proved right. Secondly, in the bargaining structures in which our affiliates are involved, at the last meeting of the regional bargaining body, a proposition for voluntary exit was put on the table. We asked where the analysis was. How does this fit with workforce planning? Where do you think the voluntary exits are going to occur? Until such time as we get proper and coherent analysis of where the service might do without staff — we believe that the service is crying out for staff — we will not entertain that. We insisted that the voluntary exit scheme came off the table. That is the kind of haphazard approach at departmental level, which is filtering right down through the structures. We have a perception of committees and bodies bumping into each other and cross-referencing, with a whole load of people doing the same thing and a whole load of money being spent on it. That is our sense of it.

The Chairperson (Ms Maeve McLaughlin): Finally — I said "finally" the last time; I am going to use my position as Chair — is Scotland moving in the right direction?

Ms Speed: I will ask my colleague. She has a co-location responsibility, so she has experience in the Scottish health service.

Ms Ronald: It is difficult. I have worked as a physio in Scotland, so that is what I knew. In this role, I cover part of Scotland and Northern Ireland. When I first came to Northern Ireland, I assumed that it would be a very similar situation, but I have to say that, four years into the post, I still do not understand clearly where decisions are made. It is constantly changing. One thing that I will say is good in Scotland is the fact that partnership is embedded at the very heart. That can be seen in the number of meetings that we have and the ability to get into the Department and chat to the Department. As soon as groups are set up, the first thing that they do is to write to the staff side and ask who the appropriate person would be to sit on a group from the staff side.

Wales is slightly different from Scotland, but it is interesting that both took a stand against privatisation. A firm stance not to outsource the NHS is still not embedded here. That is the other fear with TYC.

Committee structures and funding in Scotland seem slightly easier to follow. The Minister gives money to the health boards to make appropriate decisions at that level, which are tied into the targets that are being set. It is also about following the money, who decides who gets the money and where the money goes. There seems to be so much short-term funding here. I think that you could learn from Scotland, but you have to be aware that it is a very different structure.

The Chairperson (Ms Maeve McLaughlin): Has Scotland moved back to the traditional NHS cooperative?

Ms Ronald: Yes. It has no purchaser/provider split, and a lot of private care is coming back into the NHS, which is the big move. The Golden Jubilee National Hospital is a prime example. It was a private hospital that was bought back by the NHS. The new South Glasgow University Hospital has just opened. People are nicknaming it the "death star" and all sorts of horrible things, but it is a state-of-the-art hospital that was not funded through a PFI. There are no loans to be paid on it; it is a government-funded building, so there is no outstanding loan to drag us further into debt.

Ms Speed: I think that I am right in saying that the Assembly passed a motion — I think that it was tabled by Conall McDevitt — on privatisation. It stated that, if further strategic decisions were to be made about any of the public sector, there would be a review by the Assembly or the appropriate Committee. I think that it was something like that. I wonder whether that Assembly decision has disappeared, because it should be the mechanism by which you do your business.

Mr McCarthy: Thank you very much for your presentation. I start by acknowledging your comments, Anne. Let me say loud and clear that I have 100% faith in you and your colleagues. You should be at the front in any negotiations to make sure that the people whom you represent get nothing but the best.

I have a number of questions. You mentioned self-referral. My understanding is that it was to have been implemented. We were all excited about it, but, for some reason, it has not been implemented. As far as I know, Chair, we were informed that it was coming back somewhere.

Ms Ronald: A pilot is starting in the South Eastern Trust.

Mr McCarthy: We were as disappointed as you that that has been knocked back for some time.

One of the terms of reference for the Committee's review is to examine the Department's approach to involving staff and staff-side organisations in the workforce planning required to implement Transforming Your Care. I know the answer to this, but I will ask you anyway: how do you assess the Department's approach to date?

Ms Speed: Abysmal. It is completely unengaged with the majority of its workforce, and it is without any clear indicator of what exactly the next steps will be. We note that there is some engagement at trust level, but, because we have not been engaged at the centre, we do not know the framework in which the trusts are approaching the question. I think that, in reality, it is very much focused on the immediate needs of the trusts and maybe dealing with issues like vacancy control rather than strategic overview planning for the medium to long term. Engagement or involvement with us has been non-existent, and we are very critical of that. I repeat this point: why would you close down a partnership forum when such a significant dialogue is starting on workforce planning? It makes absolutely no sense. In our opinion — I will choose my words very carefully because I do not wish to be disrespectful to the Department or its officials — it shows a complete lack of understanding of the distinction between strategic and policy engagement, and actual negotiation and bargaining. That is at best; at worst, it indicates a prejudice that there is no place for us. We are not sure which of those two opinions really holds sway.

Mr McCarthy: Following on from that, last week we had representatives from the nursing people in, and we had the midwives. I —

Ms Speed: Representatives of some of the nursing profession, if I may —

Mr McCarthy: OK. I asked those individuals whether they had any faith in the people who are running the Department. I think that is the question I asked: whether those who are running the Department know what they are doing. Can I presume from your answers so far that you think that they probably do not know what they are doing?

Ms Speed: Well, I would not have a lot of confidence. Individually, the people who work in the Department are probably decent people. They need their employment like everybody else. However, as a coherent arm of the Executive, and for delivery of service, I do not think that it is acting in a coherent manner whatsoever. Then, of course — we do not want to gild the lily — it has had two Ministers leading it, and there is a job of work to be done to ensure that the next Minister who steps forward is there for the long term and gives good guidance to the Department.

Ms Ronald: I just want to come in briefly on the question of whether the people in the Department know what they are doing. Even in their own evidence, they highlighted that they had to have Skills for Health coming over to do training for them on workforce planning. That shows quite a big gap in the Department, if they did not have that skill set and had to build it up. We are now how many years into TYC? They are only now looking at the skills for workforce planning. That is quite frightening.

Ms Speed: I suppose a crude way of saying it is that they are all over the shop.

Mr McCarthy: In a similar vein, is it clear to you who is in charge of workforce planning? Is it the Department? Is it the board? Is it the trusts? Or are they all over the place?

Ms Speed: They all say they are in charge, according to their evidence. Kevin, would you like to answer that?

Mr McCarthy: And could you comment on your confidence in them delivering?

Mr McCabe: We all know that they have discrete functions, but I want to tie my points to the Chair's original proposition. In leadership and outcome, you need to know where the strategic direction is going. Just last week, you were getting mixed messages, which leads to confusion about where we are going and the strategic direction. You have the Health and Social Care Board chief executive saying that it is still the only strategic direction for the Department, but it needs rebranding. We have politicians calling for the scrapping of TYC, and we have heard other politicians calling for a review of TYC. It is a vision and a plan drawn up by people, but it is clear that it was never underpinned by legislation or by any strategic analysis and agreement that that is the way forward. Fundamentally, in all the submissions that were made, no one disagreed that a shift from acute care to community is necessarily a bad a thing, but it needs to be properly resourced. The shambolic outworking of TYC meant that transitional funding had not even been met, let alone the £83 million. You have to join the dots together. If the funding is there and you can move and see the strategic direction, you can then start to look at workforce planning and numbers.

To answer Mr McCarthy's question, at the moment the Department functions separately from the board; it functions separately from the Public Health Agency. Of course there has to be some coordination and working together, but the big hole is the general direction of health care and the question of what is the right model. Scotland is one to look to, but it requires all the stakeholders to come together to reassess or review where we are going because, if the funding is not there, how do we plot the way forward?

Mr McKinney: Can I jump in there, Kieran?

The Chairperson (Ms Maeve McLaughlin): Kieran, is it OK if Fearghal comes in on that?

Mr McCarthy: Yes.

Mr McKinney: Maybe this question is a bit leading. I think that you are right that there are different approaches to the TYC concept. However, TYC was at least on paper; it had been consulted on; it had 99 targets. If it has now morphed into some vague conversation about transformation, is there a danger that we will not have anything to pin the measurements, finance and strategic direction to? Do you, therefore, share the concern that TYC may disappear, perhaps because, as Valerie Watts said last week, it was published in the context of 2011 and things have now changed? I am really asking

whether there is a danger that the construct of TYC, as it was originally, will disappear, and, with it, the strategic direction.

Ms Speed: They tell us that it is mainstreamed and measured. Jonathan, would you like to come in?

Mr Swallow: I would like to see the detail of the statement mainstreamed into general commissioning. That has just been a statement in the last few weeks; there is no detail to unpick from it. I would like to see an end to the Department's sanitisation strategy, including the concealing of performance information and changing of targets. That general approach totally weakens the process. We have to look at how many people are needed to do the work; that is the essence of workforce planning. We now have a statement that normative nurse staffing, including the critical issue of district and community nurses, is now not to be achieved until March 2016. The HSCB report said that we have no investment. Without those issues being resolved, TYC becomes a series of low-funded projects that do not make a visible difference to the critical issues facing health.

Mr McCarthy: I am sure you will agree that the loss of another Health Minister will not help any of us in this cause and the direction that we are travelling in. You mentioned that you were not represented on the regional workforce planning group. Do you believe that will hinder communications between you and the Department and, indeed, the workforce?

Ms Speed: Absolutely. There is a body of people with authority and power in the health service influencing budgets. They are planning the future, and we are not there. Taking into account all the organisations, including the medical people, our own membership — there are 60,000 employed — and all the professional and trade union bodies, we must represent more than 50,000 people. Of that, the affiliates of the congress are the largest block, together with the RCN and RCM. No one is having a conversation with us.

Mr McCarthy: That brings me back to the question of whether those at the top know what they are doing. Surely you should be among the first people to talk to. Last week, the representatives told us that they were not on that group either.

Ms Speed: The RCM and the RCN, yes.

Mr McCarthy: Surely you should be the first people to be brought in, with your hands-on experience of what is going on.

Ms Speed: When you have bureaucratic layers upon layers, there are people employed in those structures who believe that they do know, and they take it upon themselves to make the decisions. There is a load of people who think that they know best, and that is what happens when you have a bureaucracy that is out of control. They believe that they know best, and that is the difficulty. Unless you take the evidence and experience of the people who are actually delivering the service on the ground, how can you evaluate and come up with plans for the future?

Mr McCarthy: Finally, Chair, I have a question for Jonathan. You mentioned Muckamore Abbey, and I have a particular interest in how Muckamore Abbey finishes, as it were. Are you satisfied with how that is going? Obviously, there are still patients or clients in Muckamore. Are they being looked after in the way that they were supposed to be?

Mr Swallow: As far as we can tell, the clinical standards remain good. As I indicated, the principle of resettlement is unconditionally backed by UNISON. Our members are going through quite fundamental change processes because people will not be there. It needs to happen and, as a union, we fully endorse the process. We have seen no issues and had no reports of any failure of clinical standards or care.

Mr McCarthy: I am glad to hear that. I presume that the deadline has gone, because there was a deadline to have that completed. It has not been done. Are you still happy that there is no push to get people out into places where they ought not to be? That is my concern.

Ms Speed: We are keeping a close eye on that.

Mr Swallow: It is proper and professional, but we follow the pace of it because of the workforce planning issues.

Mrs Cameron: Thank you for your presentations. Following on from Kieran's last point, as part of the shift left under TYC, the Department has told us that around £25 million has already been shifted from hospital services to community primary services, specifically in the area of disability and mental health resettlement. We have heard about the patient side of things, but do you have information on what the impact has been on staff?

Ms Speed: I do not have in-depth knowledge to share with you today, but we did get a presentation. We have a structure called the TYC engagement forum, and the directors from the board come and give us a presentation on what is happening. The mental health area is probably the better of all that has happened across the service in attention to dealing with the deficits or change. It is probably one of the better areas but, as we outlined in our presentation, there are still difficulties.

Even though we have asked for it three times, we have not yet seen a breakdown of where the £25 million was spent, how it was spent and where it was applied. When we go into rooms and hear fine presentations delivered by very pleasant people, we look for the detail, because that is what matters. There is no breakdown yet on what has been spent to date. Equally, to slide in another issue, we also asked for a breakdown of the savings that were to be accrued under shared services and the continuing debacle with the payroll issue. That is for another day. We do not have that information either.

There appears to be a lowering of the importance of engagement with the representative bodies, which seems to be percolating through the structures and across all the bureaucratic layers. Everybody is under pressure because of budget deficits. The directive to balance the books went out and everybody is scurrying around doing that, but, in the middle of all of that, we are undertaking important work and consider ourselves to be the guardians of not only our members' interests but the service that our membership — 250,000 of them — receives. It is just not happening. We are not getting that information. I will happily seek further information and send it to you because that is an important figure that we need to deconstruct.

Mr McCabe: To complement what my colleague said, I do not think that there is an issue with mental health because, by and large, the Bamford review was endorsed, but, unfortunately, only some of those recommendations are in TYC. Bamford was universally felt to be the right way forward. Going back to the point that Jonathan made, even within those 99 recommendations under TYC, a lot of the programmes of care were already being implemented. Part of that was already in place in programmes of care and the direction that they believed they had to travel, subject to funding. Again, I note that quite a number of organisations said that Bamford was the way forward. However, it is costly, and you are seeing partial implementation of that.

Mr Swallow: I would like to add, Chair, that the crucial figures will be in the 2015 commissioning plan, which is currently being exchanged in draft between the HSCB and the Department. Its final approval by the HSCB is on 14 May. We will be seeking to make comments during that meeting as to whether it addresses the issues raised by members here about mental health funding, for example. The last three plans have done nothing to address the 50% underfunding and the 25% higher presentation rate. That will be a key element of our scrutiny of that plan.

Mrs Cameron: Would it be wrong to presume that there has not been a big impact on the staff in that area?

Ms Speed: I cannot give you hard evidence today about the impact on staff, because we are trying to gather it. Jonathan made the point about there being underfunding in the first place anyway. I think that there have been some shifts and changes, and some of them have been positive rather than negative. We will get the statistics on the impact on staff for you, but we are still trying to find that out ourselves. Since we are not at the table on workforce planning, we cannot see closely where the detail is, but we will get that for you.

Mrs Cameron: Thank you.

The Chairperson (Ms Maeve McLaughlin): On the impact, if there is a shift from hospital to community care, what does that mean for staff? What does it mean for staff who are not now working

in a hospital setting but in the community? Those issues need to be looked at. It would be useful if you could pick up on that information.

Ms P Bradley: I declare an interest as a member of a union. Thankfully, I am still a member of a union, because in 13 months I may require that union if I am not re-elected and need to have a journey back into the Northern Trust.

Ms Speed: We are delighted to have you with us.

Ms P Bradley: I will stay with it in the meantime; my career break will be over by then.

I want to pick up on a point that Kieran made about unions being present and being part of the discussions. I wholeheartedly agree. When I was elected in 2011, I had just left an acute hospital setting and had become a member of this Committee. I heard briefings from the Department, the heads of trusts and the board, and I remember sitting here many times thinking, "I do not recognise that". I knew that what we were being told did not happen when I worked in Antrim Area Hospital. I was thinking, "That's not right. Where are they getting their information from? How is that information being fed upwards?". Without the likes of you people, who are feeding the information from the ground up —

Ms Speed: You are getting the glossy version.

Ms P Bradley: I am at a loss as to where they got some of the information from, because some of it was totally and completely off the wall. So, yes, I believe that there are many instances — I am not saying all instances — where the unions are most definitely required. I also thank the two members at either end for bringing up social work. When we talk about allied health professionals and other parts of the service, we often forget about social work. I know how much pressure that service was under, even going back to 2011. The Chair brought up the 3% reduction in the workforce: I remember thinking, "How on earth could we have sustained a 3% reduction in that workforce to meet the needs in the community?". It just would not have been able to happen.

I want to go back to what we heard last week from the Royal College of Nursing about the last four years, the reduction in our district and community nursing and how that is absolutely not in line with TYC. We also heard from the BMA, and we heard about the wonderful initiatives that we now have for treating people in their home and providing acute care at home. All those things are fantastic and in line with the TYC. However, Jonathan, you said in your briefing how concerning the reduction in our district and community nursing was. You also mentioned other disciplines in our health service. Have we any evidence to back up the claim that there has been a decline in numbers in the disciplines that we need in our communities to bring Transforming Your Care forward?

Ms Speed: It takes a little bit of time to decipher the published workforce statistics, because the headcount hides the fact that there are bank and agency staff, and there is definitely a decline in the number of permanent employees. There is an increase in people carrying more than one contract. You have heard evidence about the cost of agency working, which is itself a burden. Our experience is that, in every workplace, there will be somebody missing, and those hours will be covered by either bank or agency staff. We do not use overtime except, I think, in the Ambulance Service. Then there is the problem of health workers having to extend their shifts and cover shifts that they should not be covering. There are a lot of practices that, if you took a microscope to, you would say, "Uh-oh, there is a risk factor there."

You probably know that a number of organisations are engaged in industrial action or action short of strike. One action is trying to illustrate where the actual staff shortages are. We have started logging in the extra time that nurses, support workers, catering staff, porters etc are all doing over and above their shifts. We will compile that evidence and bring it before the Committee. It was previously notified in the survey in 2012. I think that 49% of staff work over their time.

Ms P Bradley: I can assure you that, when I worked in Antrim Area Hospital in the social work team, none of us left at five in the evening; that just did not happen. That was when you did your write-ups. I know that. I know the number of hours I worked that I was not paid for and that are done in so many disciplines across the board.

Ms Speed: We are trying to look at the latest figures and deconstruct them. The other thing that we have noticed is that, when we apply for representatives to be released for training — very necessary training to do with health and safety, for example, which the employer is legally obliged to release people for — they cannot be released because of a shortage in a particular ward or workplace. There is a lot of empirical evidence and hard stats. That is the job of work we are undertaking at the moment.

Ms P Bradley: It is important to get those figures across the disciplines, because all of them play such an important part in the complete multidisciplinary way of working.

Ms Speed: Claire wants to add something on AHPs.

Ms Ronald: It is difficult in my profession of physiotherapy to measure and get a handle on the number of posts that are on non-recurring funding, and have been for two or three years. These are services that trusts rely on, such as physiotherapy in A&E, which provides a benefit, but the physios are all on non-recurring funding. Staff are seconded from other posts, which means that we do not know the figures. When it comes to measuring staff, you do not know how many are substantive and how many should be funded. That is a fundamental part of workforce planning. We do not even do workforce counting properly.

Another thing that we are very poor at measuring is unmet need. We have physios working to prioritisations that were drawn up for a flu pandemic. That is what they are working at from Monday to Friday, and now they are asked to look at seven-day services. You cannot take a service that is not functioning over five days, or is functioning at crisis levels, and expect it to do seven. We know that there is a need, but we are not having that strategy discussion about what we stop doing, what we do more of, where we put our limited, finite resources and when non-recurring posts have to become recurring and part of the establishment.

Ms P Bradley: I think that there is another issue, Chair. Kevin will pick up on this. I know that, among social workers and other disciplines, there is an issue with protected workloads with our students and all of that. Quite often, that goes astray and those students, in whatever discipline, are used as part of that model.

Mr McCabe: That is right.

Ms P Bradley: That is unacceptable for the client and, equally, for the worker. It worries me that, sometimes, when we look at figures and numbers, we are not seeing the full truth.

Mr McCabe: Yes, some of those figures are masked.

Ms P Bradley: When we are looking at the figures and how a community, of whatever discipline, has reduced, we need to look at all those differently. There are definitely faults within the system.

Ms Speed: I have to say one thing about that. Again, you could call it silo planning, but, honestly, there is only one area in which I have seen any attempt to manage that. A district nursing officer launched a review with the participation of myself, UNISON, the RCM and the RCN. The deficits in the nursing workforce, particularly in relation to TYC, really came to the fore. She has supported an argument for new post creation and funding. I think that will be pushed through. However, that piece of work seems to be disconnected. Some serious work is being done by Department of Health staff, so I would not like to give a totally negative view of that world. They did some good work, but it exists by itself; it is not connected to the broader process. At least, we do not know whether it is because we are not there. However, there was some planning at that level. Apparently, we have been given a promise that the 200 vacancies of community and district nurses will be filled. Funding is coming through, but we have not had sight of it yet.

Ms P Bradley: They have not given you a time frame on it, I assume.

Ms Speed: No, not that I am aware of.

Mr Swallow: Chair, just to comment on social work, I am very concerned not to see any serious consideration of client ratios in TYC. Last year, I saw the HSCB calling a market-sounding exercise on intensive family support, specifically saying that providers would have a low client ratio. The reaction

of social work trade union members, faced with the current high client ratios that they have now, was not particularly polite. I am pleased to say that HSCB has withdrawn that proposal. However, if we are to do serious planning in an area like social work, we have to focus on reducing the client ratio.

Ms P Bradley: I sometimes think that health professionals — I was going to say "we as health professionals" — need to look at unmet need, and not think of it as a negative, as such, for their profession. It shows the reality and truth. They should register that there is an unmet need because we do not have the staff to meet it. It is not a negative; it is always seen as such, but it is not. It is just telling the truth.

Ms Ronald: There is a tendency for health professionals to put the patient above themselves, and I think that you can see that in the rise in sickness absence levels that often mirror that. Staff are just getting totally burnt out from trying to do everything.

The Chairperson (Ms Maeve McLaughlin): Thank you. I am glad that the Deputy Chair keeps me on my toes: I should have declared an interest as a member of a union as well. *[Laughter.]*

Ms Speed: That is not a negative; it is a positive.

The Chairperson (Ms Maeve McLaughlin): Absolutely. I am a very proud member of a union.

Ms McCorley: Go raibh maith agat, a Chathaoirligh. Thank you very much for your presentation and for coming today. I want to ask about the gender issue. The UNISON paper states that the workforce is substantially female and that there should be no stereotypes relating that fact to part-time work. Can you talk a bit more about that?

Mr Swallow: That is simply a reaction to what we hear as being stereotyped positions, particularly about the increased participation of women in certain professions, including the medical profession. We are concerned about any such direction. The statement is there for us to say, simply, that it is, above all, a female workforce and that we must not think that that can be exploited or manoeuvred in any particular way in the workforce-planning process. A full-time equivalent remains a full-time equivalent.

Ms McCorley: When you say "exploited", what does that mean? If the workforce is regarded as being substantially made up of women, how do you see exploitation happening?

Mr Swallow: The case study that we would first bring out is on the terms and conditions of the totally gendered home-care workforce in the independent and private sector, which, in many cases, is not even achieving the minimum wage. We have just managed our first successful HM Revenue and Customs (HMRC) intervention to get them back pay. They are faced with zero-hours models of contracts as a gendered female workforce, where, for example, they are disciplined if they go to work for somebody else when there is no work for them. Again, we have just won several cases on that: the exclusivity issue. Then there is the isolation and circumstances in which they have to work. Therefore, the contrast between a properly paid and structured in-house home-care service, which has about 40% of the work, and what is happening out there with this workforce that never seems to be included in workforce-planning processes in the private and independent sector is fundamental and seems to rely on gender stereotypes.

Ms McCorley: OK. Do you think that workforce planning at a departmental level takes into account the gender mix of staffing and the associated working patterns?

Mr Swallow: I think that we need to be at the table first. The whole content of the evidence today is not being at the table.

Ms McCorley: Yes. I agree. That is a huge issue. I agree totally that you should be there. This might be obvious, but why do you think that you are excluded from that process?

Ms Speed: I will repeat what I said earlier. It is either a misunderstanding of the importance of having trade unions as partners and not just as people at the end of the line — some distant stakeholder that you talk to three quarters of the way through the process — or there is a prejudicial view, which is that

we are really there only to solve problems rather than to contribute to solutions and be part of planning for the future.

Ms Ronald: Another problem is that, when you are not involved at the very earliest opportunity in making decisions, you tend to get stuck in a pattern of behaviour. We see the problems at the coalface, so we then have to confront them. You get stuck in what is almost a battle, because you are seeing it at the later stage. Therefore, I do not know whether we are perceived by somebody as being the troublemakers. If you are involved at that very earliest opportunity, you do not get to the stage of being in conflict.

Ms McCorley: You avoid it.

Ms Ronald: I think that that is the problem. We have been excluded from the process for so long that we have got into this conflict situation, where we are always seen by the Department as being adversarial. That is not where we want to be. It is where we have to be, because of when we are getting the information.

Ms McCorley: Moreover, people who work at the coalface have their ideas and contributions missed because they are not included in the discussion. Those ideas are so valuable.

Ms Speed: We on the trade union side — this is particularly true of UNISON, Jonathan — have been involved in partnership projects that arose out of a problem being identified, instead of us going into a room and having an argument about keeping the lines drawn, looking at the issue and asking how we can collectively contribute. We have had some good partnership projects; for example, the laundry services in the Southern Trust. That is an example that you might expand on.

Mr Swallow: The laundry was under threat of being tendered out and closure. We turned that around and put in a partnership. We made major improvements in staff welfare and health. We have better production, and we have even had the windows painted so that it is nice and attractive for nursing homes to bring us their laundry. Sometimes, partnership can be as fundamental as that.

The issue that I have difficulty with is this: if I look at the general practice of the Department of Health on equality, it is very poor. For example, a few years ago, under a different Minister, we discovered that its equality unit had screened 200 issues and screened out 200 from any assessment. That was a stunning bureaucratic process.

If members were to look, for example, at the recent departmental consultation on paediatric cardiology, on such a fundamental issue, they would find a tick-box equality model and four lines on human rights. If we are going to pick up on issues such as gender in workforce planning, it is incumbent on all of us, including the Department, to raise our game when practising equality rather than simply seeking to squeeze it out of the issues.

Ms Speed: Over the past seven years, and I have been involved in this field for four of them, the equality officers in each trust appear to have become less important, become less visible and been sidelined. When I first met a group of them four years ago, they had a hands-on engagement with trust delivery and strategic planning in the trust structures. That is not as visible as heretofore, so there are problems. It is like saying, "Sure, women have equality. What do we need to be talking about?" It is that kind of mindset. You need to be ever-focused on equality, because populations, people and practices change. You always need to have the mechanism in place to review and assess, and that has been downgraded.

There is no doubt that trust managements are under pressure to balance the books and to do this and not do that. At the same time, they have obligations based on the foundation and guiding principles of the NHS to make sure that none of this is lost in the mix. That is our general experience.

Ms McCorley: The issue was raised today and before about people doing work beyond the hours for which they are paid. Is there a tendency to see women doing that, or is it the type of work that more women are inclined to do?

Ms Speed: There are more women in the workforce, so, by that very fact, it would be women doing that.

Ms McCorley: Would that be as likely to be the case if there were more men?

Ms Speed: Sure, the world would change if there were more men doing it. *[Laughter.]* Let me tell you this: the living wage would have been well established — this is a personal view — people would not be existing on the minimum wage, and there would be a lot more done. It is in the nature of women who work in the health service, through their commitment, to care. I am not saying that men are not caring human beings, but by our gender we are. We tend to commit and give good measure and show a high level of participation in and commitment to our work.

A few academic exercises and bits of research show that the public sector generally delivers better equality than the private sector on a gender basis, so we would guard our public-sector employment very closely. It is important for women in this part of the world that they continue to work in the public sector, because it gives better support to them, and women give better commitment to the public sector.

Ms McCorley: You expressed concerns about a move towards privatisation. Do you feel that that —

Ms Speed: Let me tell you, as the lead negotiator for trade unions in the bargaining structure, that all trusts have shifted from a predominance of direct delivery — for example, in domiciliary care — to a minority ratio. That is very serious. The drive to continue that is underpinned by the balance-the-books directive from the Department and the trust deficits. The difficulty is that the conditions of the women working in the private home-care sector, as Jonathan said, are 50% of what the women workers have in the health sector. There is no minimum wage and no mileage. You do your 15-minute call and appear 5 miles down the road two minutes later.

The drift towards privatisation is very worrying, and I think that the Assembly, and all political parties, could make a huge contribution to stopping that drift. We could play a leading role here in defending the NHS and making sure that it is not deconstructed in Northern Ireland, no matter what happens elsewhere. Colleagues in Scotland and Wales have a bit of a fight going on as well. It is very serious. That is why I mentioned the decision in the Assembly some time back. You have a mechanism to review it and look at it. Jonathan, do you want to add something?

Mr Swallow: Just a very quick comment. To give an example relevant to the scope of the Committee but outside of health, the Fire Service is now tendering out the jobs of the 50 women who get four hours a week to clean the volunteer fire stations. There are no savings there. It is a bizarre proposal apparently to rationalise cleaning, but nobody appears to have done an equality impact assessment (EQIA) and nobody has looked at impact. Those women will be extraordinarily vulnerable under any privatisation. The HSCB is currently tendering the work of a number of offices outside of trusts, including subcontracted cleaners, and it is taking no steps to ensure proper transfer of information to potential tenderers. Again, we are going to organise those women, because they are in a terribly vulnerable position. If we look at the whole range of contracting, we find subtle ongoing processes of privatisation that affect the most vulnerable in society.

Ms Ronald: There is also fear because we are further removed from the decisions being made. When you see changes happening to services, the fear is that those changes are ultimately setting them up so that somebody can come in and take that portion of the service.

Ms McCorley: Yes, they are being packaged.

Ms Ronald: Yes, the way in which they are being packaged. There are other things coming to the fore that could be causing concerns on that.

Ms Speed: I heard reports just today that something may be happening in medical laboratories. Our colleagues who work in that field shared that news with us today, so we will have to watch that space. No doubt we will bring it to your attention if it comes to the fore.

Mr McGimpsey: Thanks for the presentation. I am sorry that I missed the beginning of it. It was quite sobering. We had something similar from the BMA, the RCN and the RCM, so things are far from easy.

I will talk a wee bit about the structures shortly, but, from my experience, the Department is not there to run the health service. That is not its job. The Department and the civil servants are there doing

their job, which is policy, supporting the Ministers in questions, debates, and so on, and managing the money that flows from the Department of Finance down to the trusts. The key instrument for managing all of that is supposedly the Health and Social Care Board. There is supposed to be a trade union representative on that board. It was Lily Kerr. Who is it now? Is it nobody now?

Mr Swallow: There is no non-executive director from a trade union background.

Mr McGimpsey: A vacancy is still sitting there, is that right?

Mr Swallow: There is no vacancy. It has been filled elsewhere.

Ms Speed: The previous Minister, Mr Poots, filled that vacancy with somebody from the financial sector, I think.

Mr McGimpsey: The key thing is that this is a team game, as we are all aware. Everybody is on the team. On the board, we have a doctor, a nurse and a pharmacist, and we had a member from staff side. It is just —

Mr McCarthy: How did you let that go?

Ms Speed: We did not let it go. We objected and raised complaints, but sometimes you are talking to people who do not want to hear you.

Mr McCabe: As a side issue and for the record, my organisation had to take a judicial review, and the judge ruled that the Minister had acted unlawfully in not appointing a trade union nominee to a trade union seat on the Northern Ireland Social Care Council (NISCC).

Mr McGimpsey: OK, but you still have representation on the Public Health Agency.

Mr Swallow: Yes.

Mr McGimpsey: And the Business Services Organisation (BSO).

Mr Swallow: The term of office is about to come to an end. We are very nervous about whether either the individual's seat or the trade union seat will be renewed.

Mr McGimpsey: Thank you for that. It was for my own information.

The key thing that you are saying to us, Jonathan, concerns the unmet need. What is the unmet need? It is people in pain and distress and coming to harm. Those are patients who are falling through the net. The other key thing that you ask is how many people are needed to do the work. It is an issue, because you have to have the workforce in place to meet the demand as it reaches you. Have you any sense of where we are at with the workforce, from your side of things? We have heard from the BMA, which is very, very nervous; we have heard from the RCN, which is very, very nervous; and we have heard from midwives who, again, are very, very nervous about the current situation and what is coming. It seems to me that the first thing that we have to do is to get a bit of stability. We need to stabilise the situation before we take ourselves back to where we want to be. Have you any sense of where you are at with the workforce?

Mr Swallow: I think that the first precondition is to have a stable financial platform that is measured against need. We have not done that, and the tendency is increasingly not to do that, and that causes us great concern. We also need confidence-building messages in the workforce rather than saying that they are the problem. For example, when every trust is meeting the Minister's sickness target, the immediate approach is to say that we want to get even less sickness. We have done really well on that, and we are not celebrating such achievements, where every trust is within the Minister's sickness target.

Obviously, we need this process of modelling and workforce planning, with trade union input, but it needs quick moves to some proper ratios and staffing models that are not there. The one, of course, that we would highlight today is the absence of progress on normative nurse staffing, which is a critical safety issue in wards. We have the guidance of the Chief Nursing Officer and that of the National

Institute for Health and Care Excellence (NICE), which, in my view, is much more rigorous and better, but we are not applying that guidance. The reports that we get are of notes of concern under the process effectively being ignored. Members are telling us that they put in the AI notes, and nobody ever comes back on them. We have even had to set up courses, as UNISON, to teach our members the law of whistle-blowing. That is the ongoing issue that we now face.

Mr McGimpsey: That is unsafe staffing levels — of nursing staff — on wards, which, by definition, puts patients at risk.

Mr Swallow: Yes.

Ms Speed: I could give you a confidence-building measure on that that could be undertaken, which is to pay the staff their pay increase, and pay them, as per minimum, the pay review body's recommendation, and not slavishly follow what the Tory/Liberal Democrat coalition undertook in England. We are now the worst. I think that we are in the poorest position across the four jurisdictions in the NHS. That will not be resolved here, but any influence that you can bring to bear on those who hold the purse strings — the Department of Finance and whoever is managing the Department of Health at the moment — would be helpful. It is very important, because, believe you me, the morale of the workforce and its annoyance is increasing and accelerating. There is a measure.

Mr McGimpsey: OK. I would not disagree with that. In fact, I agree strongly with that.

As far as the Department's finances are concerned, however, the 2011 Budget massively undershot what was required to provide for the need. It was, as I recall, about £4·8 billion, but £4·5 billion was delivered. That was clearly not enough, and, as a consequence, we do not have a large enough workforce to deal with the need, and, as such, we are getting large amounts of unmet need. The longer that this goes on, the worse that it gets. Where are we now with the Department? I understand that we are back into the situation of overspends and drastic action being taken to get our budgets into line as opposed to getting our sick people into line.

Ms Speed: We are still £80 million adrift.

Mr Swallow: The system started this financial year £31 million in deficit. One of the trusts has a £7 million deficit, which will have to be rolled forward into next year. One of the trusts actually made £2 million, which was immediately taken away by the Department to meet medical negligence claims. The system is starting in deficit, and it will be worse because of the failure to meet the savings targets that I referred to earlier. That takes us up to £60 million. We saw this pattern last year of escalating deficit and of trusts being in deficit, because it is very clear that each of them is headed for substantial deficits by the second quarter.

We cannot just go on relying on monitoring rounds and sticking plasters to keep this going. It is fundamentally unstable, and, as indicated earlier, the HSCB non-executive directors shared our view at the previous meeting that we are on the cusp of risk and of compromising patient safety. It is time not just to take radical action on the structures but to rethink the financial platform, not only to deliver what we do now, which is done under pressure, but to deal with unmet need and fundamental health inequalities. We were very concerned, in the most recent ministerial direction, that the detail of the previous one about the specific actions to reduce inequalities had been removed. It was just a statement about health inequalities, full stop. We do not appear to have a strategy linked to finance and performance to get those three issues right together.

Mr McGimpsey: OK. Thanks for that. The key instrument for management is the Health and Social Care Board. That is what it was set up for. I set it up, so I am guilty. I brought four boards into one, and that was to be the key instrument. I said that, under no circumstances would we go over 400 with that management, and when I left it was 352. I understand that it is now 525, and it seems to be loaded. How effective is the board now? The deal was that the Department would come out of running the health service. The Civil Service cannot run a health service. Therefore, you have to have a management function. The board was to be the management function that would take the burden off the trusts, allowing you to reduce management functions in the trusts and more money to go to the front line. How effective has the board been? You can give me an honest answer.

Ms Speed: We debated this earlier at the start of the meeting, but we will repeat what we said.

Mr Swallow: I would draw your attention to the York University evidence, which shows that this sort of system can generate up to a 15% overhead on the unit cost of a treatment. What we have at the moment is the Donaldson review. We have the Department's review of commissioning — I gather that the chief executive of the HSCB has just been shown the terms of reference — the HSCB's own review of commissioning and the Department's review of administrative structures. In Russian, the word is "maskirovka", which means "distortion, deliberation and confusion". It is a masquerade. We will not address the fundamental issue of how we commission and deliver services with the current disparate review process. That process has to be challenged. It is not time-limited; it is taking the issue away into the comfortable world of having reviews.

Ms Speed: It is about having one self or one structure, instead of somebody or a body or instead of a review being taken of the whole service. We thought that we were getting somewhere with that conversation, not with the Minister who has just departed but the one before. There is an awful lot that we would disagree with him on, but the one thing that he did not do was sign off on the budget, which was in crisis. Perhaps I was talking to you at the time. I am not sure.

Mr McGimpsey: Sadly, no.

Ms Speed: He did not do that. That kind of momentum around looking at the big picture seemed to dissipate. The directive then came down to balance the books. There was a scattering. We got all these decisions to cut cloth to suit measure. The crisis actually deepens.

Mr McCabe: May I make two observations? Obviously, the establishment of the board was broadly supported as part of phase 2 of the review of public administration (RPA). We wanted to see it fit for purpose. I have observed that the difficulty that you then have is that the Public Health Agency is there to commission services on behalf of the population and the board is there to do the commissioning plan. It sends the plan up to the Department, and the Department says, "We do not have any money". We are seeing this cycle being effected. Equally, the other most important point is that, if you remove commissioning from the board, someone still has to do it.

Mr McGimpsey: You see, that is not actually how it is supposed to work. The Public Health Agency is not there for commissioning.

Mr McCabe: Observations.

Mr McGimpsey: It is supposed to be the board doing that. Effectively, the board tells the trust, "Here is what we need you to do, and here is the unit cost", and so on. This is not rocket science. You know roughly how many hips you will need, and you know how much that will cost. You know how many hearts and domiciliary care packages you will need. That is what the board is there to do. We did away with four boards and got one. What I am detecting from you is that the Department is still at the old business of trying to run the health service and overrunning the board, and the board does not appear to have the authority that it should have over the trusts. Therefore, there is general confusion, and everybody appears to be chasing their tail. It appears to be fairly confused.

Mr Swallow: I have attended the past 14 public meetings of the Health and Social Care Board to find out what is going on. I am the only member of the public present. Nobody engages. Sometimes we take speaking rights to try to change things.

Mr McCabe: I was with you in December.

Mr Swallow: Yes, I agree. *[Laughter.]* There were two of us present at that Health and Social Care board meeting. It has no resonance with people. It has no resonance with confirmed organisations, when it is the decision-maker on commissioning. That absence of resonance is leading to such frustration out there among all the organisations and groups that seek to improve health care. We are actually training up the Bangor protest movement to address the next meeting. We think that those meetings need livening up a bit.

Ms Ronald: If you want to see how effective the board is, you need to look at what it was set up to do and then consider the delay with everything. It comes back to that commissioning provider split that we have this dilemma that we often do not get a commissioning plan. I think that the worst delay that we have had was almost a year.

Mr McCabe: It was over a year.

Ms Ronald: How can you deliver a service?

Mr McGimpsey: You cannot.

Ms Ronald: You have got trusts trying to continue to deliver without knowing what budgets they are getting, because they have no commissioning plans. Even now, we will not have the draft commissioning plan until next month. We are already a month into the financial year. We are already behind in the process.

Mr McGimpsey: Reading between the lines, what the board is doing is waiting to see what money will be available to add to the commissioning plan. Then, as you are saying, you are commissioning according to money and not according to need. That is why it is late.

Ms Speed: I would make the observation that you always need to have the Department that has responsibility on the part of the legislature to oversee the service. What you have with the Health and Social Care Board is a big bureaucratic structure, as distinct from a function. There is a debate to be had about housing that function much closer to the service providers, which are the trusts.

Mr McGimpsey: It is supposed to be like that.

Ms Speed: When I first came to work in UNISON, I kept meeting people who were directors of this and directors of that in one room. I then went into another room, and there were directors doing the same thing, but they were at the level of the service. You had duplication and a structure that has grown, as you indicated by your comment, far beyond the original intention. The function of commissioning must always be there, but it is about how you construct that. We now have a bureaucracy.

Mr McGimpsey: And you start with need.

Ms Speed: It costs too much.

Ms Ronald: There is an added layer because of the extra bureaucracy that TYC added.

Ms Speed: More people were appointed and some were paid out of the £25 million. I did not know what they were doing, but there you go.

Mr Swallow: Just to amplify the point, the PHA has recently been through agony to meet the departmental call for a 15% budget cut — intense debates. The HSCB, in a finance report lasting three minutes, handed 15% back to the Department without blinking. Something is profoundly wrong with the balance of funding in various parts of the health service.

Mr McKinney: Michael made the point last week that there is an emerging picture. Normally, when you look at these things, you expect stakeholder criticism, from their perspective, on the production line, but we are hearing from all the stakeholders that the production line is bust, if that language does not undermine it. The stakeholders view the system as broken. From your last meeting with the board, what is your interpretation, in the context of our discussion, of how it marked TYC to now be at green or, in other words, doable?

Mr Swallow: The member who replaced the trade union member quite rightly asked some very challenging questions about us having gone from amber to green, particularly when the unit was to be broken up, the post holder not replaced and the whole function moved elsewhere with minimal investment. There was good criticism from non-executive directors. At the end of the day, the non-executive directors on that and the trust savings required the board to write to the Department to express concern. The green designation was seen as quite extraordinary, and you could see the looks around the room.

Mr McKinney: I want to interrogate the point about the TYC group being split up. Is it your understanding that that is going?

Mr Swallow: Yes, the unit is to be restructured, to use the euphemism. The function is to be mainstreamed into the work led by the director of commissioning. The general commissioning process, including the commissioning plan, is now to include TYC. Under pressure from the non-executives, there was an agreement to continue with what is called the TYC highlight report, which is about where things are or are not — usually not. As I said previously, I await with interest the report on where we are with the 99 original proposals.

Mr McKinney: What does that say to you about the last three and a half years of being persuaded about TYC?

Mr Swallow: We have been trying to achieve something that we are not funded to achieve. There has not been the hard realism that I would have expected — I may not have approved of it — in the project. Liam Donaldson is absolutely correct in saying in his report that there has not been the pressure or the drive to deliver. Maybe the sanitisation of targets, as I referred to earlier, is part of a sanitisation strategy to make it appear that we are moving forward. We all, including union members, have to acknowledge how desperate the situation is and the need for fundamental other directions in which to move forward.

Mr McKinney: So has it been a bit of activity disguised as movement?

Mr Swallow: Particularly in respect of the integrated care partnerships. We have still not had a response to our request to see the plans for the ICPs as approved by the board.

Mr McKinney: We have asked two or three questions on that and still cannot get an answer. We get some general headlines about what they are all at. With no drive and, based on what you are saying, I suggest, no plan, how do we transform the health service?

Mr Swallow: I suggest that we start with inequalities, as I indicated earlier. We identify the unmet need and match that with the existing need for performance and care, and we match that with a sustainable financial platform.

I looked recently at an outstanding piece of work by two economists David Stuckler and Sanjay Basu. 'The Body Economic', provides the most convincing evidence, passed down over the past 100 years, that if you have a crash or a recession, you either pump-prime — I dare to use the word "Keynesian" — direct health care or you do austerity. 'The Body Economic' provides compelling evidence that austerity damages health and causes health inequalities. It appears that that compelling evidence — the book was published three years ago — is being ignored by policymakers and governing politicians at all levels of the UK.

Mr McKinney: OK. I had a specific question, but it disappears in the midst of that big strategic thought. We are at pivotal moment here. The Committee has got to take all of this seriously. We have to sit down and assess where this whole process is going. TYC somehow does or does not exist, and we have no measurement. Those are the questions that we asked at the start about this: where was the measurement, the implementation and the money? They spent a year or 18 months trying to pretend that there were measurement, implementation and money, and clearly those have not been there. We have wasted another year and a half. I just think that the Committee has to reconfigure some of its approach around this, to interrogate the Department about where it plans the health service to go.

Ms Speed: I remember being in a room when we first heard presentations on TYC, and I asked the permanent secretary at the time whether this was the "Lansley Act", to which he said: "Absolutely not". Then we got the document and it was just as though somebody had taken that approach to the NHS, looked at the financial difficulties, put the two together and landed on top of Northern Ireland this view of how the health service should be developed. We are dealing with the fallout from that and resultant crises.

I repeat that, with all the good will toward the health service across all parties and interests in this place, we could come together and do something different here. In conjunction with us and other representative organisations, something different could be done to rebuild on the founding principles of the NHS. A big transition is going on across the water, but it is open to serious challenge. Sure, the whole election process there is revolving around what happens to the NHS. It is the issue of the moment; you are quite right, and I think that we could do something fairly significant and innovative

here. We could work together. We are up for it and willing to do it, and every staff representative organisation that came before you and gave evidence is of the same mindset as we are. We could look to models elsewhere in the devolved nations and see what we can do.

Mr McKinney: Based on the factual evidence and not just the evidence as presented, this job is too big for the Department.

The Chairperson (Ms Maeve McLaughlin): There is a pattern. All of the evidence that we have heard to date has been similar. There are clear challenges. When you hear things such as the risk to patient safety, the amount that was taken back from trust savings plans, as they are called, and delivery plans, I think that we are at the stage where a hard conversation must take place about what we need to move towards a public health model that targets health inequalities. We need to discuss what system is required to do that, because it is very apparent that it is not the current system. As I said in my open remarks, the present system is not configured to deal with our society's existing challenges and need. Rest assured of this: on the back of evidence that we have heard today and previously, and will hear in the next weeks, we will reflect on and draw up recommendations for clear actions.

There are a number of actions that I have noted down. I would have thought that a vehicle like the partnership forum would have been the model to have that hard conversation in relation to the type of model that we need. So, it is time for delivery on it. Thank you all for your attendance and participation. We will keep the conversation going.

Ms Speed: Thank you for the time. You gave us a good airing today. We appreciate it. If I may be so bold, I will leave some reading material.

The Chairperson (Ms Maeve McLaughlin): Absolutely.

Mr McCabe: Sorry, Chair, I missed the deadline for the NIPSA submission, for which I apologise. There are copies here, or I am happy to send them to the Clerk.

The Chairperson (Ms Maeve McLaughlin): OK. Do you want to leave some copies here? We can circulate them. OK, members. Thank you for your attendance.

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT
(Hansard)

Review of workforce planning in the context of
Transforming Your Care:
Northern Ireland Social Care Council and
Northern Ireland Association of Social Workers

13 May 2015

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NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Review of workforce planning in the context of Transforming Your Care:
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Northern Ireland Association of Social Workers

13 May 2015

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mrs Pam Cameron
Mrs Jo-Anne Dobson
Mr Kieran McCarthy
Ms Rosaleen McCorley
Mr Michael McGimpsey

Witnesses:

Ms Carolyn Ewart	Northern Ireland Association of Social Workers
Ms Marcella Leonard	Northern Ireland Association of Social Workers
Mr Colum Conway	Northern Ireland Social Care Council
Ms Patricia Higgins	Northern Ireland Social Care Council

The Chairperson (Ms Maeve McLaughlin): I welcome the representatives from the Social Care Council and the Association of Social Workers, who are here to brief us on workforce planning in the context of Transforming Your Care (TYC). We have Marcella Leonard from the Association of Social Workers; Carolyn Ewart, country manager, Association of Social Workers; Colum Conway, chief executive of the Social Care Council; and Patricia Higgins, director of regulation and standards, Social Care Council. I invite you to make your presentation, and then we will open it up to questions from members.

Ms Carolyn Ewart (Northern Ireland Association of Social Workers): Thank you for the invitation today. We are delighted to be here to present to you this afternoon. I will make a start, and then I will hand over to Colum, who will present information from the Social Care Council. I will get the glasses on so that I can see.

As you said, I represent the Northern Ireland Association of Social Workers (NIASW). It is part of the British Association of Social Workers, the largest professional body for social workers across the UK. The association has over 17,000 members employed in front-line management, academic and research positions across all care settings. In Northern Ireland, there are now over 5,500 social workers registered in the jurisdiction with the Northern Ireland Social Care Council. Obviously, my colleagues here will speak to that this afternoon. We are the lead statutory profession in respect of protection of children and vulnerable adults, and we offer a significant contribution to the protection of the public.

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Social work is a universal service offered to everyone in our community from the cradle to the grave. Often, the public perception of social work is limited to our work with children at risk. Whilst that is certainly significant, it is by no means the reality. Social workers work with and for all communities across Northern Ireland. They work with older people, those with physical or learning disabilities, mental health problems, addictions, those who are homeless, and adults and children affected by childhood trauma, to name but a few.

NIASW is very supportive of the principles set out in Transforming Your Care, and, as a profession, we have strongly advocated for many years for person-centred services, co-directed care, self-determination, the promotion of independence and protection of the vulnerable. As such, we are well placed to lead and deliver on TYC. The values of that policy link strongly and align with our professional standards and values. Our training is rooted in and comfortable with the concepts of community development and very strongly a social model of care. We, therefore, welcome the opportunity to highlight some examples of best practice in social work provision across Northern Ireland and to illustrate the challenges that exist and present our solutions to them.

In the first instance, I will talk briefly through the specific questions set out by the Committee. The first one is in relation to resettlement. The move to community care away from institutional care in the late 1980s was championed by the social work profession. It was then and has continued to be ever since. Whilst that has been practised across all the psychiatric hospitals in Northern Ireland for some time, it has taken a real departmental emphasis on resettlement to fully realise the vision.

We are able to present to you this afternoon feedback from the social worker involved in resettling 52 patients from Holywell Hospital. That is included in the pack from me at annex 1. It is obvious from the update on that work that significant work has taken place in a TYC ethos. As a direct result of that, 43 people who have spent decades living in a psychiatric hospital have a vastly improved quality of life, living in a supported facility in a community, and three long-stay wards have been closed. Obviously, work has taken place across all the other trusts and hospitals.

In relation to workforce planning and the other specific questions asked by the Committee about the work of the regional workforce development group, unfortunately, NIASW is not represented on that group at this stage, so we cannot provide any feedback on that. We would welcome the opportunity to be an active member of that group. Likewise, we are not aware of the work of the health and social care trusts on workforce modelling, but, as the main professional body for social work, we would welcome that.

Social work is a largely female workforce, and I know that the Northern Ireland Social Care Council (NISCC) is going to give you some facts and figures on that, but we know that, as a largely female workforce, opportunities for part-time working are very good at the basic social work grade of band 6. There will be significantly fewer opportunities for part-time and flexible working once we progress to management level positions.

We have seen the move to extended opening and have seen the development of the regional emergency out-of-hours team, which operates across all of Northern Ireland. However, the majority of services still tend to be delivered from Monday to Friday from 9.00 am to 5.00 pm. There have been exceptions to that. There is development of family group conferencing across some trusts, and that has seen a move to more flexible hours. Under the social work strategy, several pilots have been identified to explore extended opening hours, and they will see services running from 8.00 am to 8.00 pm. At this stage, it remains unclear what impact that will have on capacity, as I understand that those services are going to be provided within existing staff resource.

Whilst NIASW welcomes and supports the policy direction of TYC, we wish to highlight what we see as the real challenges to realising the policy aim. For us, those are excessive bureaucracy and funding of public services. It is those two points that I will spend my time talking about this afternoon.

We have been able to spend considerable time over the past two years consulting with and surveying social workers across all of Northern Ireland, and we have produced three key papers detailing the results. Our first two papers focused on children's services, and 'Social Work Not Paperwork' highlighted the challenges. Our follow-up paper to the then Minister Poots, entitled 'Reducing Bureaucracy in Social Work' provided the solutions as the profession saw them. We have also comprehensively surveyed our adult service as social workers and produced 'A Blueprint for Change: For Adult Services Social Work in Northern Ireland' paper.

All three reports highlighted that social workers are a deeply committed and loyal workforce, who regularly work up to 50 hours unpaid overtime each month. However, they also report that social work and the social work role has become so over-bureaucratised that they regularly spend more than 70% of their working week in administrative tasks. That directly impacts and prevents them from engaging with children, parents, families and people in need.

In our blueprint paper, we use a case study that is illustrated in your packs, which is a very typical referral to a social work team. A 78-year-old woman is referred for assessment, and we are able to demonstrate that, of the 17 hours and 45 minutes that it takes to assess her needs and begin a service, only four hours and 30 minutes are spent with that individual and her family. It is NIASW's view that that is simply unacceptable. Social workers tell us that they are spending more time on filing, report writing and inputting data in a computer than doing the job that they are trained for.

The Committee asked us the specific question, "Do you think you have enough social workers to deliver on Transforming Your Care?". It is our view that, at this stage, until the model of care has been identified, followed by a proper level of workforce planning, we are not in a position to comment on the required number of social workers. However, we know from members that, at present, social workers are carrying excessive caseloads and, in many cases, are struggling to cope with increased demand.

We suggest that the key questions we should be asking are, "Are our social workers doing the right jobs?" and, "Are we making the best use of this highly skilled and trained workforce?". We at NIASW are firmly of the view that social workers can implement the vision of TYC. They already work with complexity, risk and in extremely challenging situations. They want to work more with communities, carers and individuals and to continually improve the patient experience. However, at this stage, they do not have capacity. We suggest that the key to finding additional capacity is to review what social workers actually spend their time doing and provide them with the technological and administrative support that they need to do their jobs more efficiently, free from the burden of bureaucracy.

In our paper, 'Social Work Not Paperwork' we utilised a case study from the South Eastern Health and Social Care Trust, where the service improvement coordinator, working along with the gateway team and children's services, highlighted a significant problem with a high level of unallocated referrals. She identified with the social work staff that they were spending too much time putting information into a computer system and on administrative tasks, and that they were, therefore, unable to address the backlog of unallocated referrals. By redefining the referral process and the assessment forms used, by enabling the admin staff to take responsibility for data input and designing a new template and an electronic file, the results were outstanding. Within a very short time, there was 100% reduction in unallocated cases and significant time savings for social work staff — a total of six hours and 36 minutes for every case that they had. We use that example, because we think it illustrates the benefits of having the right person and equipment to do the right job. It now takes a social worker in that trust an average of 11 minutes to input the data they need, as opposed to 75 minutes, which was the situation previously. We are delighted to report that, having updated with that trust since we did our report, it has rolled out that e-filing initiative across all of their gateway services in children's services. In addition, it is committed to delivering the initiative across all of the family intervention teams, and it hopes to be able to roll that out further. We highlight that as an example of really innovative practice, where a system can be changed. We would like to see it being rolled out across all of Northern Ireland.

We have always been clear as a professional association to say that social work practice must be underpinned by sound reporting. Learning from all inquiries highlights the importance of timely and good quality recording, and we do not want to see that being removed. However, we do want to see a reduction in the levels of excessive paperwork and duplication. To that end, in our papers, we make a number of recommendations. One recommendation that I draw to your attention is a recommendation around the current looked-after children system. We recommend that it is amended and that the existing understanding the needs of children in Northern Ireland (UNOCINI) documentation is used for those children with a disability requiring short-term placements.

If you allow me a couple of minutes, I will illustrate the changes that that could make. At present, the looked-after child system requires that any child who needs a respite placement enters the full looked-after children (LAC) process and, therefore, becomes subject to all the documentation that that necessitates. It also starts off a process that requires meetings to be held at two weeks, three months and six-weekly. Those meetings are costly in terms of time and human resource. The entire process will take place, even if the respite placement is for 24 hours. As set out in the current legislation, all children with a disability will automatically meet the criteria set out in the Children Order. Many parents are opposed to that status. They do not see their child as having to be formally looked after

by the trust, nor do they want to share corporate/parent responsibility. Most social workers would also support a change to the legal framework. Current practice is cumbersome, inefficient and overly bureaucratic. We suggest that a child's needs could be met safely, without comprising on social work processes, within the existing UNOCINI framework. Within that framework, an assessment already takes place for all children known to children's services. Documentation, which captures the same information that will be captured on the forms for looked-after children, is already completed. There is already a care plan, which is reviewed at three- and six-monthly intervals. We therefore suggest that that system can safely meet the needs of those children.

That would have the immediate effect of reducing the amount of time social workers spend on paperwork and would alleviate the pressure of duplication. It would free-up your front-line social workers to spend more time working with children and families, which is what we want them to do and what they want to do. We therefore ask that the Committee encourages the Minister to bring forward regulation changes as part of the wider looked-after children strategic statement that the Department is preparing.

My final point is in relation to the funding of public services. To truly deliver on the bold vision set out in TYC, brave decisions must be taken. Delivering on the vision of TYC is not a cheap option, and if it is simply viewed as a way to save money, it is NIASW's view that it is doomed to failure.

We continue to experience unprecedented financial difficulty, and we are aware that there is much more financial hardship coming our way. That has had a very real impact on service delivery. We have seen a flight to funding the core statutory functions, as laid out in the scheme for delegation of statutory functions reported on annually by the Health and Social Care Board. As a result, many voluntary, community and third-sector providers are losing their core grant funding and are struggling to survive. They are having to reduce their capacity and, in some cases, close. Those are the very services that you need to be delivering under TYC.

We appreciate the very real hardship that the health and social care trusts face in trying to deliver within the very stringent budget constraints of the economic climate, particularly in light of the fact that there continues to be increased demand for services. That demand is evidenced in the Health and Social Care Board's delegated statutory functions report for the year ending March 2014. Referral rates to all areas are increasing, needs are increasing, the complexity of need is increasing and the population continues to age.

The Health and Social Care Board reports that mental health services continue to face significant challenges within the economic situation in providing and fulfilling their statutory functions. A similarly challenging environment is reported across services for older people and people with a physical or sensory disability. Pressures on the ground in relation to vacancy controls have been identified by all trusts, and the provision of domiciliary care services has been identified as problematic in some rural areas.

Those concerns raised by the commissioning body are echoed by our members, who highlight that very strict vacancy controls remain in place across Northern Ireland, with many vacant posts simply remaining unfilled for considerable periods. Maternity leave and long-term sick leave are routinely not covered, and that places a particular burden on a profession that, as we have identified, is a largely female population. I am sure the Committee is fully mindful that it is against that backdrop that we are seeking to deliver on TYC. We reiterate our previous requests and comments that social care funding should be protected in future Budget rounds.

In conclusion, I will summarise my three main points. We are thankful for the opportunity to attend today. First, we want to remind you that the ethos and principles behind TYC are welcome and are supported by the social work profession. In this workforce, you have a valuable resource that is well placed to champion the TYC model. Secondly, to fully realise the vision of TYC, systemic change is required to free-up professional staff from the binds of bureaucracy. Today, we have presented you with some solutions, and we have many more in our papers. Lastly, we urge members of this Committee to consider the impact of ongoing cuts on vital public services. To fully realise the vision, TYC must be adequately funded, or the reality will be overburdened carers, who are struggling to cope with limited support, and the most vulnerable in our society being placed at even greater risk.

Mr Colum Conway (Northern Ireland Social Care Council): Good afternoon, everyone. Thank you for this opportunity and invitation to speak to you today in relation to workforce planning in the context of TYC. I am sure that you are fully aware of this, but it might be worth saying that I have noted that the Committee has received evidence from professional colleges and associations in healthcare over

the past few weeks. I am delighted to be here today with our colleagues from the Northern Ireland Association of Social Workers. The Northern Ireland Social Care Council is not a college or an association, and we are not a representative body of social workers or social-care workers; we are the regulatory body for social workers and social-care workers practising in Northern Ireland. We were established as a non-departmental public body by the Assembly in 2001 to improve safeguards for service users and strengthen the professionalism of the workforce through workforce development, registration and regulation. We are also the Northern Ireland partner for Skills for Care and Development, which is the sector skills council that works with employers and people who provide social work, social care, and children and early years services across the UK. There are similar councils in Scotland and Wales that carry out similar functions. We have provided the Committee with a briefing paper, which I hope that you received OK. We just want to take a few minutes to summarise one or two key areas.

Social workers and social-care workers make up the largest part of the workforce in the health and social care system in Northern Ireland. Of all the different parts and aspects of the workforce in health and social care across this region, the social-care workforce — social workers and social-care workers — is the largest workforce. As Carolyn said, there are 5,700 social workers, 720 registered social-work students and 28,500 social-care workers across the region. Those people work in every community across the region. They make a significant contribution to health and social care. As you will be aware, they work with some of the most vulnerable people in our communities, many of whom have complex needs and complex social needs.

In our paper, we have outlined some data in relation to social workers from our register. To summarise, the profile of the social-work profession, as Carolyn mentioned, is one of a mature, mostly female, locally trained workforce. In Northern Ireland, 70% of social workers work in the Health and Social Care trusts. Census information from the Department indicates that, of that 70%, over half work in family and childcare. The remainder of social workers in Northern Ireland work in areas such as justice, with probation and youth justice; the education and library boards in welfare; and the voluntary sector. In terms of the broader social-care workforce, social-care workers are a very diverse workforce. They are spread across a range of settings; they work in nursing homes, supported living, domiciliary care and day care right across the community. They are dispersed across all programmes of care. There is a wide range of job roles and titles, but they are underpinned by a fundamental requirement to provide direct care and support for vulnerable people in the community. The workforce is employed by over 500 different employers across the region, ranging from our Health and Social Care trusts; large private nursing homes to small nursing homes; day care; community based groups; and voluntary groups. There is a broad range of employers in the sector.

We have indicated in our paper some information in relation to the workforce. It is worth noting that, in terms of qualifications overall — it is slightly different from professional colleagues — the workforce profile looks like social-care managers will be qualified to level 5 Qualifications and Credit Framework (QCF), and the rest of the workforce will be qualified at a mixture of level 2 and level 3. Just over 50% of the workforce are qualified to a minimum of level 2.

In terms of TYC, social work and social care make a central contribution to our integrated health and social care system in Northern Ireland. They play an important part in underpinning quality, safety and standards in service delivery so that service users and families experience positive outcomes. Transforming Your Care made a compelling argument for change and transformation in health and social care. Nothing has changed to undermine the unassailable case for change put forward by TYC. We believe in the principles underpinning Transforming Your Care: making the home the hub of care; placing service users at the centre of their care; providing more services locally; and encouraging local engagement and enterprise. These principles also form the basis of service delivery in social care. Support for co-design, co-production and personalisation, a focus on prevention and integration of care, the promotion of independence and safeguarding the most vulnerable are also fundamental to social care practice, and there are many good examples from across Northern Ireland. So, NISCC supports the sort of transformational change in health and social care in Northern Ireland envisaged by TYC.

An important element in such a change process is clarity about the models of service delivery to support the principles of TYC and the development of a workforce plan that will drive the required change in culture and behaviour. At the council, our main concerns are to protect the public through workforce regulation and to raise quality standards and practice. Given the diverse nature of the social care workforce in particular, it is important that a broad strategic view of workforce planning is taken so that staff and employers across the sector have a consistent approach to supporting quality and standards in practice, regardless of the location, be it a hospital ward, a nursing home or

someone's home. To this end, we welcome the approach that has been taken by the regional workforce planning group to looking at domiciliary care in a strategic way.

The social care workforce will have a significant role to play in the implementation of TYC, because it is about people working differently, changing culture and bringing greater integration to services so that they respond to the needs of service users. The social care workforce is a great asset to the health and social care system, and it has shown that it is open to change, both new ways of working and new approaches in training and education.

The Chairperson (Ms Maeve McLaughlin): Thank you both for that. Just to clarify, the Social Care Council as a regulatory body is represented on the regional workforce planning group.

Mr Conway: We are.

The Chairperson (Ms Maeve McLaughlin): That is the first we have heard of for a period. But the Association of Social Workers is not.

Ms Ewart: That is right; we are not.

The Chairperson (Ms Maeve McLaughlin): I want to bear in mind that a lot of issues have been raised for the Committee to reflect on, including looked-after children and too much bureaucracy; but I want to try and keep this as focused as possible on workforce planning. The association's paper — Carolyn, you mentioned this as well — said that, until the new model of care was identified, it was not possible to comment on the number of social workers required under TYC. Would it be your view, then, that the model of care for social work has not been developed?

Ms Ewart: We are certainly, at this stage, not involved in planning for that. We know the numbers of social workers and that, certainly, they are overstretched. Social workers are reporting that they have too much work to do. We simply do not have the information at this stage to say whether we have enough social workers. What we can use is the information that we know, which is that they are overwhelmed and working long hours in really difficult, complicated jobs. So, we do not know how many social workers are needed at this stage, because we are not involved in the process of planning the model and the way forward.

The Chairperson (Ms Maeve McLaughlin): In the association's view, who has responsibility for developing that model?

Ms Ewart: As I understand it, that work sits at this stage in the Department of Health.

Ms Marcella Leonard (Northern Ireland Association of Social Workers): That is right.

The Chairperson (Ms Maeve McLaughlin): Is there anyone currently thinking about how social workers — I think you made the point — could be utilised differently to support the development of a more primary or community-based approach? Colum, I see you nodding your head to that. I know you made the point about whether social workers are doing the right job at the minute, but are there other ways in which social workers and social care more generally can support that shift left?

Ms Ewart: I did not have time to refer to that in the presentation because I was talking so much, but it is referred to in the paper. There is a lot of work happening, led by the Health and Social Care Board and the social work strategy. It has afforded an opportunity to shine the spotlight on social work. We are the first part of the UK that has a strategy for social work, a 10-year plan. It has taken some time for that to get up and running, but we now have an implementation group and a steering group. Staff are employed within the social work strategy to deliver on some of these changes. One of the priorities of the strategy is to reduce bureaucracy. There is a variety of work streams, and there has been involvement from the whole social work community. Our paper was adopted by that group. There is work happening on how those changes can be made, and the challenge is how they are made at the very senior strategic level, setting a permission to make changes and signalling that it is OK to begin to look at and explore new ways of working. That certainly is beginning to happen within the strategy.

We have recently been able to appoint someone to post — as I understand it, it is a short-term contract — whose focus for the next year will be specifically on reducing bureaucracy and the real changes that we can make to front-line practice to change how things are for people.

The Chairperson (Ms Maeve McLaughlin): I am alarmed when I hear that the Association of Social Workers is not involved in developing a model of care. I hear what you say about the strategy.

Ms Ewart: We are very involved in that.

The Chairperson (Ms Maeve McLaughlin): You are involved in the strategy but not in developing the model of care, and, given the centrality of social care to the delivery of our health service and the debate about centralising social care, it concerns me that you are not at the table.

Ms Ewart: We would certainly like to be. We think that it would be very appropriate for the professional association to be represented there.

The Chairperson (Ms Maeve McLaughlin): OK. Let me follow on from that, Carolyn. You mentioned the strategy, which looked specifically at the Scottish model, 'Social Services in Scotland: A Shared Vision and Strategy 2015-2020'. What caught my attention was that it was definitely developed in partnership — I think that the Scottish system is moving increasingly in that direction — with a range of organisations such as trade unions. There is a big emphasis in the Scottish strategy on social justice, reducing inequality and so on. Does the association think that we should develop a similar approach?

Ms Ewart: We are keen to work in partnership with many organisations. It is one of the fundamentals that we want to work with all the people involved in delivering social care and social work. I know from my peer in Scotland — I have a colleague who does my job there — that Scotland has a strong partnership model and that the association there, along with lots of other groups, is very closely involved in partnership working. I have to say that there are real examples of partnership working here. We try to work in partnership where we can, but there is probably room for some improvement.

Ms Leonard: I would like to come in on that one. The statutory and voluntary sectors work together incredibly well. What is significant for social work practitioners are the funding cuts. Many voluntary and community bodies carry out a huge amount of informal social care, which we need to support the formal social care system's provision of social work. Carers at home provide a huge amount of unpaid and voluntary care for the range of population in Northern Ireland. Many of those agencies are beginning to lose the funding that they need to be able to support us. It is about supporting both systems of social care: the formal system of social work and social care that we can provide; and the informal system. Our paper refers to the fact that the funds of quite a few organisations in the voluntary and community sector that work for social justice and provide a range of services to Northern Ireland are being cut. We need to stress that: voluntary and community. That is a significant factor in how we can provide integrated, 24-hour care: the significant funding gap means that people can no longer provide it. Community services are no longer able to support our formal systems. I think that, more and more, social care practitioners are losing public goodwill. Previously, they were able to provide an extra 30 minutes for somebody living at home, but now they have only 15 minutes. They are losing goodwill because they no longer have that extra bit of funding to pay people an extra bit of money to stay on.

We need to recognise that being able to support people to provide formal and informal social care within Transforming Your Care is about funding. It is not about outcomes; it is about the linear process of being able to support people in the community while recognising that there are formal and informal, and voluntary and community, systems, and we need to bring that package together. Practitioners in all fields of social work, including physical disability, learning disability, mental health and childcare, are noticing the change. Early years funding has been cut, for example, and we used those services all the time in supporting families before we had to remove children. That is having a really significant impact.

The Chairperson (Ms Maeve McLaughlin): OK. Thank you for that. A number of members want to come in.

Mr McCarthy: Thanks for the presentation. At the outset, I express my gratitude and thanks to the care staff who come in and out of my house, sometimes four times a day. They are part of the family

and do a tremendous job looking after our daughter. Without them, our daughter would have to look for institutional provision, so keep up that good work. I express gratitude on my behalf and that of my wife.

I have a couple of questions. Colum, your paper states:

> "There are 260 undergraduate places training places for social work students each year, which provides a sufficient supply for the workforce."

However, Carolyn, your organisation has stated that there are not enough social workers to cover the demand and caseloads and to cover maternity and long-term sick absence. What is the position?

Ms Ewart: Do you want to go first with that one, or will I ?

The Chairperson (Ms Maeve McLaughlin): Do we need a referee? *[Laughter.]*

Ms Leonard: Chair, am I possibly in the middle? *[Laughter.]* I will start and then give Colum an opportunity to speak. The issue is not that social workers are not qualifying but that vacancies and positions are not being filled in the trusts. I work internationally, so I say this genuinely: social workers in Northern Ireland qualify at a very high standard. The issue is that posts are not being filled because they are often temporary contracts: for example, people on maternity leave or off on long-term sick leave are not being replaced. That has a huge knock-on effect on those already carrying their own caseloads.

Social work students are qualifying, but we are absolutely not getting them into social work posts. We find that they are taking other posts that do not require their qualification. Our regulatory body must maintain our professional standards. If I were to qualify as a social worker and not work in a qualified social work position, I would quickly , as you can imagine, lose my knowledge, theory, skills base and academic understanding. That is having a significant impact on social workers meeting regulatory body requirements. People are being trained, but there is an issue with trusts and voluntary agencies not being able to replace people on long-term sick leave, maternity leave or vacancies arising from natural wastage.

The other point is that people are being given only temporary contracts. If someone already has a 12-month temporary contract elsewhere, it is a huge risk to move. So, positions go unfilled, and qualified staff are working in non-social care positions, which is a serious loss and detrimental to the people of Northern Ireland.

Mr Conway: From a workforce planning point of view, it is difficult to take a one-year or two-year look at the workforce. You need to take a fairly long-term view because of the length of training. We think that the numbers coming through should be sufficient from what we can see from a workforce planning perspective, but Marcella is right: it is about looking at the profession and how we train social workers. Are qualified social workers doing the right jobs? Are they in the right positions? Are they doing work that really uses their skills? We believe that sufficient social workers are coming through, if they were being best used. There are not the sorts of gaps, we believe, in social work that you have probably heard about in some of the other professions, such as the gap in the number being trained against the number required. There is not the same issue. There are slightly different issues.

The Chairperson (Ms Maeve McLaughlin): So we are saying that it is not that people are not qualifying. People are being trained and are qualifying. It is about not filling vacancies. Have we a figure for vacancies?

Ms Ewart: We do not have that figure. The only information that we have is probably about those who enter the social care register. As for how many people are leaving our shores, for example, we know, anecdotally, that recruitment agencies in Australia are doing fairly well through advertising and taking staff away. Maybe we could try to pursue that gap in information.

The Chairperson (Ms Maeve McLaughlin): Can we access that? It is critical to staff caseloads and workloads.

Mr McGimpsey: The Department will have that information.

The Chairperson (Ms Maeve McLaughlin): Does the Department hold it?

Ms Leonard: Yes.

That for us is, I suppose, the significant thing. It is not necessarily just about replacing people on maternity or long-term sick leave. The issue is that they are not replacing or building up the workforce. When somebody goes, they tend not to be replaced. There is another issue for us as a profession. As you can imagine, in most of these areas — I am sure that, round this table, lots of people have personal experience — it is not just the social worker; there tends to me a multidisciplinary team looking after people: a medical person, a nurse, an occupational therapist and so on. We also find that, if a social work post becomes vacant, for whatever reason, it is not being filled by a social worker. That is a significant gap in the multidisciplinary team. That is another issue that we are looking at. Perhaps they are looking for somebody else to fill it, but our view is that social work must be included in order to maintain that multidisciplinary team. It is a wider issue than cover for people on long-term sick leave. The posts are not being filled because the trusts do not have the money to fill them. That has a knock-on effect on caseloads, which means a backlog of people waiting to be seen. There is a complete system backlog. I agree with Colum about the number being trained, but we are not getting them into the right jobs.

Mr McCarthy: Both of you stated that you were not aware of the workforce modelling on social work being carried out by the health and social care trusts. What is your understanding of the trusts' role in that?

Mr Conway: The trusts have a very important role. As our paper states, 70% of social workers in Northern Ireland work in the health and social care trusts. In the trusts' workforce planning for social work, the services for which they require social workers and the teams that they need them to be part of, it is very important that they are able to identify what they need and how we can respond to that from a workforce planning point of view. If that is changing or developing significantly, it is important that we have an indication of the direction of travel.

Ms McCorley: Go raibh maith agat, a Chathaoirligh. Thanks very much for your very interesting presentation today. You mentioned a pilot scheme to look at the provision of services from 8.00 am to 8.00 pm. Is it your goal to have a seven-day service or to maintain some kind of core with emergency out-of-hours services?

Ms Ewart: One of the key aims in the social work strategy is to develop a much more flexible, responsive service. Our services are provided, largely, from Monday to Friday, 9.00 am to 5.00 pm, but there is a real desire to change and move away from that. I know from all that we have heard from service users that 9.00 am to 5.00 pm from Monday to Friday does not suit people very well. If they are working, it is difficult for them to access services. A lot of work has been done to scope out the development of the out-of-hours service. There was a determination to continue with that. One area of work of the social work strategy was that the working group produced a paper to try to develop that. It identified sites across Northern Ireland that will begin doing that. My understanding is that it will continue to be developed. There is a real desire to look at a seven-day service rather than one limited to Monday to Friday.

Ms McCorley: Given the stresses in the system that you talk about, how could that be delivered within the existing resources?

Ms Ewart: I think, in honesty, that it cannot. That very firmly needs to be part of any workforce planning. We are describing issues that we already have: a very busy workforce, strict vacancy controls and people working above and beyond their required case limits. You cannot simply continue to put on more work. I know that surveys and other work have been done on the workforce, and I think that there is a real willingness to try to extend that and look at how it might work. Realistically, there is a lot of work to be done on figuring out how that would look, what it will mean for how the service is provided across seven days and how many staff are needed to do that safely. There are issues with the supervision and management of all those services.

Mr Conway: There is certainly a willingness in the social work profession to move to much more flexible service provision. Social workers are fully aware that families live their lives across a 24-hour period, and lots of what has to be dealt with is "out of hours". That creates a different sort of workload in itself. The development of the pilots will very much help us to identify how we can use resources

better. This goes back to the issue of whether social workers' skills are being best used. If a lot of their time is spent on bureaucracy, could that be taken care of elsewhere to free up their time? It may not be as straightforward as just having more people; it may be about how things are done differently and whether being able to respond better in an out-of-hours situation may negate the need for a lot of further work later. A couple of good pilots will give us a good opportunity to look at that. Certainly, there is a willingness to do that.

Ms Leonard: For social work to work out of hours, we need the wider system to work out of hours as well. We have years of experience working out of hours, and it is all right when you are doing your bit, but the others whom you need to help a person do not work out of hours. There is that willingness, but, to provide a comprehensive package for individuals, there needs to be the sense that other services are also working out of hours. Workforce planning needs to look at all the key areas. In childcare, for example, because of family difficulties, a lot of referrals come in out of hours and over weekends. If we are to put real energy into early intervention and support families at weekends and at night, when there are a lot of stresses, we need the other services and systems in place, whether that be, for example, respite care, wherever that may be. There is willingness from social workers, but, for us to do our bit, we need the other bits to be there as well. I definitely believe that, if we are to try to look at the health of the nation, make more interventions and move on as a social work profession within the public-health approach, we need that 24-hour approach, which means other systems being in place to enable us to do it. We can make interventions out of hours. At the moment, we tend to deal with crises and nearly put them on hold until Monday morning. As practitioners, we would like to use our skills out of hours, whether that be 8.00 pm, 9.00 pm or 10.00 pm. Let me make an intervention as opposed to having to put things on hold. For me to be able to do that, I need the other resources to be available. That is the package that we are looking at.

Ms McCorley: I am looking at another stress in the system. Do you think that the regional workforce planning group takes sufficient account of the fact that most social workers and social care staff are female? Many females need maternity leave or, because of family responsibilities, part-time work. How does the system, which is already under stress, cater for that and workers' rights?

Ms Leonard: As females, we strongly advocate the need for that. We are trying to do this job, and it is a profession. The group needs to take that on board. Workforce planning has to allow for that, which means having more people available to do the job in order to allow for those equality opportunities. It is also unfair to social workers who have more to do. Our paper highlights the number of out of hours and extra hours that social workers work but for which they are not paid. It also means that they are not going home to their family. We do not want families to be affected by the work that they are trying to do. I think that there is a real sense of social workers struggling in their role and doing extra unpaid hours to try to cope with, perhaps, their family's stresses and strains. That is part of the overall pressure. The group needs to recognise that we have a largely female workforce, so we need to allow extra support, but we must not lose sight of promoting and increasing the number of males coming into the profession. There are certain areas in the profession in which we need our male colleagues. That is a really strong point as well. There is a need for publicity to promote that, which is something that we can do as well.

Mr Conway: It is worth noting that the vast majority of the social care workforce is 24/7 and is largely female, so those kinds of issues and stresses are already dealt with regularly. The question is how we extend that to make it less of an out-of-hours and more of a seven-day experience.

Ms Ewart: Some of our members said that a more flexible working pattern, rather than being constrained to working from 9.00 am to 5.00 pm from Monday to Friday, would suit them very well, given their own caring responsibilities, whether for children or older family members.

Mrs Dobson: I also thank you for your presentation. Carolyn, you made the general point that social workers are taking up far too much of their time on administrative tasks. It is quite alarming to hear that more than 70% of their working week is spent on admin. As you clearly outlined, that has a knock-on effect on their casework capacity. How will we address that and the provision of admin staff to provide the back-up? I am not sure whether it was you, Colum, or Carolyn who said that there was someone on a one-year contract to reduce bureaucracy. How effective will that be? What practical steps can be taken? I would like to hear a wee bit more about the e-filing initiative. You outlined how that freed up time. Will it be rolled out across the board?

Mr Conway: I will pick up on the bureaucracy and the person in post looking at that. Two things are happening. We talked earlier about service models and what they might look like on the ground.

Alongside that, we have, as a profession, a social work strategy, which is being headed up by the office of social services in the Department. It is a partnership, and everyone is around the table, including service users and all stakeholders with an interest in social work. The strategy is taking forward a number of key areas, one of which is bureaucracy. If you asked any social worker anywhere which one issue they would like to be dealt with first, the reply, I think, would be, "Can you relieve us of the paper mountain to let us get out and improve contact?"

Mrs Dobson: They have been saying that for a very long time.

Mr Conway: Yes, we have been saying that for a long time. The strategy is looking at this specifically. The person who has been tasked to review it and put forward concrete proposals is only just in post and has been given a year. The people around the table are in partnership: the executive directors of social work at the trust, the Department and the Health and Social Care Board. We are very hopeful that, through the strategy, real actions will be identified, agreed with social workers and then implemented through their work. That is the task for the strategy.

Mrs Dobson: Given that the person is just in position and has been given a year's contract, how quickly will this be addressed? Will we have to wait until the end of the year's contract? How soon can you make practical changes?

Mr Conway: The plan is to work very quickly because, as you rightly said, we have been talking about this for years, and, when the strategy goes out to social workers, they will ask exactly the same question: when will this change? The crucial thing about the strategy is that everybody is around the table, including the executive directors of social work in the trusts and the other main employers of social workers. The strategy hopes to move quickly to establish a series of recommendations and then task those recommendations to be taken forward by services in the trusts and wherever else they happen. A lot of the bureaucracy consists of safeguards put in place by the profession itself to ensure that work is done properly, recorded properly and properly accounted for, so this is the profession really challenging itself to move forward. That is the challenge for the strategy. They have given it a year so that they have to report and move quickly. Then the challenge will be back to the employers to say how we change this.

Mrs Dobson: With regard to having the appropriate admin staff in place for workforce planning, how will that be achieved succinctly? It was good to hear of the e-filing initiative: I would like to hear a wee bit more about how that will be rolled out.

Ms Ewart: That is one of the issues, and it is one of the difficulties and frustrations. Northern Ireland is a very small place, but we have five trusts, and trying to share information across all of them can be difficult. It is one of the things that we are trying to do through the social work strategy and the group that Colum talked about. However, what the South Eastern Health and Social Care Trust does may not necessarily be what the Northern, the Western, the Southern or the Belfast Trust does. It is about finding a way of sharing that learning and for one trust to be able to say, "Look, we have done this; it has worked. We have got real results. It has made a real impact on social workers and on service users' experience. Give it a try". That is missing and, in some ways, there is room for that to be developed.

In our paper we set out 16 specific recommendations on how things could change. While some of those are happening, and the social work strategy has taken a lot of those on, there are other solutions in the paper that could be adopted more quickly. NIASW certainly advocates that, and we do so through the social work strategy groups. There is a plethora of referral forms in services.

Mrs Dobson: And one form would do.

Ms Ewart: One form could do it, but a social worker spends their time manually filling out all the information on one form. When they want to refer a child or an adult for a support, day, or other service, they have to do another form with another bit of paper. Then that has to be put on to a computer system. There has to be more integration around the technology that social workers have access to, which, I can tell you, is very basic in some places. We are talking about a mobile phone. We recommended a social work essential kit, with technology to free people up and help them so that they do not have to drive 10 or 15 miles to make a visit and scribble in a jotter in their car, come back to the office, manually write in a file and then input that data on a computer.

Mrs Dobson: I have seen it so many times with constituents. They are busy writing on their mobile phone.

Ms Ewart: If they had something, they could do it there and then, and it would link in. The e-files that the South Eastern Trust has looked at do that. Those files are shared electronically across the multidisciplinary team, so there are examples. It is getting the message across.

The Chairperson (Ms Maeve McLaughlin): Can I take your question back a bit, Jo-Anne? I understand the development strategy and the person appointed. Those are all sound advances, but my question is really to you, Colum: what is the regional workforce planning group doing about admin? That is what I want to know.

Mr Conway: I could not tell you that, to be honest. Our involvement with the regional workforce planning group at this point has focused on the review of the domiciliary care workforce that it is looking to carry out. Specifically about administration and whether they are looking at administration as a particular theme —

The Chairperson (Ms Maeve McLaughlin): The issue that is coming up here is that we are qualifying social workers, but there is an issue about not replacing vacancies. That is impacting on workloads, yet we have a regional workforce planning group — which the Social Care Council is a member of — that is not discussing it.

Mr Conway: What we would welcome on the workforce planning group is the move to looking more at programmes of care, in the group or abroad, instead of looking specifically at the needs of particular professions. That approach means that key issues like administration and other key elements that have to support the workforce to do its work get lost, because you focus on one specific profession. We are looking forward to seeing how the framework works with domiciliary care. Here is domiciliary care across the piece, regardless of who provides it, regardless of where it is provided and regardless of the other areas that were of interest previously. What does that look like across the piece? How do we address the issues around social work, nursing, occupational therapy, domiciliary care workers and different employers across the piece within that framework? This is the first of those, and it has only just started. I would be hopeful that that approach might help to address some of those issues, but I cannot say that it will until we see it.

The Chairperson (Ms Maeve McLaughlin): I will go back to Jo-Anne, but the Transforming Your Care agenda is three and a half years down the road, and you cannot shift left if you cannot organise or understand what the workforce requirements are and the types of staff that are required. Three and a half years down the road, we are now saying, "Here is a clear demand from one sector", but we are not looking at that; we are looking at the domiciliary care programme. A holistic approach is required.

Ms Ewart: One of our recommendations in 2013 was that there should be an audit of administration staff across the sector because we knew that it had been badly affected by the review of public administration and that the number of posts had been severely reduced. We knew not just from what our members were telling us but from social workers that they were increasingly doing the tasks that had been done by skilled administrators. You are absolutely right: that fundamentally needs to be part of workforce planning.

Ms Leonard: Can I come in there, if you do not mind? To answer part of what Jo-Anne asked, part of the complexity for us in the repetitive completion of stuff is that it is difficult enough if you have a client or service user and you are trying to transfer them to a service in a trust. The difficulty is that we are a small place, yet we have five trusts. What if I move to another trust and have to start all over again with form-filling? There needs to be some sort of assisting that centralisation of information because people move all the time, and it is about making sure that information goes with them.

I am very conscious of our colleagues who work not just in trusts but in other voluntary organisations, for example, in criminal justice organisations. There is such replication of information on individuals in Northern Ireland in different trusts and different organisations in those trusts. What we need to look at, when we are talking about administration and reducing bureaucracy, is that it is also about people moving throughout Northern Ireland. Individuals move from Northern Ireland to England or the Republic; therefore we need to look not just at that person in that trust but at that person in Northern Ireland and in different agencies in Northern Ireland because we are holding replicating information on them.

We should be using much more e-filing. There should be much more accessibility as to how we do that, particularly for staff working in rural parts of trusts so that they are not driving ridiculous miles to get back to an office when they could be doing a couple more visits to a couple more houses. They should be able to do it in their cars and get the information sent straight back. So, we should be a lot more innovative to reduce staff time.

Mrs Dobson: The Chair made a very good point about appropriate administrative staff in the regional workforce planning group. Given that, I think that it was Carolyn who said that you cannot look at the backlog of cases because of the administration, yet there is no forward plan or strategy to deal with that. One side is laughing at the other. It just does not make sense.

I think that Colum outlined the 500 different social care employers in Northern Ireland. The paper states that employers report that there are recruitment and retention challenges in the social care workforce. However, you cannot quantify those challenges, as employers' reports are inconsistent and cannot be aggregated to the sector. So, given that the social care workforce is integral in the shift left, why is the Social Care Council not taking responsibility for collecting all that necessary data?

Mr Conway: There are 500 different employers across the piece, and each has their own information. Therefore, on a number of occasions, we contact employers to gather up information as best we can. We always have to be careful with that information because not everybody responds and we cannot gather up all the information that we need. We continue to gather up as much data as we can and to have the data, particularly in relation to the workforce, so that we can better put forward data into the planning process. We are in a phased approach to registering the social care workforce. We currently have on our register about 18,000 social care workers.

Mrs Dobson: Out of the 28,500.

Mr Conway: Yes, those who work in nursing homes and those working in residential care in adult services. We have the data about that workforce and can talk about it.

In the next phase, we are moving to register the workforce in day care, domiciliary care and supported living, and we are working with the Department on a timeline for that. We believe that, when we have completed that process, we will be in a better position to take a broad view of the workforce in Northern Ireland and to analyse the data and contribute to workforce planning.

Mrs Dobson: You agree that it is crucial to have that data.

Mr Conway: It is really important. At present, we have a part of the registration, which is extremely helpful, but it makes it very difficult for us to make more definitive statements.

Mrs Dobson: Why has it taken so long to correlate?

Mr Conway: It has been a phased process. The registration of the social care workforce began a couple of years ago, and we are working on it as a phased process. We are very hopeful that, over the next short period, we can complete it and that we will have much better information.

Mrs Cameron: Thank you for the presentations; they were very interesting. Colum, this question is probably more for you. You said in your presentation that the social care workforce is huge and that it is spread across nursing homes, residential homes, day care and domiciliary care. Many of the services are provided by the private sector, particularly in nursing homes and domiciliary care. Who is responsible for ensuring that there is, and will be, an adequate number of well-trained staff to work in the private sector, given that the health service is so dependent on those services? As you are a member of the regional workforce planning group, can you also tell me whether this is something that the Social Care Council is doing?

Mr Conway: Yes. The supply of the workforce is a very important issue in social care, and it is important that there is a planning process. This review of, and approach to, domiciliary care is very welcome and is a very important development. Domiciliary care is spread across 188 agencies in Northern Ireland, some large, some very small. Each will have its own approach to workforce planning and recruitment and retention, but we believe that it is very important that we have a regional view of that workforce, both in terms of its quality and the standards that it is required to have in service delivery and the work that it does, and also that there is an adequate supply.

The big numbers across Northern Ireland and the possible turnover in that workforce means that we probably need to recruit a significant number of people just to stand still to continue to provide the services that we provide. Some 250,000 hours of domiciliary care are provided across the region for about 25,000 people every week, and that remains a challenge to service delivery. The framework that the regional workforce group is looking at will give us an opportunity to understand the workforce better.

Ms Patricia Higgins (Northern Ireland Social Care Council): The important contribution that we, as a council, will make to the regional workforce planning group, particularly in relation to domiciliary care work, is that we can bridge the gap. We can ensure that the information on workforce needs in the other sectors is brought to the table so that, in workforce planning, a more comprehensive overview is taken of what is required in delivering care over the whole sector.

Mr McGimpsey: Thank you for your presentation; I found it very interesting and revealing. I have to say that it was also alarming, to a degree, in common with the presentations that we have had from nurses, midwives, doctors and others on the staff side.

I start by saying that, as far as admin is concerned, I understand the difficulties of getting the bureaucratic mind away from paper trails. However, I always understood that there was another issue: the vulnerability of social workers. If there is a stretch and something goes wrong — say, God forbid, a child comes to harm — society, the media and the political classes look to scapegoat. All too often, a social worker, unfairly and unjustifiably, becomes that scapegoat. So, some of this paperwork is about demonstrating that the workforce has taken all the necessary and reasonable steps laid down. I appreciate that social workers should not be doing admin and that there is a need for admin support, but we need to have paper trails, not least to protect the workforce.

Ms Leonard: Yes, and from a professional point of view, I fully agree with you. It is about vulnerability and protecting service users. We are looking for systems that balance protecting all people — the professional and the person receiving care — because we need both in place. As you know, a new form seems to follow every report that is completed rather than looking at adding another question to the end of an existing form. It is about streamlining and not necessarily getting rid of. The profession and the regulatory body need to be clear that we absolutely believe in maintaining our good standards. However, as a professional organisation, we also need to be held to account for our social workers and what we do.

It is about taking a fresh look at our system, because referrals are constantly increasing. We have an ageing population and referrals to childcare are on the increase; everything is increasing. We need to get accountability and maintain our professional standards, protect the public and the service and make sure that they get the right service — the one that they deserve — while making sure that it is not overburdened. It is about streamlining, having a fresh look at some things and not always producing another report as a result of an inquiry or something else that needs to be filled in. Let us go back and look, as opposed to producing new things. It is a fresh challenge, but it is something that we need to do.

Mr McGimpsey: It is, of course, an important piece work because of where you are with family support and intervention, child protection, vulnerable adults and so on, and with the system under stress and stretched. In that situation, the system becomes very brittle and the workforce often needs to be protected as well as the patient. You paint a picture of struggling to meet demand, but have you any sense of what the unmet need is?

Ms Leonard: Unfortunately, we in social work must recognise that our job is about working with individuals who often, although not necessarily always, have been harmed a lot before they come to our attention. That is very sad. There is another area of social work — learning disability, physical disability or hospital social work — where we can do interventions an awful lot sooner. We hope that there is, potentially, less a sense of an unmet, unknown need in those areas, particularly with an older population, where age is a trigger.

I am more than happy for my colleagues to come in here, but I think that the unmet need is around the vulnerable adult and child protection areas. That is because, sadly, people are still reluctant to ask for help early. We are under so much pressure to respond, but we do not have the resources to do so. We have a lot of caseloads waiting, and there are issues about how we get out to them. The problem is that social workers tend to meet cases where need is obvious. We would love to backtrack to think, "If we had only been involved in that family three years ago. If we had only been involved in that

family even 10 days ago. If we had only been able to do that sooner, we might have made a difference." That is the early years intervention stuff that people are struggling with.

I think that the unmet need is more about encouraging people to come forward and ask for help; however, we find that we do not have the resources to provide help, even if they do come forward. Early intervention comes down to deciding whether we go out to that call or to one where a child is clearly being abused or where there are issues involving a vulnerable adult. Social workers make such very difficult choices daily. I think that the unmet need is possibly coming through in those areas. You might want to come in on this, Colum, but a lot of social care individuals and staff are probably also holding a lot of need that, if we had a better system and better resources, would probably be referred to social work. A lot of other voluntary and community agencies are holding a lot of significant risk and need because of the pressures on the statutory sector.

Mr McGimpsey: What sort of support are you getting? This is not just health and social care. A lot of it comes as a result of, for example, domestic violence, drugs and alcohol and mental ill health, and you very often end up picking up the pieces.

Ms Leonard: You do. Look at mental health, for example, and the increase in the pressure on beds in mental health. There is that reluctance. I would ask and hope that we do not get into a system where we treat social care problems on the basis of how many are entering the hospital and how many are coming out. When you go in for a hip replacement, it will be shorter because it is very easily fixed and not as much care is needed afterwards. Mental health and addictions are long-term issues that require long-term interventions. It is not just that person who requires it; their family needs support as well. It is about having time to provide the carers of those individuals with as much support as possible. They are voluntary carers in the community who will keep that person out of psychiatric hospital, hopefully for longer than they would have been otherwise. If we had the resources and the time to make interventions, we could do it. Do I recognise that there is need not being met? Absolutely; that is the reality because of the pressure on the systems.

Mr Conway: It would be difficult for us to quantify it. However, if you look, for example, at the 'Delegated Statutory Functions' report, you can see that, across all programmes in the Department, there is a rising number of referrals. There is a clear indication that there is increasing activity and an increasing need to respond. One area in particular where a lot of very good and very strong work has been done, and in which there is very good policy direction in Northern Ireland, is adult safeguarding. That has raised significant issues about being able to respond in the right way and has put pressure on services, but it is still a very strong approach to safeguarding adults across the region.

Mr McGimpsey: The majority of your social care workers are in nursing home and residential care home settings. We would argue — there is some validity in the argument — that the tariff per patient paid by the Department to the operator is insufficient, and it is a struggle. The question comes up anecdotally about whether they provide the workforce that is required for patient safety. If there are not enough nurses and the operator cannot maintain the right number of nurses, it is your folks, the social care workers, who end up taking on extra responsibilities that they are not really there to do. One operator told me about paying £600 for an agency nurse for 16 hours. I do not know whether that is true, but it certainly feeds into the shortage of nurses. We are not training enough nurses, and we allow those whom we train to be sucked off to hospitals in the south-east of England. I would have thought that that has a big impact on the large number of your folks in nursing or residential homes. What is your sense as regards patient safety and the vulnerability that might be creeping in as a result?

Mr Conway: What is important to us, as a council and the workforce regulator, is the quality and standards that the workforce provides in their services and that they can work to the proper standards of conduct and practice. It is important that they work in an environment in which they can do that. We push very hard and work closely with our colleagues in the Regulation and Quality Improvement Authority (RQIA) to ensure that the environment that they work in is right for them so that they can do their work in the right manner.

This is an area where there is a very specific and particular interface between health and social care and an overlap of patient need. We are very clear about how we support social care staff to ensure that they are actually doing the work that they are required and supposed to do, that they do it to the right quality, and that they can push their employers to make sure that they have in place the right environment to provide that care. The environment is certainly a challenge, and we can see vulnerabilities. Equally, I have to say that, in our register and conduct process, we do not see a huge

number of people coming before us because they are unable to provide the care to the standards to which they should provide it. There are some, but the numbers are not huge. There are a lot of very strong and good things happening. The workforce planning process and development process will mean that we will have to continue to push hard in that area.

Mr McGimpsey: For Transforming Your Care and shift left, nursing and residential homes will play an increasing role in step-down care, intermediate care and so on. Even if we are not doing it through the health service, it has to be provided.

Mr Conway: Correct. It is important that staff in those facilities, the vast majority of whom are registered social care workers, have the training, education and support skills and competencies to ensure that they can respond to that need. That is part of our task.

Ms Higgins: The value of regulation is that, for the first time, we are putting in place for that workforce standards and a code of practice. We will need to help that workforce to understand what working to a code of practice and practising safely means.

Mr McGimpsey: And what support they are entitled to look for.

Ms Higgins: Exactly, what support they are entitled to look for and the training and development needs that are appropriate for them.

The Chairperson (Ms Maeve McLaughlin): Ok, folks. Thank you for that. This has been extremely useful for the Committee. Apologies for returning to workforce planning, but there are wider challenges in the system. I appreciate your time. I want to thank the association formally for allowing me to spend a day as a social worker. It certainly was a baptism of fire.

Ms Leonard: We were delighted to have you.

The Chairperson (Ms Maeve McLaughlin): Thank you for that opportunity. We will reflect on the evidence that we have heard today. Thank you.

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT
(Hansard)

Review of Workforce Planning in the Context of Transforming Your Care:
Allied Health Professions Federation Northern Ireland

27 May 2015

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Review of Workforce Planning in the Context of Transforming Your Care:
Allied Health Professions Federation Northern Ireland

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Alex Easton (Deputy Chairperson)
Mrs Pam Cameron
Mrs Jo-Anne Dobson
Mr Paul Givan
Mr Kieran McCarthy
Ms Rosaleen McCorley
Mr Michael McGimpsey
Mr George Robinson

Witnesses:
Ms Karen Middleton   Allied Health Professions Federation
Mr Andy McFarlane   Allied Health Professions Federation Northern Ireland
Ms Rosalind Rogers   Allied Health Professions Federation Northern Ireland

The Chairperson (Ms Maeve McLaughlin): I welcome representatives from the Allied Health Professions Federation (AHPF) who are here to brief members on workforce planning in the context of Transforming Your Care. We have Karen Middleton, chief executive of the Allied Health Professions Federation England; Rosalind Rogers, the education representative on the board; and Andy McFarlane, the elected representative of the College of Paramedics on the board. I hand over to you to make your opening remarks. Following those, I will open it up to questions or comments.

Ms Rosalind Rogers (Allied Health Professions Federation Northern Ireland): Thank you very much indeed. We very much welcome the invitation and the opportunity to speak this afternoon and to address your questions. The chair of the Allied Health Professions Federation, Kerry Clarke, sends her apologies. She is in Scotland unavoidably today.

You have had an opportunity to hear who my colleagues are. We want to give you a little bit more of a background. I am the education representative on the Allied Health Professions Federation. I have a background in workforce development from an educational perspective, and I am past chair of the Royal College of Speech and Language Therapists (RCSLT). Through that, I have sat on the Allied Health Professions Federation board in the UK. Currently, in my academic role, I manage a postgraduate course module, 'Improving my Service'. It is very much dedicated to allied health professionals (AHPs) bringing to the table a workforce issue from the service-user perspective and seeking to solve it. It is with the experience of 100-plus AHP postgraduate students, through that, that I can say that we are truly solution-focused. We seek to be flexible, adaptable and make a difference to the health care of the population of Northern Ireland. Karen Middleton is the CEO of the Chartered

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Society of Physiotherapy (CSP). She is also a physiotherapist by profession. She has had the opportunity to look at the other side of the table as the chief AHP adviser to the Department of Health in England for 10 years. Andy McFarlane is here representing the Allied Health Professions Federation, as are Karen and I. He is the also the College of Paramedics representative, and he is a practising paramedic.

We will not rehearse the briefing paper, because, obviously, you have it in front of you. The Allied Health Professions Federation is a UK-wide federation comprising the professional bodies of 13 AHP groups. In Northern Ireland, paramedics are not yet recognised as part of that AHP workforce in the DHSSPS, but, from the Allied Health Professions Federation perspective, they are, very clearly, part of the AHP family. That is why you might find a difference between 13 professions versus 12.

The allied health professionals in themselves have a depth and a breadth to their qualifications. They are qualified to degree level. They have a strong foundation in a medical model, but they also have a very, very strong value system around working in biopsychosocial models of care. We assess, diagnose, treat and discharge in our own right; we are autonomous practitioners.

With the flexibility and adaptability that is captured in the AHP workforce in the UK, and, specifically, here in Northern Ireland, we are very, very keen to be positioned correctly in the various structures that can influence and bring about the change that is needed. You can see from our briefing paper that we acknowledge very much that the contribution of AHPs to the delivery of Transforming Your Care (TYC) has been recognised in terms of the plan, but we are seeking to be able to influence it practically. We are not finding it easy to influence for good at that level. You will be as aware as we are of the changing demographics of the population. When you look at ageing and the complex needs that come about from a variety of long-term conditions coming together, you will see that the areas that are making a difference to the quality of people's lives are podiatry, speech and language therapy, communication, swallowing, physical mobility, independent living, and health and well-being. They are all parts of the remit and portfolio of AHP skills.

We have an economic argument, and you will understand why we are persuaded by it. AHPs are trained at a level with a postgraduate structure that allows specialism, but it is four times cheaper for us to reach advanced practitioner level than it is a GP, and we get to that level quicker than a GP, for example. Therefore we are seeking to help to do things differently, not to increase costs. We are seeking to find out how we can shift the flexibility of thinking and workforce profiling. AHPs are also taking on some evolving roles that are building on skills sets that have had quite a lot of piloting. We are very keen to see those translate into actual working practices and be rolled out more quickly than they currently are. Thank you.

The Chairperson (Ms Maeve McLaughlin): Thank you. Before I open it up, I ask members to be mindful of their mobile phones, because broadcasting is unable to pick up a lot of what is being said because mobile phones are interfering with the recording. In our work around workforce planning, we have heard from a number of professional bodies. You touched on the major challenges around an ageing workforce and an ageing population generally and what that brings in terms of recruitment, retention and often working conditions too. Are those issues for you as well?

Ms R Rogers: Yes. There is very much an inconsistency between trusts. The workforce review or planning really needs each trust to have an opportunity to engage properly with the AHPs to find out what the local needs are. We are finding that there is a very inconsistent approach to workforce development —

The Chairperson (Ms Maeve McLaughlin): Is that inconsistency among trusts in how they —

Ms R Rogers: It is in how they are reviewing their workforce and how they are planning. There appears to us to be no strategic workforce planning. There is a lot of promise, but we are not seeing it happen in reality. Where it is happening in pieces, it is too small and too localised to actually have an impact.

Ms Karen Middleton (Allied Health Professions Federation): The issue is around the word "transformation" in TYC. To get real transformation, there needs to be a more strategic approach to workforce planning. The local differences and the local arrangements around workforce planning are not, in our opinion, going to deliver the transformation that is really needed. It needs to be something really quite different.

Think about the workforce situation in primary care, for example. The evidence from the Royal College of General Practitioners and the British Medical Association (BMA) highlights the dire scenario around the number of GPs who are leaving primary care and the lack of doctors wanting to train as GPs. Yet, we know that 20% to 30% of what any GP sees every day is musculoskeletal: back pain, joint pain etc. That 30% could be seen straight away by a physiotherapist, which we have calculated would free up nearly 100 million appointments a year UK-wide. That is capacity freed up, but it is a more strategic approach to workforce planning that looks at real transformation in how care is delivered. That strategic approach is about managing the demand on health care differently. In the example from primary care, it is about looking at a different way of supplying the workforce, whether it is podiatric surgery provided by podiatrists that has better value and better outcomes for patients, or physios providing primary care services. I am sure that Andy will talk about paramedics.

In managing the demand, the allied health professions take a much more holistic approach in combining the medical model — with surgery and the independent prescribing that physio and podiatry has — but it is also combining it with the biopsychosocial model, which is about keeping people physically fit, keeping them well, keeping them at work and off benefit and maintaining their independence. It is about all of those things that you get from taking a much more strategic approach and looking at the workforce supply completely differently.

Mr Andy McFarlane (Allied Health Professions Federation Northern Ireland): On strategy, there is quite a lot of reference to the implementation of TYC regarding the Ambulance Service but it rarely mentions the clinicians, the paramedics. The College of Paramedics has not been engaged in any sort of strategic direction regarding TYC. In fact, as Rosalind said, we are the only country in the UK where we are not recognised as allied health professionals. We are pushing that forward locally with the Department.

I agree with my colleagues that there are so many things that we can do that we are not being allowed to do within our local scope of practice; for example, advanced care paramedics and community paramedics running minor injury units and going out to people's houses and doing a minor assessment or a wound closure that would avoid an elderly person having to go to hospital. There are lots of different ways that we can be used, but we are still very much stuck in the transport model. Now, that is changing locally, which is good. There has been some investment locally, and we are changing. We are leaving people at home. We are referring people to doctors. We are referring them to the pharmacy, the falls team and diabetic nurses, but we need to be engaged in a strategic approach.

The Chairperson (Ms Maeve McLaughlin): If it is not strategic and there is a need to be strategic, whose responsibility is it to do that strategic piece? Is it the Department's? Is it the board's?

Mr McGimpsey: It is the Department's.

The Chairperson (Ms Maeve McLaughlin): I am asking them.

Ms K Middleton: We, representing the professional bodies of the third largest clinical workforce, which is what AHPs are, really want to be part of that support and engagement in the strategic workforce planning. We have the data on our members. We have the innovation from across not only the UK but the world. We can share best practice and the evidence in order to speed up some of this innovation. The issue is that we are not looking at something that is going to happen in the future and that we can start planning for and take our time with. This is happening now, and we have solutions now, if the professional bodies could be engaged.

The Chairperson (Ms Maeve McLaughlin): But it is ad hoc and inconsistent.

Ms K Middleton: It is ad hoc and inconsistent, and the professional bodies are not involved at all.

The Chairperson (Ms Maeve McLaughlin): I want to pick up on a point that you made and which we have also heard from the unions: that 20% of GP appointments are for musculoskeletal conditions.

Ms K Middleton: It is 20% to 30%.

The Chairperson (Ms Maeve McLaughlin): That is one of the issues that the Committee took issue with around the self-referral pilot for physiotherapy. On the face of it, that made absolute sense in

terms of Transforming Your Care, but it turned into a bit of a tug of war to actually get it operational. What figure did you put on it? How many appointments would be reduced?

Ms K Middleton: One hundred million in the UK. In Scotland, 86% of the population have access to full self-referral and 14% have partial self-referral. It is 63% in Wales, while England is dragging behind on 40%. There is a real drive in England at the moment, because it has been calculated that, by introducing self-referral and doing nothing else, you save £25,000 for every 100,000 of the population.

The Chairperson (Ms Maeve McLaughlin): Has such a calculation been done for the North of Ireland in terms of the reduction in GP appointments?

Ms K Middleton: To my knowledge, no; not specifically for Northern Ireland. That is UK-wide.

Mr McCarthy: We all know the disappointment about self-referral not happening. I do not know where we got it from and whether it came from somebody at the Committee, but I have it in my diary that it was to be rolled out on 25 May, which was Monday past. Has it been done?

Ms K Middleton: As far as I am aware, the pilots have started.

Mr McCarthy: OK, that is progress.

Ms K Middleton: But that is not it rolled out. That is just the pilot. The pilots have been done all over the UK. It is tested and proven, so there really is no need to pilot it yet again.

Mr McCarthy: It was not rolled out on Monday.

Ms K Middleton: I presume that the pilot started, but that is just a pilot and not full roll-out.

Mr McCarthy: That is different. We will watch this space then.

Ms McCorley: Go raibh maith agat, a Chathaoirligh. Thanks very much for the presentation. The whole emphasis in your presentation was on doing things differently. Are you aware of any new service models being developed by the board under TYC or being used by trusts that will require AHP staff to do things differently?

Mr McFarlane: Yes, Rosaleen. As I say, locally, in the Ambulance Service, there has been some money put towards TYC. There are what we call appropriate care pathways. Instead of the normal transport model that we have focused on — whereby, if there is something wrong with you, we will take you to hospital — we have started to assess, treat and sometimes discharge at the home or at the scene; at the shopping centre or wherever it is. There are different referral pathways for different categories of patients such as diabetics and falls patients. That is happening. It is quite patchy at the moment. I do not think that any of it is Province-wide. It is very much trust-dependent. We are very much linked with the trusts and whether they can accommodate our referral to an occupational therapist or physiotherapist etc.

Ms McCorley: Is there anything different that AHPs have to offer to emergencies and the whole crisis of A&E? Can they offer something that is not already available from trusts?

Mr McFarlane: With the advanced practitioner model, a lot of our colleagues in England, who are sometimes known as community paramedics, are actually running minor injury units. Some are mobile, as we are at the moment in a car, and deal with very low acuity calls. If you have a minor injury or illness, they will go out to assess and treat, and, if necessary, they will call for transport to hospital. However, if it is minor and they can deal with it, they will deal with it and refer you to your GP, pharmacist, falls team, diabetic team, or whatever. There are a lot of figures out there to prove that it reduces hospital stays, and that translates into a cash value.

Ms K Middleton: I have another example. One of the biggest reasons for people attending A&E is falls; for over-65s, it is the major reason. We have calculated that if you developed physiotherapy falls-led services, in Northern Ireland alone, you would save £8·2 million a year and prevent over 70,000 falls. Never mind the saving in money, think of the stress and the anxiety if one of your

relatives has a fall and is admitted to hospital, besides the ongoing needs. The evidence shows that most scenarios like that do not end with people going back home; they tend to go into care. So, if we could prevent these falls through physiotherapy falls-led clinics, it would stop a lot of the demand for A&E, stop a lot of the expenditure on keeping people in care after a fall, and free up a lot of GP time. This is a demand on primary care that is unnecessary. We have calculated that for every pound spent on physiotherapy falls-led clinics, your return on investment is £1·50. The point that we are trying to make is that this makes good clinical sense — it is good for patients — but it is also good for the taxpayer and the system. That is what transformation is really about. It is about doing things radically different, but we are only going to get the difference if you engage the people who can innovate in the actual planning. If you do not, history tells us you just get the same old, same old; there is no transformation, just more of the same.

Mr McFarlane: I will give an example. One of my patients yesterday was an elderly lady who had fallen in the street. I assessed her, and she had no injuries, but she told me that it was her second fall in two weeks. As Karen said, the more falls you have, the more likely you are to break a hip and be hospitalised. In the course of my assessment, I advised her to go to her GP and have a falls referral through an OT or a physio. During the assessment, I took her pulse and found that she had an irregular heartbeat. I asked her whether she had atrial fibrillation, which is a heart condition, but she was not aware of that. Again, that is another thing that she will be telling her doctor, hopefully. But hopefully in the future there will be a system allowing us to refer someone to their doctor directly. At present, we are very much depending on that old lady, who might be forgetful or have poor self-care, to tell her doctor. If, however, I can directly refer her to her GP, who now knows that this is her second fall in two weeks and that she has atrial fibrillation, the doctor can treat that condition with medication, probably avoiding a stroke.

Ms R Rogers: At the moment, in Antrim Area Hospital, I think, physiotherapists are going in to ED at the weekend to support people with soft tissue injuries by advising them appropriately. This means that the person not only gets the best physiotherapy assessment in ED but also gets appropriate management, so that it does not become a chronic problem. There are those pockets of pilots that are taking place.

Ms McCorley: Do you think that there is an unhelpful resistance to new ideas or new ways of doing things?

Ms R Rogers: From my perspective, in looking at these 100 AHP projects coming to the surface, and from the AHPF's argument, we do not have AHPs positioned strategically at the right level to ensure that those very good and innovative new ways of working come to the surface. It seems disproportionately difficult for us to influence at Department level. There is only one AHP adviser for 13 professions — well, it is 12 at the moment, but I am sure that we will see sense and bring the paramedics on board. For those 12 professions, for one person to be seeking to advise on that number of professions is very difficult. That sits under nursing. So, even in the trusts, there is no model whereby AHPs, strategically, are positioned sufficiently to allow the agents of change, in band 5, 6 and 7 posts, to make a change. It is systemic. We see ourselves boxed as AHP input in the regional integrated care pathways as well; we are not consistently sitting round the table. It is not that we are not trying. We feel, as the AHPF, that we have been working very hard and cooperatively to engage that, but it is slow work.

Ms McCorley: As part of the shift left under TYC, the Department told us that around £25 million has already been shifted from hospital services to community and primary services in the areas of learning disability and mental health resettlements. Has that had any impact on AHP staff to your knowledge?

Ms R Rogers: We have no clarity regarding the dispersal of the money that you refer to. We would actually seek assistance in determining where the funding has been allocated. We are aware of some recent workforce spends, but we have no detail on a regional basis. That comes back to needing a more clear, open and transparent commissioning process to allow us to see what is happening at the moment. We are unaware of where the money has been spent. We do not know the breakdown, and we do not know who has benefited.

Mr McCarthy: Thank you very much for your briefing paper and your presentation. I am fascinated with your responses to Rosie's question about what you can do to help ease the burden in our A&Es. What you have told this Committee is unbelievable. Is nobody listening to what you have to offer and asking you to provide it and overcome the problems that we are hearing about so often in accident and emergency units?

Ms K Middleton: We are trying to understand why that is. It is such a compelling case, and I often describe it as a no-brainer, frankly. If it is in the interests of the person, the patients, the public, the taxpayer, the system etc, why would you not? I do not think that any other industry would not take notice of this sort of information, data and experience from other parts of the country. The conclusion that we have come to is that we are just not represented where we need to be.

Ros highlighted the AHP representation at the Department, which, again, is not at the top table. In trusts and in hospitals, once again, AHPs are not at the top table, so you are constantly pushing against "the way we have always done things". Wales, for example, has appointed a director for AHPs on every board, and then they have the profession-specific advisers below, because one person cannot possibly do it all for 12 professions and all the subspecialties. There is something about a systemic need to look at who is represented and where. If it is only ever about the medical and nursing workforce, the likelihood is that you will only ever get medical and nursing solutions to the problem. I come back to that word "transformation": it has to be something different, otherwise we will be here in two years' time still talking about these problems.

Mr McCarthy: Thanks very much. I am sure that somebody is listening to what you have just said and that action will be taken. Surely our review report will point that out. We have heard it before from other people who presented to us. We know that neither you nor your other representative bodies for AHPs is represented on the regional workforce planning group. You have just told us that. To what extent do you think that the Department is taking the views of your workforce into account in developing the overall approach to workforce planning? The answer is probably that it is not.

Ms K Middleton: It is not evident in the sense that these solutions are not being rolled out in the way that they should. However, it is not only the Department. The commissioners also need to pay attention in commissioning different service models for the future. Again, when there is only one person at the Department doing this work and trying to make the case, it is also very hard for her. It is really about how we, as professional bodies, can help to advise and support this transformation and be engaged in an integral way, not as an outside stakeholder, with the regional workforce planning group and be part of it. That may bring about some of this change, because the evidence is irrefutable.

Mr McCarthy: Is any retraining of AHP staff required to meet the shift left to move more services into the community?

Ms K Middleton: No.

Mr McCarthy: Do you think that there are currently enough staff in the AHP workforce to be able to deliver the new service models envisaged in Transforming Your Care?

Ms R Rogers: That brings us to an example of the nub of this question. We are unsure of the staffing levels, because there has been no review since 2005. We have also not been part of the information-gathering process, so we cannot even endorse the figures from the trusts. If new staff have been employed, we do not know where they are. We need to be very careful when we discuss whether we have the right numbers in the workforce because we really do not know. We also know that the figures should reflect staff in post and not posts that are holding or where vacancies exist or have not been filled.

From what we have been saying today, you have picked up that we think that the focus should not be on the number but on a collective. It should be on the profiling of that workforce. It is almost a matrix approach; you have already moved some way towards condition-specific workforce profiling. It is that, along with what is needed in the uni-professionals, which is required. You need professional groups, for example, looking at the demographics in radiography to be able to predict and plan for those new ways of working. At the moment, we cannot answer that question, which is indicative of the challenge.

Mr McCarthy: Thank you very much for your presentation. I wish you every success. I hope that the powers that be are listening to this and will take action sooner rather than later.

Mr McGimpsey: Thanks for the presentation. It is revealing and is not dissimilar to the presentations that we have had from other groups in the workforce. You say that you can offer strategic planning solutions. Is there absolutely no contact at all from the Department about the workforce? It has set up a group for workforce planning. Is it not talking to you at all?

Mr McFarlane: From our professional body's view, we are not even recognised, Michael.

Mr McGimpsey: Are you not recognised through UNISON, other trade unions or something like that?

Mr McFarlane: They are unions, which are trade bodies. We are the professional body.

Mr McGimpsey: You are a professional body, you are not getting in in any other way, and you are not being talked to.

Mr McFarlane: We are not being recognised as allied health professions in Northern Ireland, so we are not party to any strategic documents.

Ms K Middleton: Even if you were, like we are, we are not recognised as professional bodies.

Mr McGimpsey: You do not have representation on the commissioning groups. That was an oversight.

Mr McFarlane: The employers might have representation, but the professional bodies do not.

Mr McGimpsey: To my recollection, there are pharmacists, and there was also an allied health professional.

Ms K Middleton: We need to be clear: I am saying that the professional body is not recognised. There may be clinicians, and, if there is one AHP, he or she is representing 12 professions and all the sub-specialties. We are specifically seeking to engage with and involve the professional bodies, because, as I said, we have that UK-wide, much broader international perspective on innovative solutions and a lot of the data.

Mr McGimpsey: The commissioning group here informs the commissioning plans as they go forward, and, if there is a pharmacist, a nurse, doctors and so on, there should also be a health professional. Do you reckon that you are represented on those? You should be.

Mr McFarlane: There may be professionals on those bodies, but the professional body as a whole is not represented.

Mr McGimpsey: Yes, but they are representing their professional occupation, shall we say. Anyhow —

Ms K Middleton: That might be as a collective. An AHP representative, say, of nursing or medicine, represents one profession, whereas we are 12 totally different professions. You are ranging from arts therapists —

Mr McGimpsey: A commissioning group comprises 12 people — I thought that it was 14 — and you could not have all 12 professions.

Ms K Middleton: No, maybe not all 12, but there should at least be some way to feed in from a profession-specific basis.

Mr McGimpsey: You gave us the UK total. We do not have that sort of cover whereby we can find the information about how many people we are talking about in Northern Ireland. What is your rough breakdown between secondary care and, say, community or primary care as far as your professions are concerned? Do you have any idea?

Ms K Middleton: No.

Mr McGimpsey: Do you have any idea where you think you would be once we move Transforming Your Care? Are you involved in any of that planning?

Ms K Middleton: As professional bodies, no.

Mr McGimpsey: It is very disappointing that you are not involved. I can see why you are frustrated. That is the key thing that you have to do, and you have to be in the middle of it.

Mr Easton: I understand how you feel about not being listened to. I used to be the Assembly Private Secretary in the Health Department, and, any time I talked to departmental officials, they would go away, come back and pooh-pooh any good idea I had, so I understand that a wee bit. So there you go.

Ms K Middleton: What are your top tips? *[Laughter.]*

Mr Easton: I do not have any. *[Laughter.]* Can you give us an idea of the gender mix in the AHP workforce? Is part-time working an issue in the AHP workforce? Do you think that workforce planning at a departmental level takes into account the gender mix of staffing and the associated workforce patterns?

Ms R Rogers: The gender mix is predominantly female. Some of the professions have more of a male/female split than others. Speech and language therapy would be 99% female, and physiotherapy and radiography are different.

Mr McFarlane: The last figures that I saw stated that, locally, around 25% to 30% of paramedics are female. I do not think that part-time working is a big issue. It is fairly well accommodated.

Ms R Rogers: We are more interested in seven-day working because of a lot of the work that AHPs do. I am thinking particularly of speech and language therapists assessing swallowing in the acute hospitals. Very often, that swallowing assessment is the difference between someone being able to leave hospital or not, so seven-day working for some of our AHP colleagues in those sectors will help to make a difference with throughput. As a collective, the AHPF is very supportive of the ethos of a flexible workforce and, with a predominantly female gender mix, greater accessibility to work. We are also aware that seven-day working is very helpful with appropriate resources. It needs to be resourced as that. Paramedics are an optimal example of 24/7 working.

Mr McFarlane: We work 24/7, so it would be nice to have other professionals to whom we can refer our patients also to work 24/7, or at least work a seven-day week.

Ms R Rogers: There have been pilot schemes with OTs and physios working for seven days.

Mr Easton: How did that go?

Ms R Rogers: It went surprisingly well. With appropriate resource, it prevents that massive block on a Monday and the massive rush on a Friday. You are also able to provide the right support in a timely way, which is very helpful not only to families but to patients.

Ms K Middleton: We need to bear in mind that there is huge diversity in what people in the allied health professions group do, but the general ethos is to support independence and to maximise anybody's potential to work, to function, to get home and to do whatever they want to do. We do not create dependency like the medical model can, and we are often invisible because our success is based on a person being more independent and not relying on us as clinicians. Think about what happens over a weekend or an evening, for example. In my clinical practice, I can remember the difference between leaving an orthopaedic patient on a Friday and seeing him or her again on the Monday. There was deterioration. It was pain and discomfort for the person, and the length of time that that person was in hospital was elongated when he or she could have been at home being independent, starting to get back to work and so on. The other part of the transformation that we are talking about is not just about a different workforce and different service models but about a different way of thinking about health care. It is about empowering people to take control of their own health and well-being, with a focus on independence and work rather than dependence on a health-care system, because, otherwise, the NHS is constantly picking up the pieces. It is about a shift in thinking about health care. I read the TYC document, and that theme comes through. It is about care closer to home and de-medicalising our health and well-being, and that is where AHPs, particularly over seven days, have a real role to play.

Mrs Cameron: Thank you for your presentation. You have pre-empted my question, but I will ask it again for clarity. This review is looking at the desirability of seven-day working. Rosalind, you spoke about that. Is it an issue for allied health professionals? Obviously, it is not an issue for you as such,

but there is a knock-on effect, and you would need other people to work in that fashion as well. Do you have any ideas as to how that would work or how those issues could be addressed?

Ms R Rogers: From the perspective of the AHPF, nobody in their right mind would expect the same workforce to move from five days to seven days, so it comes with the caveat of appropriate resourcing. We find it invigorating that, despite the pressures and stress of being in the front line — it is tough, as we know — there is still an absolute willingness to embrace a fundamental change in a pattern of working because it is making a difference. I think that the flexibility and commitment to being innovative, because it makes a difference to the person, is percolating through our memberships across our professional bodies, which is why I think that we can say with confidence from our Allied Health Professions Federation's position that we are fully supportive of it because it makes sense.

Ms K Middleton: You cannot, however, provide a five-day service over seven days for the same amount of money or the same service. It has to be different in some way.

Mrs Cameron: I appreciate that.

Ms K Middleton: The savings would be reaped further down the line.

Mrs Dobson: Thank you for your presentation. It was certainly very frank and honest.

My question relates to one of the terms of reference for the review, which is to examine the extent to which workforce planning is taken into account in recruitment issues for particular geographical areas. Rosalind, you referred to the inconsistency between trusts and the need to engage properly and locally. Obviously, workforce planning for geographical areas is crucial. Is this an issue for AHPs, and, if so, how do you propose to address it?

Ms R Rogers: At the moment, as we said, there is one seconded lead officer post who advises the Department and oversees the 12 or 13 professions. It is very difficult for us, as the AHPF, to know about recruitment issues for geographical areas. The reasons for that come back to the fact that we do not have an appropriately positioned and resourced Department-level advisory team. The very fact that that AHP lead post is not permanent speaks volumes. There is a potential crisis if that person is on leave or on holiday. I do not know of any other significant part of the workforce that does not have the capacity for Department-level advisory issues to be picked up. If that one person happens to be on leave or is unable to work, that affects 12 professions. That inconsistency in support between the groups, medics, nurses and AHPs is very real and is damaging our ability to transform how we deliver care.

Mrs Dobson: Essentially, if anything happens to that person, it falls apart.

Ms R Rogers: It absolutely does at departmental level. In each trust, the strategic position of the AHP voice differs, so no one model is consistent across the trusts. There are anomalies in that not all trust AHP representatives represent all AHP groups, so all 12 professions might not be represented in the trusts. For various reasons, the South Eastern Trust has been identified by the AHPF as a good structure in that there is an AHP lead who is able to give appropriate evidence on waiting lists and articulate targets and whether they are being met, looking at budgets and delivery across time frames.

Mrs Dobson: How do you then replicate that across the trusts?

Ms R Rogers: We are certainly interested in the Northern Trust because it is restructuring. It is talking about putting AHPs on to the nursing lead. As the AHPF, we would clearly be seeking to influence whether they are on a par. It is about getting that AHP lead role positioned in each of the trusts at the right level.

Mrs Dobson: I note your comment: "seeking to influence".

Ms R Rogers: Yes.

Mrs Dobson: How realistic is that? How do you make it happen?

Ms R Rogers: We are here today pooling the resources of our 12 professional bodies to work and campaign together and appropriately. We are working through our networks and special interest groups. We are working across condition-specific groups. However, I have to say that any leverage — at any level, anywhere, anyhow — would be greatly appreciated.

Mrs Dobson: There certainly has to be willingness in the trusts to make it happen.

Ms R Rogers: Again, we have a responsibility, as professional bodies, for ensuring that the very positive, can-do examples are promulgated.

Mrs Dobson: You talk about the need for a culture shift in language in referring to health and social care. Do you feel that, given current perceptions, it will take a long time to achieve that shift? Where do you see it starting? Do you see it starting from the top of the health service, or do you see it being patient-led and moving upwards? Such a joined-up approach is recommended by patients. They know how it works for them. If it is patient-led, will it take a long time? Do you think that this should be patient-led, or should it start with the health board?

Ms R Rogers: I will address that first and then hand over to my colleagues. When patients have very strong charities articulating their voice and lobbying for them — the Stroke Association is a good example — that is a powerful force, in partnership, for change. In my field of speech and language therapy, when someone does not have a voice, is not empowered and does not appreciate how much better it could be, it is impossible, at an individual level, to see how change can be brought about. Through a partnership such as the long-term conditions alliance, lobbying together could make that patient voice very vocal.

Mrs Dobson: People power is very powerful.

Ms R Rogers: It is, but that is in combination with the strategic planners, the commissioners, the PHA and the trusts.

Mr McFarlane: The Department must also be a voice for us to promote what we can do.

Ms K Middleton: People power is really powerful, except that the people whom these professions see over time are often the most marginalised in society anyway and do not have a voice or the ability to get to a place to speak and so on. Every now and then, you get a very vocal, articulate person in the public eye. Andrew Marr, for example, following his stroke, has done a huge amount to express what the allied health professionals, and physiotherapy in particular, have done for him. If you want culture change, you will find that it comes about as a result of change at the very top. People forget how important language is in terms of culture change. Simply repeating "doctors and nurses" will just reinforce the message that health care is about only doctors and nurses. We spoke about the experience in Australia where Ministers refer to "doctors, nurses and allied health professionals". The nearest we have ever got to that in the UK is "the unsung heroes", which speaks volumes.

Mrs Dobson: Is that the paramedics, then? *[Laughter.]*

Ms K Middleton: There is something about creating an expectation from the top that this group of professionals — the third-largest clinical workforce — would be involved. That needs to come from the top.

Mr G Robinson: I listened to the Queen's speech today and noted that the new Government propose seven-day working for the health service.

Ms R Rogers: I was delighted to hear that on the radio. I thought that that very much echoed our thoughts in preparing for today.

Mr McCarthy: At least the Queen is listening to you.

Ms K Middleton: I said that it had to start from the top. *[Laughter.]*

The Chairperson (Ms Maeve McLaughlin): Thank you all. The session has been very useful. As we conduct the review, a clear pattern is emerging. As well as workforce planning and the need for the

federation and the professional bodies to be able to influence and participate in the process, there are issues about the system and the cultural shift to which you referred. It is bringing roles, remits and commissioning issues to the fore. That has been extremely useful for us today, so thank you for taking the time. We will reflect on your evidence.

Ms R Rogers: Thank you very much. We appreciated your time.

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT
(Hansard)

Review of Workforce Planning in the Context of Transforming Your Care: Scottish Government Officials

10 June 2015

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NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Review of Workforce Planning in the Context of Transforming Your Care: Scottish
Government Officials

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Alex Easton (Deputy Chairperson)
Mrs Pam Cameron
Mrs Jo-Anne Dobson
Mr Paul Givan
Mr Kieran McCarthy
Ms Rosaleen McCorley
Mr George Robinson

Witnesses:

Professor Ian Finlay	Scottish Government
Mr Grant Hughes	Scottish Government
Ms Shirley Rogers	Scottish Government

The Chairperson (Ms Maeve McLaughlin): I welcome Ms Shirley Rogers, who is the director of health workforce; Professor Ian Finlay, who is a senior medical officer; and Mr Grant Hughes, who is head of workforce planning. We are pleased to have this communication today. I invite you to make an opening presentation, after which we will open it up for members' questions and comments.

Ms Shirley Rogers (Scottish Government): Thank you very much, and thank you for the invitation to speak to the Committee. We are delighted to be able to *[Inaudible.]* in the context of the review of workforce planning you are undertaking in Transforming Your Care. You have asked us to give evidence on how we developed Everyone Matters, which is our workforce vision *[Inaudible.]* —

The Chairperson (Ms Maeve McLaughlin): Can I stop you while we check our sound levels? It might be our end. Can you go ahead now, and we will check that?

Ms Shirley Rogers: Is that better?

The Chairperson (Ms Maeve McLaughlin): Yes.

Ms Shirley Rogers: Thank you.

We are delighted to share that with you. I was just going to briefly touch on how we formulated the work that we have done and particularly concentrate on some of the sustainability and workforce planning issues, which I think are of particular interest to you.

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Our workforce strategy covers NHSScotland, which employs 159,000 folk. It supports a 2020 vision for health and social care in Scotland, which is essentially for everyone to live longer and healthier lives in their own home or in a *[Inaudible.]* setting. Underpinning that is a healthcare system that has integrated health and social care and a focus on prevention, anticipation and supported self-management. Within that, *[Inaudible.]* a shift in our future direction of travel that is much more about community-delivered services. So, when hospital treatment is required and cannot be provided in a community setting, *[Inaudible.]* treatment should be the norm.

Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all our decisions. There is a particular focus on ensuring that people get back into their local community environment as soon as possible, with the minimum risk of readmission. So we are looking at those issues very carefully to make sure that people are *[Inaudible.]* back home, and we are monitoring the impact on readmission, because clearly it is not anybody's interest to have patients who are sent out of hospital only for them to return in quick order.

Our 2020 workforce vision is about responding to the needs of the people we care for, adapting to new and improved ways of working, working seamlessly with colleagues and partner organisations, continuing to modernise the way we work and embracing technology. There is a huge thrust *[Inaudible.]* for technology in Scotland. We have a very concentrated population in our central belt, and areas of Scotland clearly have a huge remote rural aspect. We are not dissimilar to you in that way.

The values that we share across NHSScotland are about care and compassion, dignity, respect and openness; the sorts of things you would expect to see. That vision has been co-produced with our workforce. Everyone Matters had an extensive engagement exercise, with over 10,000 NHS workers in the first year contributing to its creation. That discussion has continued with similar numbers each year. The format for that strategy is that we produce something that we have an annual implementation plan for, and we hold our board to account for that implementation. You may wish to talk to us a little bit about how we do that later on.

There are five key priority areas, including something about culture, sustainability and the capability of our workforce. I have just described significant change, and we are supporting our workforce so that they have the skills and confidence to deal with that. A big piece for us is integration, not just in terms of health and social care but also primary and secondary care. Effective leadership and management make all that come to fruition. We produce an annual plan, and we are just about to produce the first annual plan to demonstrate how this approach is having an impact on our system. Some of that has been quite interesting and quite transformative.

I suspect the bit that is of particular interest to the Committee is in the space around sustainability and how we use workforce planning to do that. We have a sustainability and seven-day services task force with a ministerial direction, which I chair. That is a hugely important area of work that has the potential to make significant improvements in care, because it is about service redesign to create excellence and create services for patients in a manner that is appropriate to our vision whilst ensuring that we are doing so in a manner that is sustainable in terms of our workforce.

We recognise, as anybody would, that the NHS already delivers a range of services across seven days. However, we accepted that we could and should do more to ensure that those services that are developed are readily accessible across the weekends, so that we do not get dips in performance and we do not get the characteristic Monday morning pile-ups of activity because services have not been available over the weekend.

Sustainability, as I said, is written all over it. That is the prize of our workforce strategy. We recognise the particular challenges of sustainability in remote and rural Scotland *[Inaudible.]* of activity in that place. We have also been looking fundamentally at the sustainability of rural general hospitals, and there has been some really interesting early success in that area. It is not a quick fix; we know that. It is a complex piece of work, and some of the changes that we will need will take time. We have an interim report from the task force, which went to Parliament earlier this year. The Scottish Parliament has endorsed that, and we have an action plan that we are taking forward in respect of it.

Workforce planning has been a key focus in our work on sustainability. Essentially, we are trying to put some science and some really robust data into what had previously been the art of workforce planning. We are working with a range of stakeholders to improve on the established models and processes. We are keen to identify workforce risks earlier and make sure that, instead of those risks

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coming to us as a surprise, we have done sufficient analysis to be able to adjust our pipeline to give us a ready supply. We have worked very closely with HR directors and medical directors in boards to put this in place, and we have established a community of our workforce planners across boards, which government leads, to make sure that all the boards are supporting government action and vice versa in respect of it.

There has been a lot of work around developing better intelligence. We now have medical specialty profiles for every one of our acute hospital-based specialties, and we are just starting to do the same in respect of our GP workforce so that we have got all of the supply chain that we need to make that happen. It is not restricted to medicine: we are doing similar work in respect of nursing and the allied health professions (AHP) workforce. We have a significant amount of work underpinning that in terms of nurse workload profiling, so we know the numbers of nurses we need in particular specialties in particular wards at a particular time.

Some of the stuff that we have been using to yield that information includes medical training establishments; pre-emptive, targeted and strategic approaches to management of rota gaps and service pressures; working much more intelligently around recruitment processes in our hard-to-fill posts; taking forward the transition to the shape of training, which you will be aware of, and I am sure that other people have spoken to you about the Greenaway review; and making sure that we have appropriate information to be able to feed into other processes, such as *[Inaudible.]* in terms of shortages, gaps and so on. As I said, we have got all of our hospital specialties profiled. When I say "profiled", I am talking about the consultant workforce that we already have and the *[Inaudible.]* trainees and medical students who are in the pipeline coming forward. We have focused a lot on some of the key acute specialties, including emergency medicine, anaesthesia, intensive care, clinical oncology, psychiatry, radiology and that kind of stuff. We have also developed profiles for newer specialties such as intensive care medicine, joint infection training and so on. As I mentioned, the focus for 2015 is on the GP medical workforce.

We believe that sustainability will be delivered through different service models and through our ability to craft a workforce that is genuinely multiskilled and multidisciplinary as appropriate, not just in terms of health but in terms of our local authority colleagues and others working in the voluntary and independent sector.

If I may, I will stop there. I can go back through all of the five priorities of Everyone Matters if that is helpful, but I think that your Committee is concentrating particularly on workforce planning. If that is helpful to you, that is great, and we are very happy to take whatever questions you might have.

The Chairperson (Ms Maeve McLaughlin): Thank you, Shirley, for that. Apologies; we probably missed a bit at the start because the sound was not great. The sound has improved in the last while, but be mindful of all of us here speaking clearly into the mic. Apologies, Shirley, if we ask you a question that you have already dealt with. Please bear with us.

I am particularly interested in the planning guidance for workforce planning. You talk about workforce planning being a statutory requirement that was established in 2005. Can you maybe give us more detail around that in relation to who monitors its compliance with the law?

Ms Shirley Rogers: I will give you the general parameters of that and then invite Grant to put some of the flesh around that. Our relationship with our 22 boards is very close. We have a requirement on boards to produce something called a local delivery plan (LDP). They do that annually, and that is, essentially, their contract with Government. When we receive that LDP, that gives us an opportunity to talk to them about budgets and all of that kind of stuff. We have an annual accountability process with those boards, and that accountability review is generally chaired by a Minister. Sometimes not, if it is a small board with not that many issues, but almost all of those accountability reviews are ministerial reviews. In the course of that LDP process, which includes workforce planning, we will go through with the board all of the issues of concern that they may have, development plans and, essentially, their plan for ensuring the sustainability and the delivery of that service.

The guidance that underpins that is produced in something that we call chief exec letters (CEL), which are essentially the instruction from our director general, who is also the chief executive of the NHS in Scotland. He issues those letters, which cover how we expect boards to do that. We will go back to them if we believe that the plans that have been produced are not sufficiently robust or not sufficiently

detailed for us to be able to make an assessment. We sign that off as part of their contractual arrangements — contract is too strong — with the Scottish Government. Grant, do you want to talk through the specifics of the statutory bit?

Mr Grant Hughes (Scottish Government): Yes. Thanks, Shirley. Hello there. I am the head of workforce planning. I am responsible for ensuring that the boards adhere to the guidance that we put out. You have a copy of the most recent of that guidance. That is in what is known as CEL 32 (2011). Regarding the practice around that, it is mandatory that boards have to provide us with workforce plans. That has been mandatory for around 10 years now. Quite a lot of background is given in that chief executive's letter and the guidance that accompanies it, and I will focus in one or two things that might help members to understand where we sit on those areas.

We play a monitoring role within the Scottish Government in terms of our requirements on boards to provide workforce plans, and also three-year projections. Part of that is around the local service planning process, which they are required to fulfil by the Scottish Government. As Shirley mentioned, the implementation framework for Everyone Matters, which is the overriding policy strand that we deal with, is also something by which we hold boards to account.

Workforce planning is integral to all of that. That is what the CEL 32 guidance covers. We give boards guidance on a methodology of how to workforce plan. We give boards tools to enable them to match their service requirements with the right workforce. For example, on the nursing and midwifery workforce, we currently have some groundbreaking tools that are helping boards to determine what their future nursing workforce needs are. What boards provide to us is evidence about what they are doing and how that links to service planning.

I will stop there for the moment, because I am conscious that I could probably go on for quite a long time here. I do not know if members have particular areas that they want to highlight.

The Chairperson (Ms Maeve McLaughlin): Thanks for that. Has the fact that workforce planning is statutory raised the profile of workforce planning within Government?

Ms Shirley Rogers: Absolutely. We publish national workforce statistics on a quarterly basis in February, May, September and December. We use that to ensure that the boards are absolutely cognisant of our direction of travel. There are certain things that we are starting to be able to look at — for example, spend in the primary care world. If our objective, as I said at the outset, is to have more services provided on a community and primary care basis, it follows that we should be spending more in that area, so we look at how we are allocating resources from the centre. We have comprehensive plans around doctors, nurses, midwives and AHPs. We subject those to quite considerable levels of scrutiny, both as entities in themselves and to see whether or not there are sufficient numbers of each of those groups to be able to provide multidisciplinary teams.

The profile is extremely high. It is demonstrating Government's commitment to sustainable health services, so it comes in for a great deal of public scrutiny, media scrutiny and so on, as well. It runs alongside certain other of our commitments about supporting our workforce in an appropriate way to adapt to change and making sure that they are invested in in the appropriate ways through training. Workforce planning is as high profile as it gets. As the director for workforce, which is everything from how many people we allow into med school in the first place to paying for pensions and everything else, including uniforms and standards of conduct, I would certainly put workforce planning at the top of my job description in terms of the things that we absolutely have to get right.

The Chairperson (Ms Maeve McLaughlin): Thank you; that is very clear. What we are struggling with is that we have a policy direction of shift left but are only now, some three-plus years into that policy direction, looking at the area of workforce planning. I am very interested in your clarity around workforce planning as a statutory requirement and how that is assisted in terms of the profile, monitoring and priority that it is given.

One of the issues that are very apparent — it was also apparent when our Committee visited the Scottish Health Committee recently — is the area of partnership and cooperation. I notice that your workforce vision states that it was informed by 10,000 people, including NHS staff, trade unions and professional organisations. I am very interested in that model. The question for me is this: who was the lead in charge of that overall vision and strategy?

Ms Shirley Rogers: I will give the easy answer to that bit first. The lead responsible for the formulation of the workforce vision is me. It was me at the outset and it continues to be me and my team. On those other two issues, fundamentally, whatever you want to do with health and the delivery of health is dependent upon — I am going to say something blindingly obvious, so forgive me if it sounds blindingly obvious — having a workforce to be able to do it with. The first objective of the vision of workforce planning was to make sure that the people of Scotland were going to have a sustainable health service because we had enough people to be able to deliver it. More importantly, perhaps, given that a lot of this agenda is about changing the workforce and not just about adding to it, we had to have a workforce that was flexible enough and could be planned enough to be able to deliver sustainable solutions. Our approach has been that workforce planning is a bedrock thing from which you can vision, as opposed to a second-order thing that you come to when you get to it, because you cannot do without it.

The partnership approach is deeply embedded in the way that NHSScotland does its business. I am a workforce director within the Scottish Government, but I have previously worked in a board, and our relationships with the boards are very strong and our partnership model is very strong. It is not fluffy. It is not that we engage with people because we want them to feel that we are engaging with them. It is about saying, "We co-produce with you because you have responsibilities in this space as well as we do." We take it for granted that we will engage with our workforce and listen to the issues that it has, but we will also seek responsibility from it in terms of the implementation.

I will give an illustration that is not solely in this space. We have a no-compulsory-redundancy policy in the NHS in Scotland. The price of that is that we expect people to be flexible in order to allow us to manage service change. That works for us. We are strongly in the space of co-production and spend a lot of time working with our trade unions to do that, but part of the benefit of that, apart from the fact that they are on the front line and know some of the stuff that is going on, is that we expect them, when they are co-signatories to something, to also be part of the implementation of that. That expectation is very high.

Ms McCorley: Thanks very much for the presentation. Can I ask you about the shift left, if that is what actually happened in Scotland and that is how you would describe it? Here, we have a policy known as Transforming Your Care, which is an overarching road map for change in the provision of health and social care services, and its aim is to provide more care at home or in the community and to reduce the amount of care required in hospitals. Was there a similar attempt in Scotland to shift left?

Ms Shirley Rogers: Yes. We do not use that expression. I know what you mean by that. I think that the commonality of it is quite tight, though. Our premise is health care for an aging population. To ensure that that aging population is able to age as healthily as possible, we believe that it is best delivered in community settings or at home. As a result of that, we are in the process of shifting some of our resource to be able to do that. It is also a feature of how we are designing specialist services, because we recognise that Scotland cannot have all those high-intensity specialties in every town, particularly in rural Scotland. Our commitment to our population is that for heart/lung surgery, you will go the Golden Jubilee National Hospital in the west of Scotland, because, frankly, a population of five or six million people would not sustain a heart/lung centre in every town in Scotland. The price of that is that you will have enhanced community-led and other services in the place where you live. It is about having high-end specialties where we need them.The quid pro quo for the public is that, for the things that you do not need high-level intensive acute therapy, we will make sure you have sustainable local services.

Ms McCorley: OK. I was going to ask you whether service delivery models were required and had been developed, but clearly they had. Were service delivery models in place before you started to look at the workforce and the workforce strategy?

Ms Shirley Rogers: Some were; others were not. Parts of the system flexed because they needed to do so because of the nature of its sustainability. There was some creative thinking at a local level. Some of that required policy thought. I mentioned in the presentation that we looked at the sustainability of our district general hospitals. That required us to help local systems by producing models that look at their workforce.

Another illustration might be helpful. We were struggling to get hospital specialists who wanted to go into district general hospitals, and when we spoke to them, they said that they wanted to be in a rural setting but were anxious about losing some of their educational and other links as a result of being in rural locations as opposed to big centres of excellence. We were able to work with them to develop a

model of mentoring and educational links, and fellowship links in some instances, allowing them to adopt rural practice and get all the benefits of that, while not feeling that they had abandoned all their links to the great centres of excellence in the centre belt. So, some things happened locally, and some things we developed and shared with the boards to help them steer a different route than they might take to a sustainable workforce.

Ms McCorley: Did the workforce strategy necessitate training or retraining in new skills, and, if so, who took the lead in implementing that?

Ms Shirley Rogers: I think that a version of our workforce strategy was sent to you. In it, one of the five priorities was capability, which addresses exactly the points you have made. Capability was about making sure that people had educational support where necessary to allow them to make the necessary changes. Some of that was driven by me and my team, and Ian Finlay might want to say something about it in a second. Some was driven by NHS Education for Scotland. We have a special health board that delivers education solutions, sponsored by my directorate. It works with the deans, the medical schools, the nursing colleges, the nursing universities, and AHP development across the piece to make sure that people have good skills.

We have also done quite a lot of work in leadership and management development, because we wanted managers to lead the NHS in Scotland who were looking for creative solutions and were happy working in an integrated space. There is an awful lot of activity that takes place in the boards too. We have a network of organisational development and education leads in the boards. Some people from the Scottish Government and my team helped support them by sharing the vision and helping them to craft a syllabus that would deliver educational excellence. Ian, would you like to add something?

Professor Ian Finlay (Scottish Government): Thank you. I am Ian Finlay. I am medical adviser to NHS Workforce for the Scottish Government. The only thing I would add is that this is a dynamic process. Our anticipation is that we will need to find a different kind of doctor now and going forward to meet the differing needs of patients. In that respect, we are quite interested in some aspects of the Greenaway review, which talks about a more general doctor providing a wider range of care in the community. We are actively exploring whether the time is right to look at new training programmes that will help us blur the interface between the community and the acute hospital sector. We are considering pilots of that type even as we speak.

Ms McCorley: I have one final question. What do you feel is the importance of self-referral physiotherapy and suchlike in transforming the delivery of healthcare in Scotland?

Ms Shirley Rogers: If the question is targeted at the workforce as regards self-referral to occupational health services (OHS) and physiotherapy, then it is a lot. We have done a lot around the working longer agenda. If the question is about patient care, then I do not know whether you heard me at the beginning talking about our triple ambition, which is safe, effective and person-centred. We are working as hard as we can to support the population of Scotland to be healthy. Like you, we have been very thoughtful and proactive in anti-smoking, minimum pricing for alcohol, obesity, and exercise and its contribution to physical and mental health well-being. We encourage patients and their carers, as best we can, to access services that are appropriate to them. We have had quite an interesting debate about the extent to which access has to be through the gateway of a GP. We have a model emerging that is GP-led but not necessarily GP-delivered. There is something there about how people access. We have a number of walk-in facilities and minor injuries units that allow people to access services in that way. We have also spent a lot of time looking at extended nurse practice. We are working with AHPs around extended practice.

Mr McCarthy: Thank you very much. Good afternoon, Shirley, Ian and Grant. I detect that the answer to my question was probably given to our Chair earlier. It seems from your workforce vision implementation framework and plan for 2014-15 that your NHS boards and the Scottish Government have the majority of the roles and responsibilities. What is the relationship between those two bodies when it comes to workforce strategy?

Ms Shirley Rogers: The policy for workforce strategy sits with the Scottish Government. We developed that strategy with the boards. We have also been a bit more direct in some of this. As you would expect, boards have a very strong strategic role, but they are also in the everyday and work in very close time frames sometimes. If we look at medical education, in particular, then I struggle to think of anything in public-planning terms, other than big capital builds, that takes longer than it does

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to get somebody from medical school through to a certificate of completion of training (CCT) and a consultant's licence.

Our direction has been quite strong. Essentially, we are planting the seeds for the whole of Scotland to harvest. We have not necessarily relied on boards anticipating some of these things. Government has a legitimate place in the 15-year or 20-year planning time frames for that workforce. It is probably a place that only government can have.

We work very closely with the universities. We have the Scottish Board for Academic Medicine, which is, essentially, a board created from the five medical and two dental schools in Scotland. I meet it on an annual basis to discuss how many people from Scotland we are going to allow into the medical schools and how that is going to operate. We are represented there.

On occasions, we have looked at the information we are getting from our profiling and have said that the boards are not looking far enough ahead. For example, we have seen a significant expansion in consultancy in emergency medicine in Scotland. We have been able to do that because, essentially, we took a view a few years ago that we were going to need more consultants in emergency medicine. So, it is not a strategy that is done to the boards. We work very closely with them and try, as best we can, to have something that suits everybody's needs in the short-, medium- and long-term.

In strategic terms, it is probably driven more by us in government than it is by the boards. Of course, board management is only one group of people who make healthcare strategy come alive. We need the cooperation of our medical schools and colleges of nursing. We need a whole raft of different organisations. We worked very closely with colleagues in education and worked very strongly to reduce inequalities in Scotland; so we are looking at things like the postcodes from which we draw our medical students, and we are working with education colleagues to see if there is more we can do to target them. I guess the point I am making is that there are some things that government can do much more easily than boards can. There is also a coherence from government that can knit together what the varying positions of 22 boards might be and can project a bit further to think about what we might need to do in strategic terms. That is what we try to do.

Mr McCarthy: Thank you very much. It sounds like it is very important, indeed vital, that all organisations work closely together to get to the end result that you want. I will take this opportunity to wish you all the best and thank you very much for enlightening us this afternoon. Thank you very much.

Mrs Cameron: Good afternoon. Thank you very much for your time today.

Ms Shirley Rogers: It is a pleasure.

Mrs Cameron: The Committee has received evidence from a number of professional bodies. One of the major issues here is recruitment and retention of healthcare staff, particularly doctors and nurses. Is that the case in Scotland? If so, how are you addressing those issues? For example, are you using any incentives or penalties to keep qualified staff in your jurisdiction?

Ms Shirley Rogers: Recruitment and retention are issues for us in certain key specialties and in certain locations. The practices that make up for those recruitment and retention issues are multiple. Some are about work/life balance choices. We operate a significant number of our services on an on-call basis, and earlier we touched on some of the rural issues which make that the case. We have the same kind of challenges that some of our UK brethren suffer from in relation to the general dearth of certain specialties. We are being very proactive there, and some of it comes about because of the intelligent data we now have from planning.

I will share with you that we now know, precisely, the destinations of the kids from Scotland who go to medical schools: we know how many we retain in Scotland, how many have an aspiration to work on a full-time basis, and whether any of them wish to work on a part-time basis. That has allowed us to adjust the ratios of numbers that we train to fill those key specialties. For example, for certain key specialties such as anaesthetics, paediatrics, and so on, we now train on a 1·6:1 ratio. That is really to make sure that we have a sufficient supply at the end of it.

Currently, we do not incentivise our medical workforce with bonuses for joining, or anything like that. We have a bonding scheme for our dental students, which we use to good effect, and we now have a

sufficient supply of dentists. We are thoughtful about that as we know that other parts of the UK are thinking in that area, and we have not yet reached a position on it.

We do not operate any kind of disincentive to leave. We work on the principle that we are trying to create a working environment in Scotland that is good enough so that people will want to participate in it; and in the vast majority of cases, that is the case. We are thoughtful about how we support people; so, for example, we have a GP returners scheme for people who left general practice a little while ago and are seeking to come back. We have several initiatives about returners into the workforce that encourage people to be able to do that.

We are as creative as we are can be in talking to people about the career choices they want to make and in sending a very strong message that the NHS in Scotland values its people and wants them to continue to work with us. That has generated significant payback for us; there are a lot of people who appreciate the fact that they are appreciated. We are not perfect by any means and there are challenges around sustainability, particularly in remote and rural areas.

Our spread of hospitals is quite significant. We have 29 A&E receiving units across Scotland. Some rotas for units in rural Scotland are quite small, so a gap on a rota can be quite significant. The rota in the Southern General Hospital in Glasgow has hundreds of people on it, but some smaller hospitals in rural Scotland have rotas with half a dozen people on them. Gaps in those rotas can have a significant impact. A member of my team here works very closely with the boards to look at how rotas can be designed to be most attractive and how we can support junior doctors through those rotas. We have been very creative in saying that our expectations of junior doctors are that we no longer have seven night shifts in a row in Scotland. We are just about to be able to say something similar about our day shifts. Our message is that the workforce in Scotland is valued and that, as a result of that, we want them to stay.

You will have heard evidence — I hear it too — of individual instances where we have issues and need to address them. I am not saying that we do not have recruitment and retention issues, because we do, but we are working very hard and creatively in that space. That is why we started the Everyone Matters vision with some values. In my experience, people want to work in the health service, and when we reinforce those messages we have found that it has generally had a very positive effect.

Mrs Cameron: Thank you very much.

The Chairperson (Ms Maeve McLaughlin): Were the Scottish Government able to influence GP contracts?

Ms Shirley Rogers: The Scottish Government have a slightly different position on GP contracts, in that they were negotiated with a view that there would be a two-year window to allow us to look at and review service redesign. My colleagues in primary care work very closely with the GPs and I am just in the foothills of starting to think about what a GP contract in Scotland might look like. However, it will reflect the changed service delivery model that we have just been discussing.

The Chairperson (Ms Maeve McLaughlin): Thank you for clarifying that.

Ms Shirley Rogers: May I just make an observation? There is an interesting point there about the tactics of how this has worked. In all the service redesign work we have done, we have been very up front with all our staff side partners that service redesign will drive the terms and conditions rather than the other way round. We will design the service model that is appropriate for the needs of the people of Scotland and then we will talk about the pounds, shillings and pence attached to that, rather than having a more negotiated terms and conditions package which, in the early 2000s, left us with service issues to address.

The Chairperson (Ms Maeve McLaughlin): I understand that. I ask about this because one of the issues has been about recruitment, training and retention. Every time the issue of retention is raised, we are informed that we cannot negotiate and that GP contracts are set. I am talking about retention in terms of GPs being trained and then, in terms of their contractual commitment, delivering the service in the North. I am interested in the approach you have taken on that because this is an issue for us.

Ms Shirley Rogers: We looked at the quality framework used for GP contracts quite carefully, and we looked to see what it was that we wanted to buy. We have tried to get ourselves into a position where we are having some very positive early discussions about how a GP contract needs to reflect the reality of how GP services are delivered in Scotland.That is not the same as the way that they are delivered in Westminster, Kensington or wherever. We have to have a contract that reflects the nature of the practice here.

While we are on the subject of GPs, we are also very thoughtful about some of the messages that we are getting from young GPs who were talking to us about their desire for a different kind of contract. Coming back into the vocabulary in Scotland is a much more positive discussion about the potential around the salaried GPs, for example.

Mrs Dobson: Good afternoon. Thank you for your briefing. It is always interesting to hear of experiences in other regions. We can learn so much from that, and we should do it more often. The majority of the health and social care workforce in Northern Ireland is made of up women: is that the case in Scotland?

Ms Shirley Rogers: Yes. I think that the feminisation of the workforce in health and in our medical communities is evident, and that is also the case in our nursing communities and among our care providers; yes, absolutely. There are variations in that. Ambulance Service provision is still largely male, for example, but a number of other specialities are now more than 50% female.

Mrs Dobson: I noticed earlier that you talked about a workforce that is flexible enough to deliver that vision. With that in mind, whilst developing your workforce strategy, did you have to take into account the number of women and, for example, maternity leave and part-time working patterns?

Ms Shirley Rogers: Yes, absolutely. I made reference earlier to the ratios that we are currently supporting through training, and those ratios are largely predicated on the fact that women make different choices and that we have extended training programmes; for example, there are extended time frames for the delivery of those training programmes, because people take maternity leave and come back on a part-time basis. Indeed, as we have an aging population, people have caring responsibilities for their parents as well as for their children increasingly, and obviously that is not just restricted to women. Yes, there is flexibility and an approach that says that we should come at an issue with a view to finding a flexible solution. We have a high degree of part-time working, a high degree of school contract hours and term-time working and a raft of provisions that allow for as much flexibility as we can give. We have to be thoughtful of that through the rotas, because we want to do that as an employer, and, at the same time, we know that we need to be able to deliver a 24/7 service to patients. We work very hard to craft rotas that allow for that flexibility and maintain appropriate levels of staffing at all times.

Mrs Dobson: It was good to hear you speak about work/life balance issues earlier and how important that was in Scotland. That takes me on to my next point, which is the provision or desirability of seven-day working. One of the terms of reference for this review is to examine the extent to which work planning is taking account of seven-day working. Is that an issue for Scotland, and, if so, how long has it been addressed?

Ms Shirley Rogers: As I said at the beginning of my presentation, one of the messages that we have worked really hard to get over publicly in the seven-day service debate is that the NHS in Scotland has always delivered a seven-day service. If you have a heart attack on a Saturday, you will get treated; it does not matter that it is not a Friday. We have had a slightly different tone in some of the seven-day services stuff in Scotland than has come from the Department of Health in England stuff. We have tried very much to make clear that we are not talking about a Tesco solution; we are not saying everything every day and every hour of the day. We are not talking about old ladies being taken in for hip replacements at 2.00 am and then being ejected out onto the street. We are talking about things that really make a difference to the quality of care. Some of those have been the ability to have diagnostic tests at the weekend, and we have concentrated hard on that area. There is a whole raft of other wee bits that you will have seen in seven-day services plan.

All that has been mindful that we have a workforce that has a number of aspirations. Some are able to extend their hours and want to do that. Some want to work in different ways, so Agenda for Change has been helpful for the number of people who want to look at extended hours. However, some people simply cannot do that, and we have to be mindful of that because we want to retain the people we have.

When we started the 2020 Vision a few years ago, one point that I needed to make routinely was that a good 90% of the workforce that we were going to have in 2020 we already had. So it was not enough to focus on new folk coming in; we had to produce something that was supportive of the people we already had and that adapted to their changing needs and to the fact that our workforce is ageing and how we support them. Therefore, we have spent a lot of time on education and training and supported occupational health. All those things allow people to feel that they can be fully effective at work and have a life.

Mrs Dobson: It sounds good. Thank you.

Mr G Robinson: Good afternoon, Shirley, Ian and Grant. Does Scotland have recruitment issues in particular areas, such as rural locations? If so, how is that addressed? Are incentives used to recruit staff?

Ms Shirley Rogers: We have recruitment challenges in rural Scotland, particularly in the area of GP recruitment. Ian mentioned the work we are doing to look at the community GP training model to see if there is more that we can do in that space. We have, in common with you in some parts, high use of locums in order to maintain delivery. We are looking hard to see whether or not there is a salaried GP model that might help us.

We are doing a lot educationally to look at how we support GPs. We are also working hard with our medical schools to encourage people to look at general practice in the first instance as a specialty in its own right. I know it sounds a bit perverse to talk about a specialty around general practice, but essentially it is to make sure that general practice is perceived to have the same status and level of credence as everybody else. We have rural fellowships that I might invite Ian Finlay to talk about in more detail. There is a lot of activity in the area of rural recruitment.

We have been active internationally, working with European colleagues through the EURES. We were in Amsterdam a couple of weeks ago, looking at how to recruit from countries of oversupply in Europe. We are committed to ethical recruitment, so we do not go fishing in the ponds of countries where they need their GP workforce as much as we do. We have generated a good deal of interest internationally, not least because most people's second language is English. So we are attracting a good deal of interest from the European Union from general practitioners who may be interested in coming to work in Scotland. We are doing work with NHS Education for Scotland to make sure that we support them with whatever it is that they need to be able to practise to the fullest extent of their licence in Scotland.

Ian, do you want to pick up the rural fellowship thing?

Professor Finlay: Yes, I will talk about rural initiatives in general. About 15% of our population live in remote and rural areas. Shirley said a bit about general practice, but we have developed specific rural fellowships where people have the opportunity to train specifically to provide a wider range of services in rural areas.

One of our key challenges has been the sustainability of our six rural general hospitals. One solution that we recently developed was to network those hospitals with larger urban hospitals for training and the provision of staff. That has proved to be very successful. Finally, we have been looking at multi-skilling in the community hospitals, where our general practitioners have a wider range of skills supported by enhanced-skill non-doctors, enhanced-role nurses and others, in delivering the service from community hospitals. Some of those have now become non- *[Inaudible.]* So we have a raft of initiatives to try to support our remote and rural services.

Ms Shirley Rogers: I will give an illustration to try to put a bit of meat on the bone of that. We have a district general hospital in Fort William, in the south of the Highlands. It has had some sustainability issues in terms of recruitment. It had a couple of consultant posts that had been vacant for some time. We worked with NHS Lothian, which is the Edinburgh board and which has our biggest concentration of teaching hospitals, and we asked its consultant population whether, if we expanded its establishment a little bit, we could put those two vacant posts into Edinburgh and develop with them a rota that allowed some of those consultants to go and work in Fort William. I was not terribly optimistic about that, but actually it worked incredibly well. There are a number of people who are very interested in rural practice but do not want to commit to it full time. We went from a situation where

they had had a couple of vacancies for 18 months to having seven suitable applicants for those two posts.

Mr G Robinson: *[Inaudible.]* Do you use any incentives to recruit staff? You may have already answered that question.

The Chairperson (Ms Maeve McLaughlin): Do you want to ask that question again, George? I do not know that they heard it.

Ms Shirley Rogers: We heard the question: do we incentivise them in any way?

Mr G Robinson: That is correct.

Ms Shirley Rogers: We do not give any additional payments in that respect. There is a small payment for those who operate on the island boards, because it reflects the high cost of living and some of that stuff. So there is a remote rural island allowance, but there are no specific financial incentives to encourage people to work in rural practice at the moment.

Mr Easton: Good afternoon and thank you for your presentation. Just to let you know, I have a good Scottish family background.

Ms Shirley Rogers: You ought to be very proud of that.

Mr Easton: The Eastons come from Aberdeen, so there you go. My question is this: given the financial climate, has Scotland any plans for voluntary exit schemes for the healthcare workforce, and, if so, how will you coordinate it with the workforce strategy in planning?

Ms Shirley Rogers: I mentioned earlier that we currently have a no-compulsory-redundancy policy in Scotland. It is our intention to keep that. It has served us well to be able to reassure our workforce that we are not looking to make cuts, and, as a result, I believe that we have reached some flexibilities because people have not been fearful that, if they are flexible, they will lose their job. The NHSScotland pension scheme already allows for voluntary exit when somebody has reached 50 years of age. As everybody has, we have been thoughtful about the impact of the reduction in the pension pot cap. For our highest-paid workforce, it does not take that long to accrue that amount of money in your pension pot. Earlier, I mentioned our workforce planning tools. I do not know whether you heard the bits where I was describing that we now have profiling, which allows us to model. We currently calculate an average age of retirement from the NHS at 61, and that allows us to model for a workforce that works to 65 or, indeed, 55, and we are therefore able to predict where we think we may have bulges or undersupply and, essentially, turn the tap on a bit further upstream to make sure that we have sufficient workforce coming through in that respect. It is not our view that we will be looking to any large-scale voluntary severance package available to the NHS at the moment. Our efforts are much more around encouraging our workforce to stay with us and continue to work with us, healthily and happily, for as long as they can.

The pension scheme that we operate already gives that voluntary severance exit through the pension route from the age of 50. I have not actually seen a massive growth in that in the last wee while. In fact, the contrary has been true. We have found that, actually, the number of people who are now working beyond 65 is growing. When we ask people the reasons for that, they cite some of the economic challenges that family members and others may be facing, so we have not had the huge mass exodus that we might have thought we were going to have with the pension stuff.

The Chairperson (Ms Maeve McLaughlin): Finally, I am just interested, in general, in the reconfiguration of your system, if you like, and your model of delivery for health from the 28 trusts to the 14 boards. I think I am right in saying that. Has that assisted in responding to workforce planning needs and requirements?

Ms Shirley Rogers: Immeasurably.

The Chairperson (Ms Maeve McLaughlin): Sorry, I did not get that.

Ms Shirley Rogers: Absolutely.

The Chairperson (Ms Maeve McLaughlin): That is one of the things that we find in relation to our system here that we are interested in pursuing with you. The shift in Scotland to the cooperative, traditional NHS model seems to be closer to providing a system that can strategically respond.

Ms Shirley Rogers: Yes. If I reflect on what it used to be like when we had primary care trusts and acute trusts, I have no doubt that we spent a bit of time trying to make those two systems talk to each other. In the formation of the 14 territorial boards that we currently operate, those relationships work better, so when we are talking to boards about their ability to workforce plan, I do not have to talk to them about primary care as a separate thing from the acute sector. When we talk about service models, we talk about how we flex the workforce to do that, so we have GPs who work in hospitals sometimes, and we have consultants who go out into primary care parts of the estate. We are delivering services. We have nurses who work across those areas, so we are working across the estate in a much more intelligent way, which means that boundaries that do not need to exist do not. I think that has helped us immeasurably.

It also means, frankly, that we are talking about 14 workforce plans, which is manageable for us, as opposed to 20, 30, 50 or however many, so for us it has become a much more manageable exercise. It is much easier for us to spot risk, so when those workforce plans come in, my team looks at them through all of the lenses, workforce planning being one of them, but they also include pay risks, staff governance risks or whatever it is that we are particularly interested in. They are looked at through every workforce lens. We can do that because there are 14 of them. If there were 50 of them, that would be a hell of a lot harder. It would be much harder to identify issues that we need to be thoughtful about. So, yes, it is immeasurably improved by the reconfiguration into the existing board structure.

The Chairperson (Ms Maeve McLaughlin): OK. Thank you, all three of you, for today. This has been extremely useful and clear for us in going forward. Obviously, we will reflect on the evidence that you have given us today in our inquiry, and we hope that we will be able to come up with some clear recommendations about reform of the delivery of the service around workforce planning. I thank all three of you for taking the time, and we certainly look forward to continuing this cooperation and collaboration.

Ms Shirley Rogers: Thank you for the very great privilege of being able to speak with you this afternoon. It is always great to share information. We do not have all of the answers — in fact, some of the time, we do not have all of the questions — but we are very happy to help in whatever way you think we can, and it is a very great opportunity for us to learn from *[Inaudible.]* yourselves. Thank you very much indeed for giving us the privilege of being able to speak with you.

The Chairperson (Ms Maeve McLaughlin): Thank you.

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT
(Hansard)

Review of Workforce Planning in the Context of Transforming Your Care:
Health and Social Care Trusts

17 June 2015

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Review of Workforce Planning in the Context of Transforming Your Care:
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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Alex Easton (Deputy Chairperson)
Mrs Pam Cameron
Mrs Jo-Anne Dobson
Mr Paul Givan
Mr Kieran McCarthy
Ms Rosaleen McCorley
Mr Michael McGimpsey
Mr Fearghal McKinney
Mr George Robinson

Witnesses:

Mr Damian McAlister	Belfast Health and Social Care Trust
Ms Clare Duffield	Northern Health and Social Care Trust
Mr Eamonn Molloy	South Eastern Health and Social Care Trust
Mr Kieran Donaghy	Southern Health and Social Care Trust
Ms Ann McConnell	Western Health and Social Care Trust

The Chairperson (Ms Maeve McLaughlin): We have with us Clare Duffield, HR director at the Northern Health and Social Care Trust; Ann McConnell, HR director at the Western Trust; Damian McAlister, director of HR and organisational development at the Belfast Trust; Kieran Donaghy, director of HR and organisational development at the Southern Trust; and Eamonn Molloy, director of HR and corporate affairs at the South Eastern Trust. You are all very welcome. Thank you for attending. I invite you to make your opening comments.

Mr Damian McAlister (Belfast Health and Social Care Trust): Good afternoon, Chairperson and members of the Committee. Thank you for giving us the opportunity to address you as you continue to take evidence on your review of workforce planning within the context of Transforming Your Care (TYC).

Our provision of oral evidence is further to the written evidence that each of our organisations provided to your ongoing review in mid-May this year, and the subsequent request to each of the Health and Social Care (HSC) provider trust chief executives, which was received on 14 May. In that correspondence, the Committee specifically asked that, in our opening statement, the trusts provide evidence on the following: the progress that we have made to date on workforce planning in support of the implementation of Transforming Your Care; details of the strategic direction our trust is being given by the regional workforce planning group, the Department and the HSC board; investment made

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in retraining of staff to achieve an appropriate skills mix; investment in leadership and capability development; how the money shift from hospital-based settings to community-based settings under TYC — £25 million to date — has impacted on staff, and how trusts have dealt with that; whether our trust has been asked by the regional workforce planning group if the Health and Social Care Board is to do workforce planning to support a shift of services out of hospital settings into community and primary care settings; how trusts as employers are taking account of recruitment issues for particular geographical areas; the desirability of seven-day working; and the composition of the workforce with regard to gender mix and associated work patterns.

We will address each of those issues in turn, starting with the regional workforce planning group. Each of our organisations is represented by a HR director or deputy director. At least four members of that group are present today. As HSC trusts, we fully support the establishment and operation of the regional workforce planning group, and we believe that it has provided the necessary vehicle by which, first, the appropriate means of approaching workforce planning has been agreed. That will help us to achieve a workforce of the right size, with the right skills, to work in the right place at the right time. Secondly, we have secured a workforce planning approach which, while patient and client centred, is flexible and responsive to change in service demands. Thirdly and finally, facilitated workforce planning through appropriate training means that it can be based around programmes of care, while determining the impacts on single and multi-professional groups.

As provider organisations, we all have contributed to the development and agreement of the regional HSC workforce planning and framework document, which sets out in detail the methodology to support workforce planning and the key roles and responsibilities of key parties in the process, including the Health Department, the Health and Social Care Board (HSCB), the Public Health Agency and ourselves as trusts. However, we would like to assure the Committee that, while this document has only recently been agreed, all the trusts have had prior involvement in workforce planning initiatives at a local level.

In its most basic form, workforce planning is about modelling the workforce to meet demand. While arguably not adequately resourced to do that, each trust, through local managers, has considered workforce-needs planning in determining how service demand can be met or how new services, with the support of our local commissioning groups and the Health and Social Care Board, can be delivered.

The outworking of some of these initiatives has resulted in new service delivery models. We will shortly provide an example of each of those models from our organisations. There has been retraining for some staff in new activities or the creation of new or merged goals based on the concept of skill mix, some of which have worked across traditional professional workforce groups. On the latter, I want to highlight the development of the allied health professional support worker in the community, which has allowed a merged role to be created to support allied health professional staff who carry out home treatment plans. Previously, each allied health professional grouping had its own support worker but now one person works across physiotherapy, occupational therapy and speech and language therapy disciplines. We also point to the development of advanced nurse practitioners in HSC emergency departments, which, while not fully replacing hard-to-fill middle-grade medical posts, has allowed some of the shortfall to be addressed through extended nursing roles.

Having specifically described our role as trust representatives on the regional workforce planning group, it may be worth providing an overview of our role in workforce planning as trust directors of human resources. At a high level, by way of example, our roles and accountabilities for workforce planning locally include the following: the provision of workforce data and information for the organisation; the provision of recruitment and selection processes and initiatives to meet workforce needs; supporting the development and delivery of directorate and service improvement working plans through HR business partnering, which responds to forecasted workforce supply and demand and which are aligned to strategic direction; and the development and delivery of a strategy for learning and development to meet current and future skills and capability requirements in the organisation.

The Committee also asked for information on leadership and capability development. A range of initiatives have been undertaken in that regard across each of our organisations. For example, the HSC knowledge exchange is an actual and online forum that provides an opportunity for HSC employees to discuss, debate and address emerging issues in health and social care. It has provided access through the HSC leadership centre to a range of additional resources for HSC leaders and access to best practice from across the national and international markets.

As a result of workforce planning, regional and trust-led succession planning initiatives have analysed recruitment and turnover trends and determined that more needed to be done to grow future HSC leaders. We have also introduced formal coaching and mentoring strategies, which have assisted general and clinical leaders and managers to focus on performance, service delivery and productivity improvements. We also have regional and trust-led leadership and management development programmes, which are aimed at developing senior and middle-management health and social care staff to be able to practise and operate in a range of situational models, including distributive and collective leadership, applying organisational development methodologies, including Lean, Six Sigma and Institute for Healthcare Improvement (IHI) Triple Aim, and managing change programmes and their impact on staff and patients alike.

We will now turn, with your permission, to specific examples of service change initiatives that have resulted in new services being developed in the context of Transforming Your Care.

Ms Ann McConnell (Western Health and Social Care Trust): I will concentrate on an example of outpatient reform that has been implemented in the Western Trust area. My colleagues will give examples in other areas. It is important to note that outpatient reform is integral to the reform of pathways for long-term conditions and acute care reform. The current process for outpatients, as you are aware, is that the GP sees and assesses the patient and may or may not do investigations. In some cases, the GP may not have access to all the investigations that they would need without going through hospitals. The GP decides whether specialist advice is needed and makes a referral by letter or electronically, and the patient then attends an outpatient clinic. The average cost of that is £205 per outpatient appointment.

The opportunity to reform the process requires GPs and consultants to change their referral patterns and behaviours, and for referrals to be seen as requests for specialist advice. The change also requires the upskilling of the primary and community care staff to support the new models and ways of working. That is the workforce planning element of the service redesign.

The Western Trust aims to reduce outpatient attendances by 15% in the west in 2015-16.An example of that that is already under way is the respiratory care service. A workforce plan was developed and the HSCB local commissioning group provided the funding to support the transition to a new model of service. The multidisciplinary model comprised a consultant, an oxygen specialist nurse, a respiratory pharmacist and a respiratory physiotherapist. The service was changed so that there was a consultant-led focus on the community. That involved outreach clinics being held, phone or virtual clinics, phone and email consultations, home oxygen assessment, drugs reviews and physiotherapy being available at home.

The outcome in one year has been a 38% reduction in the length of stay in the South West Acute Hospital for respiratory inpatients. There were 152 new referrals contacted, and 48 of those patients were discharged. Using phone and email consultations, 33 admissions and 89 review clinic appointments were averted. The waiting time for oxygen assessment reduced by 10 months and, while all of that undoubtedly reduced admissions, there have also been considerable savings on drugs. Five of the top six drugs prescribed in the Western Trust are respiratory drugs. In four months, there was a saving of approximately £70,000, and almost 100 admissions were prevented through physiotherapy interventions. From a performance perspective, that demonstrates real improvement. More importantly, from the patient perspective, it demonstrates improvements in the quality of care. Patients have reduced side effects from drugs, have interventions to avoid admission, are supported in a more timely fashion and, if admitted, have shorter hospital stays. Haematology in the west has also transformed outpatient services using similar approaches. That transformation in services can be replicated in other service areas. That work is under way in diabetes, cardiology, ENT and renal services.

Ms Clare Duffield (Northern Health and Social Care Trust): Good afternoon. I would like to provide you with an example of how workforce planning has contributed to and supported the implementation of reablement services in the Northern Trust.

The reablement ethos is a person-centred approach that promotes and maximises independence and allows people to remain in their own home for as long as possible. The reablement service is a planned short-term intervention, which provides support to a patient in their home. It is designed to enable people to gain or regain their confidence, ability and the necessary skills to remain independent after having experienced a health or social care crisis, such as an illness, a deterioration in health or, perhaps, an injury. The aim of the reablement service is to help people to perform their

usual daily living skills, such as personal care, walking or preparing meals so that they can remain independent in their own home.

The Northern Trust has developed a reablement service from within its existing home-care resources. Anticipated demand was forecast from domiciliary care referrals and package requirements. Initially, the services were established through a dual-role approach. In other words, existing staff were trained for dual roles, supported by the redeployment of hours within in-house domiciliary care.

In the past year, the trust has developed specific reablement teams in line with the regional model by redeploying individual staff from core services into specific reablement teams across the trust. That has enabled a large percentage of new referrals to domiciliary care to be accepted through reablement. The service benefits also from the specialised focus provided by occupational therapists to maximise the overall effect to meet the individual's optimum level of independence. In the trust, the service comprises approximately 92 whole-time equivalent domiciliary care reablement staff who are supported by around 10 occupational therapists. Both workforce groups have a mix of skill level aligned to referral needs and demands.

The workforce plan to enable the development of the service included a comprehensive training programme for allied health professionals, occupational therapists, social workers and district nursing teams. The training was designed to address both skill and competency requirements and covered topics such as the values underpinning the service, reablement experiences, professional perspectives, person-centred planning, recording and reporting, and communication skills. Most importantly, the staff training programme focused on developing behaviours and skills that would help make the shift and transition from an ethos of "doing for" to one of "doing with".

As previously described, the workforce plan also helped to identify the number of staff required and where they could be sourced from. From a workforce perspective, service change is also supported by a framework for the management of people change to ensure that employees affected are engaged and consulted as appropriate. The trust continues to develop and improve the service, and plans to integrate it into its locality multidisciplinary teams in the future.

Mr Kieran Donaghy (Southern Health and Social Care Trust): Chair, if you are content, I will continue with an example from the Southern Trust. In July 2009, the Health Minister approved proposals for the future provision of mental health and learning disability services. The implementation of that decision provides an example of how workforce planning works within the Southern Trust.

The changes were brought about through the Bamford review, which, as members know, required a fundamental shift in the balance from hospital-based to community settings. At that time, the trust had 108 mental health and learning disability beds at the St Luke's sites. Some 220 staff of various grades provided care to those patients. The current position is that all the staff have been redeployed, apart from a small number who requested voluntary early retirement (VER), and all the patients have been placed in community settings. The only thing that is left on the St Luke's sites is the Gillis Centre, which is a dementia ward.

As the Committee is aware, effective workforce planning can be introduced only when the model of service delivery has been developed and agreed through the commissioner and the Department. For that reason, I will concentrate on three examples of new service delivery models that we agreed within the Southern Trust in order to allow the move from St Luke's to happen. Those are supported living, assessment and treatment, and crisis response times.

The Southern Trust has now developed 13 homes for supported living within its area. The latest of those is Granville, which is a learning disability home in Dungannon. It provides for 25 tenants in five separate but connected houses. Each house has been assessed and required staffing levels have been assigned according to the complexity of patients' conditions. Each patient has been assessed according to needs. Staffing is on a 24-hour shift pattern, seven days a week and, within that home, 60 staff have been provided from St Luke's to provide that service. Each of those staff has undergone retraining.

The next example is the assessment and treatment unit, which was relocated to the Craigavon Area Hospital site in the summer of 2014. The trust recognised the need for a continuing level of inpatient assessment and treatment, and created the Dorsy unit at Craigavon Area Hospital, within the Bluestone unit, which has 10 beds. Some 25 staff now provide a service through that unit to learning disability clients.

The third example is the crisis and home support team. We had 30 staff within that area but, more recently, within learning disability, we have also created a crisis response and home treatment team which is the first of its kind for that particular client group. It provides services that are very effective in allowing clients to remain in their own home.

Many of the 120 staff who were formerly on the St Luke's site required retraining, and that was given by the trust. They have all now been redeployed into new areas of work, including the Bluestone mental health unit; supported living homes; support and recovery teams; home treatment and crisis response teams; primary mental health care; and community psychiatric liaison teams. Again, the trust was mindful of its decision about the St Luke's site. Working in partnership, we actually redeployed and centralised our support functions on that site to take account of the gap that was left by moving those clinical services. We re-provided up to 200 jobs through the replacement of HR services, finance services and some element of shared services.

Mr Eamonn Molloy (South Eastern Health and Social Care Trust): One of the biggest issues facing the delivery of health and social care is undoubtedly the forecasted increase in the prevalence of dementia in our population. In Northern Ireland, as you are well aware, we have one of the fastest growing elderly populations in the UK. Currently, over a quarter of a million men and women are of pensionable age, which is nearly one in six of our population. By 2028, that will have increased to nearly one in five, and I will be in those ranks. By 2050, the number will be almost one in four.

Demographic changes have a specific impact on demand for health and social care services; that is fairly obvious. As life expectancy increases, the number of people affected by conditions associated with old age will increase commensurately. Based on rates from across Europe, we may see dementia numbers rise from 19,000 currently in our trust population to around 60,000 by 2051. We must also remember that dementia does not only affect the elderly. There are a significant number of people who live with dementia who are under the age of 65. Early-onset dementia is especially difficult to diagnose, so the actual number is uncertain at present. However, estimates suggest that there could be as many as 1,000 people affected by early-onset dementia in Northern Ireland. Considering the specific needs of that group is another challenge that must be tackled.

I would like to tell you a little bit about a specific approach that has been piloted in the Lisburn sector of our trust. Although it is on a small scale, it is proving highly successful in meeting two of the stated objectives and recommendations of TYC, namely changing care packages for people in the residential and nursing home sector and, more importantly for our clients, avoiding unnecessary admission to acute hospitals.

Traditionally, care homes sought assistance for residents who had dementia and other unmanageable challenging behaviours from the already overstretched GP network. GPs would often refer those cases straight to acute psychiatry so as to cause no delay in the treatment plan for the patient, without full and proper assessment of any delirium or risk factors that they may be experiencing. That led to acute psychiatry receiving an increasing number of referrals and a poor response for the patient, as waiting lists grew longer. At one stage in that sector, whilst the waiting-time target was nine weeks, in reality it was extending to waiting times in excess of four months. As you can imagine, that could only lead to an unsatisfactory outcome for the patient, the safety of other patients being compromised and unacceptable levels of disturbance within the facility or home in which they were living.

With the help and expert assistance of a number of our staff, we sought to examine what we could do to respond to this situation, using TYC as the linchpin. Our aims were to improve the treatment of patients with delirium and dementia living in our care homes; reduce the number of referrals to acute psychiatry and admission of patients who have dementia being inappropriately admitted to the acute psychiatry unit; assist nursing and residential staff and general practice to become more aware of delirium and the impact that it can have on our patients; and reduce waiting list times.

On examination, our community psychiatric nursing (CPN) service came up with the simple solution of aligning itself with each of our care homes in order to provide the first response to the home in cases of delirium, rather than the GP. The community psychiatric nurses were willing to extend their role to undertake that range of functions and develop a new skill set in that service area. They developed a systematic checklist that standardised the approach of the CPN on examination of the patient. The commissioner has now recognised that this solution works and has allocated funding to support the initiative through the addition of five new CPN posts in that sector, with a social worker and two part-time posts with the new title of dementia navigators. Essentially, the job of the dementia navigator is to signpost people to particular services and specialties. The outcomes of this simple service model are a marked reduction in waiting times for patients with dementia who exhibit challenging behaviour

from a four-month wait for an acute psychiatric referral or appointment to one week within our new CPN-aligned service; and a marked reduction in the number of straight referrals to the department of acute psychiatry by 26%. Care home staff have reported that they now feel more confident and supported in dealing with delirium and challenging behaviours, the CPNs have consolidated their knowledge and there is less chance of the symptoms of delirium being missed in the treatment of our patients.

As an offshoot or by-product of the CPNs consolidating their knowledge, they have now taken on responsibility for running nurse-led clinics in dealing with delirium and challenging behaviours. They act as liaison and triage points for the medical team. They now organise post-diagnostic support clinics, they are involved in anxiety management groups and they are participating in a new and innovative well-being hub in the Dunmurry and Stewartstown area. In summary, we used the ideas of our current staff group to shape a new service model that is responsive to our patient needs. We have extended the existing role of the CPN, which has provided us with a solution to a service need that is likely to increase over the foreseeable future. Our next steps are to share the evaluated outcomes of this approach with other CPNs, to begin further alignment of those staff with all homes in our geographical area, and to encourage the homes to use the checklist independently to identify and treat delirium at the earliest possible juncture.

The Chairperson (Ms Maeve McLaughlin): Thank you all for that. Damian, did you want to say more?

Mr D McAlister: Yes, Chair, just to finish off our presentation. The programme treatment unit was launched in the Belfast Trust during the 2010-11 financial year following receipt of comments from a patient who questioned the amount of downtime that they experienced while waiting for specialist clinical treatment as an inpatient within the hepatology service in the hospital. They queried why much of the clinical treatment could not be provided as an outpatient.

By way of background, the programme treatment unit falls under the traditional title of ambulatory care and offers care in the day predominately by a nurse-led team, which has been empowered to take the lead in pathway care. All nurses working in that area are educated to a level of practice to ensure that they are competent and safe in providing the specialised clinical treatments that are offered, and they are also supported by specialist nursing teams who work to the unit. Trust medical staff who traditionally provided that specialist clinical treatment before the service was created now offer a clinical advisory and support role to the unit which, in turn, has freed them to concentrate on other more highly specialised tasks. In addition to being supported by other specialist nurses and medical staff in the hospital, the nursing staff also receive support from pharmacy and allied health professional staff, and the patient pathway is now such that all patients receive their treatment, are discharged and booked for follow-up appointments all in one visit.

When launched as a trial, the service comprised of one nurse providing one specialist clinical treatment to 68 patients in a room off the main ward. While that was a very small launch of the service, it served to demonstrate the concept and, quickly, the service began to gain the confidence of the wider clinical team, for whom those 68 patients would have otherwise been admitted for the same care. Quickly, one nurse became two and the number of clinical treatments that were being offered grew, so much so that, by 2014-15, 6,800 patients were receiving 32 different clinical treatments in a larger but still relatively small location in the Royal Victoria Hospital — a unit comprising five day beds and five chairs from an enhanced team led by nursing. The results achieved have also been very significant. The average overall length of stay for patients in the hepatology service has fallen from 13 days in December 2011 to 10 days in December 2014, while the length of stay for a liver transplant patient has reduced from 11 days in hospital before transplant surgery to now not requiring any.

The service is now seeking to expand the range of clinical treatments that it can offer and to provide more clinical treatments to support the flow of patients to the unscheduled care pathway in the trust. Given the success gained to date in enhancing the safety and quality of the service provided and reducing the need for admissions and length of stay within the hepatology service, it is envisaged that, with a larger footprint area to work from, and with an increased nursing-led resource invested in the programme treatment unit, we could equally help improve patient outcomes and avoid some unnecessary admissions that may occur through the trust emergency departments. The trust is currently working with the Health and Social Care Board and the local commissioning group to seek the means of securing the resources needed to achieve this, recognising that, in the first instance, this will require some support and an initial financial investment to help the bigger unit to be established before any projected savings can be realised.

We hope that the examples we have offered provide reassurance to the Committee that workforce planning, often in its most simple form, is central to the development and delivery of services offered within all settings in health and social care.

I will turn briefly to the issues of our involvement in workforce planning led by the regional workforce planning group, the Health and Social Care Board and the Public Health Agency. We are all currently participating in the regional workforce planning group's approach to domiciliary care and the various speciality medical workforce plans that are being led by Dr Carolyn Harper from the Public Health Agency on behalf of the Department. The trust fully welcomed both of those approaches as, while each takes account of the regional service delivery model principles that pertain, they are also sensitive to local and specific service needs. For example, the workforce planning review of domiciliary care, which is being significantly influenced by the near-completed Health and Social Care Board-led review of domiciliary care services models, will, in our opinion, provide a regional overview of the workforce growth in numbers and the changes in skills that are needed to meet the increased demand brought about by the needs of an ageing population but will take into account demographic issues that each of the five trusts faces.

The current challenges that face health and social care are significant. There is a growing demand across a wide range of services in a context of reducing budgets. Specialties in the area of unscheduled care, including emergency medicine, acute medical care and surgical services, are now being challenged to move to full service provision across seven days. Setting aside the very evident financial challenges that growth and demand invariably bring, that also presents significant workforce challenges, particularly in view of the existing configuration and service delivery models. Local service planning gives consideration to those workforce needs. Each trust has a range of posts, mostly medical, for which ongoing recruitment difficulties are being experienced. A number of our trusts have sought to address those difficulties through international recruitment through agencies, but that has had very limited success. The trust, with the support of the Health and Social Care Board as commissioners, is working collaboratively to explore solutions, including the establishment of clinical networks, targeted recruitment internationally in countries and regions where there may be an oversupply of workforce, and the creation of extended roles, such as physician's assistants.

Workforce planning plays a formal and informal role in how services are planned and delivered in health and social care in Northern Ireland. It involves many managers, staff, trades unions, our patients and clients and our stakeholders in those processes. It can be both complex and straightforward, and informed and informing in how we commission services to meet population needs, by how we commission university and educational places for our health and social professions, and by how we develop the roles and skills of our workforce.

We are pleased that the topic of workforce planning is under the consideration of the Committee. At a time of such challenge, the trusts appreciate the help that this focus will bring in supporting the continued development of services and the implementation of patient-centred Transforming Your Care initiatives through employee and workforce transformation and change, particularly in the constrained financial climates that we are operating in.

We again thank the Committee for the opportunity to address you on this critical function. We hope that this opening statement supports the written evidence that we have submitted as the provider organisations in health and social care.

The Chairperson (Ms Maeve McLaughlin): Thank you all for those opening comments. We have heard much about particular individual service delivery models from outpatients through to mental health, reablement and a number of fronts. We heard from professional organisations in our inquiry and review that they were unaware of the workforce implications of Transforming Your Care on their members because the service delivery models had not been established, or even designed, and certainly were not in place. Who is responsible for that? Is it the board, or is it a joint responsibility between the board and the trusts?

Mr D McAlister: I think that we all are, Chair, to be honest. There are local service delivery models that we develop locally and then seek the support of the commissioner to provide funding for. There are also regional service delivery models that are very much led by the Health and Social Care Board, as a commissioner, and influenced by the Department that we would be party to in terms of resolving the impacts that that might have on our workforce. In direct answer to your question, both of us are responsible.

The Chairperson (Ms Maeve McLaughlin): So, it is a joint responsibility.

Mr D McAlister: Yes.

The Chairperson (Ms Maeve McLaughlin): If there is a responsibility also on the board, do you, as trusts, feel that you are in any way being hampered if those responsibilities are not being actioned?

Mr D McAlister: I can speak only for the Belfast Trust; colleagues may want to speak on behalf of their trusts. We have a very healthy relationship with the Health and Social Care Board as a commissioner. There are often cases that we put to it that it does not support as a commission; it does not see them in the overall service delivery model. That is fine, but we are supported by it, and, equally, by the Department. I go back to the comments that we made in the opening statement: we are very supportive of the regional workforce planning group and the principles that it established. While we were probably displaying and putting in place many of the principles locally, having them now in the regional context of the regional workforce planning group and the workforce planning framework document only further enhances the ability of the service to respond to population need.

The Chairperson (Ms Maeve McLaughlin): I am watching others shaking their head in agreement. You think that it is joint responsibility and that there is a good working relationship.

Mr Molloy: Each one of us has a role to play. The role of the commissioner is important in assisting us to interpret strategic direction from the Health Department, but their primary responsibility is to assess the need of the population and to specify and design services to meet that need. From our perspective, it is up to us to try to ensure that we put the proper staffing model in place to deliver that care. I take it from what you said earlier that some of the representations that you received were from members of our trades unions and professional organisations. You may not necessarily see a direct link to TYC, but a lot of the workforce reform that we are involved in is done in partnership with our trades unions. They are very aware of what we are doing; they subscribe, in the main, to most of the things that we are trying to do. That is about trying to develop new roles, new skill sets and new ways of approaching problems that previously were intractable. Everyone has a role to play in this. The simple example that I was giving you was about asking our own staff because, on occasions, front-line staff have the best solutions to some of these problems because they are doing the job every day.

The Chairperson (Ms Maeve McLaughlin): Other sectors can speak for themselves, but I suggest that it was much more than a direct link. All the organisations that gave evidence felt that they were not participating in the process. They were not at the table, bar one.

Mr D McAlister: To reinforce what Eamonn has said, in the Belfast Trust, we very much take a partnership approach to service development and service delivery, and our trades unions locally are involved in it. That may not necessarily mean at all times that trades unions regionally will be intimately aware of what is going on in the local organisation, but our trades unions locally are very much involved in the process.

Mr Molloy: I think that that is potentially the answer. Many of our local trades unions are deeply involved in areas of service planning and development.

The Chairperson (Ms Maeve McLaughlin): Again, I am talking about the regional workforce planning group, which is not necessarily your responsibility, but every sector requested that it be an active participant in the process.

Mr Molloy: That issue is with the Department of Health at the minute.

Ms McConnell: I think that it is fair to say that, at the moment, the trades unions are not at the table at the regional workforce planning group, but they have been invited to nominate a representative to the regional domiciliary care working group, which is where the workforce planning is taking place for reshaping that model. As Damian said, the issue of representation at the regional workforce planning group is with the Department at the moment.

The Chairperson (Ms Maeve McLaughlin): Somebody mentioned recruitment and retention issues. That can be an issue in rural areas, but I know that it is also an issue, for example, in the Western Trust. That was acknowledged in your briefing paper today. Do you as trusts feel that, in relation to retention and recruitment, the Department could be doing more at a regional level?

Ms McConnell: Because you mentioned the Western Trust, perhaps I will speak first. One of our biggest challenges is our medical workforce, and the Department is very aware of the issues that we have there. We are working with the Health and Social Care Board and the Department to resolve some of the issues that we have. I think that the challenge is that the difficulties that we are experiencing are happening now and that the solutions are a little bit off in terms of the planning piece. Being able to deliver all the solutions that we need right now means that we are having to look at other things. We are looking to our cross-border colleagues; we met the Royal College of Surgeons in Ireland this week. We do training grades with it in the South West Acute Hospital. We are looking at whether we can get postgraduate level doctors onto our rotas to fill some of the middle grades. That would be a very welcome development. We are looking at solutions, and I suppose that the trust has to take some responsibility for trying to find some of the solutions. That is what we are doing.

The Chairperson (Ms Maeve McLaughlin): Equally, the example was given that there was a £10 million cost last year for locums in the Western Trust alone.

Ms Duffield: I can provide some examples or thoughts on whom we are looking at, medical workforce shortages in particular. First and foremost, as you mentioned, we have to ensure the continuation of services, so the short-term fix is, obviously, through the use of agency and locum doctors in the absence of a pipeline of candidates coming through. However, there is an example where the Northern Trust and the Western Trust have worked together and collaborated to look at how services are being delivered to take a more regional or geographical approach to address any shortages. We are also looking at attraction and recruitment strategies, and I think that it was Damian who mentioned the fact that we try to be creative and look at other ways of attracting candidates, whether through overseas recruitment or a different model. For example, in emergency medicine, we are looking at using physicians' assistants to account for the shortfall there.

The Chairperson (Ms Maeve McLaughlin): I absolutely understand that, and I know the work that a lot of the trusts are involved in, but, specifically, does the Department need to do more in relation to this issue?

Following on from that, Damian, when it comes to, for example, GP contracts, do the trusts have a view as to how those contracts are drawn up and how you could influence those contracts to ensure that doctors are retained here or deliver their service here?

Mr D McAlister: In answer to the latter question, we do not employ general practitioners, so we have no view on GP contracts per se, but we have a view on the contracts for hospital consultants and trainee-grade doctors. Our sponsor Department was involved in national negotiations that we, as trusts, joined in. The Department organised regular briefing sessions, and much of its approach on that policy was influenced by how we found things on the ground. We were giving them the reality of the situation and highlighting things about how we needed to incentivise productivity, for example.

To go back to the earlier question about whether we feel supported by the Department, we engage on a monthly basis with the HR director from the Department in its HR directors' forum, and medical workforce shortages have been on the agenda of nearly every meeting for the last six months. The Department gives us a listening ear. We sometimes have the ability to look at incentivisation under the terms and conditions.

I can quote an example that we used some years ago where we had real difficulty in a specialty in the Belfast Trust. We introduced a very highly specialised service, unique only to the Belfast Trust, and we brought forward a requirement for recruitment and retention premia. A case was made to the Department, which was ultimately approved by the Department of Finance and Personnel. For a time-limited period, we were able to offer those premia to attract the right people to the service and to retain them. That meant that stability was brought to a service that was so unique that it was going to have to stop being provided by the National Health Service.

The Department has those abilities if we approach it, but, as Ann said, there is a certain responsibility on us. Clare gave an example of clinical networking: the solutions are multifactorial; sometimes, it is not simply all about money. We need to do better to package what we have in Northern Ireland and the educational facilities that we have, through Queen's University, to offer research facilities. Sometimes, it is not just about adding more money but about being able to put together a better package to sell the idea of coming to work and live in Northern Ireland.

The Chairperson (Ms Maeve McLaughlin): I appreciate that detail, but do you have a view as to whether there should, if possible, be a requirement in the contracts of doctors and consultants that they must work here in the North or in a particular trust, for example?

Mr D McAlister: Do I believe that they should be?

Ms McConnell: We had that type of contract for clinical psychologists a number of years ago. The difficulty is that it is quite hard to enforce. These people have gone through specialist training, and if their life circumstance change, if they marry someone and that person, through their job, has to live in a different country, it is very hard for any employer to say that they need to stay here. Legally, it is hard to enforce. Even if you had that condition, it may be hard to make it stick.

Mr Molloy: Those individuals are now very highly sought after internationally. We find that it is extremely difficult to staff shifts in our rural hospitals; we have had to look at other models of service. Whilst we can include "Work with us for the next two years" in the contract, in reality, as Ann said, it is difficult to enforce. We are competing with the bright lights of Sydney and Auckland and the rest of the world; they want to get out and about and around the globe, and that is what they can do.

Ms McCorley: Go raibh maith agat, a Chathaoirligh. Thanks very much to all of you for your presentations today. The Committee is interested in the relationships between the board, the trusts and the Department. In workforce planning, what is the key difference between those roles as you understand it?

Ms Duffield: I will respond initially by saying that we have found it very helpful in past months that, through the regional workforce planning group, a framework document has been created that helps to outline the roles and responsibilities of each stakeholder group represented. There is also a clear commitment by all those groups to the workforce planning methodology that has been agreed. That document helps to provide some clarification.

Mr Donaghy: I suppose that the roles have been fairly clearly set out in a document that was submitted to the Committee. The Department feels responsible for setting the strategic direction, ensuring commitment to a high-level workforce strategy to underpin the Department's wider policy objectives; the HSC is there to be the commissioner and to ensure that HS trusts and the practitioners have considered and identified the workforce needs for service delivery, through, for example, demand-and-capacity exercises. As Eamonn pointed out earlier, trusts are ensuring that we have the right people in the right place at the right time, trained to deliver services to our patients and clients.

Mr D McAlister: I often describe it as almost a "virtuous circle". We are sitting in one part of it, where we are delivering local services. We might identify a local service need, which we then push to the HSCB commissioner, who takes a view on it. It may ultimately end up with the Department, which may be required to commission more educational training places from universities for nursing, medicine or whatever. The securing of the funding then comes back round to the trusts, the Department funds the board and the board, as the commissioner, gives us the money to implement the service. I see it as a circular relationship as opposed to a hierarchical one.

Mr Molloy: In reality, the relationship can be fraught on occasions; it is not all sweetness and light, as you can imagine. When you deal with a scarcity of resources, particularly money, you will always compete with other priorities, and on occasions that brings tension into the relationship. Those are just the realities of the situation.

Ms McCorley: Do you feel that the model works?

Mr Molloy: I think that we alluded to this earlier on, but it is important that we keep close. The prize is trying to ensure that we use every pound that we spend in the most effective way possible, particularly in workforce. From our perspective, it is important that we have a clear definition of the type of service that we are trying to create, using the ideas of our existing workforce, and others, to shape service models. Workforce planning is not a black art by any stretch of the imagination; there is no real science to it. It is quite simple when it comes down to it, but some of the issues that we encounter daily are primarily about the competing yearning for additional resources. However, we know that there is no bottomless pit of resource.

Ms McCorley: In the document from the Belfast Trust, there was not very much reference to TYC, per se. Will the way in which you change how services are delivered be driven by the board, or will the trust take its own initiative?

Mr D McAlister: I think that there is a dual relationship. There is a lot going on on the ground in the trust. We have our own Transforming Your Care programme board, where a lot of our service development initiatives are brought and governed in the TYC framework. We have a very strong relationship with the local commissioning group, which is our conduit into the Health and Social Care Board. There is no one size fits all. There is very much a dual partnership relationship — between us, the LCG and the Health and Social Care Board — as to how services are being transformed. TYC provides the umbrella by which it is all being taken forward. It gives us leverage to secure bids that we can make to the board for the development of new services coming under the TYC banner. It is very much a partnership relationship between us, LCG and the board.

Ms McCorley: Is the reablement programme working successfully? People have that support for up to six weeks. Beyond that does it just cut off?

Ms Duffield: I do not want to speak on behalf of colleagues from that area or that service who are not here today, but the success is about it being integrated into broader locality teams that have access to specialists and clinical advice from across a whole range of professions. That is how we are developing the model at the moment.

Mr D McAlister: It is needs-assessed. We could all answer that.

Ms McConnell: I suppose the —

Mr Donaghy: Sorry, Ann. I will just add that I suppose, for reablement in the Southern Trust, it is about giving people the confidence to keep living at home. As a result of that, we have seen at least 50% stopped from going to residential homes or hospital beds. It is now beginning to reap the dividends, but it takes a considerable time. We have been implementing it for nearly two years, but now we are, hopefully, seeing the shoots coming up.

Ms McCorley: It is a really positive idea, but my concern is that it will just merge into normal domiciliary care. There are lots of issues being raised about that being inadequate.

Mr D McAlister: That might be the case, depending on what the individual client's needs are assessed as being. After the reablement process, it may be that they are assessed as needing ongoing domiciliary care to live at home, or it may be that there are other pathways that they need to go down. However, it does not just stop. Once reablement is completed, we do not just walk away and leave the client; there will be a continuum of care provided.

Ms McCorley: So you maintain that support.

Mr D McAlister: There will be an element of care maintained, yes.

Ms McCorley: Is that above and beyond what domiciliary care provides?

Mr D McAlister: Again, it depends what the individual client's needs are assessed as being. It may be that they only require domiciliary care, or it may be that there are needs over and above that, which can be met in another way. It is individually needs-assessed.

Ms McCorley: My concern is that we are hearing, from the other angle, that people are under threat. They are at risk of ending up in hospitals because domiciliary care has been reduced and, because of that, they end up in greater need. It is the other end that you are dealing with, but that is the aspect that would prevent people from going into hospital if that was better.

Mr Molloy: The primary objective of the service is to ensure that that very thing does not happen and that ending up in hospital is the last resort.

Mr D McAlister: That is what we have to avoid.

Ms McCorley: That is what we are all trying to do.

Mr D McAlister: Absolutely.

Mr McCarthy: Following on from Rosie's concern, the Committee has certainly voiced its concern about the lack of domiciliary care over a long period. I am delighted to hear that the reablement programme is working. At the back of that, the Committee's and my concern over a long time has been that the number of individuals, particularly elderly lonely people, entitled to community meals was vastly reduced. The reason given by the various trusts was the enabling process. Are you all confident that the vast reduction — you know what I am talking about — in people entitled to community meals is working? As Rosie said, those people are not being left behind. You are trying to get the enabling thing. We are all supportive, but we want to make sure that nobody is left behind when getting a decent meal each day.

Mr Molloy: That is right, Kieran. It is a very highly charged and contentious issue across the Province. We want to make sure that the services that need to be maintained in an individual's home are maintained at the appropriate level and to the appropriate needs that the individual has. In respect of the by-product of the supply of community meals, the biggest issue that has been drawn to our attention is the socialization aspect: that whoever calls gets an individual taking time to talk to them, seeing how they are and listening to the difficulties of the day. We are trying to replace a number of those things with targeted befriending services and by looking at how we can best support an individual living at home. Meals are fine for those individuals who need meals, but by the same token there are specific issues about ensuring that people's socialization and human contact is maintained during the day, without the necessity of a meals provider.

Mr McCarthy: Thanks very much for that. Your briefing papers and your contribution this afternoon are very welcome. I was encouraged by the enthusiasm of each of you about what we are talking about, and that you seem to be saying that you are making progress. That is to be very much welcomed. Keep it up.

Speaking as a constituent representative, another issue, apart from community meals, is waiting times to get into hospital or for treatment. I got a list of waiting times from the Portaferry health clinic. It was unbelievable. There was one person who had to wait 80 weeks for something in the hospital. Surely that is not acceptable.

The Chairperson (Ms Maeve McLaughlin): I will ask the trusts to deal with that separately afterwards, because I am conscious that we are straying into constituency matters. Important though that issue is, I want to keep us on workforce planning.

Mr McCarthy: I am being told off for standing up for my constituents, *[Laughter.]* but, anyway, do you get my point?

Mr D McAlister: Yes. I do not think that anybody on this side of the table would accept that that is a position that we find acceptable. Absolutely not.

Mr McCarthy: Damian, you said that you were supportive of workforce planning. Can you give us an assessment of the progress of the regional workforce planning group?

Mr D McAlister: It is one of those things where progress will happen on an evolutionary basis. Going back to the statement that we made, one of the things where there has been the biggest progress is the regional agreement on what the approach should be to workforce planning at a regional level. When you previously had five organisations doing their own thing in respect of workforce planning, which may, in itself, have been successful, the fact that we now have a regionally agreed framework gives us a very clear direction of travel. Factoring it around programmes of care is very important, as opposed to focusing on uni-professional need.

There is absolutely no point in going away and doing a social work workforce plan or a nursing workforce plan for the provision of older people's services in the community. What you need to do first and foremost is assess the demand for older people's services in the community and, subsequently, look at the uni-professional and multi-professional requirements that fall out of that. What are the consequences of the demand that we face for older people's services in the community? How do we best meet that and work outside the traditional professional boundaries? It does not necessarily

always need to be about the recruitment of more nurses or social workers. Really begin to look towards the development of new roles, such as we mentioned in the allied health profession or support role — an opportunity to modernise and innovate, as opposed to continuing to deliver the service in the traditional means by which it has always been delivered.

Mr McCarthy: OK. The Allied Health Professions Federation has stated that there seems to be an inconsistency in how the trusts review their workforce and plan. That association stated that it was not aware of the workforce planning happening at trust level. What is your response to that? Is it a communication problem?

Mr D McAlister: Who did you say it was?

Mr McCarthy: The Allied Health Professions Federation.

The Chairperson (Ms Maeve McLaughlin): And the Association of Social Workers.

Mr D McAlister: The Northern Ireland association?

Mr McCarthy: Yes, that is right.

Mr D McAlister: I must admit that I know the second group, but the first one is new on me. We deal locally with the Chartered Society of Physiotherapy and the Society of Radiographers, which are the recognised professional associations and trade unions for those allied health professionals. They pretty much are involved at a local level on a weekly, daily and monthly basis for how we approach the workforce in that regard.

I know that each trust is having discussions with the Northern Ireland Association of Social Workers. I recently had a meeting with it, and the Belfast Trust is now beginning to engage with it on our social work forum. The association has a vested interest in it, and we agree that it can be a key participant and make a contribution, and we are engaging with it in that regard. I will need to go and see who the previous group is and see how we engage with it if we need to.

Mr McCarthy: There is a lack of communication.

Mr Molloy: Kieran, I think that it might be another example of the regional level not necessarily knowing what is happening at the local level. I stress again that there is very high collaborative working between professional organisations at local level and trust level on the whole issue that we are talking about now. At the regional level, people might not necessarily recognise that that is the case.

Mr McCarthy: Finally, we probably have touched on this, but does the trust believe that the make-up of the regional workforce planning group is right? For example, would it be better served if education providers or training bodies were represented on it? Would it be enhanced if professional bodies and trade unions were represented on it? I think that we spoke about this earlier. There are gaps. What is your reaction to that?

Mr Molloy: Do you want me to answer that, Damian?

Mr D McAlister: Yes.

Mr Molloy: Our regional trade union colleagues I love dearly, but I think that they believe that there is something going on in the regional workforce planning group that actually is not. We had a very frank and open discussion with them over recent days, and it is really important that they engage with trusts at local level in the highest possible way that they can, because that is where this happens in reality. From our perspective, we have been saying to them that, whilst a seat at the table would be nice, they may find that, after a period of time, it is not necessarily where they can make the biggest input and impact. I think they have broadly accepted that as being the case, but, frankly, I have absolutely no difficulty with them being at that table. I do not see any issues for them at all. It is just where best they can play an active role.

Mr D McAlister: They currently have a request with the Department for membership.

Mr McCarthy: I wish you all the best; keep it up. Nobody knows who will need your services tomorrow or the next day.

Mr Easton: I was interested in the Western Trust. You were looking at doing different outpatient reductions, and you mentioned respiratory conditions and haematology. Are all the trusts doing the exact same thing?

Ms McConnell: There are four pillars of reform, and outpatients is one of them, so every trust is doing similar types of work. We are particularly being driven by things like our medical workforce shortages and working smarter within those disciplines. We have prioritised the disciplines. For instance, we have fewer haematologists than we would like, so we have a consultant who is inspirational in maximising his input, and we have designed the service around him, but, yes, everyone is doing that type of work.

Mr Easton: The Northern Trust paper states that it would like a greater leverage on the workforce planning in areas such as pharmacy and primary care. What do you mean by that?

Ms Duffield: As we have described already, it is about the opportunity to work in collaboration with all of the different stakeholders that impact our workforce or the pathway of care for a patient. Whether that patient accesses services initially through the GP or goes to the emergency department, it needs to be a clear journey for that individual depending on their requirements. That has an impact on the workforce, the skills and capabilities of the workforce and the required change in culture so that people work outside of silos and in particular directorates or areas so that there is more of an integrated approach to care for the individual. That demands and requires that we work across boundaries. Hopefully that describes what we were referring to. It is across boundaries, whether it is acute care, care in the community, primary care or building our relationships. You will be aware that we have integrated care partnerships. That is one way that we build those relationships and, hopefully, build the ways of working within our community workforce so that we have locality-based teams that work in partnership with GPs.

Mr Easton: I know that you are all working together and that you have all of those things to try to improve that, build relationships and all the rest of it. Would you say that the likes of pharmacies and different things are sort of holding you back a wee bit, because they are not all part of it? Obviously, you are building the relationships, but they are not part of it. Is that holding you back a wee bit in developing?

Ms Duffield: I am not sure that I am equipped to comment on that specifically, but, in the spirit of workforce planning, I think that, if there is any weakness in the cycle that affects the patient's journey, that will hold us back.

Mr D McAlister: Is it community pharmacy or hospital-based pharmacy? Community pharmacy? I do not think they would.

Mr Easton: This is my last question. Is the lack of finance for Transforming Your Care — the fact that you have not progressed it — holding you back quite a bit and you are not able to progress things as quickly as you want?

Mr D McAlister: Workforce planning?

Mr Easton: Yes.

Mr D McAlister: We have not been funded for workforce planning. Any workforce planning that we are doing is being done within our own resources locally. Of course, if there was funding available and it was invested in workforce planning to support local managers then, yes, it would be very welcome.

Mr Easton: Would that speed things up for you?

Mr D McAlister: I think Sir Liam Donaldson made particular reference to Transforming Your Care. I think the commentary that he received indicated that there was frustration on how to progress in that

regard. I think the responses that have gone back to the Minister on that indicate that it could be given a bit of impetus with some resources, so, yes, we would welcome it.

Mrs Cameron: Thank you for your presentations. In relation to mental health and learning disability resettlement, I know that you mentioned the Southern Trust's point of view, Kieran. You have probably answered most of my questions, but I will ask again, and maybe ask each of you to answer the same question. What has that meant for each of the trusts in terms of the staff who were previously based in the hospital settings? Did they follow the clients to the new community settings, or were they redeployed to other areas?

Mr Donaghy: I will start, perhaps, and then my colleagues can come in again. In the model that we chose, we had one-to-one meetings with all of our staff to try to find out where they wanted to go. Some of them wanted to follow the clients. For instance, quite a number of our staff followed the clients within supported living, which required a great deal of retraining. Others, however, chose to go and work in Bluestone, which is a mental health facility. Home crisis response in the community was again an option that some others decided to go for. Of 220 staff, we had 14 who took voluntary early retirement; all the rest were redeployed within the trust to various roles, not just in mental health, but in the other programmes of care in the trust. That was again done with the agreement of trade union colleagues, particularly UNISON and NIPSA, which were very helpful in that whole process.

Mr Molloy: Almost 100% of ours have followed the patient. I am thinking specifically of recent times, of the closure of wards in Downshire Hospital and their replacement by places like Cedar Court. All the staff have moved with them. It is really important, particularly in the areas of mental health and learning disability, that the relationship that has been built up between the clinician and the patient is maintained.

Mrs Cameron: Was retraining required for staff?

Mr Molloy: Where it was, it was provided. These are very highly skilled, adaptable and flexible individuals.

Mr D McAlister: It is exactly the same story for us. We are moving people out of traditional institutions where they were cared for and resettling them, both in sheltered accommodation and supported living environments, as well as looking at home treatment teams. No staff have been made redundant; all staff have been redeployed. I would say, like Eamonn, that nearly 100% have followed. Probably all of them have stayed in their speciality area, but whether they have followed the individual patients they cared for is another thing. Certainly, they have stayed in their traditional professional area.

Mrs Cameron: And again —

Mr D McAlister: Again, where reskilling has been required, but very little has been, because this is more about where they are cared for. Once it was in an acute inpatient bed; then it is at home. There is little difference in the actual care.

Ms McConnell: I will not say anything very different. In the redeployments that we have been involved in, a core group go with the client. Some individuals may choose to stay in a hospital-based setting. As Damian said, they are qualified to work in the different settings, and it is more about changing the ethos of the care than having a lot of intensive retraining.

Mr McCarthy: My question is for you, Damian. How is Muckamore progressing? It is due for closure, or at least emptying, very shortly.

Mr D McAlister: The traditional institutions within it are emptying, but other services are now being provided on the Muckamore site — fantastic, leading-edge, first-class services. We are progressing very well, particularly with the resettlement from learning disability. We have a wee bit further to go, but we are working in partnership with families so that nobody feels they are being forced out of the institution. We are very much working in partnership with them to make this as seamless as we can for the client.

Mrs Cameron: I just wanted to get to the Northern Trust on the back of the Muckamore issue. I know that there have been issues in the community. Are you working with the community? I know that you

do not have to, but nearby residents and stuff can be an issue and can have real concerns about who is moving in near or around them. I know that is a huge issue, certainly in parts of south Antrim, where resettlement is planned.

Mr D McAlister: I cannot comment specifically on the situation in south Antrim in respect of Muckamore, but our approach as an organisation is very much in fulfilment of our personal and public involvement (PPI) scheme, where we engage the population in those geographical areas as part of any consultation exercise around changes to the service delivery model. It would not just happen without community involvement. While I cannot comment specifically on that case, I would be surprised if that has not happened in respect of how we have approached it with the Belfast Trust and Muckamore.

Ms Duffield: I have not a great deal to add to what has already been said, but in the Northern Trust there has been a programme of resettlement of patients from the Holywell Hospital into community living services. From a workforce perspective, that has been about managing that change in line with our engagement and consultation framework for employees, retraining employees with the right and appropriate skills, but also, through individual meetings with them, finding out where their skills are best placed. There may be different individual decisions depending on the employee, with a large percentage obviously being deployed and following the patient as per the examples that my colleagues have given.

Mrs Dobson: I also thank you for your briefing. It is good to see Kieran here. I usually torture him with emails on a regular basis.

Now that we have heard that there are plans to resume permanent admissions to statutory homes and there has been a reversal of trusts' previous decisions — thanks goodness common sense has prevailed on that one — whose responsibility is it to provide adequate staff to cover those homes? Given trusts' reliance on the private sector for domiciliary care and nursing home placements, who is responsible for providing an adequate workforce to staff those homes?

Mr Donaghy: I will comment on that first. We work very closely with our service directorates. In this particular instance, Jo-Anne, having, as you know, been involved in it for the last two years, we are very comfortable that we are able to provide that level of service to those residents. As you know, the decision has been made to facilitate residents to stay in homes for as long as they wish. We are very comfortable that we will be able to meet those service needs and demands.

Mrs Dobson: Going forward with regard to the reversal of the trusts' previous position with certain homes and the reliance on the private sector, who is responsible for providing an adequate workforce? Is it you? There has been a reliance on the private sector.

Mr Donaghy: If I understand your question, we will look to the service directorates to identify any gaps, and support the service directorates in delivering that service, but it will be the —

Mrs Dobson: Does that go for whatever sector it is, whether it is private or otherwise?

Mr D McAlister: If it is a trust statutory residential home, it is our responsibility, as the employer, to staff it.

Mrs Dobson: And the domiciliary care too? Is that something that the regional workforce planning group is considering, given the fact that the homes will remain open and that it is something that you are responsible for?

Mr D McAlister: Yes.

Mrs Dobson: What impact does the gender mix in the workforce have on trusts' workforce modelling in terms of working patterns? I am thinking of females and part-time workers.

Mr Donaghy: I will allow one of our females to answer.

Ms McConnell: I am a female who works full time, but anyway. The reality is that lots of staff choose to avail themselves of flexible working options. That is an issue for workforce planning, and part of the

challenges that we are finding with the medical workforce is the change in the gender group that is coming through. As lifestyle trends change, we learn more and more about how people are working and try to do what is called scenario planning, which looks at what people are likely to want in the future.

Mrs Dobson: Have you had initiatives to encourage more women back to work?

Ms McConnell: We have things like back-to-nursing courses and so on. We never close the door on people who are keen to work with us. We try to have routes to retrain people if they have taken a break. If they are having an employment break for a few years, we try to offer them refresher days or training days. It is the same with extended maternity periods and so on. They can come in and keep in touch. We continue to engage with them and keep them —

Mrs Dobson: Holistically, given the pressures that staff are under anyway, how do you work with them to encourage that when very valuable members of staff feel under pressure? We had an excellent presentation from representatives from Scotland, who told us that they have initiatives to work around women in particular to keep them in their careers and help with workforce planning. Do the trusts work together, or are there individual schemes? How do you plan?

Ms McConnell: I think that we all have our own internal management processes. Clare, do you want to say something about that?

Ms Duffield: I can maybe provide a bit more of an example and one specific thing in relation to the question that was asked. In the Northern Trust, there is obviously a much higher percentage of female employees. At the end of the day, however, we have to recognise that the changing demographics of the workforce in general mean that people want much more flexible working arrangements. They have different lifestyle choices, and we have to have working policies and procedures that can accommodate that so that people enjoy coming to work, whilst also not disrupting the continuity of the care and services that we provide. At a very basic level, that comes down to great rota and roster management at ward or service level. At a more corporate level, we provide a lot of workforce information an analysis to look at the trends and patterns in the workforce. For example —

Mrs Dobson: That would be, if people are leaving, on why they are leaving and what could have been done to —

Ms Duffield: Exactly: it is on labour turnover. We know, for example, that approximately 3% of the female workforce in the Northern Trust is on maternity leave at any one time. By knowing that, we can plan for it. It is about using workforce information and analytics to allow us to plan on a very local level, but also on a more strategic and corporate level.

Mrs Dobson: I note that you talk about hard-to-fill positions. Have you any indication of which ones you find the hardest to fill? Can you outline those and what you are doing to address that?

Mr D McAlister: We have a number of medical posts that, probably in common with all five provider trusts, are hard to fill; for example, consultants in emergency medicine or consultant surgeons. Particularly with specialisation now, it is no longer just a general surgeon that you are looking for but a breast surgeon, gastroenterologist, radiologist, urologist or dermatologist. You could almost name all the specialties. From our perspective, some of those are actually national shortages across the entirety of the United Kingdom. That is why predominantly we are having to push the boundaries of where we traditionally look for supply to beyond these shores and internationally. Recently, in the Belfast Trust, we advertised for consultants in emergency medicine. We ran specific campaigns in Australia, because we knew from people who had returned to work in the organisation after having spent two years in Australia that there were a number of indigenous Irish people there who could potentially come back. We did not have great success, but actually testing the boundaries of it at least gives us more evidence that, in the eventuality that we ever do need to engage the Department in a conversation about a hard-to-fill post, at least we can demonstrate that we have tried significantly to recruit and have been unsuccessful.

Mrs Dobson: Ann, you talked about different methods that you are using in the Western Trust and changes that you are making regarding outpatients. You mentioned work that was under way in renal services. You know my particular interest in renal services. Can you outline —

Ms McConnell: I am not aware of your particular interest, sorry. It is about more home dialysis and skilling up community nurses to support people at home so that there is less need for them to attend outpatient or day clinics.

Mrs Dobson: Will that be rolled out across the trusts?

Mr D McAlister: Yes.

Mrs Dobson: Is that given more significance due to the fact that more people need dialysis? Is that why you are trying to push the home dialysis route more?

Ms McConnell: Yes.

Mr McGimpsey: Thanks, folks, for your presentation. What interests me is actually the time frames and resources that are available, and the shift left in Transforming Your Care. Kieran, you gave us a good example from the Southern Trust of supported living for mental health and learning disability, the crisis in home support and crisis response. Eamonn, you gave us an example of dementia services in the South Eastern Trust. Those are good examples and show good progress. The issue for me, therefore, is this: across how many ranges are you making that sort of progress? You have other areas, obviously, like support services, domiciliary care, respiratory care or whatever. How many others are actually in place and making that sort of progress? First of all, you have the service delivery model, then you match the workforce, then you match the resource and then you match the time frame. You appear to have done that in those two examples in the Southern Trust and South Eastern Trust. Where are you across the further range of service deliveries? Where are the other trusts in this? Are those they matching you? What we do not want, for example, is good service delivery in your trust but the Belfast Trust being nowhere. It is about making sure that there is coordination. There are also the financial implications. Damian hedged a bit on Liam, his report and the money, but you need money to make this work. If you are to move services into primary and community settings to dampen demand on secondary care, there will be a serious financial implication. Where are you with that? You have a good story to tell. There were two examples. Kieran, I take it that you are one of the Donaghy gang, are you, with Sean and Colm?

Mr Donaghy: Fortunately.

Mr McGimpsey: If you are Colm's brother, you can be sure that I will believe every word that you tell me.

Mr Molloy: How do you answer that? We picked the examples that we gave you today to give you a blend of the services. We are all doing similar things. We are all looking at reablement, how we run our outpatient clinics and various bits and pieces, and we learn from one another. So if there is a unique response or service model design in an organisation, we share that information so that we are not reinventing the wheel. I think that that is sensible. You asked how many more there are. The list is endless, Mr McGimpsey. In our organisation, we have 20 bids — investment proposal templates (IPTs) — under consideration between us and the board. Prioritisation will be important, but each has merit in its own right. When those 20 are complete — if they ever are; I will probably never see them in my lifetime — there will be another 20 to replace them. The environment in which we work is so dynamic that it is important that we always try to use our resources in the best possible way. As HR folk, that is when we come to the fore. It is about trying to ensure that we use our resources in the best possible way, allying that to patient need. There are examples of what we outlined to you today happening in each organisation, and I think that we will probably have another 20.

Mr McGimpsey: You gave dementia as an example, but could you have given me many more examples?

Mr Molloy: Yes. I used that example because the suggestion came from the staff group. We looked at this on the basis that we potentially need a new type of service. The community psychiatric nurse (CPN) workforce is normally a quiet lot, but those individuals said that they were willing to take it on. They knew that people were being referred directly to GPs, and they said that they could help.

Mr Donaghy: I will give another example in the Southern Trust that I think is fairly common in all the trusts. It relates to acute care at home. Basically, we are trying to prevent some of the elderly population going into acute beds. We set up an acute care team that provides cover for 36 nursing

homes, which equates to 1,500 beds and 21 GP practices. Team members look at clients in the community setting and provide a plan to look after their needs. It is headed by a consultant geriatrician and comprises a number of professional staff who meet the needs of those clients on an ongoing basis. That takes pressure off the acute system and allows those people to be looked after in their own home, which is another good example of where we have gone with TYC. That is common to each of my colleagues.

Mr McGimpsey: So this is not ad hoc; there is a plan. We want to see the plan and the time frame, and we want to see those benchmarked against workforce and finances. Can you supply us with that?

Mr Molloy: I think that there will be a plan.

Mr McGimpsey: There will be a plan.

Mr Molloy: There will be a plan. To be honest with you, there will be a plan.

Mr McGimpsey: Kieran mentioned that his example dated back to 2009, which is way before TYC. We are not sceptical at all, but I believe firmly that, unless you have the money, you cannot do it. That is why we need to see the plan. We need to see what you want to do, benchmarked against workforce and money, and what resource is required to do it.

Mr Molloy: You will know this better than me, Mr McGimpsey, but it is important for us to have clarity about the commissioning direction of the service. It is about us trying to translate that into the workforce component. We take our lead from that.

Mr McGimpsey: Does it work better if all of you go together —

Mr Molloy: Precisely.

Mr McGimpsey: — and if you all want to do mental health and learning disability and to produce this together?

Mr Molloy: As Damian said, the issue in the past was that workforce planning was seen in professional lines and right down to uni-professional lines. We are now trying to ensure that that does not happen. All professions have a part to play, and we are trying to do this on the basis of what the service tells us we need, what our patients need and what professionals and individuals can supply.

Mr McGimpsey: It is about the demand that you see for the future and how you address that. You have a long way to go.

Mr D McAlister: Absolutely, but, to very clear, workforce planning is not the solution. It is a vehicle by which we could arrive at the solution. The solution is probably driven by commissioning, because commissioning has to meet population needs.

Mr McGimpsey: It is for the local commissioning group to determine the need and inform the board accordingly. As far as I can see, there appears to be a break there. In any case, that is the theory: the board commissions, and you provide.

Mr D McAlister: We provide.

Mr McGimpsey: As far as the regional workforce planning group is concerned, I think that it is a serious mistake not to include the staff side. That is a major blunder. I do not entirely buy the line that regional and local elements are not talking and that there is dysfunction. You are talking to the unions, UNISON or whatever, and they know exactly what is going on. I am sure that it is not meant, and it is not your decision. You just have to go along with it, but it sounds like this: "We are the bosses. We will tell you what to do, and you folks will do it". This is a team game. We are all on the one team.

Mr D McAlister: I want to reassure you that we did not intend any slight whatsoever against our regional trade union colleagues when we made our comments about local trade union officials. We are dealing on the ground with our trade union colleagues in delivering in partnership the services that

we provide. We accept the regional position with the absence of trade union colleagues on the regional workforce planning group, but, as my colleague Ann said, they have been invited to sit on the domiciliary care regional workforce planning group, and I know that they are actively considering who can take that seat. It is very important. We are very much in the world of partnership working with trade unions. There is absolutely no question about that.

Mr McKinney: As you are probably aware, we are a bit sceptical from time to time. I will follow up on some of Michael's points. If you are following a plan, how come there is such a disparity between your written contributions today?

Ms McConnell: Can you give me an example?

Mr D McAlister: What do you mean by "disparity"?

Mr McKinney: Your paper, for example, is 15 pages long, and it is my understanding that it refers to TYC once. The South Eastern Trust's paper is about a page and a half long. In content alone, there are huge differences in what has been presented today. Is that consistent with a plan?

Mr D McAlister: As individual employers, we all have our own plan. I reflected the Belfast Trust plan. Obviously, I cannot speak for others. You comment that we mention TYC only once. We have had a service reform plan, which was a requirement, since 2008, when the first comprehensive spending review was put in place against the trust, and we have been carrying out that plan for the last seven years. When Transforming Your Care came along, it brought the plan together regionally and gave us a very strong direction. We would contend that we were on that path, but it certainly gave us very clear and credible evidence of where we needed to be. My response to the Committee was an attempt to be as full and frank as possible.

Mr McKinney: Yes, so is the South Eastern Trust operating to a different agenda that is much more bald?

Mr Molloy: No, not at all. I tend not to write long letters, unfortunately.

Mr D McAlister: I do.

Mr Molloy: From our perspective, as we have demonstrated this afternoon, we work across a broad canvas and have similar ideas and plans on what we are trying to do to put services in place.

Mr McKinney: Can you point me to the plan that Mr McGimpsey asked for? Where is the plan? Where are the timescales?

Mr Molloy: Ongoing work in the regional workforce planning group is to develop that plan. It is important that that group is given the opportunity to do so and to bring it forward in the way that we described.

Mr McKinney: What timescales are you operating to?

Mr Molloy: To be frank, that question is probably best addressed to the Department, which is leading the regional workforce planning group. We have an idea of what we would like to do in our organisation. We follow the commissioning direction and try to put in place the services that we believe our patients and clients need. If that is a plan, it is a plan. If you are looking at something that is more overarching in structure across all organisations, that, hopefully, will come sooner rather than later.

Mr McKinney: We are, however, four years into a process that was supposed to last five years. Are you reflecting that fact back up the line?

Mr D McAlister: To reassure the Committee, we have not been doing nothing in the last four years; we have been very busy reforming our services locally. I accept the point that the regional workforce planning group and the regional workforce planning framework document were agreed and established only recently. The document was agreed only in March. Now is the time to put significant impetus and energy behind them.

The work that we are doing on domiciliary care, which is complemented, as I mentioned in our opening statement, by the Health and Social Care Board's review of domiciliary care and the service delivery model, is the first attempt. We are very clear that that work needs to have significant energy and commitment behind it. As organisations, we are all committed to it, because we recognise that it is a fundamental part of the service we provide, particularly to our older population, so it has to be provided right.

Mr McKinney: Just recently, Julie Thompson told us that it was now an eight- to 10-year plan. Has that been reflected to you?

Mr D McAlister: Sorry — an eight- to 10-year plan in respect of what?

Mr McKinney: TYC.

Mr D McAlister: Locally, we all have our own TYC programme boards, and we each have a plan that we are working to. Our plan —

Mr McKinney: I am trying to work out what plan and timescales you are operating to. Are there any timescales?

Mr D McAlister: I have not seen an eight- to 10-year plan, but that is not to say that one does not exist.

Mr McKinney: Are you operating to the original five-year plan, then?

Mr D McAlister: We are operating locally, and we operate within our trust delivery plan, which is an annual document that reflects all that we undertake to do as an organisation.

Mr McKinney: I get that, but I am trying to work out where the Transforming Your Care initiative is at. It was a five-year plan. We are being told it could be an eight- to 10-year plan. What is being communicated to you about that?

Mr D McAlister: We understand that TYC is an iterative plan. I was here on 11 March with Heather Stevens from the Department when we talked about TYC. When TYC was launched in 2011, it was a document that put a stake in the ground and established a direction of travel. However, as we reflected that day, the service has developed and grown as well, and it has not just been about shifting things left. There has been a growth in our community staff, for example, but, equally, there has been a growth in those staff working in the acute hospital service, because service demand and service developments have occurred.

It is a rolling plan that you do not simply put time frames to and work to. It needs to be sensitive to the way in which services are commissioned and to how population need, health and well-being change. It is a stake in the ground, but it has to evolve. It does not just set down one direction of travel.

Mr McKinney: It is OK to say that in 2015, but that was not what was being said in 2011, and it is not what people bought into during the Executive's consideration of the business case.

Mr D McAlister: It set down very clear principles. Everybody would accept that it was about providing care, insofar as possible, in people's homes, and that is still the aspiration of each organisation in Health and Social Care. We want people in hospital only when they need to be there. As long as we can keep people out of hospitals and institutions, that has to be a good thing, and that is all that we are working towards.

Mr McKinney: How many of the cuts that you were asked to see through in the last while impacted the plan — if it exists — negatively?

Mr D McAlister: The efficiency savings that we have been required to make have been challenging. I do not necessarily believe that they have cut into any plan that we have. Indeed, they can be used as a force for good in expediting the plan.

Mr McKinney: At other levels, the defence has been an acceptance that it is counter-strategic. Do you accept that you have been forced into counter-strategic measures?

Mr Molloy: When possible, we try to avoid that. In reality — this has been well documented — the financial situation that we are working in is extremely difficult. It is as difficult as I have ever seen, and I have been around these parts for a long time. Over the last three to four years, it has been very challenging, and there is the potential for us to do things that are counter-strategic. We want to try to ensure that we do things that are strategically sound and relevant.

Mr McKinney: Do you accept that some of that counter-strategic approach has impacted older people more than in other areas, given the cutbacks in domiciliary care packages?

Mr D McAlister: No, I do not agree with that.

Ms McConnell: Our approach is to try to make those savings across the range of directorates and services. The reality is that there are some services that you intend to make savings in that you just cannot because, if people present themselves at the door of a hospital, they need treatment.

Mr McKinney: I get that, but, when you provide brief domiciliary care packages, with people potentially finding themselves malnourished as a result, those people who could be kept in their own homes are now presenting themselves at the very door where you are trying to cut costs and prevent them entering. I am looking for the strategic approach that puts the resource into the area that TYC recognised as being the biggest area of concern.

Mr D McAlister: That is exactly why I said that I think that we need to put a significant impetus and energy behind the ongoing review that is being led by the board on domiciliary care and the associated workforce planning that falls from it. I do not accept that we have salami-sliced older people's services, particularly in domiciliary care. It is still an assessed need, and we believe that we are providing an assessed need on that basis. The regional workforce plan will, hopefully, secure the agenda of clearly identifying future demand and the workforce that we require to meet such a demand. That cannot come soon enough.

Ms Duffield: The financial challenges that all the trusts are presented with means that we must have a more diverse approach to workforce planning, because we have to use resources in the most productive and efficient way. From a workforce perspective, the financial challenges mean retraining, diversification of skills, redeployment, productivity and ensuring that we retain and attract the best talent, because the pipeline of talent is not as available as it was. There are implications for the way in which we plan and use our workforce, but I believe that that could be argued in any organisation.

The Chairperson (Ms Maeve McLaughlin): One TYC assertion is that a 3% reduction in the workforce is required. As trusts, do you have a view on the actual requirement? We are now told that that was a working assumption.

Mr D McAlister: As I said, it was a working assumption in 2011, but, in 2015, the service is different to what it was in 2011. There has certainly been a growth in demand, and, while we gave examples of where the expected shift left, as it is called, of moving resources out of hospitals into community settings has occurred, it has now clearly been offset by a growth in hospital services. So it is difficult to say transparently that there has been a 3% reduction. There has been growth in both sectors.

The Chairperson (Ms Maeve McLaughlin): Are we now saying that what is in fact required is an increase in the workforce?

Mr D McAlister: Our demand is growing at 6% a year, yet the financial investment into the health service has been set at 2%. While there are productivity challenges for us to rise to, equally, the demands on service in our current configuration of service delivery model in the Health and Social Care family and environment is not only a challenge financially but a challenge for the workforce.

The Chairperson (Ms Maeve McLaughlin): What I am hearing and trying to tease out is that, to implement Transforming Your Care and the shift left, there would be a requirement to increase the current workforce.

Ms McConnell: I think that it is fair to say that, for a lot of the initiatives that we need to put on the ground in the community, we need transitional funding. I shared some examples of respiratory services making a real impact on admissions and so on. When they start to make a real impact, it means that, at some stage, we will no longer need the transitional funding and will be able to shift the money from one source to another. It is fair to say that quite a few of the initiatives need transitional funding.

The Chairperson (Ms Maeve McLaughlin): Does it also mean an increase in staff?

Mr D McAlister: It could do, temporarily.

Ms McConnell: Our funding is primarily spent on staffing.

Mr D McAlister: The example that I gave about ambulatory care is prime: we still have patients occupying beds who are admitted to the emergency department while we grow the ambulatory care service to try to prevent those things happening. It does not stop on a Friday and start on a Monday. There will be a potential need for investment funding at the start and an increase in the workforce.

Mr Molloy: The traditional workforce that we employed 10 or 15 years ago compared with the workforce that we now employ are poles apart.

The Chairperson (Ms Maeve McLaughlin): Yes, but do we have a sense of that overall? I know that this is the board's responsibility, but, as trusts, if it is not a 3% decrease, what is it? How much of an increase is it?

Mr Molloy: It is a different workforce. Our workforce numbers might increase, but they might be completely different to what they are now. I used the word "dynamic" earlier, and I really mean that in its truest sense. The individuals whom we now employ are the types that we mentioned in some of those examples, such as AHP support workers. There are people with a generic range of skills whom we would not have employed five or six years ago. A physician's assistant would not —

The Chairperson (Ms Maeve McLaughlin): Does the regional workforce planning group have that analysis?

Mr Molloy: It is important that we work together to try to ensure that we develop that thinking in a coalescent sense, right across the totality of everybody as a —

The Chairperson (Ms Maeve McLaughlin): OK, I will close there. I find it ironic that somebody, somewhere was able to calculate a 3% decrease in staff required to implement TYC, and we are now saying that that was a working assumption, but we do not have a figure. We know that it is an increase, but we do not know how much. That is part of the difficulty that we find ourselves in with this policy direction.

Thank you for your time and evidence today.

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Review of Workforce Planning in the Context of Transforming Your Care: Department of Health, Social Services and Public Safety/Health and Social Care Board

24 June 2015

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NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Review of Workforce Planning in the Context of Transforming Your Care: Department of Health, Social Services and Public Safety/Health and Social Care Board

24 June 2015

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Alex Easton (Deputy Chairperson)
Mrs Pam Cameron
Mrs Jo-Anne Dobson
Mr Paul Givan
Mr Kieran McCarthy
Ms Rosaleen McCorley
Mr Fearghal McKinney
Mr George Robinson

Witnesses:

Mr Mark Lee	Department of Health, Social Services and Public Safety
Ms Caroline Lee	Department of Health, Social Services and Public Safety
Mrs Heather Stevens	Department of Health, Social Services and Public Safety
Mr Dean Sullivan	Health and Social Care Board

The Chairperson (Ms Maeve McLaughlin): We have with us today Heather Stevens, director of workforce policy and chair of the Department of Health, Social Services and Public Safety's regional workforce planning group; Mr Mark Lee, the Department's director of healthcare transformation; Mr Dean Sullivan, director of commissioning at the Health and Social Care Board (HSCB); and Caroline Lee, the Deputy Chief Nursing Officer in the Department.

Before we start, I want to raise an issue. Officials chose not to provide a new briefing paper for us today. Why was the Committee not given a briefing paper, and why was it notified at such a late stage?

Ms Heather Stevens (Department of Health, Social Services and Public Safety): In that case, Chair, I apologise. We were not under the impression that the Committee had particularly asked for a briefing paper. We had intended, by way of presentation, to give you a brief update on developments since the previous time that we appeared before the Committee. We are happy to follow that up in writing, if that will be helpful.

The Chairperson (Ms Maeve McLaughlin): It will be useful to put it in writing, but we had expected to receive the briefing paper in advance.

Ms Stevens: I will take that on board, Chair. We did not appreciate that. Apologies.

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The Chairperson (Ms Maeve McLaughlin): I invite you, Heather, to make the opening remarks, and we will then open up the meeting to questions.

Ms Stevens: Thank you and good afternoon. We are grateful for the opportunity to discuss with you further the issues emerging as a result of your review into workforce planning. With me today are Dean, who has responsibility for commissioning at the HSCB, Caroline, who is the professional lead on nursing and midwifery workforce issues, and Mark, who has policy responsibility in the Department for the broader transformation agenda, including Transforming Your Care (TYC) and primary care policies, such as GPs.

By way of introduction, I will set out some of the positive developments that have taken place since I last appeared before the Committee. First, the regional workforce planning framework has been signed off, and you have received a copy of that. That framework is key to moving forward, as it sets out the respective roles of the Department, of the HSCB and the Public Health Agency (PHA) as commissioners, and of the trusts. In summary, it establishes that it is the Department's responsibility to set the vision; to ensure that a regional approach is taken; to provide regional information and trends; to facilitate capacity building; and to make decisions on the commissioning of pre- and post-registration education and training as a logical conclusion of the workforce planning process. It is the role of the board and the PHA as commissioners to determine and agree the various models of service delivery, including the outworking of TYC; to challenge the trusts or providers to ensure that they have identified their workforce needs to be able to deliver the commissioned services; and then to flag to the Department where intervention on the supply side is needed, recognising that there is a lead time to making an impact on the workforce through training. It is the role of trusts to ensure that they have an appropriate and skilled workforce in place to develop operational workforce plans, to adapt to what is being required and to makes changes to their own workforces as required. That is the framework, and, as I said, it has been signed off.

On the programme of workforce reviews, you will recall that, at our previous appearance, the regional workforce planning group had just approved taking forward a workforce review of domiciliary care. That work is progressing well. A steering group and a project group have been established, drawn from across the relevant stakeholders, including the trade unions, and there is a linkage to the independent sector providers.

Terms of reference and time scales have been agreed, so we are aiming to complete that work by the end of 2015. An initial data-capture analysis has been performed to assess the size of the workforce, the number of contract hours provided, expenditure, and so on. That is very much building on the regional review of domiciliary care led by the board, the purpose of which was to determine the service models for future delivery. That is almost complete.

That future service model is moving away from time-and-task towards an outcome-focused service, which will build in continuous improvement and innovation. It will look at the skills needed, at the training required and at how we can develop attractive career pathways for individuals who want to work in that key area.

The area was selected to enable us to test a programme-of-care approach to workforce planning focused on older people. Our work to date shows that it will do that, as older people make up 80% of the client base.

Last time, I mentioned that a rolling programme of medical specialty reviews was ongoing, led by the PHA. That works continues. Paediatrics was completed in September 2014, and no additional trainees were recommended. General practice was completed, as you know, in October 2014. The initial interim report, which you will have seen, has been confirmed as final, with a recommendation for a phased introduction of a minimum of 15 additional trainees by next year to meet the current ratio of trainees to population in England.

For radiology, radiography and medical physics, workforce data has been completed and submitted to the Department as part of its regional review of imaging services. The aim of that wider review is to produce recommendations on service configuration, skills mix and optimal use of skills to best address future demand, all of which will inform the development of an associated workforce plan.

Shortly to be completed are reviews of occupational medicine, trauma and orthopaedics, and emergency medicine. A further tranche of reviews will encompass geriatric medicine, anaesthetics, intensive care medicine, acute medicine, urology and haematology. In fact, the plan continues from

July to December 2015. Other specialties identified include neurology, opthalmology, psychiatry and dermatology.

You may ask why those are relevant in the context of TYC, but they are, because, for each of the specialties, we have the opportunity to challenge how it is delivered and whether there is a better way. What is the service model that we need to plan for? For example, I mentioned dermatology. Will we need as many consultants and junior doctors in that specialty if, for example, GP federations facilitate cross-referral in practices to GPs who have particular expertise in the area?

In addition to the work on medical specialties, separate work on a general medical workforce review that is focused on informing the number of medical undergraduates is continuing. The regional workforce planning group met on Monday of this week, 22 June, and considered the emerging need for workforce reviews relating to allied health professions, paramedics and the range of dental professionals. They will be scoped and built into our programme of work.

However, we need to be absolutely clear that we will looking at them through both a professional and a programme-of-care approach, informed by the domiciliary care experience, all with a view to progressing and furthering the aims of TYC.

For completeness, I should mention that a comprehensive and robust workforce review of nursing and midwifery has been completed. Work continues on implementing the various phases of normative nursing, which Caroline can expand on, if that will be helpful.

The primary purpose of the raft of workforce reviews has always been to identify where there are projected shortages or potential oversupply in order to inform our decisions on the commissioning of education and training places. However, we have recently been discussing what we can do to address our "leaky bucket" situation, which is how the chief executive of Health Education England (HEE) described the situation whereby the NHS, or Health and Social Care (HSC) in our case, trains people at huge expense only to lose them to other countries. We commissioned some work internally that looked at how other countries incentivise the recruitment and retention of medical staff. The work looked at issues such as work-life balance and the possibility of introducing more downtime between shifts and providing childcare discounts. It looked at work-related incentives; for example, enhanced periods of study leave or extended leave to undertake further training after a period of time, such as five years. It also looked at staff recognition incentives, such as mentoring or the awarding of extra leave for a completed project; regional incentives, such as bonding schemes, whereby fees are paid off for every year worked in the health service; and recruit-and-retain initiatives, including finding ways in which to support spouses or partners to find work, childcare or schools and strengthening urban and rural links to minimise rural isolation. We now need to consider those ideas and decide what we can apply or adapt for use here. Of course, although our initial focus has been on the hard-to-fill medical posts, there is nothing to stop us applying the same principles to any and all disciplines.

A further development has been in the area of skills mix. You may be aware that, elsewhere in the UK, the role of physician associate (PA) has been piloted. That has drawn on experiences in the US and has been found to be a very valuable alterative to middle-grade doctors in some areas of secondary care, and a valuable source of support in primary care as well. PAs are generally individuals with, for example, a biomedical science degree. Therefore, with a further two-year postgraduate medically orientated training programme, they are equipped to work along a medical model and under medical supervision. We have liaised with colleagues in the Belfast Trust and the Western Trust, and we are pleased that the Belfast Trust will utilise some resources that would otherwise have been used to pay for locum cover to pilot a small number of PAs in the emergency department setting. We have also discussed with the Northern Ireland General Practitioners Committee (NIGPC) how we can test the added value of such a role in the primary care setting in Northern Ireland to help address the workforce issues that have been flagged up by the GP workforce review. Alongside that, we are seeking to expand the number of advanced nurse practitioners, as a further opportunity for those who want to develop their skills and expertise, while at the same time helping to address areas that have been traditionally hard to fill.

Finally, I want to mention specifically recent developments with GPs. Back in March, no decisions had been made on the 2015-16 Budget, and, in fact, we are still in a situation in which budgets are not confirmed. However, a bid for the full 15 places recommended in the workforce review has been submitted as part of the June monitoring round. The GP workforce review also made a series of other recommendations on retaining our workforce, and the GP package that the previous Minister, Jim Wells, announced on 1 April takes those forward. Therefore, as well as providing additional funding for out-of-hours GP services, the package recognised the need to invest in the skills mix in primary

care, with £1·2 million for trialling different approaches in primary care, including increasing the provision of GP-led phlebotomy services. The package also included up to £300,000 to recruit and retain more GPs in Northern Ireland.

I hope that that has given the Committee some sense of the range of the work that is and has been happening in the area of workforce planning. We have a framework and a plan, and we are taking those forward. In taking those forward, we will certainly consider the structures that we have for workforce planning in order to get them right.

I hope that that has been helpful. We are happy to expand on points or to answer any questions that you may have.

The Chairperson (Ms Maeve McLaughlin): Thank you, Heather. To start with, I want to clarify something. Who leads on workforce planning?

Ms Stevens: Workforce planning is led on a regional basis by the Department through the regional workforce planning group. However, it is also undertaken at a local level.

The Chairperson (Ms Maeve McLaughlin): It is the Department that ultimately leads on it.

Ms Stevens: The Department leads on regional workforce planning.

The Chairperson (Ms Maeve McLaughlin): To be clear, the original strategic implementation plan for TYC stated:

"The HSBC will lead on the TYC transformation programme."

It went on to state that it recognises:

"that the responsibility for workforce planning rests with the DHSSPS".

Is that an oversight or flaw?

Ms Stevens: I will let Dean come in as well, but my sense is that it is not, because the board is responsible for service model delivery and development, and that is the space that TYC is in.

The Chairperson (Ms Maeve McLaughlin): Do you agree, Dean?

Mr Dean Sullivan (Health and Social Care Board): Yes, I do.

The Chairperson (Ms Maeve McLaughlin): What about the level of importance that is given to workforce planning? Is its profile in the Department high enough?

Ms Stevens: It is certainly a key priority for the Department, and I think that the work that has been done to move workforce planning along is indicative of its current level of priority. We are taking forward work on a number of fronts. We are not only taking forward the workforce reviews that I mentioned but looking at helping trusts do more interesting things to recruit and retain staff. We are more heavily involved in workforce planning than we have been.

The Chairperson (Ms Maeve McLaughlin): A lot of the commentary that we have received in evidence to date has talked about being three-plus years into the process and how workforce planning, in its entirety, is only being activated now. Do you accept that?

Ms Stevens: I agree that there was a hiatus while work needed to be done, as a result of Skills for Health coming in, on a diagnostic report, which stated that there was not clarity around roles and responsibilities. That took some time to work through. However, we now have a framework that sets out those roles and responsibilities very clearly. It is indicative of the ability to move at pace since we agreed those roles and responsibilities that we have been able to take forward the work quite quickly. Therefore, that time was well invested. In the meantime, at that very operational level, the trusts, which I know support the position, have continued to plan their workforces on a regular basis to deliver the services that are commissioned by the board and the PHA. That work does not stop.

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The Chairperson (Ms Maeve McLaughlin): Ultimately, the Skills for Health report helped initiate some of that work around roles and responsibilities.

Ms Stevens: It certainly did. It identified that as a clear need, and we have responded to meet that need.

The Chairperson (Ms Maeve McLaughlin): OK. Does the process of commissioning require the board and the PHA to produce a workforce plan?

Mr Sullivan: It is hard to respond to that in the abstract. I will talk about a specific service and a number of processes that are ongoing at the moment. In something like the Transforming Cancer Follow-up (TCFU) programme, for example, the board and the PHA, working with the Department and in partnership with Macmillan, have fundamentally changed the way in which women with breast cancer are followed up after treatment. Previously, following that treatment, ladies would have had a number of review appointments with a surgeon and an oncologist, regardless of the added value of some of those appointments, and potentially, for five years and more, they would have continued to have those review appointments. The arrangement that is now in place across Northern Ireland is that only by exception do women, following breast surgery treatment, have a series of review appointments with an oncologist. The typical position now is that they are allowed to get on with their life and to focus on their well-being. They are supported in that regard by clinical nurse-specialists, third-sector organisations, and so on; by having the right information; and by support groups. If we take that as a snapshot example, what it means is that, compared with what would have been the case, the pressure on oncology staff — on consultant oncologists — is lower than it would otherwise have been. The number of consultant oncologists is lower than it would otherwise have been, while the need for clinical nurse specialists, and other support staff to work alongside them, is greater than it would have otherwise been. Ultimately, that will feed through into the sort of work that Heather is describing when we are thinking about the consultant oncologist workforce and the nursing workforce, and, specifically within that, the clinical nurse specialist workforce.

Oncology is a factor in that, but it is a relatively small one. There are much bigger pressures driving the number of consultant oncologists that we need in Northern Ireland, such as the number of patients with cancer in Northern Ireland and the development of the second radiotherapy centre in Derry. There are several other pressures, and they are all far bigger drivers of change. Even though that is a fundamentally different service model, in relative terms, it has an impact that is small in scale compared with that of growing population need and demand, and the impact that that has. The work that Heather described so comprehensively earlier is drawing on all of those. It is drawing on the impact of demographic pressures, the impact of different approaches to providing care within a profession and the different approaches to providing care across professions.

The Chairperson (Ms Maeve McLaughlin): Therefore, there is no requirement for the board or the PHA to produce an annual workforce plan.

Mr Sullivan: I do not believe that there is, Chair.

The Chairperson (Ms Maeve McLaughlin): Is that something that the Department may consider or has considered?

Ms Stevens: It is an interesting idea. With the extent to which the work is developing, and as service models are changing all the time, an annual workforce plan would be just a snapshot of what is required at that particular time. Again, it is questionable whether the work to invest in describing what is happening is worth it.

The Chairperson (Ms Maeve McLaughlin): What time frame is the Department working towards for workforce planning? Is it a three-year plan, a five-year plan or a 20-year plan?

Ms Stevens: It is a rolling programme. We identify the issues to be reviewed and explored. Any of the workforce reviews that we do, such as that on domiciliary care, will have a five-year horizon. We look to a five-year plan, because we think that one for any longer than that is looking too far in advance to be able to plan for. What might the demography and the situation at the time be? We therefore have a five-year horizon for those individual workforce plans, and that will constantly move on a rolling programme.

The Chairperson (Ms Maeve McLaughlin): You are ultimately saying that any longer than five years will not be feasible.

Ms Stevens: I think that it is not feasible. Five years tends to be the optimum period in which to create the opportunity for lead-in times and for training to be able to impact on the workforce. It does need to be done over that horizon.

The Chairperson (Ms Maeve McLaughlin): Can you clarify who is responsible for delivering the new service models?

Ms Stevens: That is very much the responsibility of the board and the PHA in discussion with the trusts.

The Chairperson (Ms Maeve McLaughlin): There is much debate around the current status of Transforming Your Care. Is that still advancing and driving the workforce planning agenda?

Ms Stevens: It is certainly the driver. That is the context in which we are operating.

The Chairperson (Ms Maeve McLaughlin): It is absolutely still the driver. There has been no shift.

Ms Stevens: No. We are working to implement TYC, and the shift-left agenda.

Mr McKinney: Why did you use the word "context" and not "plan"?

Ms Stevens: Sorry?

Mr McKinney: You said that the TYC is the context.

Ms Stevens: It is. It is the policy driver. Its whole ethos and its objectives are fundamentally the foundation on which we build our work. I could say "plan".

Mr McKinney: It is just that we have recently had it described as a "philosophy". The Committee would worry that it is losing some of the practical, planned, targeted nature that it set out with.

Ms Stevens: Mark, do you want to comment on that?

Mr Mark Lee (Department of Health, Social Services and Public Safety): The 2011 TYC document is not a plan per se; rather, it is a set of proposals and a description of a service model to move to. I guess that the things that follow that, such as the strategic implementation plan that the Chair referred to, are the plans. TYC itself is described as a service model. It talks about things that we should seek to achieve. The detailed plans follow on from that, so TYC is delivered through the commissioning plan and through other plans that exist across the system.

The Chairperson (Ms Maeve McLaughlin): How far advanced is the Department with the service models? How many are in place, how many have to be implemented and who is monitoring them?

Ms Stevens: Again, that is for the board and the PHA to lead on.

Mr Sullivan: The way in which you framed the question, Chair, is interesting. I am not sure that it has a beginning and an end. It is a live issue all the time. What Heather was alluding to when she described TYC as a context was a way of thinking. As recently as this morning, Mark and I were at a meeting on outpatient reform. Providing outpatient services closer to a patient's home is referenced in Transforming Your Care but not in any huge detail. This morning, we were talking about whether there were opportunities whereby, rather than being referred to secondary care to see a consultant, a patient could be cared for safely in a primary care setting by the GP operating in a different way, perhaps with different support from GP colleagues. Are there circumstances in which a patient can avoid being sent into secondary care, potentially by a GP working in partnership with secondary care colleagues and being able to refer for advice, and so on, or having access to a specialist opinion in some way? Is there potential for primary care colleagues to refer patients to secondary care without

the need for an outpatient appointment and directly list them for a diagnostic test or surgical treatment? All of that was discussed this morning. All of that will result in different service models, but they are unique to individual specialties. The answer in dermatology will be different from the answer in ear, nose and throat (ENT), which will be different from the answer in orthopaedics. It is all the time. It is not the case that we have to produce 10 service models, and, when we produce those, the job is done. It is a way of thinking. It is a context for the way in which we think. It is about trying to work from a patient's point of view.

The Transforming Cancer Follow-up example that I mentioned earlier is exactly the same thing. Going up to see the hospital doctor every six months might have a negative impact on a patient — the worry, and so on. If there was no value in that process, from the patient's perspective, why would we continue to do it? The service model has been designed and implemented and is now in place. We are at the leading edge of that across the UK. No one else in the UK is close to how far we have progressed that TCFU model.

There is never an end to this. There will always be a new service to look at and a different opportunity in an existing service. Therefore, I do not think that we can say, "That is 10 done. Closed off". It is a live, open-ended position.

The Chairperson (Ms Maeve McLaughlin): It is an area in which you need to have your service models in line with your vision. At what point do we get there?

Mr Sullivan: I do not think that we ever get there, Chair. That is exactly the point that I am making. The day and hour that we decide that we have got there, we have missed something. It is about continuously looking at the service and about continuing to look at opportunities to improve the service to make it more responsive to patients and more cost-effective.

The Chairperson (Ms Maeve McLaughlin): Can we say, "We need x number of service plans"?

Mr Sullivan: No, I do not think so.

The Chairperson (Ms Maeve McLaughlin): We cannot say that. You do not have a sense of how many new service delivery plans will be needed.

Mr Sullivan: Take the example that what Mark and I were talking about this morning around outpatient reform. It was quite an effort to begin even to scope out where we might focus our attention. Through that process, we will probably focus on five or six things at a regional level, but there will be another five or six after that, and another five or six after that, and further iterations within each of those as to where we go. Therefore, I do not think you can put a hard number on it. It is not a case of saying, "There are 26, and when we have implemented 26, the job is done", because something else will come along that provides an opportunity and a new way of looking at a service, perhaps something that was reformed a year ago.

The Chairperson (Ms Maeve McLaughlin): If it is so much of an evolving process — again, the monitoring is critical — who oversees it all? Who makes sure that the processes are evolving and being actioned? I assumed that a service plan requires a start date, an end date and an estimated cost.

Mr Sullivan: Individual bits of the service will have that. The process that I mentioned from this morning is a subset of the Transforming Your Care implementation agenda, because it is a key regional programme. That process reports through a formal infrastructure. Within that process, there will be a defined timeline by which each of the reform projects that is taken forward will be planned, rolled out within a local commissioning group (LCG) or trust area, and, if successful, rolled out across the region. Therefore, there are hard timelines for elements within that. A fraction of the reforms that are being taken forward on any day are formally under the Transforming Your Care banner.Again, the cancer example that I gave, and many other examples that I could give, are just work that is being taken forward as part of routine work in trusts and primary care working alongside commissioner colleagues and, as appropriate, where there are policy implications, the Department.

The Chairperson (Ms Maeve McLaughlin): I go back to the point that there were very clear directions given in TYC that would require workforce planning models. I use the example of the five to seven hospital networks, which was a target agreed. So, you either do that or you do not.

Mr Sullivan: The way that you get at that though is more from the end that Heather described, which is that you focus on areas of greatest workforce challenge. I think that Heather mentioned radiology. The Department has initiated a regional radiology review. As part of that review, we are looking at where the demographic changes are going, the role of radiologists, the role of interventional radiologists and the role of radiographers and support staff in all of that. Again, that is a process with a defined start date and end date, and, out of that process will come the number of different staff groups that will be required.

The complicating factor in that is what is assumed around staff turnover, staff retirements and so on, and it is all done within a framework where finances, as we around this table know and have rehearsed before, are very tight. So, we do not have the luxury of training a surplus of staff. Indeed, it is quite the reverse; we are struggling even to train the bare minimum of staff that we know we need in any circumstance.

The Chairperson (Ms Maeve McLaughlin): With regard to oversight, is the Department saying that you can reasonably and realistically monitor the board in relation to the implementation of TYC or workforce planning to do TYC?

Ms Stevens: We have a process, through the workforce reviews, of examining each of the areas in the work of the regional workforce planning group and making sure that TYC has been taken into account when looking at the service delivery model that we are workforce planning for. So, that is a scrutiny role that we can do and a challenge function that we will exercise.

The Chairperson (Ms Maeve McLaughlin): Do you envisage at some point that the workforce planning group will produce an overarching plan, which will be one plan with requirements and timetables?

Ms Stevens: Like an overarching workforce plan or workforce strategy document? We clearly have a plan that we are working to. If you are asking whether we can pull those strands together and create a document that sets out what we are doing and shows the programme, we can do that. We are doing it, and our Minister has given us a clear steer that he wants to see action as opposed to documents describing what we will do. So, we are focusing on doing the work, but we could pull it all together.

The Chairperson (Ms Maeve McLaughlin): But it is not something that you are actively working on at the minute, is it?

Ms Stevens: No, we are progressing the work and taking forward the different strands that a document would comprise, and we want to see progress in relation to those.

The Chairperson (Ms Maeve McLaughlin): OK. Thank you for that. A number of members have indicated that they want to ask questions.

Mr McKinney: I think that it should be put on record that a lot of time and momentum has been lost, given the original plan that we referred to was for TYC to happen in 2011 and given that the headline in it was specifically and clearly about a growing older population and pointed in the direction of doing some of the work that we are now talking about. It is a no-brainer. I will reflect on a number of concerns that we have been hearing through the review, particularly around the silo mentality, a lack of a holistic approach and failure to have gathered sufficient data for the decisions? Heather, you touched earlier on the scoping exercise. Will you give us a bit more on the workforce review in respect of domiciliary care?

Ms Stevens: OK. That work kicked off after it was approved back in March. What we have is a project group pulling the work together, overseen by a steering group. In that steering group, we have, for example, requested trade union membership and independent sector providers —

Mr McKinney: You have requested them, but are they on the group and are they participating?

Ms Stevens: We have asked for the nominees. We are waiting to get confirmation. They asked for two places. That is fine; we are going to get the nominations in.

Mr McKinney: How much work has been done ahead of that, or is their presence required for the work to be started?

Ms Stevens: Work has started on gathering the information. That, literally, is just a matter of gathering the information that already exists from the different sources. That work is being pulled together at the moment. It has not been analysed, so those people will be very much at the table when that work is pulled together and there is something to discuss. We have taken forward what I describe as the very practical initial pieces of work that have to be done for proper discussions to be had with all the stakeholders. That is happening, and we have drawn —

Mr McKinney: Just to clear up that issue, some people, when they are brought along later to a meeting, feel that the meeting has already been sorted out and packed; I do not mean numbers but the terms of reference and things. So, is the review now set and they are to come along, or are they to scope out the review further?

Ms Stevens: Terms of reference have been developed. They were discussed at the first meeting of the steering group, and they were amended and were felt to be appropriate. When our trade union colleagues join us at the next steering group meeting, I have no difficulty with taking their views. If things need to change, or if, for whatever reason, there has been an oversight —

Mr McKinney: So, you will invite them to change the terms of reference if need be?

Ms Stevens: We can invite them to comment —

Mr McKinney: That will be —

Ms Stevens: Absolutely. There is no difficulty with that. We want them at the table. This is something that I want to very strongly convey to the Committee: we value very much the impact of staff- and employee-side representatives. They have played a really valuable role already. For example, in the nursing and midwifery review, we had unions at the table. They played a tremendous role in that. We engage with the staff side on every detailed workforce review. The British Medical Association (BMA) is involved in the medical reviews. We are inviting the relevant domiciliary care union representatives to be involved in that one. We see them as crucial to taking that work forward.

Mr McKinney: Given what you have just said, do you regret not doing this work earlier?

Ms Stevens: The domiciliary workforce review?

Mr McKinney: Yes; the workforce review.

Ms Stevens: We really were reliant on the service models being developed. That work needed to be done by the board. That work is now just completing, so we could not really have started the work any sooner.

Mr McKinney: What does the model look like?

Ms Stevens: I am not party to the detail of that yet because I am waiting for that to come through from the board, but it will certainly envisage a mixed economy where domiciliary care is provided by not only the statutory sector but the independent sector. We expect the model to encompass both sectors, and we are going to plan for that because we know that we rely very heavily on contracting with the independent sector. Independent sector representatives are at the table as we discuss *[Inaudible.]*

The Chairperson (Ms Maeve McLaughlin): Can I come in on that, if you do not mind? Going back to the implementation plan, you talked about the joint forum with trade unions that was set up back in 2013. What happened to that forum?

Ms Stevens: A joint forum?

The Chairperson (Ms Maeve McLaughlin): Yes. It is in the strategic implementation plan.

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Ms Stevens: For TYC?

The Chairperson (Ms Maeve McLaughlin): Yes.

Mr M Lee: I do not know the details of that. There is ongoing engagement between the trade unions and the Department —

Ms Stevens: Yes, and I can describe that. There is a joint negotiating forum, which —

The Chairperson (Ms Maeve McLaughlin): A partnership forum was established.

Ms Stevens: Sorry. There was a partnership forum that was in existence a while back. It fell into abeyance because both sides recognised that there was a duplication of the conversation that was happening in that forum and the joint negotiating forum. We have spent some time with our trade union colleagues looking at the structure of the joint negotiating forum and putting in place a new structure, which we are going to implement from September. That provides us with a really good opportunity to build in that partnership element and to keep trade union colleagues really closely involved in the policy development process.

The Chairperson (Ms Maeve McLaughlin): OK, but it was said to us that it was unilaterally abolished as opposed to falling into abeyance.

Ms Stevens: It had not met for some considerable time.

The Chairperson (Ms Maeve McLaughlin): But the forum was then abolished.

Ms Stevens: It was not, technically, abolished, but it was not reintroduced. That is probably a better way to say it.

The Chairperson (Ms Maeve McLaughlin): Who would have taken that decision?

Ms Stevens: It was the Department's decision because the Department chaired it. It was felt that there was another forum for that engagement to happen. I am very keen, as one of the joint chairs of the joint negotiating forum, to make that work and for that engagement to happen through that.

Mr McKinney: What about timescales, then? You talked about the end of 2015 in terms of the scoping exercise.

Ms Stevens: In terms of the whole workforce review? In its work to develop the new service delivery model, the board has gathered together a tremendous amount of information, which, in effect, speeds us along. The group is confident that it can pull that together and come up with workforce recommendations by the end of this calendar year.

Mr McKinney: What happens then?

Ms Stevens: Then we will look at those recommendations. At this stage, it is too early for me to say, but we want to look at the skills mix that is necessary to take forward the provision of domiciliary care, the levels that people need to be at and the composition of the workforce currently. Do we need to recruit, or do we need to put in place some sort of career-progression pathway to make it attractive to younger people? Our intelligence is that it is very much an older-people delivery model in that there are older people in the workforce delivering the care. All those elements need to be taken forward, and we need to look, with our colleagues in the Department for Employment and Learning, at the training that is offered, because it will more likely be done in a further education setting. We have all that to work through.

Mr McKinney: Why do you say further education setting? Oh, sorry; I thought you meant FE settings, as in —

Ms Stevens: Well, vocational training, yes, if they need further training it could be in the area of NVQs. These are areas that we need to look at.

Mr McKinney: That is domiciliary care. You have mentioned other forms of workforce reviews. Have you other plans for care workforce reviews?

Ms Stevens: Yes, in terms of social care more broadly. At the moment, the focus is on domiciliary care, and we are conscious that we need to look at paramedics. We have highlighted the whole dental profession and, more broadly, social care would probably come after that in a rolling programme. That is a matter for discussion with the regional workforce planning group. In fact, if the work on domiciliary care throws up something that we think needs to be looked at sooner, we can do that.

Mr McKinney: Would you accept that the approach to date has been too silo-based?

Ms Stevens: No, I would not accept that. I am trying to be really objective about that because in everything that we do, we try to be as inclusive as possible. We bring together the key stakeholders who we know have a vested interest in the outcome, and we want their views. I do not think that it has been done on a silo basis. Traditionally, the approach has been uni-professional. To date, that has been because we rely on those workforce reviews to determine whether we need to train more doctors and nurses. In recent times, our understanding has shifted as part of the whole new way of thinking under TYC. We need to look at things on a much broader basis, with the patient and the client at the centre. We need to look at the older person and the cadre of professionals who need to be around that person in order to deliver care. That means that it is slightly messy from a workforce planning point of view. It means that we also have to do uni-professional reviews, but alongside, as opposed to instead of, the others. Does that answer your question?

Mr McKinney: Would you accept, at least, that a lot of your thinking has been around those in the employ of the trusts or within your employ, as opposed to looking at GPs and, potentially, community pharmacy and the wider workforce employed in domiciliary care, for example?

Ms Stevens: I do not agree that it has very much been focused on the trusts, but I would agree that it has been very much focused to date on single professions, wherever they happen to be. That could be GPs, pharmacy or wherever, but to date it has been on a uni-professional basis. That is now changing.

Mr McKinney: It appears that when something erupts, corpuscle-like, in the system, not just in terms of workforce planning, the resource goes to deal with that pressure point and the wider strategic thinking may not have been employed in the way that you are talking about now.

Dean, you mentioned GPs. There are 25,500 people waiting for first referral to a physiotherapist and some 12,500 for occupational therapy. What consideration is being given to allowing self-referral? It goes back to what I am saying about dealing with the pressure point. Your immediate reaction is to train more GPs, whereas you could take the strain off the GPs and allow self-referral to allied health professionals and the range of services that they provide.

Ms Stevens: I will let Dean answer that, but, before I do, I will point out that it is not our first reaction to say, "Train more GPs". It is not.

Mr Sullivan: And we have done that, as I said we would, when I was here two times ago. That pilot is up and running now in the South Eastern area. There is direct referral to physio in the South Eastern area.

Mr McKinney: Dean, there are still 25,500 people waiting for first referral. We cannot really get past those figures.

Mr Sullivan: I fully accept that, and those figures are very difficult. However, it comes back to a couple of things that are not directly related to workforce planning in relation to allied health professionals, because there is not particular difficulty in securing additional staff resource for the majority of the allied health professionals. The greater difficulty is simply funding additional capacity, whether that is short-term or longer-term capacity. An exercise that has taken quite a time to complete will be complete, I expect, in the coming few weeks in relation to better understanding exactly the

flows of patients into the system for various allied health professional services and the capacity of the system to respond to that. That will flag up areas where there are pinch points and for which, again, in the wider resource context, it will not be straightforward for us to address. We simply cannot put our hands on additional funds to address that, but at least we will be clear about where there are opportunities for trusts and staff in trusts to be more productive, and there are issues that are just barn-door demand issues. We will need to look at that.

You could ask me about elective care waiting times in other areas, for consultants and so on, which we have rehearsed before. We face the same challenges there. Our approach in AHPs and, more generally, referrals for consultant services is what I was talking about earlier, which is that, as things sit at the minute, we have no prospect of material recurrent additional resource going into the system. Therefore, we have to look, in ways that are as imaginative as possible, at existing staff, be it GPs and nurses in primary care or doctors, nurses, allied health professionals and other practitioners in secondary care, working differently to try to not let this get too far away from us. I would not try to understate the problem at all; there are huge challenges out there in the system.

Mr McKinney: It goes back maybe to the question that the Chair asked at the start about who is actually in charge of some of this. Clearly, as you have touched on, there will be resource implications out of the workforce review, so trusts employ directly and the private sector provides some itself etc. Overall, who is in charge of making sure that we have the adequately trained, properly directed staff looking at the service model as it emerges?

Ms Stevens: I see it as a cyclical thing. The board and the PHA work to determine what the service model for delivery is. They instruct the trusts and contract with the trusts to deliver that. The trusts' obligation is to make sure that they have a workforce that is suitably trained to do that. If there is a problem in the supply chain, they flag that to the Department, and we have to see whether that is a training issue or an issue that is more about how you are recruiting your staff and how you are retaining them. Is there something at that point that needs to be done as opposed to starting to feed a supply chain through training? That is an expensive way, and it is a lengthy way of getting people into the workforce. In some cases, the need is such that we have to do that, but, in some cases, actually what we need to do is to just keep the people that we have.

Mr McKinney: Finally, how do we make sure that the model that emerges is a mixed economy and that the service level is of the same quality not a floor? There will also be issues around pay and conditions that will differ. Does that have an impact on delivery of care beyond the floor?

Mr Sullivan: The service delivery model is ours to determine, Fearghal. It will be done in partnership with providers and in discussion with patients and clients, but it is for us to determine. There is legislation about the requirements of the specific behaviours, policies and so on of employing organisations in the private sector. We would not get involved in that directly, other than in tendering arrangements, obviously, and being assured that any organisation is consistent with those.

Mr McKinney: At the moment there is huge stress on the private-sector end of this. You will be aware of it from the headlines in the papers, we have heard it in evidence and I am sure that all our offices are aware of it too. The folk who tendered the contracts are, even at the outset, undermining potential safety and care.

Mr Sullivan: What I am aware of is that we have tendered, and will continue to tender, for services to put a sensible and deliverable service specification out for any appropriate provider to respond to. Before we accept a tender response, or if it is a sub-contractor to a trust, before a trust would accept a tender response, they would undertake due diligence to satisfy themselves that what is being put forward is not at such a price that it is undeliverable. If we go back to the elective care side of things, we do not tender for that at a floor price for whatever organisation comes through. Typically, our expectation is that the price that is brought forward is consistent with the tariff across the water. The tariff across the water is one that has gone through a huge amount of work to ensure that it provides a reasonable return for the organisation delivering the service. I can see how what you are describing is a risk, but I am satisfied that the tendering arrangements that are in place should avoid what you describe. The risk is there, but I am satisfied that there are mitigating factors in place to address it.

Ms McCorley: Go raibh maith agat, a Chathaoirligh. Thank you for the presentation. Did the Department consider a voluntary exit scheme for Health and Social Care (HSC) when undertaking workforce planning?

Ms Stevens: Yes, the Minister has approved a voluntary exit scheme for HSC, and a bid for funding has been submitted to the public sector transformation fund. Being able to proceed with that, however, will be entirely dependent on securing funding. The trusts have carried out modelling of who may be able to avail themselves of the scheme in parallel with, and in order to implement, their savings plans. They have looked at areas where savings are required, and they will offer the opportunity for voluntary exit in those areas, if funding is secured. I cannot stress enough that it is if the funding is secured. Workforce planning, in the round, has to take account of that, but that will proceed in relation to implementing their savings plans.

Ms McCorley: Are you saying that you do not have any estimate, at the minute, of how many workers might take up the scheme?

Ms Stevens: Our initial estimates are in the region of 400 people across the whole health and social care sector. The Minister has made it very clear that he does not expect front-line staff to be released as part of that. The fact that it will be in areas other than front-line staff certainly ties in with the savings plans that have been put forward.

Ms McCorley: Is there still a policy of no compulsory redundancies in the HSC?

Ms Stevens: Yes, the Minister has made it very clear that we are not looking at compulsory redundancy.

Ms McCorley: You are saying that it is not on the cards? That is not going to happen?

Ms Stevens: Not to the best of my knowledge. That is what the Minister has said, and that is what we are working towards.

Ms McCorley: You mentioned a figure of 3%, which was a reduction in Transforming Your Care. Can HSC explain how that was arrived at in the first place? It is a figure that we have probed several times, but we have never had a satisfactory response.

Mr Sullivan: I doubt that I can give you one today, Rosaleen, I am afraid. I would describe a very complex set of issues that would change the number of staff in individual parts of the workforce that are required to deliver individual services. I will stick with the example of outpatients that we described today. I talked earlier about outpatient reform for, say, something like dermatology. If there were, which there are, opportunities for fewer patients to be referred into secondary care for consultant outpatient appointments, all other things being equal, that means that we potentially need fewer staff, doctors, nurses and others in secondary care to respond to that. That assumes a system that is static and perfectly in balance at the minute. We are not static and perfectly in balance, as Fearghal described earlier in relation to AHPs. We have a position now where thousands of patients are waiting more than nine weeks for a first outpatient appointment. The reality may be that we need to keep all the staff in secondary care that we have there now in dermatology, and, in primary care, we will simply bring the system back into balance rather than create headroom so that we can reduce the number of staff in secondary care.

Straightforwardly, I do not know where the figure of 3% came from. I think that perhaps, consistent with what Heather said, it was intended to signal a direction of travel that our default position going forward has to be that, where it is appropriate, safe and cost-effective to deliver care near to someone's home, that is exactly what we do. Where it is appropriate, safe and cost-effective to deliver care in an ambulatory setting rather than admitting someone to hospital, that is what we do. To give a flavour of what that might look like, the figure of 3% was arrived at. I do not know the extent to which that took account of demographic change, as we have talked about around this table before. There has been a 2% increase year-on-year. In the time between when TYC was published and now, there has been an 8% demographic growth alone. So, was it 3% assuming no demographic changes? That would swamp any 3% that was talked about at the time. Just to stand still, we would have needed to have increased the workforce by 8%. That is before we begin to think of all the other complicating factors.

Caroline and I work very closely with the Royal College of Nursing (RCN) and others on normative nursing. That, as an example, is not responding per se to demographic pressures, whether we are looking at phase 1 in terms of nursing staff on medical and surgical wards. That is simply us working

in partnership with professional colleagues and identifying reasonable staffing levels for medical and surgical wards. In most trust cases, that required an increase in permanent and temporary staff working on those wards. As we talked about before, there are plans in place, which are being implemented now, to work towards that position. That would not have been foreseen or foreseeable at the time when TYC was written, but it will result in an increase, just on its own, of hundreds of nursing staff working in a hospital setting. That is the challenge. There are so many inflows and outflows from all this. If you did arrive at a -3% figure, it would be as much by luck as by judgement, and I do not think that, if anything, that would be the direction of travel. It is more in the context of TYC signalling a direction of travel. You should be, and I know you are, looking for demonstrable evidence from the Department, the board and trusts that we are not just routinely investing in secondary care services and more staff in there but are actually looking very hard all the time at opportunities to provide care closer to patients' homes and investing in staff to support the delivery of that model.

Ms McCorley: It comes back to this question: where did the figure of 3% come from? I understand all the different aspects that you are talking about and that it is hard to predict, but somebody came up with 3%, and we have never been able to get a satisfactory answer. It makes you wonder what else in there was plucked out of the air. You cannot have much confidence.

Mr Sullivan: Hopefully nothing else, Rosaleen.

Ms McCorley: How do we know?

Mr Sullivan: I guess that you can take assurances from the discussion that we have had today. Hopefully, there is nothing else, but it would be hard to explain the figure of 3% and come up with a strong rationale for it.

Ms Stevens: Absolutely. It was certainly never endorsed by the Department and did not find its way into the final document.

Mr M Lee: It should be seen in context. A document was published at the end of 2012 or in early 2013 that stated that we had Transforming Your Care, which sets out a strategic approach to changing our care. What does that mean for our system? It sought to set out some of the implications and working assumptions. If it is helpful, we can enquire about how much of the history is still on record on how 3% was arrived at to see whether someone kept background calculations. As I said, however, the key thing is that the document sought to start a public discussion on what TYC meant.

We might see a shift from the hospital sector to the independent sector as a consequence of TYC. As part of the document asking what the public thinks about TYC, it was trying to say what that might mean for the way that service delivery happens. We can look to see whether any material was kept anywhere as to how the 3% was arrived at, but, as I see it, it was intended to be illustrative. From what I can remember, it was not reflected in the specific proposals in the strategic implementation plan. It was about trying to inform a public understanding and debate on what the shift to the TYC model of care meant.

The Chairperson (Ms Maeve McLaughlin): May I just ask on that —

Ms McCorley: I am no wiser.

The Chairperson (Ms Maeve McLaughlin): — if you do not mind, Rosie? Why put the percentage in? Why did it appear?

Mr M Lee: I do not think that any of us here put it in the document or wrote the document, so it is very hard for us to answer that. My reading of the document as a whole is that it is about trying to have a public debate on what the move to the TYC model of care meant.

The Chairperson (Ms Maeve McLaughlin): People were also being asked to sign up to a vision and policy direction that clearly said that that required a 3% reduction in staff.

Mr M Lee: I do not think that it said that it required a 3% reduction. I think that it said —

The Chairperson (Ms Maeve McLaughlin): It was in the document in black and white. I do not know how much clearer it could be. What happened, Heather? You indicated that it never got as far as the strategic implementation plan. What changed, then?

Ms Stevens: It was a working assumption in a board response to the original TYC document. It did not appear in the next iteration.

The Chairperson (Ms Maeve McLaughlin): It was not in the strategic implementation plan.

Ms Stevens: It was not taken forward.

The Chairperson (Ms Maeve McLaughlin): Something obviously changed with that working assumption.

Ms Stevens: Yes, and that will presumably have taken place in discussions in the board.

Mr Sullivan: I will interpret it. I cannot give a straightforward rationale for the 3%, but I could spend all afternoon, if you let me, giving you examples of things that we are doing that are entirely consistent with that. Palliative care is one example. There are 15,000 patients in their last year of life, plus or minus a bit at any point in time. We know about 5,000 of those, so 10,000 patients who are in their last year of life are not formally known to the Health and Social Care system, with care plans or advanced care plans setting out their health and social care needs, and their emotional needs and expectations. A lot of those patients are dying in hospital, where they do not want to die and where their families do not want them to die.

The arrangements that we have in place, through a regional steering group that I chair with Mary Hinds, the director of nursing in the PHA, are looking at processes whereby we will be able to identify as many of those patients as possible and be much closer to the figure of 15,000. We will have a care plan — an advanced care plan, if appropriate — for each patient and a nominated key worker. In many cases, but not all, it is likely that that nominated key worker will be the district nurse. That will put an additional burden on the time of the scarce resource that is district nursing, but that feeds straight through to normative nursing, and we have had discussions as part of the normative nursing process. That factor is being built into the modelling of the district nursing resource that is required in Northern Ireland. Again, that is an example whereby, in a do-nothing scenario, we have extra nursing, medical and porter staff in hospitals.

By comparison, if those patients are not dying in hospital but in their own home, a nursing home or another place of choice, that investment is being made in the community. What does that mean in practice for palliative care? Whilst the impact on bed days is material, it is a bed here and a bed there across Northern Ireland. It is nearly impossible to get that out of the system. What it means is that, compared with a do-nothing scenario, there will be investment in primary care to support GPs, district nurses and others that would otherwise have been made in secondary care to buy additional beds. When it comes to putting a definitive hard number on that, I know the number of beds and the impact on district nurses, but we still have to work through some more detail to reassure the Committee that all our focus is in this space.

The default position is not that we do what we have always done. The default position is the exact opposite. Fifteen thousand patients, some of whom are probably from the families or extended families of us all, are unnecessarily and against their wishes dying in hospital, either because we have not identified them or not put the wrap-around services in place to allow them to die at home. Just as a very hard example — I may be reassuring you, Fearghal, about the system joining up — that strand of Transforming Your Care directly leading into normative nursing is more joined up than you might think. Maybe we need to have more conversations like this to reassure you.

The Chairperson (Ms Maeve McLaughlin): I am sorry, Dean. I get it about the links, but, if we are saying that the 3% is a working assumption, it is no longer accurate. What is the guesstimate? To shift service delivery left and £83 million from acute to community or primary care, what, roughly, are the staffing requirements?

Mr Sullivan: That leads us into discussions about what we mean by a shift left. The example I gave from palliative care is a shift left every day of the week. A patient who, in scenario A, would have died in hospital, in a reformed scenario, dies at home or in another appropriate place. If, in scenario A, I

am taken to an emergency department and then admitted to hospital and an ambulatory or same-day/next-day service is put in place, still in hospital but avoiding my being admitted to hospital, that is still a shift left. It would be possible, and, indeed, I believe that we have put a ballpark figure of £70 million or £80 million on this. To me, it is about being assured that all possible opportunities are being taken by the Department, by commissioners and by trusts to move care left, closer to people's homes, putting them back in charge of their own care as far as possible and supporting them to live independently. As I say, we could fill the afternoon with such examples. If it is seen as helpful to try to scale that to give you an idea where we are and where we might be going —

The Chairperson (Ms Maeve McLaughlin): I find it irregular that a figure was used. We are listening to what you say, and we heard that it was a working assumption and that we do not now need a 3% decrease in staff, but we do not know what we need. There is no indication of our staffing requirements to implement the policy direction.

Ms Caroline Lee (Department of Health, Social Services and Public Safety): May I add a little on the education budget? We can show that community practice placements have increased dramatically. In 2011-12, we had 39 nurses in training for community placements, district nursing, health visiting, community mental health, community children's and community learning disability. In the following year, that increased to 54, then to 84 and 94, and the plan is for 97 this year.

The Chairperson (Ms Maeve McLaughlin): I am sorry, Caroline. I accept that, and I accept that work is going on in specific parts of the system, but I am talking about the overall figure. Heather, maybe you need to answer this to provide us with the means to shift left. In general, what do we need in terms of workforce?

Ms Stevens: I struggle to see how we could do that. It presupposes that we can immediately say that we will look at all the service models, say what needs to happen and aim for a certain figure.

The Chairperson (Ms Maeve McLaughlin): I struggle to comprehend why we did it in the first place. Why was it there in black and white that we needed to deliver a figure of −3% of the workforce? Why would we do that to start with?

Ms Stevens: We cannot give you an answer, because we also struggle with that figure as a working assumption. I do not think that we can ever put a figure on it, because this is an iterative process that we need to work through, and it will involve people changing roles but probably still being shown in the statistics as being employed by a trust and working in a hospital while the actual nature of their role has changed. How can we measure that in a meaningful way?

The Chairperson (Ms Maeve McLaughlin): There is no estimate, no figure and no target.

Ms Stevens: No; there is no figure that we are working towards.

The Chairperson (Ms Maeve McLaughlin): It is not, however, a decrease in workforce.

Ms Stevens: What we are seeing is an increase.

The Chairperson (Ms Maeve McLaughlin): Right, but we do not know how much of an increase.

Ms Stevens: No. There is no target for that.

The Chairperson (Ms Maeve McLaughlin): Sorry, Rosie, I was just trying to tease that out.

Ms McCorley: This question is probably not necessary. I was going to ask you whether there was an estimate of the overall size of the workforce required and whether there has been any advance budgeting to see whether it is affordable. However, you are saying that you do not have an estimate.

Ms Stevens: No. We cannot do it in that way. We have to look at it as the process develops in different areas, and the service models become clearer. We look at it on that basis.

Mrs Cameron: We have already talked about trade unions. However, a wide range of professional bodies — the BMA, the Royal College of Nursing, the Royal College of Midwives, the Allied Health Professions Federation and the Northern Ireland Association of Social Workers — told us that they would like to be on the regional workforce planning group. As a Department, are you considering expanding to include those organisations?

Ms Stevens: We had a conversation about the membership of that group when we completed the work on the framework. We felt that we needed to make sure that we had an inclusive process, because we absolutely recognise the value of those stakeholders in the workforce planning process. However, we need a system and a structure that is manageable and in which we can, in practical terms, facilitate meetings that are meaningful. That in itself provides an inherent tension.

At the minute, the proposal is that we have a fairly tightly subscribed regional workforce planning group but a wider stakeholder engagement group that involves all those organisations that you mentioned and many more, such as the Northern Ireland Medical and Dental Training Agency (NIMDTA), the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) and all the organisations that have a training role. The list is really quite extensive, and we could not have everyone round the table. In the joint negotiating forum (JNF) alone, for example, at least 12 trade unions are represented. We have a massive number of stakeholders to manage, and yet we want them to be involved in the process. The structure that we envisage involves key stakeholders who have a direct interest in particular workforce reviews and are very closely involved in the steering of those workforce reviews. Nursing is an example, and I have already spoken about domiciliary care. They are absolutely at the table, and it is the right table for them to be at to be able to influence the direction of the work and the recommendations. In wider stakeholder engagement, we can keep them informed when we are looking at areas that are perhaps less relevant. That is the model that we are working through. If that model does not work, and people feel that they do not have the level of engagement that they want, I am quite happy to review it and to look at how best we can engage people, but my priority is to have a model that is manageable, fit for purpose and does the job.

Mrs Cameron: I take your point, but the Royal College of Midwives, the Royal College of Nursing and the BMA are at such a level that they should have been in from the very beginning of the process.

Ms Stevens: They were, absolutely. They helped to scope and shape the nursing and midwifery review, and they agreed the recommendations. There is nothing in there that they did not have the ability to influence. The BMA has the opportunity to be involved through the specialty reviews. It has been involved in workshops in the general medical review. It was at the table for that.

I described the JNF structure, which is the non-medical staff side representatives. We also regularly meet the BMA and the British Dental Association in other forums, and we have the opportunity to discuss those things there, so there is engagement.

Mrs Cameron: Why are there departmental leads only for doctors and nurses in the Chief Medical Officer and the Chief Nursing Officer? Why are there not leads for pharmacy, dentistry or allied health professionals?

Ms Stevens: The remit of the Chief Nursing Officer includes allied health professionals. The remit of the Chief Medical Officer includes pharmacy, and there is the Chief Dental Officer. They are implicitly involved through that membership. However, as we take forward proposals for a dental workforce review, I have been working closely with the Chief Dental Officer in shaping up what that might look like and to make sure that it includes the range of dental care professionals. We are looking not just at qualified dentists but at dental hygienists and the full range. They are closely involved in that work.

The Chairperson (Ms Maeve McLaughlin): I am anxious to pick up on something that Pam said. Seven of the eight organisations that we spoke to did not feel that they were actively participating in the process, despite what you are saying about engagement. Except for one organisation, they did not feel that they were active participants in the process.

Ms Stevens: I suppose that that is because they are equating active participation with membership of the regional workforce planning group and not looking beyond that. The membership of the steering group oversees the particular workforce reviews, which is where their voice can be most powerfully

heard. They are at those tables. I am disappointed that they have not reflected that back to you, because that really is the key place for them to exercise influence, and they are at those tables.

The Chairperson (Ms Maeve McLaughlin): I have to say that that was a pattern with all those sectors and organisations, bar one.

Ms Stevens: I am disappointed that that is their perception, because that is certainly not the intention. We need them at the table, and our discussions in taking forward those areas of work are the poorer if they are not there. We recognise that.

Mr G Robinson: Thanks to the team for your presentation. We heard from the Scottish Government that they also experience recruitment and retention issues in healthcare. They have initiatives such as rural fellowships, salaried GPs in rural areas and the recruitment of GPs from the EU. Has our Health Department considered any of those initiatives?

Ms Stevens: We are starting to look at that. I will let Mark come in later, specifically on GPs. We have been looking more generally at hard-to-fill medical posts to see what other countries are doing to attract and keep people. This is a problem the world over, so it is not unique to Northern Ireland, but other countries have come up with other ways that are connected not to salary levels but to other things. By and large, those crystallise around additional leave. What highly qualified and skilled people in stressful jobs probably want most of all is time. They want extra time between shifts, extra leave and extra long-service leave if, for example, they have worked for a long time. We have gathered that from the information.

A European study that looked at this issue is about to publish later this month or early next month. We await with interest what it recommends as successful mechanisms to be able to retain and recruit staff. We are very keen to look at it.

There is a cost, so we have to be mindful of that. Even if we are saying that this is not about increasing salary levels, there is a cost to everything that we would do, including giving people time off; that time has to be filled in some way. It will not be easy, but it must be better than the current situation in which we have vacancies and locum spend. It is about the better use of that money.

Mark, do you want to comment on doctors?

Mr M Lee: Sure. We are happy to take good ideas from wherever we find them. You mentioned salaried GPs. There are 80 salaried GPs working in Northern Ireland at the minute. A number of those work for trusts, perhaps as out-of-hours GPs. I am having discussions with some of my colleagues at the board about whether we could make more use of salaried GPs for some services. We are looking at things like the GP development scheme, through which people return to or start to practise in Northern Ireland when they have come here from another country to see whether we can make it more attractive and easier to bring people back into GP practice in Northern Ireland.

The GP package that the previous Minister announced on 1 April includes a pot of money to look at recruitment and retention issues and to see what more we can do. We are certainly seeking to explore ways to ensure that the GP workforce in Northern Ireland increases, or at least does not decrease, alongside looking at increased training places and the skills mix in primary care, including whom we can use alongside GPs to make the most of them.

Mr G Robinson: Has the Department looked at debt relief for student fees as an incentive for hard-to-fill medical posts?

Ms Stevens: That is like a bonding scheme. That approach is certainly being looked at in other areas. We are open to looking at it as a way of helping to prevent people who have been trained here from leaving. Obviously, we cannot ever prevent people leaving — there is free movement; people have to be able to leave — but we can incentivise them by saying that we will start to pay off student debt for every year that they stay. We need to explore that proposal alongside a range of other things and come to a view.

Mr G Robinson: From what you are telling me, it seems to be a work in progress.

Ms Stevens: Yes, it is a work in progress. It is another strand of the workforce planning agenda. I am keen to say that it is not all about increasing training places; we have to look at keeping the people we have.

Mr G Robinson: With modelling and the ratio of training places required to fit the number of staff required, is the Department taking into account things such as maternity leave and the move to more part-time working as a result of work-life balance and caring responsibilities, or is it still working the 1:1 ratio?

Ms Stevens: Absolutely; all that is factored in. We know —

Mr G Robinson: That is all factored in as well.

Ms Stevens: Yes. More professions are more affected by a higher proportion of females and a higher proportion of people taking maternity and paternity leave.

Mr G Robinson: Given the role of primary care under TYC, how is the Department, when planning GP numbers, taking into account the growing number of women GPs and their need for part-time working and maternity leave?

Mr M Lee: Heather will pick up on the GP numbers. One positive development is the work that the BMA has led on GP federations, which will provide more flexible employment. You might have more part-time posts across a number of practices or delivering a particular specialism. We need to continue to work on that so that women who want to work part-time can be facilitated rather than being lost to the workforce.

Ms Stevens: We factor that into the numbers. We find that it can take longer for women to come through their GP training because they want to take time off. A high proportion of women want to train as GPs, so the specialty is very female-dominated, but it takes longer for them to come through. It is a delay on the Department's return on investment for training them, but it is just a delay, and they will come through. The Department has invested in their training, so it is important that there are opportunities to keep them on those terms, whether that be part-time, flexible working or whatever. We need to be responsive to that and to recognise that that is the demography and profile of the profession, which is absolutely crucial to TYC. We need to be mindful of that. We factor that into the length of time that we expect GPs to take to complete their training, and it is usually longer than the minimum period.

Mr G Robinson: Chair, with your indulgence, this is my last question. Is the Department looking holistically at moving to seven-day services across the spectrum? That was mooted fairly recently. A sustainability and seven-day services task force has reported to the Scottish Parliament. Does our Department have anything similar?

Ms Stevens: Both pay review bodies — the Doctors' and Dentists' Review Body (DDRB) and the NHS Pay Review Body (NHSPRB) — were asked to make observations on the barriers and enablers to seven-day working in Northern Ireland. The NHSPRB report has just been published, and we expect the DDRB report shortly. Those will set out the context in Northern Ireland, what is holding us back and what they think would help us to move to that process.

As I am sure Dean will vouch for, we already deliver a huge number of services on a seven-day basis, and, increasingly, we are seeing the allied health professions moving to seven-day services. It is really a case of the consultant workforce catching up with what other parts of the workforce are largely doing. Nurses do it, junior doctors do it and social care does it — everybody is doing it.

The important thing with seven-day services is that we are not trying to move to a situation in which someone is taken in at 2.00 am for a very serious operation and discharged in the middle of the night. It has to be about high quality and providing the right service at the right time.

Mr G Robinson: Will there be consultation with local GPs on that aspect?

Ms Stevens: Absolutely. They will have had an opportunity to feed into those reports as well. They will have been approached by, for example, the Doctors' and Dentists' Review Body to get their views on the barriers and enablers, and they will have had that opportunity. As the Department reflects on

their observations and decides what needs to be done, we will, of course, engage with them again through our channels.

Mr G Robinson: That is grand. Thank you very much.

The Chairperson (Ms Maeve McLaughlin): In a similar vein, is there a ratio for GP training?

Ms Stevens: A ratio, as in —

The Chairperson (Ms Maeve McLaughlin): How many training places there are. I know that Scotland has one.

Ms Stevens: We fund 65 training places.

The Chairperson (Ms Maeve McLaughlin): No. Scotland has a ratio of training places to provide a GP, and it is something like 1·6 for one GP. Do you have a ratio?

Mr M Lee: Is it the number of GPs we get out of the system for the number whom we train?

The Chairperson (Ms Maeve McLaughlin): Yes.

Ms Stevens: We could calculate that. I do not have that figure to hand, but we could work it out.

Mr M Lee: It varies quite a lot by year, Chair. We would need to find some way to show that.

Ms Stevens: They also take longer to come through. Our sense is that GPs take longer to come through because they are more likely to take breaks in their training.

The Chairperson (Ms Maeve McLaughlin): I thank you for your presentation. We will reflect on what we heard as we take the review forward. Thank you for your time.

Ms Stevens: You are very welcome.

APPENDIX 2

WRITTEN BRIEFING PAPERS FROM WITNESSES

ahpfni

Allied Health Professions Federation Northern Ireland

Briefing Paper – Workforce Planning in the context of Transforming Your Care (TYC)

The AHP delegation will consist of: - Karen Middleton, Rosalind Rogers, Andy McFarland and Pauline Mulholland

Introduction

Allied Health Professionals are a group of autonomous practitioners who work with many other professionals and at many points along the care pathway. AHPs are members of health and care teams who help to support care and treatment that can transform people's lives (NHS Careers, 2012).

AHPs work in a variety of settings, can be first-contact or sole-contact practitioners, and work at multiple points in the care pathway – from diagnosis and prevention, to specialist disease management and rehabilitation (DH, 2008).

Any practising AHP, whether privately or publicly funded, must be registered with the Health & Care Professions Council (HCPC). The HCPC ensures that all AHPs meet a standard of training, professional skills, behaviour and health, so that they are fit for practice (HCPC, 2013).

Figure 1: Number of AHPs registered with the Health & Care Professions Council, 2013

Prosthetists and orthotists (944)
Orthoptists (1,312)
Dramatherapists and art and music therapists (3,429)
Dietitians (8,340)
Chiropodists/podiatrists (13,060)
Speech and language therapists (13,942)
Paramedics (19,955)
Radiographers (29,052)
Occupational therapists (33,789)
Physiotherapists (48,863)
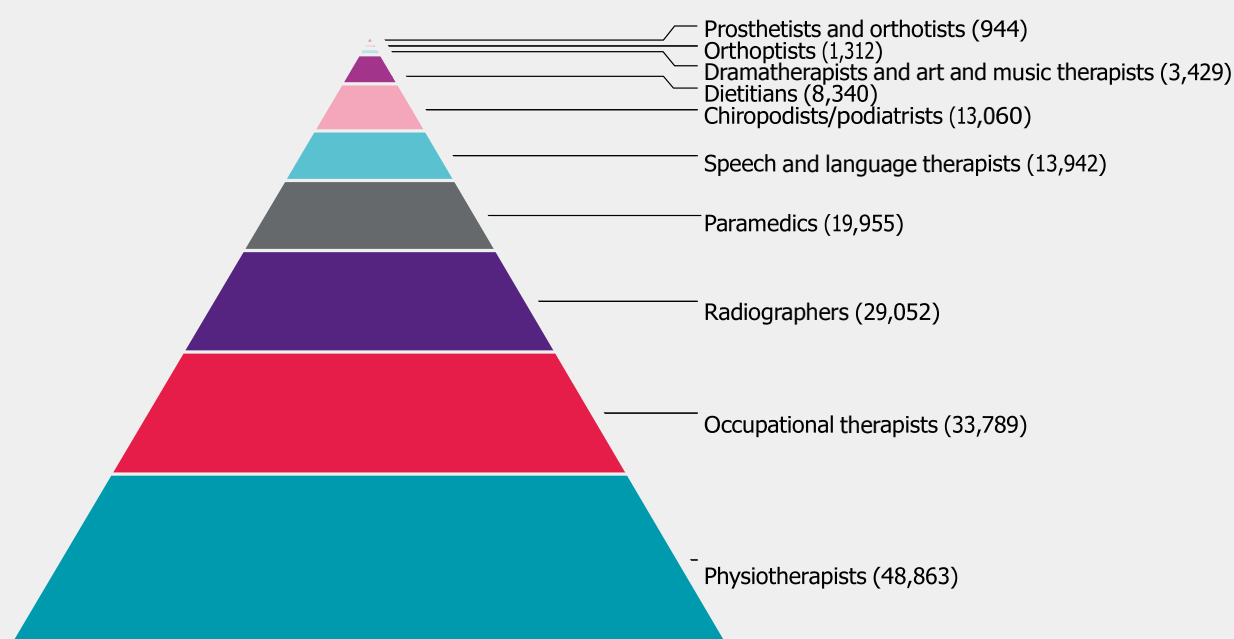
Source: Health & Care Professions Council, 2014

1. *Department of Health (2008) Framing the Contribution of Allied Health Professionals: Delivering high-quality healthcare.* http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089513 *Accessed 17/05/15*
2. *Health & Care Professions Council (2013a) 'About us'.* http://www.hpc-uk.org/aboutus/ *Accessed 17/05/15*
3. *NHS Careers (2012) Careers in the Allied Health Professions.* http://www.nhscareers.nhs.uk/media/1487503/AHP.pdf *Accessed 17/05/15*
4. *Health & Social Care Information Centre (2013c) 'CDS V6-2 type 020 – Outpatient Commissioning Data Set overview'.* http://www.datadictionary.nhs.uk/data_dictionary/messages/cds_v6-2/data_sets/cds_v6_2_type_020_-_outpatient_cds_fr.asp?shownav=1. *Accessed 17/05/15*

In 2013, there were 172,686 registered AHPs and 64,377 full-time equivalent (FTE) AHPs working in the NHS across the UK; AHPs equating to **the third largest group in the NHS workforce**. In England this equated **to 1.2** full-time equivalent **(FTE) AHPs** working in the NHS for **every 1,000 people**, **compared with 2.6** for all **doctors and 6.0** for **nurses**, and yet Information from national Hospital Episode Statistics data suggests **AHP appointments were one of the largest outpatient consultant specialties in 2012/13, with 7.5 million outpatient episodes; making up 9.9 per cent of all outpatient appointments that year.** Over 50 per cent of these appointments were attended by people aged 61 and over (HSCIC, 2013). Despite the size and importance of the AHP workforce, AHPs are rarely the subject of major policy debates and there is strong concern that their **contribution to care is often hidden, overlooked or undervalued.**

The Allied Health Professions Federation

The Allied Health Professions Federation (AHPF) is a UK wide organisation and has management boards in England, Scotland and Northern Ireland. The Allied Health Professions Federation Northern Ireland (AHPF NI) provides collective leadership and representation on common issues that impact on its 13 member professions, as per figure 1. Key aims of the AHPF are

- Ensuring recognition of the contribution and value of the whole workforce in supporting patients by maintaining the number of AHPs trained, based on full, robust data from all providers – not just the NHS.
- Acknowledging the important role of AHPs and ensuring that all policies, speeches and documents reference AHPs.
- Ensuring health and wellbeing boards have access to expertise and advice from AHPs through AHP representation on the board and securing AHPs' expertise in local health networks.

The purpose of this briefing paper is to demonstrate the unified view of AHPs in relation to workforce planning and review in order to contribute to the delivery of the modernisation and reform agenda of health and social care services in Northern Ireland. Our submission focuses upon 4 key themes which we consider support the case for including AHPs in workforce planning for Transforming Your Care.

These are:

1. **The Contribution of AHPs to the delivery of TYC** a focus upon more self care, personal choice, self referral, AHP led clinics, saving GP time by reducing referrals signposting them to AHPs instead (for example muscular skeletal/back pain, access to physiotherapy direct avoiding GP or outpatient appointment)
2. **The Changing demographics** of the population which includes aging and complex needs this will require AHPs to enable people to remain in their own home longer (for example OT providing aids and adaptations thus avoiding hospital admissions for falls and improved management of pneumonia by AHP/SLT assessment of swallow).
3. **The Economic argument** AHPS are already highly trained at degree level there is no need to upskill nurses into new roles or employ more doctors if AHP skills are already available (for example using AHPs who are already trained in dysphagia, diabetes management, podiatric surgery, medical prescribing, back care)
4. **An Integrated workforce planning mechanism - new ways of working** AHPs need to ensure that their skills are utilised appropriately in the planning cycle.

The Asks - What needs to happen to make this vision a reality:

Permanent recruitment and review of the AHP leadership function at the DHSSPSNI to include more equitable sharing of resources thus enabling AHP officers to better engage at the Senior Management Team and have a place at the Top Management Group.

Reinstate Advisory Committee Allied Health Professionals advice to DHSSPS

Uniform model /structure of AHP leadership in Trusts- It requires an AHP lead in each trust at Director or Assistant Director level and a professional head of each AHP service – look to South Eastern Health and Social Care Trust

AHPFNI/ Professional Bodies should be represented on the new workforce planning steering group to ensure that AHPs can contribute to the integrated workforce planning models

A review of the AHP workforce so that we can have accurate information of gaps in service

A directive from the permanent secretary regarding a culture shift in the language used when referring to health and social care – shift away from doctors and nurses to Health Care professionals (the Donaldson Review engaged with doctors and nurses groups).

BMA

Northern Ireland

Briefing Paper for HSSPS Committee Members on the Review of workforce planning in the context of Transforming Your Care

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2 April 2015

Briefing Paper for HSSPS Committee Members on the Review of workforce planning in the context of Transforming Your Care

Executive Summary

Introduction

BMA Northern Ireland is both a Professional Association and a Trade Union which represents the medical profession across all branches of practice. Our mission is "we look after doctors so they can look after you".

BMA has 155,000 members worldwide and 75% of doctors and medical students are members in Northern Ireland.

BMA Northern Ireland welcomes the opportunity to give evidence to the HSSPS Committee on the review of workforce planning in the context of Transforming Your Care (TYC).

BMA Northern Ireland and TYC

The health service in Northern Ireland is facing a considerable challenge in the short to medium term due to constraints in resources and increasing demands on health and social care. We are currently experiencing serious medical staff shortages in Northern Ireland particularly within specialties such as radiology, anaesthetics, psychiatry, laboratory medicine[1], emergency medicine, and general practice. An ageing population and an increasing number of people living with complex medical conditions are steadily increasing the demand on the health service. If this care is to shift closer to home as envisaged by TYC, without the necessary shifts in workforce happening in parallel, then bottlenecks in the system will occur affecting quality of patient care. The crises in general practice and unscheduled care are clear examples of this.

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[1] April 2010 DHSSPSNI Review of the Medical Workforce Final Report

BMA Northern Ireland is extremely concerned that the medical workforce to support TYC has not been adequately planned for and we are recommending that this is executed as a matter of urgency with the allocation of appropriate funding.

General Practice: The consequences of a failure to plan

Committee members will have received BMA Northern Ireland's recent publication "*General Practice in Northern Ireland: The case for change[2]*" in which we detail the need for immediate action to ensure the sustainability of general practice. Key points from our report on the challenges facing general practice are:

- Increased workloads
- Recruitment and retention
- Lack of investment in primary care

BMA Northern Ireland believes that as workload in general practice has reached saturation point, the intolerable demands on GPs means that young doctors are choosing not to enter general practice and experienced GPs are choosing to leave.

Conclusions and Recommendations

Medical workforce planning is a high priority for BMA Northern Ireland and we have consistently called for the DHSSPS to develop a strategy for planning the medical workforce as a matter of urgency. We continually and proactively contribute to review after review and are increasingly frustrated at the lack of progress that has been made.

BMA Northern Ireland considers that effective medical workforce planning is essential to enable clinicians to deliver high quality and safe care for all patients. Whilst we remain supportive of the intentions of TYC, we are disappointed that given the time that has lapsed since its introduction, resources have not followed the direction of policy.

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[2] BMA Northern Ireland (2015) *General Practice in Northern Ireland: The case for change.* Belfast. BMA

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BMA Northern Ireland recommends:

1. **The immediate funding of a minimum of 80 GP training places**

2. **That the reviews into the remaining specialties where shortages have been identified are prioritised as a matter of urgency**

3. **Real time monitoring of major medical workforce trends to avoid further shortages**

4. **Development of credible short, medium and long term plans with the resources for implementation**

Briefing Paper for HSSPS Committee Members on the Review of workforce planning in the context of Transforming Your Care

Introduction

BMA Northern Ireland is both a Professional Association and a Trade Union which represents the medical profession across all branches of practice. Our mission is "we look after doctors so they can look after you".

BMA has 155,000 members worldwide and 75% of doctors and medical students are members in Northern Ireland.

BMA Northern Ireland welcomes the opportunity to give evidence to the HSSPS Committee on the review of workforce planning in the context of Transforming Your Care (TYC).

Northern Ireland has a world-class medical workforce and patients rightly expect accessible, high-quality safe care delivered by highly skilled clinicians across all specialties and in all settings. However our members are reporting that external pressures such as prioritisation of targets, financial and otherwise, over quality of care, under-funding and the failure to recognise the importance of professional development activities have compromised their capacity to deliver high quality care to their patients.

Why good medical workforce planning is necessary

BMA Northern Ireland considers that good medical workforce planning is essential to enable clinicians to deliver care that is both safe and of high quality to their patients. Committee members will be aware that review after review of the medical workforce has taken place without the resulting improvements that would be expected.

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Our members see and feel the consequences of a lack of effective workforce planning which impacts on service delivery and patient care:

- General practice has a major workforce crisis
- Gaps exist in specialties across secondary care
- Poor and ineffective rota design
- Over-use of locums
- Lack of continuity of care for patients

We believe that the continued failure to recognise and adjust to the changing health needs of Northern Ireland, particularly in areas such as general practice and emergency medicine, has resulted in crises within these areas of medicine.

Changes in medical practice through the use of new techniques and procedures, in addition to changing demographics, have all contributed to unacceptable levels of pressure on our health and social care service in Northern Ireland.

The committee will be aware of the recent figures published on the use of locums across the health and social care trusts. BMA Northern Ireland believes that an over reliance on locums is a very clear symptom and consequence of the absence of effective workforce planning. This may have a direct impact on patients as they do not have the continuity of care that they need. The use of locums is also significant in terms of cost to the NHS and we believe that this money could be more effectively invested in training sufficient numbers of doctors in appropriate specialities rather than addressing the issue in a short term way.

We continue to express our concern regarding the lack of implementation of previous recommendations from earlier reviews. This is against a backdrop where the Minister in correspondence with BMA Northern Ireland has stated,

> *"My Department is currently considering the General Practitioners Workforce Planning Group Report interim recommendations. Increasing the number of GP trainees would, of course, require increased funding and any decision would*

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need to take account of the overall financial position of my Department ….Again the recommendations of this Review [by Mouchel] *will have to be considered in the context of available financial resources".*[3]

BMA Northern Ireland and TYC

BMA Northern Ireland remains supportive of the intentions behind TYC and have consistently called for these changes to be planned, managed and resourced. In our response to TYC[4] we argued that this presented a significant opportunity for workforce planning but expressed our disappointment that a medical workforce plan had yet to be delivered.

The health service in Northern Ireland is facing a considerable challenge in the short to medium term due to constraints in resources and increasing demands on health and social care. We are currently experiencing serious medical staff shortages in Northern Ireland particularly within specialties such as radiology, anaesthetics, psychiatry, laboratory medicine[5], emergency medicine, and general practice. An ageing population and an increasing number of people living with complex medical conditions are steadily increasing the demand on the health service. If this care is to shift closer to home as envisaged by TYC, without the necessary shifts in workforce happening in parallel, then bottlenecks in the system will occur affecting quality of patient care. The crises in general practice and unscheduled care are clear examples of this.

BMA Northern Ireland is extremely concerned that the medical workforce to support TYC has not been adequately planned for and we are recommending that this is executed as a matter of urgency with the allocation of appropriate funding.

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[3] Letter from the Minister, Jim Wells, MLA to BMA Northern Ireland on workforce planning, 6 March 2015
[4] BMA (NI) 2013 *Transforming Your Care: from vision to action*
[5] April 2010 DHSSPSNI Review of the Medical Workforce Final Report

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Who are the medical workforce in Northern Ireland?

Medical workforce summary					
	Headcount	**Whole time equivalent (WTE)**	**Age: % of doctors over 50 years old**	**Working patterns: % of part-time workers by headcount**	**Gender: % of women**
GPs ▫	1171	950	41%	*	**45%
Consultants	1594	1500	33%	17%	35%
SAS (Staff, Associate Specialists and Specialty Doctors)	493	412.6	31%	37%	66%
Junior Doctors	1881	1823.9	2%	8%	48%

Source: Department of Health, Social Services and Public Safety, March 2014
   ▫***Based on figures from** BSO 2013/2014*
   **Calculation based on NIGPC survey*
 *Data not available					

The demographics of the medical workforce are changing considerably and this needs to be factored into workforce planning. We can see from the above table that the ageing workforce, particularly within general practice, is concerning. The average age of retirement for GPs is 58 for women and 60 for men which would suggest that over 50

GPs will retire in 2015/16[6]. In addition, the increasing numbers of women in the medical profession creates further pressures due to maternity leave and caring responsibilities which needs to be considered.

We know that the failure to plan for these issues in general practice has come to a head as we will outline later in this report. If medical workforce planning is not addressed as a matter of urgency within secondary care, we can see a similar crisis emerging in the very near future. What is important to note, is the time that it takes for doctors to qualify and become fully trained. Even by acting now, it will take an average of eleven years before this new cohort of doctors become available within much needed specialties:

- Consultants: it takes a **minimum** of 14 years to become a Consultant (five year degree, two years at foundation level and an additional seven+ years)
- General Practitioners: it takes a **minimum** of 10 years to become a GP (five year degree, two years at foundation level and three years specialist training)
- SAS doctors: it takes a minimum of nine years to become a SAS doctor (five year degree, two years at foundation level and a minimum of two years specialist training)

Medical workforce planning to date

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[6] HSCB, (2014) *General Practitioner Medical Workforce Planning Group: Interim Report.* Pg 8.

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There has been no shortage of workforce planning reviews commissioned by DHSSPS in recent years. Reports were published and recommendations made in:

- 2004[7]
- 2006[8]
- 2010[9]

BMA Northern Ireland has had direct input into these reviews commissioned by DHSSPS and carried out by Deloitte over the last 10 years which resulted in reports being published and recommendations being made in both 2006 and 2010. Although we are aware of the financially constrained environment in which we work, we are becoming increasingly frustrated by the distinct lack of progress being made. It appears that money can be found to carry out these reviews but not to implement any of the recommendations, many of which are repeated review after review. For example, all reviews to date have recommended an immediate increase in training places for general practice yet this has not been actioned. BMA Northern Ireland is of the view that had these recommendations been acted on, we would not have the crisis we are currently experiencing. We must learn this lesson or we will simply repeat what is happening in general practice within secondary care in the not too distant future.

Regional Workforce Planning Group

The Regional Workforce Planning Group (RWPG) was established in 2012 and was tasked with taking forward the TYC recommendations relating to workforce issues across all staff groups. As the committee is aware, there are a number of medical workforce reviews currently ongoing:

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[7] DHSSPS Workforce Planning Initiative Medical Review February 2004 http://www.dhsspsni.gov.uk/workforce_planning_initiative.pdf

[8] DHSSPS Review of Workforce Planning for the Medical Profession Final Report September 2006 http://www.dhsspsni.gov.uk/sept_2006_-_final_report_-_medical_profession.pdf

[9] DHSSPS Review of the Medical Workforce Final Report April 2010 http://www.dhsspsni.gov.uk/medical-workforce-review-final_report-april-2010.pdf

- Overarching review of the medical workforce being carried out by Mouchel, part of the Centre for Workforce Intelligence
- A specialty by specialty medical workforce review being carried out by Dr Carolyn Harper. This review, despite starting in 2013, has only completed a review of paediatrics and has published an interim report into general practice

BMA Northern Ireland has recently learned that the Department are now changing direction and are currently scoping out a pilot project. We understand this will move from a dedicated workforce analysis to being based on programmes of care beginning with domiciliary care. We fail to understand the reason for this shift as the POC are in essence an administrative tool to facilitate the identification of spend across these specific areas for commissioning purposes and we cannot see how this will help in arriving at the conclusion we need i.e. the number of doctors within any given specialty. We are deeply concerned by this approach and consider this to be a diversionary tactic and stalling mechanism on behalf of the Department.

BMA Northern Ireland is now calling into question the competency of the Department to effectively plan for the medical workforce. We are four years post TYC implementation, three medical workforce planning reviews have been completed and we are in the process of yet more reviews through the work of the RWPG which have just changed direction. Meanwhile the significant shortages that have been identified in a number of specialties remain unchanged to the extent that, in the case of general practice, we have reached crisis point despite all the work completed and the early warning signs given.

Key Issues for BMA Northern Ireland

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Medical workforce planning is a high priority for BMA Northern Ireland and a motion was passed at the Annual Representatives Meeting (ARM) in June 2014 stating:

"That this Meeting recognises the two strands of work being carried out on medical workforce planning in Northern Ireland i.e. the specialty by specialty approach and the discussions with the Centre for Workforce Intelligence to support this, however, there is grave concern over the timescales involved and urges the Department of Health, Social Services and Public Safety (DHSSPS) to develop a strategy for planning the medical workforce as a matter of urgency in terms of overall numbers required and for the specific requirements of individual specialties.[10]"

BMA Northern Ireland has persistently engaged with the Minister regarding our concerns about workforce planning, particularly around timescales. Whilst the Minister has recognised the urgency of this work, our fears have not been allayed given the absolute lack of action on previous reviews. Whilst we welcome the work currently being done and we continue to actively contribute to both current work streams, we are becoming increasingly frustrated at the timescales involved and fear that a full blown workforce crisis will be upon us before these reviews are acted on or recommendations implemented.

General Practice: The consequences of a failure to plan

Committee members will have received BMA Northern Ireland's recent publication "*General Practice in Northern Ireland: The case for change[11]*" in which we detail the need for immediate action to ensure the sustainability of general practice. Key points from our report on the challenges facing general practice are:

- Increased workloads
- Recruitment and retention
- Lack of investment in primary care

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[10] BMA (2014) Annual Representatives Meeting, Harrogate
[11] BMA Northern Ireland (2015) *General Practice in Northern Ireland: The case for change.* Belfast. BMA

BMA Northern Ireland believes that as workload in general practice has reached saturation point, the intolerable demands on GPs means that young doctors are choosing not to enter general practice and experienced GPs are choosing to leave.

There is a significant shortage of fully qualified GPs in Northern Ireland due to the lack of training places. The ageing and gender demographics that we outlined earlier in this briefing paper have not been factored into workforce planning for this specialty. This is causing an increasing workload for the current workforce and has significant ramifications for patient care.

The Northern Ireland Medical and Dental Training Agency (NIMTDA), the body responsible for funding, managing and supporting postgraduate medical education has only 65 training places for general practice. The committee will be aware that of these training places in 2014, only 33 completed their training. This, however, only equates to a whole time equivalent of 18 GPs. This has been a noticeable trend in recent years where the number of fully trained GPs has been significantly lower than the annual intake due to the effects of maternity leave and the increased uptake of part time training which has not been factored in.[12]

Therefore it is important that we do not assume that 65 training places per year relates to 65 new GPs in the workforce each year. As outlined previously we are also expecting in excess of 50 GPs to retire in the next year alone.

The *General Practitioner Medical Workforce Planning Group: Interim Report*[13] recommended that the number of GP training places should be increased to 111 annually, phased over four years with an initial target to increase the number by 15 to commence by August 2105, but implemented no later than August 2016[14]. This increase to 80 is welcomed by BMA Northern Ireland but as we outlined earlier, correspondence from the Minister that there may not be available funding is of deep concern to our members.

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[12] DHSSPS 2014 General Practitioner Medical Workforce Planning Group: Interim Report
[13] Ibid
[14] Ibid, page 20

This is just one example where recommendations not being implemented has added to the current workforce crisis we face. This in turn has created a vicious circle of making the profession less attractive discouraging people from joining the profession, leaving or retiring early or choosing to work in a different country, all of which detrimentally impact on the quality of care we can give our patients right across the health service.

BMA Northern Ireland is extremely disappointed that whilst the review into general practice has been completed for some time, the interim report has yet to be finalised[15]. The recommendations made, especially with reference to the increase in the need for GP training places, has been recommended over a number of reviews but has yet to be actioned. For example, a recommendation made in the 2006 report was to increase the number of GP training places from 65 to 75 – this has never been implemented and the situation in Northern Ireland remains unchanged except the need has now escalated leading to the most recent recommendation of 111 training places[16].

Conclusions and Recommendations

Medical workforce planning is a high priority for BMA Northern Ireland and we have consistently called for the DHSSPS to develop a strategy for planning the medical workforce as a matter of urgency. We continually and proactively contribute to review after review and are increasingly frustrated at the lack of progress that has been made.

BMA Northern Ireland considers that effective medical workforce planning is essential to enable clinicians to deliver high quality and safe care for all patients. Whilst we remain supportive of the intentions of TYC, we are disappointed that given the time that has lapsed since its introduction, resources have not followed the direction of policy.

BMA Northern Ireland recommends:

1. **The immediate funding of a minimum of 80 GP training places**

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[15] Ibid
[16] Ibid, page 20

2. **That the reviews into the remaining specialties where shortages have been identified are prioritised as a matter of urgency**

3. **Real time monitoring of major medical workforce trends to avoid further shortages**

4. **Development of credible short, medium and long term plans with the resources for implementation**

Ends

Submission on Workforce Planning and Transforming Your Care by the Northern Ireland Association of Social Workers to the Northern Ireland Assembly Committee for Health and Social Services and Public Safety

The Northern Ireland Association of Social Workers (NIASW) is part of the British Association Social Work (BASW), which is the largest professional body for social workers across the UK. The Association has over 17,000 members employed in frontline, management, academic and research positions in all care settings. BASW is a member of the International Federation of Social Workers (IFSW) and adheres to the world wide definition of the profession.

Global Definition of the Social Work Profession

"Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing".

In Northern Ireland there are now over 5500 social workers registered in this jurisdiction with the Northern Ireland Social Care Council (NISCC) working in Health and Social Care, the voluntary sector, in Education and Training as well as independent practitioners. We are the lead statutory profession in respect of protection of children and vulnerable adults and we offer a significant contribution to the protection of the public.

Social work is a universal service offered to everyone in our community from the cradle to the grave. Often the public perception of social work is limited to our work with children at risk and whilst this is certainly significant, it is by no means the reality. Social workers work with, and for, all communities across Northern Ireland with older people, those with a physical or learning disability, with mental health problems, addictions, those who are homeless adults and children affected by childhood trauma to name a few.

NIASW are strongly supportive of the principles set out in "Transforming Your Care: A Review of Health and Social Care in Northern Ireland" 2011. Social Work as a profession has strongly advocated for person centered services, co-directed care, self-determination, promoting independence and protection of the vulnerable.

Social Workers are well placed to lead and deliver on Transforming Your Care, the values that underpin the policy direction are strongly aligned to our professional standards and values (https://www.basw.co.uk/codeofethics). Social work training and practice is rooted in and comfortable with the concepts of community development and a social model of care. Social Workers will not experience some of the challenges this "shift left" may present to other disciplines.

We therefore welcome the opportunity to highlight some examples of best practice in Social Work provision across Northern Ireland and to illustrate the challenges that exist and present our solutions to them.

Specific questions raised by the Committee:

1. Resettlement

The move to community care away from institutional care in the late 1980s was championed by the social work profession then and has continued to be ever since. Whilst this has been practice across all of the psychiatric hospitals in Northern Ireland for some time it has taken a real departmental emphasis on resettlement to fully realise this vision. Today we present feedback from the Social Worker involved in the resettling of 52 patients from Holywell Hospital - see Annex 1. It is obvious from this update that significant work has been done within a Transforming Your Care ethos and as a result 43 people have a vastly improved quality of life and 3 long stay hospital wards have been closed. We highlight this example to evidence the Committee's specific question around resettlement and illustrate the innovative practice in Northern Ireland.

2. Workforce Planning

In relation to the other specific questions asked by the committee about the work of the regional workforce development group (RWPG) unfortunately NIASW are not represented on that group at this stage but we would certainly welcome the opportunity to be an active member of same.

Likewise we are not aware of the work of the Health and Social Care Trusts on workforce modeling but would welcome discussions as the main professional body for social work in Northern Ireland.

Social Work is a largely female workforce and opportunities for part-time working are good at a basic grade level, i.e. band 6 and 7. There would be significantly fewer opportunities for part-time work once people progress to a management level. The HSCB have detailed figures on the staff breakdown across Northern Ireland and these are available upon request.

The move to more extended opening has seen the development of the Regional Emergency Out of Hours Team which operates across Northern Ireland. The majority of services still tend to be delivered Monday to Friday 9am to 5pm; the development of family group conferencing in some Trusts has seen a move to more flexible hours and several pilots for 8am to 8pm opening have been identified by the Social Work Strategy.

Challenges and Solutions

Whilst NIASW welcome and support the policy direction of Transforming Your Care, we would wish to highlight what we see as the real challenges and blockages to realizing this policy aim, they are:

- Excessive bureaucracy within Social Work within regional strategies and regional and local processes
- Funding of public services

NIASW has spent considerable time over the past two years consulting with and surveying social workers across Northern Ireland and we have produced 3 key papers detailing the results. Our first two papers focused on children's services, "Social Work not Paperwork" (https://www.basw.co.uk/resource/?id=1581) highlighted the challenges and our follow up paper for the then Minister Poots "Reducing Bureaucracy in Social Work" (https://www.basw.co.uk/resource/?id=3981) provided the solutions as the profession saw them.

We also comprehensively surveyed our adult services social workers and produced "A Blueprint for Change for Adult Services Social Work in Northern Ireland" (https://www.basw.co.uk/resource/?id=3054).

All three reports highlighted that social workers are a deeply committed and loyal workforce who regularly work up to 50 hours unpaid overtime per month. However they also report that the social work role has become so over bureaucratized that social workers regularly spend more than 70% of their working week in administrative tasks which prevent them in engaging with children, parents, families and people in need.

In the Blueprint we use a case study, illustrated below, where a 78 year old woman is referred for assessment and we demonstrate that of the 17 hours and 45 minutes that it takes to assess her needs and begin a service that only 4 hours and 30 minutes are spent with the individual and her family. NIASW's view is that this is simply unacceptable. Social workers tell us that they are spending more time on filing, report writing and inputting data into a computer than doing what they are trained for.

A typical referral to a social worker in an Older People's Team.

A referral is received from a GP for a 78-year-old woman who has a history of angina and limited mobility. She lives alone and is struggling to cope at home.

The table below sets out the recording requirements for a case requiring assessment and service provision.

1. Referral received and entered in client record computer system ie SosCare or ElCid	1. 15 minutes
2. All telephone calls, face-to-face contact and meetings are manually recorded into a case record	2. 1 hour
3. Assessment with service user and NISAT contact screening documentation (time with service user 1.5 hours)	3. 2 hours
4. Further home visits with service user	4. 2 hours
5. Completion of NISAT Core Assessment	5. 6 hours
6. Referral to other services – eg Day Care (NB In some Trust areas referral to day care requires 4 separate forms. Each service provider requires different forms)	6. 2 hours
7. Domicillary care form completed manually and entered into a computer system	7. 30 minutes
8. Care Plan	8. 1 hour
9. Carers Assessment (includes a client contact of 1.5 hours)	9. 3 hours
This time plan does not include reviewing services, dealing with changes to the care plan or unplanned crises.	Total time: 17 hours 45 minutes Time with service user: 4 hours 30 minutes Time spent on documentation and bureaucracy: 13 hours 15 minutes

The Committee has asked if we have enough social workers to deliver on Transforming Your Care. It is our view that until the model of care has been identified followed by the proper level of workforce planning that NIASW cannot comment on the required number of Social Workers. We do know from members that at present Social Workers are carrying excessive case and in many cases struggling to cope with increased demand. NIASW suggest that the one question should be are we asking is "are our social workers doing the right jobs?" Are we making best use of this highly skilled and trained workforce? We are firmly of the view that social workers can implement the vision of Transforming Your Care, they already work with complexity, risk and extremely challenging situations. They are on board with the values and have the right knowledge and skills. They want to work more with communities, carers and individuals to continually improve the patient experience; however what they do not have is capacity. NIASW suggest that the key to finding additional capacity is to review what social workers actually spend their time doing and provide them with the technological and administrative support they need to do their jobs more efficiently free from the burden of bureaucracy.

What they told us:

1. Over two thirds spend less than 30% of their working week in direct client contact.
2. 96% highlighted report writing as a specific activity which negatively impacts on their ability to spend time with clients.
3. 90% reported that recording in client files had a similar impact.
4. 73% identified inputting data into a computer as impacting on their time to see clients.

We utilized a case study from the South Eastern Health & Social Care Trust, where the service improvement coordinator in conjunction with a Gateway team highlighted a significant problem with a high level of unallocated referrals, with social work staff spending too much time on inputting data and admin tasks, unable therefore to address the backlog of unallocated referrals.

The aim of the project was:

1. To reduce the number of unallocated referrals by 50% over 6 months.
2. To reduce social work time spent on admin tasks.

By redefining the referral and assessment process, enabling admin staff to take responsibility for data input and designing a new template for recording and beginning an electronic file the results were outstanding.

There was a 100% reduction in unallocated cases, significant time savings for social work staff, and a total of 6 hours and 36 minutes per case. This example illustrates the benefit of having the right person and equipment to do the job, it now takes a Social Worker on average just 11 minutes with 18.3 minutes of admin time to input a referral where it used to take 75 minutes. NIASW are delighted to report that this E filing Initiative has been rolled out across all of the SEHSCT Gateway teams and is fully implemented. In addition the Trust is committed to delivering this initiative

across all Family Intervention Teams, the project has met with great enthusiasm from staff who are keen to see a reduction in bureaucracy.

NIASW offers this excellent example of innovative practice to highlight what can be done when systems are changed, we would like to see this model being rolled out across Northern Ireland as a whole.

The NIASW documents have been adopted by the Social Work Strategy (SWS) and indeed reducing bureaucracy has been a year one objective of same. NIASW welcome and support the appointment of a project manager to the Social Work Strategy with the specific remit of reducing bureaucracy and would repeat our call for a regional taskforce to drive forward the changes needed.

The Western Health and Social Care Trust has availed of money from the Social Work Strategy Innovation Fund and implemented a pilot using digital dictation "Voice Recognition System" within Family and Child Care. Social work staff who have adopted the system and are using it regularly have indicated the benefits as follows:

- Less paperwork
- Less stress
- Case files up to date meaning more control of caseload
- Less time in office spent on administrative tasks resulting in more time with families and more time to carry out direct work with clients
- They feel they record more concisely also which has a positive impact on their time management

One social worker in the WHSCT says:

> *"I feel that G2 ensure that I have more of a balance to my day. I feel that I no longer record constantly and that my social work day consists of more than constant typing. I feel that I have more time with families and much more time to do direct work with children."*

This example highlights what can be achieved with limited resources but the impact on staff and service users could be immense. NIASW look forward to seeing analysis of the results in due course. As the Social Work Strategy enters its third year NIASW is committed to working with those involved to deliver real change.

NIASW have always been clear to say that social work practice must be underpinned by sound recording, all learning from enquiries highlight the importance of high quality, timely recording and we do not wish to see a removal of that. What we do wish to see is a reduction of the levels of excessive paperwork and duplication. To this end we make a number of recommendations on how to achieve this in our papers. One I would draw to your attention is:

"The current looked after children system is amended and the existing Understanding the Needs of the Children in Northern Ireland (UNOCINI)

documentation is used for those children with a disability requiring short term placements."

At present the Looked After Child system (LAC) requires that any child who needs a respite placement enters the full LAC process and therefore becomes subject to the full documentation this necessitates. The LAC system requires a meeting to be held within two weeks of the start of the care episode and then at three and six monthly intervals. These meetings involve a social worker, a senior social worker and a principal social worker alongside the child, parents and carers. This entire process will often have to take place even if the respite placement is for 24 hours.

As set out in the current legislation all children with a disability will automatically meet the criteria set out in the Children (NI) Order 1995 and many parents are opposed to this status; they do not see their child as having to be formally looked after by the Trust as their corporate parent. Most social workers would support a change to the current legal framework to enable children with a disability requiring a short term placement to have their needs met outside of the LAC system.

The current practice is cumbersome, inefficient and overly bureaucratic and we suggest the child's needs could be met without compromising on social work process or client care as the children's needs could be met within the existing UNOCINI framework (Understanding the needs of children in Northern Ireland). A UNOCINI assessment already takes place for all children known to children's services, documentation which captures the same information as the LAC forms. The UNOCINI forms also contain the assessed needs of the child and family and a care plan which is required to be reviewed at three months and then at six monthly intervals. This would have the effect of immediately reducing the amount of time social workers spend on paperwork, it would alleviate the pressure of duplication and free up frontline staff to spend more time on direct client work.

We would ask that the Committee encourage the Minister to bring forward regulation changes as part of the wider Looked after children Strategic Statement the DHSSPS is preparing .

Funding of public services
To truly deliver on the bold vision set out in Transforming Your Care brave decisions must be taken, delivering on the vision of Transforming Your Care is not a cheap option and if it is simply viewed as a way to save money then it is doomed to failure. Northern Ireland continues to experience unprecedented financial difficulty and this has had a very real impact on service delivery. What we have seen is a flight to funding the core statutory functions as laid out in the Scheme for Delegation of Statutory Functions reported on annually by the Health and Social Care Board. As a result many voluntary, community and third sector providers are losing their core grant funding and so we are seeing services struggle, reduce and in some cases close. Volunteer Now, for example, who provide the Keeping Safe Guidance for the voluntary sector have had to lay staff off. Uncertainty around the DHSSPS Core and Service Funding is causing extreme concern within the voluntary, community and

third sector providers who currently deliver on core statutory services on behalf of the HSCTs.

This results in the very preventative, community based services that we require to deliver on Transforming Your Care being reduced and diminished.

NIASW appreciate the very real hardship that the Health and Social Care Trusts face in trying to deliver within the very stringent budgetary constraints of our current economic climate particularly in light of the continued increase in demand for services.

This demand can be evidenced by reviewing the Health & Social Care Board Delegated Statutory Functions Report for the year ending March 2014; referrals rates to all areas are increasing, needs are increasing, complexity of need is increasing and our population continues to age. The detail of this report highlights some of the very real challenges to service delivery in this financial climate.

The Health & Social Care Board report that mental health services "continue to face significant challenges within the current economic situation in providing and fulfilling their statutory functions. The Trusts report that vacancy controls cause difficulties". A similarly challenging environment is reported across services for Older People and People with a Physical Disability and/or Sensory Disability. Financial constraint in terms of availability of services on the ground and pressures relating to vacancy control are identified by all Trusts. Provision of domiciliary care service is problematic in some rural areas and increasing rates of referral to adult safeguarding teams adds to the pressure.

These concerns raised by the commissioning body are echoed by NIASW's members who highlight that strict vacancy controls remain in place across Northern Ireland with many vacant posts remaining unfilled for considerable periods. Maternity leave and long term sick leave are routinely not covered and this places an extra burden on those staff in post to continue to deliver a quality social work service. The Committee should be mindful that it is against this backdrop that it seeks to deliver on Transforming Your Care.

NIASW would reiterate their previous requests to protect social care funding in any future budget rounds.

Conclusion
NIASW thank you for the opportunity to attend today and in conclusion would like to summarise our three key points. Firstly, that the ethos and principles behind Transforming Your Care are welcome and supported by the social work profession, in this workforce you have a valuable resource who are well placed to champion the Transforming Your Care model. Secondly to fully realise the vision of Transforming Your Care systemic change is required to free up professional staff from the binds of bureaucracy. NIASW have today presented you with suggestions around changes to Children Order regulations in respect to LAC children and a less radical e-filing and digital dictation approach, all three could make huge improvements to the staff efficiency and effectiveness and most importantly the patient experience. Lastly we would urge the members of this committee to consider the impact of on-going cuts to

vital public services. To fully realise the vision of person centered services, providing the right care at the right time, focused on prevention, promoting independence whilst continuing to safeguard the vulnerable, then Transforming Your Care must be adequately funded or the reality will be more overburdened carers, struggling to cope with limited supports and the most vulnerable in our society placed at even greater risk.

Annex 1

Northern Health and Social Care Trust

Progress Report on Adult Mental Health Resettlement – Holywell Hospital Northern Trust

Target Numbers identified for Resettlement between April 2012 and March 2015 where 52.

9 patients remaining at this current time, of whom 5 are identified as requiring low secure type accommodation, and continued plans in place for further potential resettlements.

The patient group comprised of a population of individuals, with severe and enduring mental illness with complex care needs and associated challenging and high risk behaviours. The majority of the patient group have resided within the hospital in locked door environments for over 10 years, a smaller but significant number of the patient group have resided within the hospital between 30 and 50 years. Due to the complexity of needs, previous attempts at discharge either proved unsuccessful, or sadly had never been explored with the acceptance that the patient would live in hospital, being labelled as having no potential for rehab, unsuitable for discharge and 'too high risk'.

Many challenges have been faced and overcome in relation to risk management for the patient group. Equally patients, family and at times staff have had concern and been opposed to the process of resettlement, worrying that needs could not be met in the community and that the 'institution' was the best place.

The Trust have both developed our own services and worked with private and voluntary providers to develop enhanced patient centred care packages, at the core modelled on patient centred care delivery, and enhancement of choice and independence. There is now a greater community alternative for the service user group.

Social Work

Social workers have been instrumental in challenging negative perceptions regarding the process of resettlement. Social work has been heavily involved with providers and hospital

teams in both securing suitable accommodations and then taken the lead in transition planning with a patient centred focus.

Social work has been involved on both on a very practical level, but with an equal input in providing support and guidance in regard to the emotional level with patients and their families throughout the process. This skill input and time is not to be under-estimated within the process of resettlement.

<u>Outcomes</u>

- The patients who are now resettled refer to their new accommodation as 'home'.
- There is an obvious enhancement in their level of functioning and independence on a practical level.
- 100% significant enhancement in socialisation, integration and inclusion with community life.
- Improvement in the patient's social interactions with others around them, self-esteem, confidence, autonomy and independence.
- The patient's continue to experience on-going symptoms of their mental illness, but they feel supported and safe, risks and care and support needs are safely maintained within the community setting.
- Closure of 3 wards. The vast majority of mental health rehab is now community based within the supported housing schemes, with only a smaller number of patients requiring inpatient rehabilitation.

7th May 2015

Northern Ireland Assembly Committee for Health, Social Services and Public Safety

Briefing Notes from the Northern Ireland Social Care Council in advance of the evidence session planned for 13th May 2015

Introduction

In this paper for the Committee in advance of the NISCC evidence session on the 13th May 2015 we will:

(i)   Give a brief background on NISCC and its role in social care in Northern Ireland;
(ii) Give a summary profile of the social work and social care workforce;
(iii) Address the specific questions put to us by the Committee in relation to workforce planning for TYC.

(i)   NISCC Background

Northern Ireland Social Care Council (NISCC) is the regulatory body for the 35,000 social care workers and social workers practising in NI. NISCC was established as an NDPB by the NI Assembly in 2001 to improve safeguards for service users and strengthen the professionalism of the workforce through workforce development, registration and regulation.

NISCC is also the Northern Ireland partner in Skills for Care & Development (SfC&D) which is the Sector Skills Council working with employers and people who provide social work, social care and children's and early years services across the UK.

Social workers and social care workers make up the largest workforce in the Health and Social Care system. They work in every community across the region and make a significant (often unseen) contribution to health and social care. They work with vulnerable people, many of whom have complex care and social needs.

This workforce is made up of:
- 5,700 professionally qualified social workers;
- 720 social work students; and
- 28,600 social care workers (estimated & including 660 social care managers).

The main areas of responsibility for NISCC in relation to this workforce are:

1. **Workforce Registration -** Maintaining a register of social care workers, social workers and social work students who are committed to the NISCC Standards for their conduct and practice. Compulsory registration is being implemented in phases according to job role. Already almost 23,000 people are registered.

NISCC is working on a timeline with DHSSPS to register the remaining 10-15,000 people employed predominantly in supported living, domiciliary and day care services.

2. **Workforce Regulation -** Strengthening public protection by taking action in cases where a registrant does not meet the required standards for their conduct and practice as laid out in the NISCC code of conduct and code of practice for social work and social care workers.

3. **Workforce Development -** Working in partnership with stakeholders to ensure that people can be assured of effective services from a safe and skilled workforce. NISCC has a statutory responsibility for the standards of social work education and training provided in NI.

   As a Sector Skills Council partner, NISCC also has responsibility for training and development of social care workers including:
   - Promoting on-going development & training opportunities for workers at all levels in their career development
   - Reviewing training and qualifications, or developing additional training for new areas
   - Developing alternative learning solutions based on new technologies

(ii) Profile of the Social Work and Social Care Workforce

Social Work Workforce
There are 5,700 registered social workers in Northern Ireland. The profile of the social work profession in Northern Ireland, based on the Register data, is one of a mature, largely female and locally trained workforce which has remained relatively stable over the last ten years.
- 81% of social workers are women
- 63% of the workforce is aged over 40 years
- 21% are aged over 55 years
- 84% of social workers practising in Northern Ireland gained their social work qualification here.
- 15% of social workers hold a social work qualification which they gained in England, Scotland or Wales and 1% qualified outside of the United Kingdom.
- 70% of social workers work in Health and Social Care Trusts.
- The remainder works in other sectors including: Justice (Probation Board and the Youth Justice Agency); Education and Library Boards (Education Welfare Officers) and the Voluntary sector.
- Within the HSC Trusts, 54% of social workers are employed in family and childcare services (DHSSPS Northern Ireland Health and Social Care Workforce Census of March 2014).

Social Work Undergraduate Training
Social work undergraduate training is provided by Queen's University and Ulster University on a full time and part-time basis. This training is regulated by NISCC.

There are 260 undergraduate training places available for social work students each year which provides a sufficient supply for the workforce. The number of applications received for places on social work training courses remains high with a ratio of 8:1 applications for each place for the September 2014 intake.

- In September 2014, 85% of students enrolled on undergraduate training courses were women.
- Over the last 10 years an average of 16% of men entered social work training, reinforcing the largely female profile of the workforce.
- 61% of students enrolled on NI social work training courses in September 2014 were aged between 21-34 years.

Social Work Postgraduate Training and Continuous Professional Development
All social workers are required to undertake a minimum of 90 hours CPD during their three-year registration period and this can be achieved through a range of learning opportunities, both formal and informal. This requirement is audited on a sample basis by NISCC when social workers renew their registration.

NISCC is responsible for the CPD Framework for social workers '*Professional in Practice*' (PiP). NISCC delivers this in partnership with employers, commissioners and education providers. '*Professional in Practice*' sets out the CPD standards for social workers from initial consolidation training for newly qualified social workers, through to specialist training in practice, and leadership training.

Within the Framework, training courses are delivered by universities, employers and other training organisations and lead to professional PiP awards in social work. There are 28 training courses approved and regulated by NISCC. The Framework also recognises the learning which social workers undertake in the work setting through in-house training, by providing credits towards CPD achievement.

- To date, 3800 social workers hold professional PiP awards in social work
- 1611 social workers are currently actively engaged in formal training leading to PiP awards.

Funding for social work CPD through the PiP Framework is made available to the HSC Trusts by the HSC Board through commissioning arrangements. The DHSSPS provides funding to the voluntary sector through a Training Support Programme.

Social Care Work
Social care workers make up a diverse workforce, spread across a range of settings from nursing homes and supported living to domiciliary care. They are dispersed across all programmes of care – children, mental health, physical disability, learning disability, and older people.

There are a wide range of job roles and job titles however they are all underpinned by the fundamental requirement of providing direct care and support to vulnerable people living in every community in Northern Ireland.

There are more than 500 different social care employers in the statutory, private, and voluntary and community sectors – ranging from the HSCTs, to large private providers, through to small community groups.

88% of registered social care workers are women. The overall age range of registered social care workers is:
- Under 25 years - 16%
- 26 years to 40 years - 32%
- 41 years to 55 years   - 36%
- 56 years to 66 years - 14%
- Over 66 years - 2%

This age profile suggests a relatively robust and sustainable split across the age ranges. Employers report that there are recruitment and retention challenges in the social care workforce. It is difficult at this stage to quantify precisely the extent of the recruitment and retention issues as employers' reports are inconsistent and cannot be aggregated for the sector. The numbers of social care workers registered with NISCC has remained relatively consistent over the previous two years and more robust data on the extent of staff turnover in the social care sector will be captured when registration is completed.

Social Care Work Training and Education
Social care workers and managers are not required to have any specific qualification to be registered with NISCC. DHSSPS minimum standards do require social care managers to be qualified to QCF level 5; while social care workers have mandatory training requirements and are encouraged to complete vocational training and qualifications there are no compulsory qualification requirements on social care workers. However the qualifications profile of the workforce is relatively positive with just over 50% of workers holding a minimum QCF Diploma level 2 in Health and Social Care or equivalent.

Funding for training for social care workers in the statutory sector is made available to the HSC Trusts by the HSC Board through commissioning arrangements. The DHSSPS provides some funding to the voluntary sector in social care through a Training Support Programme. The private sector and voluntary sector employers have also availed of a range of regional funding programmes – for example the apprenticeship scheme run by DEL, however employers report that it is increasingly difficult to access such funding streams for training and education.

The nature of provision in social care
To capture the diverse nature of the profile of social care workers the Committee members may find it useful to have a summary of the profile of social care provision across Northern Ireland.

Nursing Homes
- 7,300 registered social care workers employed across 268 registered nursing homes in Northern Ireland providing 11,600 beds

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- The overwhelming majority of nursing homes are in the private sector with a very small number in the voluntary, housing association or statutory sectors.
- 113 different organisations running nursing homes, 32% of nursing homes are run as single homes, 17% of homes are run as a group of 2 or 3 and the rest are run in groups of 4 or more.

Residential Homes
- 3,500 registered social care workers employed across 200 registered residential care homes in Northern Ireland providing 4200 beds
- 132 organisations involved in running residential homes. 23% of homes are run by the HSCTs, the rest are run by a mix of the private, voluntary and housing association sectors. 61% of these homes are run as single homes.

Day Care
- 185 registered day care facilities providing 7600 places.
- The workforce in day care is not registered – workforce estimated at 2,000.
- 36 organisations proving day care across Northern Ireland and 58% of facilities are run by the HSCTs. The majority of the rest are run by organisations in the voluntary and community sector, 12% are run as single facilities and the rest are run in groups ranging from 2 to 16.

Domiciliary Care
- 304 registered domiciliary care providers in Northern Ireland. It is possible to consider these providers as:
  (i) organisations that provide domiciliary care through the provision of supported living; and
  (ii) those organisations that are directly domiciliary care agencies.
- Applying this distinction, 59% of organisations come under the first category and 36% come under the second, with 5% falling under other categories including recruitment agencies.
- Across both of these categories 68% of domiciliary care is provided by the independent sector and 32% provided by the statutory sector.

(iii) Committee Questions

The Committee has asked NISCC to consider a number of questions in relation to our evidence session.

1. **Views on the progress of workforce development/planning to implement TYC / whether the NISCC has representation on the RWPG and how we are included in the workforce planning process / views on the number of social workers required to properly implement TYC:**
   The principles underpinning Transforming Your Care – 'home as the hub of care'; placing the service user at the centre of their care; providing more services locally and encouraging local community engagement and enterprise – are all principles supported by social work and social care. Supporting co-design, co-

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production, and personalisation; a focus on prevention and integration of care; promoting independence and safeguarding the most vulnerable, these are concepts that are familiar to social work and social care practice and there are many strong examples of good practice in these areas across Northern Ireland.

Social work is a skilled profession that offers a unique service to individuals, families and communities. In April 2012, the DHSSPS published a 10 year Strategy for Social Work. The Strategy is focused on 3 key areas to support the development of the workforce:

1. Strengthening the capacity of the workforce
2. Improving social work services
3. Building leadership and trust in the profession

Strengthening the capacity of the workforce includes within it a strategic priority to improve workforce planning and deployment of social workers to meet demand. It also includes work to review the role of social work in older peoples' services. Currently social work undergraduate training is producing enough social workers to meet workforce demand. However, as employers start to identify the future service models needed to deliver TYC, the debate will extend to how social workers are currently deployed and how they can be used to support the development of community based services. NISCC is actively engaged with the Social Work Strategy.

Social care workers will have a significant role to play in the implementation of TYC. Part of the implementation of TYC is about people working differently, changing culture, bringing greater integration to services so that they respond to the needs of the service users and not the service provider. Social care workers are a great asset to the health and social care system and they are open to change, to new ways of working, to new approaches in training and education – however they will need to be supported and they will need investment to ensure quality and standards in practice are consistent and sustainable. For workforce planning and development much will depend on the nature of the service models that are developed to support TYC and how the workforce will need to evolve to deliver the new service models envisaged by TYC.

If there is a greater mix of service delivery within community settings and within the home, then the nature and pattern of work for social care workers will change and evolve. Matching skills, knowledge and competency to service delivery needs will be key for workforce development, as will establishing a baseline for training and education in this workforce.

At NISCC our main concern is for the protection of the public through regulation and the raising of quality and standards in practice. Given the diverse nature of the social care workforce in particular, it is important that a broad strategic view is taken to workforce planning so that staff and employers across the sector have a consistent approach to supporting quality and standards in practice, regardless of the location of that practice.

The NISCC is a member of the DHSSPS Regional Workforce Planning Group. We welcome the opportunity to actively participate in this group and the recognition that we are in a position to contribute information to the process based on the regulation of the social care workforce and our engagement with social care employers across the sector. We also welcome the commitment of the group to take a 'Programme of Care' approach to workforce planning. We support the priority being given to identifying the workforce required for domiciliary care within the older persons' programme of care, as we view this as a priority area in the development of TYC.

2. **Whether NISCC has any knowledge or role in the work that is currently being under taken at Trust level in relation to workforce modeling:**

We are aware that the Trusts are involved in a workforce modelling process however NISCC is not directly involved in the process and at this stage we would have no knowledge of how it is progressing and what outcomes might be expected.

3. **Views on the gender mix of the social care workforce and the flexibility of the profession:**

Social work - 81% of social workers are women, and on average 16% of students undertaking social work training are men. NISCC has identified the need to promote social work as a valuable career choice for men and will work with the two universities on promotional materials and recruitment activities. We are also establishing an Ambassador scheme for social work to include male social workers – who will be able to provide a role model for young men choosing their career.

Within the current terms and conditions of employment, flexible working arrangements are available for social workers and NISCC is not aware of any issues in this regard. Flexible working can be an important consideration in job selection, particularly for women. The Social Work Strategy has undertaken some work to look at opportunities for flexible working arrangements to better meet the needs of service users. This may be through the possible development of extended working hours. This work has yet to report.

Social care work - Social care workers are also predominantly female – 88%. It may be worth noting that there are more males working in the area of Mental Health than in other areas of work – this may be to do with the nature of the work. NISCC in its role as a Sector Skills Council (Skills for Care and Development) has been working with partners in the other UK nations to promote social care as a career of choice for people and to encourage more men into the workforce. This issue has been identified at UK levels by the UK Commission for Employment and Skills (UKCES) and as the Sector Skills Council NISCC will be working in partnership with employers to take forward initiatives in this area.

In terms of the flexibility of social care workers they already work in services that are provided on a 24/7 basis and the workforce has a range of work patterns that ensure services are maintained. Different employers have different arrangements in place to ensure staff are supported to provide flexible work patterns.

4. **Whether the NISCC knows of recruitment issues for particular geographical areas:**

   NISCC is not aware of any significant recruitment issues in the social work profession. However we are aware of recruitment and retention issues in social care work as reported by employers. This appears to be more marked in the independent sector and in the nursing homes and domiciliary care sectors. It is not possible to quantify the extent of the issue at this stage, however we are aware that it may have an impact on service delivery and the availability of packages of care in the community. We are not aware of issues within specific geographic areas.

   The review of domiciliary care to be completed by the RWPG is likely to go some way towards clarifying the extent of the issue of recruitment and retention in this sector and to examine ways in which a strategic framework for workforce planning in domiciliary care might help address it.

5. **Views on the impact of the £25m already shifted from hospital services to community/primary services in the areas of learning disability and mental health re-settlement:**

   Social work has been a lead profession in the re-settlement of patients and has worked to drive the reforms in Learning Disability and Mental Health. Social workers have worked with other disciplines to help change the culture to one of positive risk taking and have supported the community sector to develop the capacity to meet the needs of patients. The re-settlement programme has enhanced patients' rights to a family life and supported recovery. Work continues to re-settle patients and the social work profession views the progress following the Bamford reform programme as successful.

Conclusion

NISCC is an NDPB sponsored by the Office of Social Services at the DHSSPS. It has responsibility for the registration, regulation and workforce development of the social work profession and the social care workforce. The social work and social care workforce is diverse and works across a large number of employers in the statutory, private and voluntary and community sectors. It is the largest workforce in the health and social care system working mostly in the community with some of the most vulnerable people in our society.

TYC is about shifting resources and services into the community and is underpinned by the principles of person centred care with home as the hub of care. TYC can only be enhanced by the skills, knowledge, competency and values that exist within the social work and social care workforce. The implementation of TYC should contribute to the raising of quality and standards in practice and ensure greater value is placed

on social work and social care work. As a regional body NISCC is working with partners across the sector in Northern Ireland to take a strategic view of workforce development for the social care workforce so that community based services have the right workforce to deliver consistent, sustainable quality services that respond to the needs of service users and their families.

NIPSA SUBMISSION TO THE HSC HEALTH COMMITTEE
WEDNESDAY 29TH APRIL 2015 (2.00 PM)
IN RELATION TO WORKFORCE PLANNING

Given the recent announcements by the Chief Executive of the HSCB that Transforming Your Care remains the strategic direction of the Department but requires some rebranding NIPSA must refer back to the submission it made in relation to the original TYC consultation document Vision to Action in terms of Workforce Planning.

At its inception there was a working assumption that there would be a reduction in overall workforce of around 3% over the next 3-5 years. In January 2013 the HSC employed around 54,000 whole time equivalents and that would equate to 1,620 whole time equivalents. TYC was predicated on a 3-5 year implementation period but given the lack of progress and budgetary constraints and vacancy controls we believe further work is required to identify the actual workforce figure and accurate projections required for the future. If the 3% (3,000) cut in the workforce remains the likely target if TYC is implemented as it was originally planned then NIPSA is firmly of the opinion that such cuts will put the welfare and lives of the people in Northern Ireland at risk. NIPSA continues to be concerned that such a figure is on top of the vacancy controls individual Trusts have had in place for a number of years due to pressure from the Department/HSCB for cost improvements across the Health Service. Such job reductions are unrealistic and will result in the Health Service providers being unable to fulfil their statutory obligations.

Another strand of TYC was the 5% shift of funds from the acute/primary care to community care. We believe this to be insufficient and there is emerging evidence that any monies that are being released are not going to front line services. NIPSA would wish to see a breakdown in terms of the distribution of both the transitional funding and all other monies moving from acute to the community budget to support front line services. **This should be prioritised.** In our view this becomes even more critical in light of the fact that the original transitional funding proposed has not materialised so workforce numbers and planning must be skewed and somewhat unpredictable. Fundamentally NIPSA believes TYC demands a more skilled, better trained, better rewarded staff and not one which is privatised and delivered on the cheap.

NIPSA is firmly of the view that TYC is not about choice and personal social services but is about doing things on the cheap, with less skilled staff, who have less time to give service users and who work in a health system that is being systematically eroded over the years. NIPSA believe that care in the community is reliant on a knowledge rich and confident HPSS workforce, able to deliver quality care interventions without the "at hand" support models of institutional care settings. TYC with its overarching themes of procurement and privatisation dressed up as value for money initiatives, runs a risk of asset stripping the framework of knowledge, skills and the ethos of public service that defines the HPSS workforce replacing key sections of it in a profit driven race to the bottom line.

NIPSA is also of the view that the Health Service has never been more vulnerable of being outsourced to the private sector as where it currently stands now. This is evident in recent domiciliary care reviews and recent value for money audits. The reality is that morale amongst nurses, admin staff, social workers, social care staff is at an all time low because the kind of service these committed public servants want to deliver is unable to be delivered despite their best efforts. There is a clear view prevailing in the thinking that services are being run into the ground so that the private sector appears like a credible alternative.

Finally we represent a number of disciplines. In terms of Social Workers we want to ensure that there are a sufficient number of social workers to meet the requirements as set out in the 10 year Social Work Strategy launched by Minister Poots. Throughput of student numbers placements, demand and supply will need analysed in detail to match the needs of the strategy. In relation to Admin and Clerical these are key staff who should be considered front line services because in their absence clinics will not operate, consultants will not be able to perform their duties and there will be a systemic failure in all services if not properly resourced. They have been crippled by vacancy controls. Finally the Social Care Workforce are being targeted for privatisation, value for money audits and it is evident from reports from the RQIA and others that work outsourced leads to a considerable decline in standards given that in some Trust areas we have award winning quality assured professionals replaced by less skilled, qualified or experienced staff.

This completes the NIPSA submission.

Objective of briefing paper

This briefing paper aims to provide an overview of the primary workforce challenges faced in Northern Ireland.

Background

1. **Demand** for general practice services is increasing, and this is causing additional workload pressures for GPs and their teams. An indicator for this is the patient reported ease of getting an appointment at their GP surgery. A recent Patient and Client Council report found that 26.5% of patients were not satisfied with access to their GP practice.[1] A survey conducted by RCGP Northern Ireland found more than a third (37%) of adults asked said that they were concerned that the amount of time they have to wait for an appointment to see their GP could have an impact on their health. In addition, 63% of adults believe that the number of patient consultations that GPs conduct each day, which can reach up to 40-60 consultations, is a threat to the standard of care they can provide to patients.[2]

2. The College believes that if GP workload continues to increase without general practice receiving resources to support this, the situation will continue to get worse. On an individual basis, Northern Ireland GPs conduct the highest number of consultations in the UK, as shown in Figure 1.[3]

Figure 1. Number of consultations conducted per doctor (headcount), 2012/13

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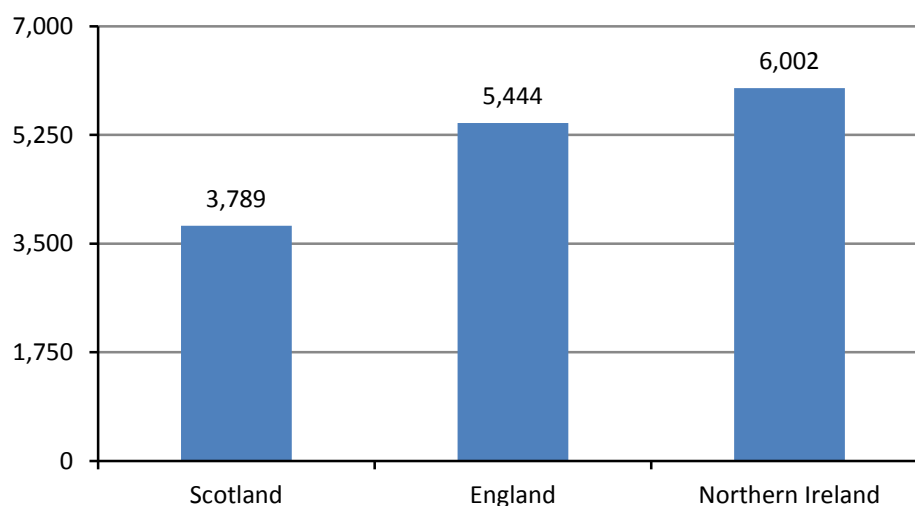
[1] Patient and Client Council (2014) *Access to GP Services* Accessed at:
http://www.patientclientcouncil.hscni.net/publications/index/reports
[2] Com Res (2014) *Royal College of General Practitioners Northern Ireland General Practice Study*
[3] RCGP analysis. Data is not available for Wales. Assumes that Northern Ireland GPs conduct 55% of all consultations (assumption based on English data due to data availability).

3. There is also strong evidence that the care general practice is required to deliver is becoming more **complex**. The impact of long term conditions is growing in Northern Ireland. The population of people aged 65 years and over is projected to increase, which will lead to a rise in their needs. NI has the fastest growing population in the UK and it is anticipated that the number of people over 75 years will increase by 40% by 2020.[4] In addition, in a 2012 study across the UK, NI was estimated as having the highest average need per person with England the lowest.[5]

4. Mirroring the population, general practice also has an **ageing workforce**. Deloitte's Centre for Health Solutions argued that the greatest supply challenge facing primary care is the average age profile of GPs.[6] The proportion of GPs aged 55 years old and over in Northern Ireland is 24%, meaning that the region's GP workforce is the oldest in the UK.[7] Additionally, the practice nurse workforce is also ageing as the percentage of treatment room and practice nurses aged 55 and over is almost 24%.[8]

5. In 2013, Northern Ireland had the **lowest GP coverage** per population in the UK at 6.4 per 10,000 population. This compared to 8.0 in Scotland, and 6.6 in both England and Wales. In 2014, Northern Ireland had 6.3 per 10,000 registered patients. However, due to data availability, direct comparisons with other UK nations is not possible.[9] In addition, Health Minister Jim Wells has acknowledged that there is a 20% shortage of GPs, which equates to 242 GPs. The 2014 interim report on the GP Medical Workforce said that "There is material evidence that a shortage of GPs available to the medical workforce is having a detrimental impact upon the delivery of GMS in NI. There is a further likely consequence in that this will undermine any attempts to deliver a 'shift left' commissioning policy, moving service provision from secondary to primary care."[10]

6. The ONS forecasts that the population in Northern Ireland will grow by either 2.2% or 4.4% between 2015 and 2020. The low estimate assumes constant fertility and no improvement in life expectancy. The high estimate assumes high fertility, high life expectancy and high migration.[11] Given this forecast growth in population and the ageing GP workforce, the RCGP estimates that Northern Ireland could need up to 575 GPs over the next five years. This maximum, cumulative value is based on reaching and maintaining the 2013 UK average coverage of 6.7 headcount GPs per 10,000 population. It uses the high population growth estimate and assumes that all GPs aged over 55 years old in the 2014 workforce retire during the next five years. Counterfactual supply of GPs is estimated using a 10-year linear trend (2004 to 2014). Another probable scenario forecasts a cumulative shortage of 424. This scenario assumes that 75% of the 2014 GP workforce aged over 55 years old retires over the next five years and uses the midpoint between the low and high estimates of population growth.

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[4] DHSSPS (2011) *Transforming Your Care: A Review of Health and Social Care in Northern Ireland*
[5] National Audit Office (2012) *Healthcare across the UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland*
[6] Deloitte (2012) *Primary care: Today and tomorrow, improving general practice by working differently.* Accessed at: http://www2.deloitte.com/uk/en/pages/life-sciences-and-healthcare/articles/primary-care.html
[7] Health and Social Care Information Centre (2015) *General and Personal Medical Services, 2004 – 2014*
[8] DHSSPS (2014) *Northern Ireland Health and Social Care Workforce Census*
[9] Health and Social Care Information Centre (2015) *General and Personal Medical Services, 2004 – 2014*
[10] Department of Health Northern Ireland (2014)*General Practitioner Medical Workforce Planning Group: Interim Report*
[11] Office for National Statistics (2014) *National Population Projections,2012-based Statistical Bulletin*

7. These estimates are subject to revision in June 2015 when the ONS releases its revised population forecasts. Furthermore, these estimates do not take into account the following factors: new models of care, non-retirement attrition from the workforce, potential changes recruitment patterns, age of population, multi-morbidity, case complexity, prevalence of long term conditions e.g. obesity and diabetes. It is also a normative approach that implicitly assumes that the 2013 UK average coverage of GPs is correct. There are numerous approaches to workforce modelling and therefore further collaborative analysis should be conducted in the future.

8. Despite having the oldest GP workforce in the UK and the lowest GP coverage, GPs in the province have faced a dramatic **increase in workload** over the past decade. In 2013/14, general practice carried out 12.7 million consultations compared to 7.2 million in 2003/04 (which equates to a 76% rise from 2003/04).[12] In addition, Out of Hours services have experienced an 18% rise in consultations over the past five years, compared to A&Es which saw a 2% reduction in the same period.[13] The RCGPNI expects workload in primary care to continue increasing during the implementation of TYC as more care is shifted into the community.

9. These challenges to workload and the ageing workforce have also correlated with a **long term decline in investment** in general practice. Research undertaken by Deloitte shows that funding to general practice across the UK as a share of total NHS funding has decreased from 10.3 per cent in 2004/5 to 8.39 per cent in 2011/12.[14] In Northern Ireland, there has been a real terms cut in funding for general practice of 6.59% from 2009/10 and 2012/13, which equates to £16.8 million.[15] In 2013/14, general practice only received 8.3% of health service spending despite delivering 90% of health contacts. The College is asking for a commitment to an increase in the share of the budget spent on general practice to 11% across the UK by 2017.

Recommendations

1. To tackle the workforce crisis in general practice, it is imperative that the workforce is built up through increasing **recruitment** in order to replace those leaving the profession.
   - GP workforce reports in 2006, 2010 and an interim 2014 report all highlighted that a workforce crisis was looming and recommended an increase in the number of GP trainees.
   - There are only 65 GP training places available in Northern Ireland. The 2014 interim workforce report highlighted that this provision significantly fell below the 95 GP training places that would be equivalent to existing GP training provision in England, based on a population ratio extrapolation. However, if the number of training posts in England are increased as has been recommended, this would equate to 111 GP training places in NI.
   - The 2014 interim workforce report recommended that the number of GP training places in NI should be increased to 111 annually, phased over 4 years with an initial target to increase the number from 65 to 80 for commencement

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[12] Department of Health Northern Ireland (2015) *Estimating the volume and growth in consultation rates in general practice in Northern Ireland, 2003/04 to 2013/14: Analysis of survey returns from general practices*
[13] DHSSPS (2014)*General Practitioner Medical Workforce Planning Group: Interim Report*
[14] Deloitte (2014) *Under pressure: The funding of patient care in general practice*
[15] RCGP analysis (2015) General practice spend excludes dispensing costs and reimbursement of drugs. GDP deflator is the measure of inflation used. GDP deflator values are sourced from HM Treasury (March 2015).

by August 2015, but implemented no later than August 2016. It was estimated that this would cost an additional £90,000 per training place, or £1.35m in total.[16]

- One area of particular concern is the lack of experience that undergraduates in NI receive in general practice. At present, approximately 5% of undergraduate time is spent in general practice and this is the third lowest in the UK (with the average being circa. 14.5%), with only Oxford and Cambridge offering less time. The College is calling for a major overhaul of the funding of the undergraduate medical school via the Supplement for Undergraduate Medical and Dental Education (SUMDE) as it believes that increased and early experience of general practice will be beneficial for recruitment. In addition, increasing exposure to general practice will help prepare medical students for a workforce which will be more community based, in line with TYC.

- Incentives could be introduced to encourage doctors into general practice, particularly in rural areas. The College understands through anecdotal evidence from our members that locum doctors tend to be concentrated in urban areas, leaving a shortage of locums in rural areas such as Fermanagh.

- Remove barriers preventing GPs from returning to the workforce.

- Introduce a long-term target for increasing the numbers of GPs.

2. More should be done to improve GP **retention** as significant numbers of newly trained GPs leave the general practice profession in Northern Ireland.

   - This would primarily focus on improving the working environment of GPs to make the career more attractive. This can include addressing issues around the support team and infrastructure.

   - Research could be carried out into why GPs are leaving general practice early.

   - As 47.3% of GPs are women, it is important that workforce planning adopts a long term approach which takes into account the need for more flexible working and a better work/life balance.

   - Scotland and Wales have recently announced £40m and £13.5m respectively to help boost general practice, and England has been allocated a £1bn fund for general practice infrastructure (spread over four years), and a £200m transformation fund for 2015/16 to start delivering the Five Year Forward View. In addition, both the Conservatives and Labour in England have pledged to increase GP numbers (5,000 and 8,000 respectively).

   - The RCGPNI welcome the announcement made on 1 April 2015 that £15m funding would be made available for general practice. Whilst the allocation of an extra £15m is welcome, we note that only £300,000 was identified for improving recruitment and retention. Substantially more investment is needed to prevent a possible 'brain drain' from Northern Ireland, as GPs trained in the region may choose to migrate to other regions of the UK if long-term investment is not made here.

3. Develop a clear national target for increasing the proportion of the **NHS budget spend** on general practice in line with the objectives of TYC

   - There is growing evidence that investing to strengthen general practice will ensure that the NHS is sustainable in the future. Research conducted by Deloitte, commissioned by the RCGP, concluded that improving access to general practice could generate annual savings in NI of between £9m and £13m. Deloitte has estimated that treating 54,000 to 95,000 unnecessary A&E attendances in

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[16] Department of Health Northern Ireland (2014)*General Practitioner Medical Workforce Planning Group: Interim Report*

general practice could cost between £2m and £3m, leading to a significant net saving for the NHS.[17] However, this would require giving practices resources to hire more staff (including GPs but also practice nurses and support staff), improve infrastructure and spend more time with patients – particularly those living with multiple long term conditions.

- Regular statistics monitoring how funding is best shifted should be published.
- Invest in better access to diagnostic technology in general practice. Providing more care in the community and avoiding unnecessary hospital admissions will mean that more diagnostic tests will need to be conducted in GP practices.
- Improved collection of workforce data including vacancy rates, demographics, proportion of part-time workers, locums etc.

Additional comments

- The RCGPNI had representation on the Regional Workforce Planning Group and stated the case for the need to increase the numbers of GPs being trained.
- The College has significant concerns over the lack of investment in TYC and the lack of specific outcomes.
- The RCGPNI is unaware of any visible and positive impact of the £25m already shifted from hospital services to community/primary services in the areas of learning disability and mental health resettlements.

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[17] Deloitte (2014) *Spend to save: The economic case for improving access to general practice*

Midwifery Workforce Planning in Northern Ireland

Transforming your Care identified challenges for maternity services into the future as:

- Giving a realistic choice of birth location for women
- The need for more continuity of care throughout pregnancy
- Reducing unnecessary interventions
- Dealing with the public health issues facing women of childbearing age to reduce ill-health and disability of mother and child
- Supporting the expectant mother in her antenatal care and connecting that support to the early years of parenthood

It went on to say that it therefore 'expects change to follow the pattern set out in the forthcoming Maternity Strategy, from pre-conception, through pregnancy, brith and the postnal period. In addition it recommends a specific regional plan for supporting the small number of mothers with serious psychiatric conditions'.

The DHSSPS *Strategy for Maternity Care in Northern Ireland 2012-2018* has accepted the recommendations outlined in *Transforming your Care* and has clearly identified the vision and the future direction of maternity services in Northern Ireland. It addresses women's choice, accessibility of services and who is best placed to be the lead maternity professional.

Service developments within maternity care are in line with the Maternity Strategy and there has been a robust implementation of the strategy since 2013 with women now having a wider choice of birth location with more continuity of care throughout their pregnancy. Unnecessary interventions including non medically indicated caesarean sections are being reduced and midwives are at the forefront in discussing public health issues including drug and alcohol abuse, smoking, nutrition and exercise with pregnant women. The only recommendation still to be implemented is the development of a specific regional plan for supporting women with serious psychiatric conditons.

Whilst there has been an increase in the number of women choosing to have midwifery led care throughout their pregnancy, there has also been an increase in the number of women with complex needs who require to have care provided by an extensive team of health care professionals.

The midwifery workforce in Northern Ireland is predominately female with only two male midwives out of the 1300 midwives employed in Northern Ireland. It is an ageing workforce with almost 60% aged over 45. Indeed 22% of the workforce is aged 55 and over. It is a part time workforce with almost 70% of midwives working part time and at any given time up to 5% of the midwifery workforce may be on maternity leave.

Midwives work flexibly across hospital and community boundaries; this is incorporated into their pre-registration training and carries through into clinical practice.

The midwifery workforce is reviewed annually in conjunction with the DHSSPS, service commissioners and providers, higher educational institutes and professional organisations including the RCM. There are two routes into midwifery practice - in addition to the normal three year midwifery education programme, there is a shortened (18 month) training programme for those who are already registered nurses

The introduction of maternity support workers (MSWs) to the maternity workforce has provided support to midwives caring for women and has provided added value to the care that women receive.

The major threat to the midwifery workforce is that an ageing workforce with the ability to retire at 55 may in today's difficult environment, choose to exercise that right.

Breedagh Hughes
Director RCM NI
22nd April 2015

Submission to the

Northern Ireland Assembly Committee for Health, Social Services and Public Safety:
Review of workforce planning in the context of Transforming your Care

Introduction

1   The Royal College of Nursing [RCN] represents nurses and nursing, promotes excellence in practice and shapes health policy. The RCN represents registered nurses, health care assistants and nursing students across all care settings and throughout Northern Ireland.

2   The RCN thanks the Committee for the invitation to submit views on the issue of workforce planning in the context of *Transforming your Care* [TyC]. We hope that the Committee will give due consideration to this submission in informing its deliberation on this issue.

Transforming your Care: workforce planning

3   In July 2013, the RCN presented to former Health Minister Edwin Poots a detailed analysis of the nursing workforce in Northern Ireland, highlighting a number of challenges that needed to be addressed in order help build a nursing workforce that would be fit for purpose in addressing the significant health care challenges confronting Northern Ireland in the years ahead.

4   An effective Health and Social Care service [HSC] is repeatedly cited by the people of Northern Ireland as a major political priority. *The People's Priorities*, published by the Patient and Client Council in November 2010, confirmed this

view. The survey highlighted that the number one health priority for the people of Northern Ireland is the protection of frontline staffing levels, particularly nursing. A subsequent 2011 report also indicated the importance of health and social care staffing levels and advocated "... a greater focus on strengthening numbers of nursing and medical staff". The most recent edition of *The People's Priorities*, published in November 2014, once again identified the number of frontline health and social care staff as the over-riding priority for the HSC, with the need for more nursing staff identified as a specific objective.

5   The RCN's submission to the Minister also pointed out that, at that time, there had been no regional workforce planning for nursing and midwifery in Northern Ireland since 2008. It noted that, of all HSC workforce groups, the nursing workforce had seen the smallest percentage increase during the period of overall growth between 2003 and 2012. The number of registered nurses increased by 11% and health care assistants by 6%. This was despite significant increases in demand and the development of new roles such as hospital at night, patient flow and nurse-led initiatives, together with the impact of a reduction in junior doctors' hours. During the same period, the social care workforce increased by 65%, with professional/technical and medical/dental staffing increasing by 32%. The HSC workforce overall grew by 16%.

6   The DHSSPS Workforce Policy Directorate is responsible for regional workforce planning and ensuring that there are sufficient suitably qualified staff to meet the needs of the HSC. This includes taking forward workforce issues for TyC, ensuring that all HSC staff are adequately trained and qualified, and the commissioning of education and training for all HSC staff, together with the management of education and training budgets. No DHSSPS workforce strategy has been published since 2002 and the most recent human resources assurance standard was published in 2009. Over the last five years, and in the absence of any workforce review, the nursing and midwifery education and training budgets have been unilaterally and disproportionately reduced by the Workforce Policy Directorate of the DHSSPS. The pre-registration education and training budget and expenditure for nursing and midwifery has been

decreased by 9%, and the post-registration education and training budget and expenditure has been decreased by 19%.

7   In terms of pre-registration programmes, DHSSPS commissioning has been informed by DHSSPS workforce reviews carried out in 2005 and 2008. Workforce reviews are informed by data collected by the DHSSPS from HSC trusts about vacancy levels and service developments. The DHSSPS defines a vacancy as a post to which the HSC trust is actively recruiting. It is worth noting that information is not collated by the DHSSPS about posts that are being held vacant as part of HSC trust cost-saving proposals. All HSC trust cost-saving proposals are approved by the DHSSPS. Cost control measures as part of financial break-even plans are given priority over the requirement to provide an adequate nursing workforce, resulting in an over-reliance on bank and agency supply. The RCN is not aware of any workforce modelling at HSC trust level.

8   Arrangements for the commissioning of post-registration education programmes in Northern Ireland are amongst the best in Europe. The DHSSPS has a well-established Post-Registration Education Commissioning Group. Membership of the group is drawn from the Directors of Nursing in each of the five HSC trusts and the Director of Nursing in the Public Health Agency. The group is chaired by the latter and is supported by a business manager, a DHSSPS Nursing Officer from the Chief Nursing Officer's section, and an officer from the Workforce Policy Directorate at the DHSSPS. Commissioning requests are submitted by HSC trusts following completion of a training needs analysis to identify what education and development programmes are required.

9   There are a number of issues worth noting in relation to post-registration education commissioning. The DHSSPS includes salary costs within commissioning arrangements for some post-registration education programmes but not others. If HSC trusts commission programmes for which the DHSSPS does not support salary costs, the HSC trusts have to meet the salary costs of staff undertaking DHSSPS commissioned programmes. HSC trusts already struggling to make cost savings contest that they do not have the financial resources to support staff to undertake these programmes. In some cases,

even where the DHSSPS does support salary costs, HSC trusts are not commissioning sufficient places on DHSSPS commissioned programmes such as district nursing and health visiting. This has, for example, resulted in 65 unallocated health visiting caseloads across Northern Ireland and a compromised and at risk health visiting service. District nurses routinely cover two or three caseloads and the consequence once again is a compromised and at risk service. In contrast, as a result of DHSSPS cost-saving measures, HSC trusts are requesting development programmes for nurses and a significant number of requests are being refused.

10   Following the RCN's meeting with the former Health Minister referred to in paragraph three above, he announced a series of measure to address the issues that the RCN raised with him. These included asking DHSSPS officials to: "Develop a new workforce plan for nurses and midwives to ensure that these key professionals are best placed to support the delivery of safe and effective care as change takes place into the future".

11   In the absence of any Workforce Policy Directorate review, a Regional Steering Group was established as a sub-group of the DHSSPS Central Nursing and Midwifery Advisory Committee [CNMAC], on which the RCN has been represented, to oversee the development of the plan.

12   Late last year, a draft document emerged from the DHSSPS entitled *A workforce plan for nursing and midwifery in Northern Ireland (2015-2025)*, about which the RCN had a number of concerns and to which the RCN responded formally. The RCN is particularly concerned about:

- The growing numbers of nurses who are leaving Northern Ireland to work elsewhere as a result of short-sighted cost-saving measures that deny them the opportunity to obtain permanent posts and severely limit their employment opportunities.

- The increasing staff vacancy levels in nursing reported in the DHSSPS vacancy survey.

- The growing number of entries on HSC trust risk registers detailing the risks associated with nurse staffing shortages.

- The increasing use of bank and agency staff, and associated escalating agency costs.

- Insufficient financial resources to meet demand for the specialist and advanced nursing roles required to support the medical workforce, resulting in the further depletion of an already over-stretched nursing workforce.

13   Despite all these challenges and evidence that demand in the nursing workforce is outstripping supply, Northern Ireland is the only country in the UK that has not increased the numbers of places on pre-registration nursing programmes.

14   The RCN is also concerned about the inadequate exploration and consideration of the nursing workforce requirements of the independent (nursing home) sector, which is currently experiencing serious staffing difficulties. There are 10,000 nursing home beds in the independent sector in Northern Ireland and current staffing shortages present a serious risk to the viability of this sector. Due to nursing shortages, one larger provider currently has 150 registered nurse vacancies and is having to recruit overseas. One particular single provider nursing home, which has been stable for ten years with a team of highly skilled nurses, in recent months has lost five registered nurses who were recruited by an HSC trust, representing around 50% of the home's registered nurse staffing. This constitutes a significant threat to the business for the home owner, poses a serious risk to the viability of the home and, most importantly, is devastating for the people who live there.

15   Registered nurses are employed within general practice to deliver highly skilled, evidence-based care to people across all age groups, from infants to older people, and to provide a range of services from pre-natal to end of life care. They work as partners in care, anticipating health needs and promoting self-care and self-management for people with complex needs, enabling people to take responsibility for themselves and to be as independent as possible. There are

currently around 350 general practitioner practices in Northern Ireland, employing approximately 600 registered nurses. Practice nurses have been consistently raising issues with the RCN about their terms and conditions of employment, professional development, appraisal, clinical supervision and career progression. The RCN has raised these issues with the British Medical Association, the Royal College of General Practitioners and the Health and Social Care Board. However, little progress has been made to date by these organisations in addressing the issues.

16 Table one on page 11 indicates the ageing demographic profile of this section of the nursing workforce. In order to support the effective recruitment and retention of practice nurses to help facilitate the delivery of TyC, GP employers need to be able to ensure that they offer competitive terms and conditions of employment to those whom they directly employ. It is also important to ensure the future supply of new practice nurses. However, the practice nurse specialist practice programme is no longer being commissioned in Northern Ireland, as practice nurses have not been supported by employers to undertake the programme. This has significant implications for recruitment and succession planning within this important area of professional nursing practice.

17 In summary, the RCN welcomed the commitment of the former Health Minister to the development of a new workforce plan for nursing and midwifery in Northern Ireland. However, it is not clear how this new workforce plan will resolve some of the serious underlying problems that remain, not least the inability to address the issues that are impairing the implementation of TyC. These are discussed in more detail below.

18 The RCN endorsed the original *Transforming your Care* report and the strategic shift in the focus of care provision in Northern Ireland that it was designed to promote. However, building public confidence in community services and creating viable alternatives to inappropriate acute hospital attendances depends upon putting in place effective workforce planning and workforce development in order to build public and professional confidence in community nursing services. However, as the Committee is aware, this has simply not happened.

6

Regional Workforce Planning Group

19   In September 2014, in response to an Assembly question tabled by the Chair of this Committee, the Health Minister observed that there are three specific proposals within TyC related to workforce planning. Recommendation 79 refers to: "Make necessary arrangements to ensure critical clinical staff are able to work in a manner which supports the new arrangements". Recommendation 95 specifies the: "Development of new workforce skills and roles to support the shift towards prevention, self-care, and integrated care that is well co-ordinated, integrated and at home or close to home". Recommendation 97a sets out: "More formal integration of workforce planning into the commissioning process to drive the financial transformation".

20   The Minister's response further states: "Responsibility for taking forward workforce planning, including these recommendations, lies with the Human Resources Directorate in the Department which is headed at Director level supported by a dedicated full-time staffing resource. A Regional Workforce Planning Group [RWPG], has been established, which is chaired by the Director of Human Resources and includes membership from across the Department and the wider HSC. This group's initial focus has been to develop a strategic framework for workforce planning to inform the basis for integrated future workforce planning."

21   The Committee has specifically asked the RCN to confirm whether or not it has representation on the RWPG and the answer to this question is that it does not. The RCN is surprised and disappointed that a group of this nature, which specifically purports to include "membership from across the wider HSC", could exclude the organisation representing the largest professional group within the HSC workforce. It is not at all clear to the RCN how, if at all, the work of the RWPG links to the CNMAC sub-group referenced in paragraph 11 above. Not only is the RCN not represented on this group, it has not been informed about the work of the group and is not aware of any proposals developed by the group.

Transforming your Care: implementation

22 The community nursing workforce is key to improving and extending services to meet the health and care needs of the people of Northern Ireland, particularly older people, in line with the aims and ethos of TyC. As the Committee is aware, emergency departments specifically and acute hospital services generally simply cannot sustain the current pressures deriving from increasing admissions from the community because alternatives, such as nurse-led minor injuries units, providing care at home for people with long-term conditions, and effective out-of-hours GP services, are not being developed and resourced appropriately.

23 TyC is intended to focus on how best to provide integrated care for a growing older population. However, the health and social care system in Northern Ireland has so far proved to be incapable of shifting resources from acute hospitals to the community in order to allow this to happen. In September 2014, the Minister confirmed to the Assembly that a total of £28.49 million had been spent on the implementation of TyC since 2012-2013. However, one-third of this sum (£10.18 million) was deployed on voluntary redundancy and voluntary early retirement, with just £5.67 million allocated to associated service changes. In January of this year, the Minister confirmed to the Assembly that just £2.53 million of a projected budget of £27.53 million had been deployed during 2014-2015 on core TyC services such as community dementia care, home dialysis and the relocation into the community of mental health and learning disability services.

24 As the Committee is also aware, in the autumn of 2014, the five HSC trusts announced a series of service cuts as a result of the Northern Ireland Executive's financial crisis. Minor injuries units, respite facilities and intermediate care and rehabilitation beds throughout Northern Ireland have now been closed (supposedly on a temporary basis), with staff being redeployed to acute hospitals. Financial crisis or no financial crisis, this is, as the RCN has constantly pointed out, bordering upon insanity.

25 The ultimate benchmark for the success of TyC is, or should be, its impact upon emergency department admissions. This, after all, is what TyC was established

to address. However, a simple glance at the Department's own emergency care statistics demonstrates the failure of TyC at this key strategic level. Between December 2013 and December 2014, the total number of attendances at the major (Type 1) acute hospital emergency departments in Northern Ireland increased by 6%, from 45,842 to 48,867. Across all emergency departments, the increase was 3%. If TyC has been designed as a means to keep people out of hospital and ensure that they are able to access health care services in their own homes and communities, then it has, to date, singularly failed.

26   Last year, when the RCN was invited to provide evidence to the Committee on the factors underlying the crisis impacting upon emergency care departments in Northern Ireland, we stated that TyC is "a vision without action". We now need to reassess that conclusion. The Northern Ireland Executive budget paper for 2015-2016 states (pp 93-94) that: "The Department's budget does not allow for the funding of new service developments in 2015-16, across a number of areas including … *Transforming your Care* [TyC] transitional funding". Knowing that alternatives to acute hospital admission are being closed, with more and more patients being funnelled in to our emergency care departments because they are the only viable points of access to the health system, the RCN believes that we are entitled to ask if TyC remains in any meaningful respect a viable strategy.

27   Despite this, the RCN is still supportive of the principles behind TyC. However, as the recent Donaldson review has concluded, the DHSSPS, commissioners, trusts and workforce planners need to look beyond the acute sector and develop the types of 24/7 alternative sources of treatment and care that TyC is supposed to deliver but has failed thus far to do. Workforce planning, in the judgement of the RCN, is an integral part of this process.

Transforming your Care: the community nursing workforce

28   The community nursing workforce in Northern Ireland faces many significant challenges. These include high workloads and demands on the service, the excessive burden of paperwork, poor or non-existent technology, and a fear of

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letting patients down due to cuts in service and workforce. The demands on community nursing services have also affected the work-life balance of nurses, with many working longer hours unpaid, simply because this is the only way to make sure that patients receive the care to which they are entitled.

29   A summary analysis of the HSC community nursing workforce is presented at table one below. All of these figures are taken directly from the DHSSPS annual HSC workforce census. Two key issues emerge from this. Firstly, the table illustrates the numerical decline in the community nursing workforce over the last four years, at precisely the time when this workforce should have been developed in order to deliver TyC. Secondly, the figures demonstrate the ageing demographic profile of the community nursing workforce, particularly in relation to school nursing and treatment room/practice nursing.

30   For example, the current ratio of school nurses to school children in Northern Ireland is 1:3758. The RCN recommends that there should be one school nurse for each secondary school and its associated cluster of primary schools. Around one-third of the school nursing workforce in Northern Ireland is aged 50 and over. School nurses have routinely highlighted to the RCN their concerns that managers are restricting their role to one of safeguarding and that this hinders their capacity to undertake the essential public health aspects of the role, such as sexual health, health promotion, and signposting to other HSC services.

31   The DHSSPS admits that the current health visiting service in Northern Ireland does not have the capacity to carry out its statutory requirements, let alone develop the type of comprehensive public health role that is central both to TyC and in tackling the significant health inequalities that persist in Northern Ireland. The current average ratio of health visitors to children per case load is 1:363. The maximum recommended by the Community Practitioners and Health Visitors Association is 1:250.

32   Just 9% of HSC nursing staff currently provide care in community settings. This is another indicator of the failure of TyC and the direct link between this failure and the absence of associated workforce planning.

Table one: HSC community nursing workforce selected groups: 2010-2014

Whole time equivalent

	March 2010	March 2014	Change (%)
School nursing	95.20	91.60	-4%
Health visiting	445.00	460.50*	+3%
District nursing	908.10	853.30	-6%
Treatment room and practice nursing	157.70	141.50	-10%
Learning disability nursing	437.30	428.10	-2%

* figures include post-registration student health visitors

Headcount

	March 2010	March 2014	Change (%)
School nursing	140	125	-11%
Health visiting	541	541*	-
District nursing	1121	1058	-6%
Treatment room and practice nursing	235	224	-5%
Learning disability nursing	474	465	-2%

* figures include post-registration student health visitors

Age profile: percentage of workforce aged 45 and over

	March 2010	March 2014
School nursing	51%	67%
Health visiting	53%	59%
District nursing	49%	41%
Treatment room and practice nursing	53%	68%
Learning disability nursing	48%	44%

Source: DHSSPS HSC workforce census: 31 March 2010 and 31 March 2014

33   There is a further point to be made with specific reference to the district nursing workforce. Official DHSSPS workforce figures show that the number of district nurses in Northern Ireland has fallen by 6% since 2010. However, the RCN has recently discovered that less than one-third of nurses classified by the DHSSPS as district nurses hold a specialist district nursing qualification. In the South Eastern Health and Social Care Trust, only one-quarter (25.49%) hold the specialist qualification. The Belfast Health and Social Care Trust employs 15 nurses at band 6 level who do not hold the specialist qualification, whilst the equivalent figure for the South Eastern Health and Social Care Trust is three.

34   Moreover, as table two below demonstrates, many of the nurses categorised as district nurses by the DHSSPS are not employed as district nurses at all, but as registered nurses deployed to work in the community. The distinction may not seem important; registered nurses working in the community are, after all, a valuable part of our community nursing workforce. However, district nurses are nurses who have undertaken a specialist programme, subsequent to their initial registration, to equip them with the high level skills and expertise that are needed to lead and deliver the provision of specialist nursing care to people with complex conditions. It is disingenuous and misleading of the DHSSPS to claim, as it does, that all nurses working within the community in this way are district nurses, when this is true for less than one-third of them. In simple terms, two out of every three nurses whom the DHSSPS categorises as district nurses are not district nurses at all.

35   Given the state of the community nursing workforce, do we need, therefore, to ask if the central expectation of TyC to provide care for patients, particularly older people, at home or in the community is now unrealistic? There is a lack of public awareness and understanding of the imbalance between funding for acute services and that which is currently available for community care. Are patients being short-changed under TyC?

Table two: HSC district nursing workforce as at March 2015

Belfast Health and Social Care Trust

AfC band	Headcount		Whole-time equivalent	
	Total	Of which: headcount with specialist district nursing qualification	Total	Of which: WTE with specialist district nursing qualification
Band 5	122	7	101.52	4.2
Band 6	79	64	69.93	59.2
Band 7	11	11	11.0	11.0
Band 8A	0	0	0.0	0.0

These figures relate to agreed core district nursing staff only within the Belfast Trust.

Northern Health and Social Care Trust

AfC band	Headcount		Whole-time equivalent	
	Total	Of which: headcount with specialist district nursing qualification	Total	Of which: WTE with specialist district nursing qualification
Band 5	141	3	121.58	3.0
Band 6	22	22	19.70	19.70
Band 7	15	15	13.50	13.50
Band 8A	1	1	1.0	1.0

South Eastern Health and Social Care Trust

AfC band	Headcount		Whole-time equivalent	
	Total	Of which: headcount with specialist district nursing qualification	Total	Of which: WTE with specialist district nursing qualification
Band 5	157	8	104.1	6.3
Band 6	45	42	41.99	41.99
Band 7	2	2	2.0	2.0
Band 8A	0	0	0.0	0.0

Southern HSC Trust

AfC band	Headcount		Whole-time equivalent	
	Total	Of which: headcount with specialist district nursing qualification	Total	Of which: WTE with specialist district nursing qualification
Band 5	113	0	87.70	0.0
Band 6	58	58	48.18	48.18
Band 7	8	8	8.00	8.00

The Southern Health and Social Care Trust has included all qualified nursing staff from its district nursing service, including twilight nurses and excluding treatment room nurses

Western Health and Social Care Trust

AfC band	Headcount		Whole-time equivalent	
	Total	Of which: headcount with specialist district nursing qualification	Total	Of which: WTE with specialist district nursing qualification
Band 5	114	13	85.36	11.47
Band 6	0	0	0.0	0.0
Band 7	35	35	31.4	31.4
Band 8A	4	4	3.0	3.0

These figures relate to core district nursing staff only within the Western Health and Social Care Trust

Source: Northern Ireland Assembly written question and answer AQW 43547/11-15

36   The RCN believes that it is nursing that holds the key to building and sustaining the 24/7 services that will meet patients' increasingly complex needs. Nurses are in a unique position across the health and social care system to connect systems and organisations. However, we also need to make sure, in our integrated health and social care system, that we are not trying to deliver nursing care within a domiciliary care model, or denying patients access to specialised high quality nursing by decreasing the number of district nurses and thereby diluting the specialist community nursing workforce in favour of a generic model. Domiciliary care is domiciliary care, and nursing care is nursing care. Let us not try to conflate the two. In this respect, the RCN is extremely concerned about a current

consultation on a proposed outline model for domiciliary care services. This includes, within the definition of domiciliary care services, programmes of care for older people, physical and sensory disability, mental health and learning disability. It goes on to claim that domiciliary care includes meeting "a service user's health needs (eg managing medication)".

37   This is, in the judgement of the RCN, unacceptable and potentially dangerous. Patients and clients with complex care needs being cared for at home may require support to meet their personal care needs. Domiciliary care workers are, of course, well-placed to meet these personal care needs. However, when it comes to meeting the health needs of patients and clients, they require skilled, professional nursing care from a registered nurse who has been trained to provide that care and is accountable for the quality of care provided and the experience of the patient or client. We must never lose sight of the fact that people with personal care needs require personal care but patients and clients must be appropriately assessed and a prescribed plan of care developed to meet any identified health needs. That plan of care must be provided directly by, or implemented under the direction and supervision of, an appropriate health care professional. Where a patient or client has identified nursing needs, then care must be provided within a nursing context.

38   If we are to deliver the type of health and social care service that the people of Northern Ireland, and especially older people, deserve and that health professionals wish to deliver, we need to listen to the patient voice, make sure that health and social care needs are met in a timely and appropriate manner, and support and nurture the people who deliver that care.

Transforming your Care: systems reform

39   When the RCN gave evidence to the Committee early last year, we highlighted a number of other issues that, in our view, remain equally valid now. There is an urgent need to promote and resource nurse-led discharge and to ensure that the right numbers of senior nursing leaders are available on wards at evenings,

nights and weekends to facilitate this. We pointed out that unscheduled care (such as emergency services) is largely predictable in terms of the peaks and troughs that occur according to the time of day, day of the week, and month of the year. However, deployment of the HSC workforce resource as a whole does not effectively match the peaks and troughs in the system. Areas such as radiology, laboratory services and community out-of-hours services are not sufficiently responsive and dynamic to meet demand proactively and, from a community perspective, in a preventative manner.

40   The RCN also highlighted how one practical and relatively simple strategy for improving patient flow, enhancing the patient experience and improving emergency department performance would be truly to focus on meeting the needs of older people, and particularly people with dementia. A disproportionate percentage of in-patient beds are occupied by patients over the age of 70. More appropriate health and social care, such as short-stay units, that is truly focused on meeting the individual needs of older people can prevent emergency admission in the first place and reduce length of stay. Both of these would significantly impact upon emergency department waiting times, as well as helping to inspire public confidence in the reform of the system and the implementation of TyC. It is important to ensure that the right community services are in place, and are appropriately staffed and resourced, to treat people with, for example, chronic lifelong conditions whose condition deteriorates temporarily and who could be cared for as far as possible in the community without necessarily requiring hospital admission.

41   The RCN Northern Ireland Nurse of the Year Awards have highlighted innumerable examples of nurses who are leading the development and delivery of new community-based nursing services that provide cost-effective alternatives to traditional hospital-based care. Despite the failure of the Northern Ireland Executive to support and fund the underlying strategic process, nurses are taking the lead in making TyC happen at a local level. The RCN believes that the valuable lessons from these initiatives should be adopted by commissioners and applied to the future commissioning of services throughout Northern Ireland.

Transforming your Care: safe staffing

42 The Committee has sought views from the RCN on the number of registered nurses required to implement TyC. There are a number of organisations within the HSC that are responsible, in various different ways, for the commissioning of health and social care services to meet the needs of the people of Northern Ireland. Commissioning involves assessing health and social care needs and then planning and designing services to meet those needs. As we have pointed out throughout this briefing paper, workforce planning is, or should be, an integral part of this process. It is, equally, a commissioning responsibility to seek assurances about staffing in the context of patient safety, quality and experience within services commissioned.

43 The RCN has been involved in a regional initiative to establish a framework for safe (normative) nurse staffing ranges to support person-centred care in Northern Ireland. This work is being undertaken in phases. Phase one defined safe nurse staffing ranges for acute medical and surgical settings. The ranges are determined by four agreed domains, covering the workforce, activity, environment and support, and professional activity. The previous Health Minister announced the establishment of the framework for these areas of practice early in 2014. Implementation has yet to begin, however. Phase two is intended to cover emergency care and phase three community settings. However, the Northern Ireland budget for 2015-2016 paper states (pp 93-94) that no funding is available to support work on subsequent phases of the normative staffing work.

44 The RCN believes that this is unacceptable. The development of safe nurse staffing levels across the HSC is not an optional extra to be pursued as and when resources and other priorities permit. It is a matter of fundamental public safety that must be implemented fully and as a matter of urgency.

45 The nursing workforce in Northern Ireland is 92% female. Whilst there are opportunities within the HSC for part-time working, these are often only available by registering with a bank or agency because the numbers of permanent posts and how HSC trusts employ and deploy nurses is somewhat

restricting. This has significant implications for the impact of maternity leave on the nursing workforce. Phase one of the safe staffing work referenced above addressed this by building in an allowance for maternity leave and the RCN welcomed this initiative. However, much more needs to be done in ensuring that the gender balance of the nursing workforce in Northern Ireland is appropriately reflected in staff working arrangements.

Concluding comments

46   The RCN is seriously concerned about the lack of progress on the modernisation and reform of our health and social care services and the adverse impact this is having on the nursing profession and, ultimately, patient safety, quality and experience. We would draw to the Committee's attention a statement made in the executive summary of the Mid Staffordshire NHS Foundation Trust Public Enquiry Report and ask that the Committee gives this serious consideration.

47   **"The report has identified numerous warning signs which cumulatively, or in some cases singly, could and should have alerted the system to the problems developing at the Trust. That they did not has a number of causes, among them*:***
A culture focused on doing the system's business – not that of the patients;
An institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern;
Standards and methods of measuring compliance which did not focus on the effect of a service on patients;
Too great a degree of tolerance of poor standards and of risk to patients;
A failure of communication between the many agencies to share their knowledge of concerns;
Assumptions that monitoring, performance management or intervention were the responsibility of someone else;

A failure to tackle challenges to the building up of a positive culture, in nursing in particular but also within the medical profession;

A failure to appreciate until recently the risk of disruptive loss of corporate memory and focus resulting from repeated, multi-level reorganisation."

48   The RCN believes, therefore that the answer to the Committee's question as to how many nurses are required to implement TyC lies in developing a robust commissioning and workforce planning process that is supported and under-pinned by the implementation of safe staffing levels across all health care settings, including community health care settings.

49   The RCN also believes that it now time to be open and honest about whether there is still a commitment to the principles of TyC at a Departmental level. In our judgement, the overwhelming recent and current evidence suggests that there is not. Workforce planning is not only fundamental to TyC but it is also the essence of how TyC can be made to work. Services do not metamorphose from acute hospitals to community settings. The focus of care delivery will only change when it is planned, resourced and supported by appropriate workforce planning that, in the context of nurses and nursing care, delivers the right numbers of the right nurses with the right skills in the right locations.

50   The RCN hopes that this submission has been helpful to the Committee.

April 2015

NHS SCOTLAND

EVERYONE MATTERS:
2020 WORKFORCE VISION

healthier scotland
SCOTTISH GOVERNMENT

MANY VOICES: ONE VISION

Scotland's Health Service aims to provide safe, effective and person-centred care. Our vision is that by 2020 everyone is able to live longer, healthier lives at home or in a homely setting[1].

Our 2020 Workforce Vision

We will respond to the needs of the people we care for, adapt to new, improved ways of working, and work seamlessly with colleagues and partner organisations. We will continue to modernise the way we work and embrace technology. We will do this in a way that lives up to our core values.

Together, we will create a great place to work and deliver a high quality healthcare service which is among the best in the world.

"The majority of the 2020 workforce already work here or are in training. The workforce vision will affect all of us."

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FOREWORD

We are proud of the work we do in Scotland and our passion, drive and enthusiasm to deliver a world class health service. Scotland's Health Service will continue to be a publicly funded and publicly delivered healthcare service free to all our citizens. Our Vision for Healthcare[1] and our Healthcare Quality Strategy[2] put people at the heart of everything we do and we are committed to delivering the high quality healthcare that the people of Scotland expect and deserve.

Our health service is facing many challenges: growing demand, health inequalities, increasing public expectations, an ageing workforce, recruitment challenges and budget pressures.

❝We will deliver the high quality healthcare that the people of Scotland expect and deserve.❞

The 2020 Workforce Vision has been developed in recognition of the vital role of the workforce in responding to these challenges. It has been informed by 10,000 people[3] including NHS staff, trades unions, professional organisations and partners in the delivery of healthcare. It makes a commitment to valuing the workforce and treating people well. A commitment to innovation and making better use of technology. And a commitment to working with other healthcare providers to deliver improved and integrated services.

Everyone who is involved in the delivery of healthcare in Scotland is asked to play their part in making this Vision a reality and to live the values that are shared across Scotland's Health Service to guide the way they work and the decisions they take.

Alex Neil
Cabinet Secretary
for Health and Wellbeing

OUR VALUES

Over 150,000 people work for Scotland's Health Service and the majority of the 2020 workforce already work here or are in training. We know from evidence[4] that staff who are valued and treated well improve patient care and overall performance. The 2020 Workforce Vision sets out a commitment to valuing the workforce and treating people well.

Together, we will put people at the centre of everything we do and work to a common set of values which guide the work we do, the decisions we take and the way we treat each other.

> The values that are shared across Scotland's Health Service are:
>
> - care and compassion
> - dignity and respect
> - openness, honesty and responsibility
> - quality and teamwork.

Embedding these values in everything we do will help to make our vision a reality. In practice, we need to:

- demonstrate our values in the way we work and treat each other
- use our values to guide the decisions we take
- identify and deal with behaviours that don't live up to our expectations
- be responsible for the way we work and not just the work we do.

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DELIVERING BETTER HEALTHCARE

Our work will increasingly focus on preventing and detecting health problems and keeping people well in their own homes and in the community. And when hospital treatment is required it will be provided to the highest standard of quality and safety. There will be changes to the way we work, the work we do, where we work and the people we work with. Some of the changes include:

- ensuring healthcare is available where and when it is needed

- providing wider and more equitable access to healthcare

- working seamlessly with colleagues in NHSScotland and partners who provide care

- making more and better use of technology and facilities to increase access to services and improve efficiency

- strengthening workforce planning to ensure the right people, in the right numbers, are in the right place, at the right time

- putting new and extended roles into practice

- providing a safe environment for innovation and improvement

- using a continuous improvement approach to deliver better ways of working.

❝Our work will increasingly focus on preventing and detecting health problems.❞

EVERYONE CAN HELP

Everyone can help by living our shared values of: care and compassion; dignity and respect; openness, honesty and responsibility; quality and teamwork.

Everyone who works for Scotland's Health Service is an essential and equal member of the team and needs to be valued, treated well and empowered to work to the best of their ability. This will help to improve patient care and overall performance. This will be done by ensuring that everyone:

- is managed fairly and consistently

- is provided with a working environment which promotes their health and well-being

- is supported to make the best use of new technology

- has fair and appropriate access to learning and development opportunities

- has time for learning and is supported to develop their skills, knowledge and competence

- has a meaningful appraisal that helps to improve performance and encourages behaviours that reflect our core values

- has the skills needed, including professional, technical and people skills

- has the tools, equipment and resources needed to work effectively.

❝People who are valued and treated well improve patient care and overall performance.❞

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MAKING SURE IT HAPPENS

We need to make sure the 2020 Workforce Vision becomes a reality. Some of the things that will help to make this happen include:

- putting the Staff Governance Standard[5] into practice in all that we do and encouraging our partners to share these principles

- ensuring that everyone is clear about the values and behaviours expected of them and that our values are put into practice

- empowering teams and individuals to innovate and make things better

- nurturing and developing team-working and professionalism

- employing people who demonstrate our core values by improving recruitment practices

- recognising the achievements and efforts of individuals and teams

- valuing and developing management skills and competencies and having managers who lead by example

- developing leadership skills and competencies at all levels

- recognising and supporting the role of carers in the delivery of healthcare

- creating a culture of organisational learning

- valuing on-the-job learning and recognising the workplace as a major source of learning

- building on our ground-breaking partnership with trades unions and professional organisations.*

*Research carried out by Nottingham University Business School[6] describes NHSScotland's approach to employee relations as

"...probably the most ambitious and important contemporary innovation in British public sector industrial relations."

WHAT WILL HAPPEN NEXT?

Together we will deliver the 2020 Workforce Vision through increasing collaboration and integration. We will do this through ongoing engagement with staff and partner organisations and an implementation framework including:

- annual implementation plans

- national, regional, and local delivery arrangements

- priorities for action

- monitoring and reporting arrangements.

For more information, references (1-6) and links see:
www.workforcevision.scot.nhs.uk
or call **0131 244 2478**

The Scottish Government
Riaghaltas na h-Alba

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EVERYONE MATTERS:
2020 WORKFORCE VISION

Implementation framework
and plan 2014-15

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1. Foreword

Scotland's Health Service aims to provide safe, effective and person-centred care. Our vision is that by 2020 everyone is able to live longer, healthier lives at home or in a homely setting.

We need to take action to ensure that the high quality healthcare we currently provide is consistent and fit for the future. This document contains the framework and first implementation plan for delivering *Everyone Matters: 2020 Workforce Vision*[1]. It sets out five priorities for action by NHS Boards and the support that they will be given.

Everyone Matters was published in June 2013 with input from 10,000 people across NHSScotland including trades unions, professional organisations and partners in the delivery of care. The commitments in *Everyone Matters* reflect the things that staff said need to change and be done better by 2020. The messages from the 2013 NHSScotland staff survey reflect many of the things that staff said.

The workforce vision is to create a great place to work and deliver a high quality healthcare service which is among the best in the world. This vision is ambitious but I believe it is achievable because it is what the workforce want and it is what the people of Scotland expect and deserve.
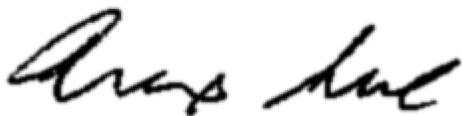
There will be many changes to the way that services are delivered and the work that we do, but the values that underpin the way people work will not change.

Everyone Matters recognises that people make change happen and that the support and contribution of the NHSScotland workforce is crucial in delivering reform. The workforce will play a pivotal role in improving patient care and overall performance.

Everyone who is involved in health and care in Scotland needs to be valued, treated well and empowered to work to the best of their ability. Everyone has a role to play in making this vision a reality and needs to be asked to play their part. In implementing the plan, Boards are expected to engage with staff, stakeholders and partner organisations, building on the collaborative approach adopted so far.

The framework sets out the arrangements for holding NHS Boards to account for delivering the commitments in *Everyone Matters*. It should be used by NHS Boards to support their work with partners in local authorities and the third and independent sectors in taking forward the integration of health and social care.

A great deal of work is needed over the next seven years to deliver *Everyone Matters* and Boards should start this work as soon as possible.

Alex Neil
Cabinet Secretary for Health and Wellbeing

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[1] Scottish Government (2013) Everyone Matters: 2020 Workforce Vision

2. Executive summary

The Route Map to the 2020 Vision for Health and Social Care[2] focuses on improving quality and making measurable progress towards high quality, sustainable health and social care services in Scotland. It describes Scotland's record of excellence in healthcare, the challenges we face over the next 10 years, and identifies 12 priority areas for improvement. Workforce is one of the 12 priority areas for improvement identified in the *Route Map*.

In June 2013, *Everyone Matters: 2020 Workforce Vision* was launched by the Cabinet Secretary for Health and Wellbeing. It recognises the key role the workforce will play in responding to the challenges that NHSScotland is facing, and in improving patient care and overall performance.

Everyone Matters sets out the values that are shared across NHSScotland and asks everyone who works here to live these values and demonstrate professionalism in the way they work. Boards have already been asked to make early progress in embedding the core values.

Over the next seven years, all Boards are expected to deliver the commitments set out in *Everyone Matters*. Boards are expected to engage with staff, stakeholders and partner organisations in planning and delivering this work.

The arrangements for delivering *Everyone Matters* are set out in the implementation framework and plan.

The implementation framework outlines the arrangements for planning and monitoring progress which includes a series of annual implementation plans setting out the priorities and supporting actions. Progress will be monitored through Local Delivery Plans (LDPs) and Boards are expected to use existing monitoring information, local intelligence and feedback to inform local plans and actions. Progress will be reported to key stakeholder groups and to the Health and Social Care Management Board.

The implementation plan sets out the actions that will be carried out locally and nationally during 2014-15. These are the minimum actions that need to begin during the year and Boards are encouraged to start this work as soon as possible. An indicative timeline shows which of these actions Boards are expected to complete during the first year.

The table opposite summarises the five priorities for action in 2014-15.

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[2] Scottish Government (2013) A Route Map to the 2020 Vision for Health and Social Care

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Priority	2014-15 focus
Healthy organisational culture	By developing and sustaining a healthy organisational culture, Boards will create the conditions for high quality health and social care. **The focus this year is on embedding the shared values in everything we do.**
Sustainable workforce	The health workforce will need to change to match new ways of delivering services and new ways of working. We need to ensure that people with the right skills, in the right numbers, are in the right jobs. We also need to promote the health and well-being of the existing workforce and prepare them to meet future service needs. **Strengthening workforce planning is identified as one of the early actions.**
Capable workforce	All staff need to be appropriately trained and have access to learning and development to support the *Quality Ambitions* and *2020 Vision for Health and Social Care*. **The focus this year is on ensuring that development reviews/appraisals are meaningful, providing fair access to learning and development for support staff, and building capacity and capability to improve the quality of what we do.**
Integrated workforce	We need to make sure that the workforce is more joined-up across primary and secondary care, across Boards and with partners across health and social care. **The focus this year is on developing the right conditions for an integrated workforce.**
Effective leadership and management	Managers and leaders are part of the workforce and have a key role to play in driving service and culture change. They also need to be valued, supported and developed. **This year, the focus is on supporting and developing line managers, particularly their people skills.**

Further information to support the implementation framework and plan is available on the workforce vision website (www.workforcevision.scot.nhs.uk). In keeping with the commitment to continuous engagement, visitors to the site will have an opportunity to provide comments or suggestions about the implementation process and the priorities.

3. 2020 workforce vision and values

NHSScotland aims to provide safe, effective and person-centred care. Our vision is that by 2020 everyone is able to live longer, healthier lives at home or in a homely setting.

The 2020 workforce vision
Everyone Matters: 2020 Workforce Vision captures the vision for the NHSScotland workforce. It was developed in consultation with thousands of staff and stakeholders, and supports the 2020 Vision for Health and Social Care[3] and the Healthcare Quality Ambitions[4] for Scotland.

> 2020 workforce vision
> We will respond to the needs of the people we care for, adapt to new, improved ways of working, and work seamlessly with colleagues and partner organisations. We will continue to modernise the way we work and embrace technology. We will do this in a way that lives up to our core values.
>
> Together, we will create a great place to work and deliver a high quality healthcare service which is among the best in the world.
>
> *Source: Everyone Matters: 2020 Workforce Vision*

Our values
Everyone Matters: 2020 Workforce Vision makes a commitment to putting people at the centre of everything we do, and using our shared values to guide the work we do, the decisions we take and the way we treat each other. The values that are shared across NHSScotland are:

> • Care and compassion
> • Dignity and respect
> • Openness, honesty and responsibility
> • Quality and teamwork
>
> *Source: Everyone Matters: 2020 Workforce Vision*

These values need to be embedded in everything we do to help make *Everyone Matters* a reality. In particular, everyone should:

- demonstrate our values in the way we work and treat each other
- use our values to guide the decisions we take
- identify and deal with behaviours that don't live up to our expectations
- be responsible for the way we work and not just the work we do.

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[3] Scottish Government (2013) A Route Map to the 2020 Vision for Health and Social Care
[4] Scottish Government (2010) Healthcare Quality Strategy

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4. The implementation framework

4.1 The framework

A great deal of work is needed over the next seven years to deliver *Everyone Matters: 2020 Workforce Vision*. It will require a continuous process of planning, implementation and progress reviews. The table below provides an overview of the framework.

Implementation plans	**Priorities for action**
Annual implementation plans will build on each other up to 2020 and will encourage a continuous improvement approach. Some actions will be taken forward at a national level and others locally by Health Boards, through engagement and co-production with those who deliver or are involved in the delivery of health care.	Priority actions will be identified and will be supported by project plans with key milestones for delivery. The priorities are: • Healthy organisational culture • Sustainable workforce • Capable workforce • Integrated workforce • Effective leadership and management.
Monitoring and reporting arrangements	**Governance arrangements**
Progress will be monitored locally through relevant reporting arrangements. Progress will also be monitored nationally through the Local Delivery Planning (LDP) process, along with results from the staff survey and staff governance monitoring arrangements. Workforce Plans may also be used to help monitor progress. Progress will be reported to the Everyone Matters Implementation Group and the Health and Social Care Management Board.	The Everyone Matters Implementation Group will be responsible for producing the annual implementation plans. The Group will report to the Health and Social Care Management Board and this will contribute to the wider discussion about joined-up planning for workforce, finance, service, IT and capital infrastructure to deliver the 2020 Vision.

4.2 Implementation plans

A series of annual implementation plans will build on each other until 2020. This first implementation plan covers the 2014-15 financial year. The next plan will be published in November 2014, around the same time as the LDP guidance. Each year, adjustments will be made to ensure that work is on track and continues to support the *2020 Vision for Health and Social Care.*

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In keeping with the commitment to engagement and co-production, staff and stakeholders will continue to be involved in shaping and informing the actions that are being planned and in reviewing progress. Responses to the early engagement and consultation will continue to inform future implementation plans, and additional techniques, such as focus groups, may be used to support the planning process. The process will also build on well-developed partnership arrangements at both national and local level involving the Scottish Government, NHSScotland employers, trades unions and professional organisations.

4.3   Priorities for action

The commitments in *Everyone Matters* have been grouped into five areas which represent the long-term priorities for delivering the workforce vision. A matrix showing how the commitments have been grouped is available from the workforce vision website (www.workforcevision.scot.nhs.uk). The priorities may evolve over time to reflect current and emerging issues as the need to address them increases.

Each annual implementation plan will focus on a small number of actions in support of each priority. These actions are expected to commence during the period of the plan. For completeness, work already planned or underway will be referred to but not detailed in the plans.

4.4   Monitoring and reporting arrangements

Progress will be monitored through Local Delivery Plans (LDPs), supported by the Staff Governance monitoring arrangements and results from staff surveys. The Annual Review process will also have a role to play in taking stock of progress.

Annual monitoring and reporting cycle

NHS Boards are expected to use existing monitoring information, staff survey results, inspection and audit reports, and other sources of intelligence, including feedback from patients and service users, to inform local plans and actions.

A high-level review of progress against the previous year's priority actions will be produced by the Scottish Government each year. Progress against the implementation plan priorities will be reported to key stakeholder groups and to the Health and Social Care Management Board.

4.5   Governance arrangements

The Everyone Matters Implementation Group will be responsible for producing annual implementation plans and reporting progress to the Health and Social Care Management Board.

The table below sets out the key organisations responsible for delivering *Everyone Matters* along with their high-level responsibilities.

Organisation	Responsibilities
NHS Boards	- Implementing specific actions locally - Working in partnership with others responsible for delivering integrated health care services, including Health and Social Care Partnerships - Supporting/leading specific actions across NHSScotland in partnership with others - Monitoring and reporting on local progress - Engaging with staff to secure their involvement and support
The Scottish Government	- Developing and publishing annual implementation plans - Leading on specific national actions and commissioning solutions - Ensuring robust governance arrangements are in place - Measuring and monitoring progress across NHSScotland - Working in partnership with stakeholders to secure their support

5. Implementation plan 2014-15

5.1 The 2014-15 plan

Over the next seven years, all NHS Boards are expected to deliver the commitments set out in *Everyone Matters: 2020 Workforce Vision*. This will not be achieved through business as usual, compliance and a tick box culture. Real, transformational change will be needed. Delivering *Everyone Matters: 2020 Workforce Vision* is everyone's business.

A series of annual implementation plans will provide a structured approach for delivering the workforce vision commitments and will outline the support that will be given to Boards. The implementation plan for 2014-15 intentionally focuses on the health service in Scotland. Once legislation for health and social care integration has been enacted, the focus will be extended beyond health to include social care.

The commitments in *Everyone Matters* have been grouped into five areas which represent the long-term priorities for action. A table showing how the commitments are grouped is provided on the workforce vision website. The diagram below shows the five priorities and how they support the *2020 Vision for Health and Social Care.*

Priorities for action
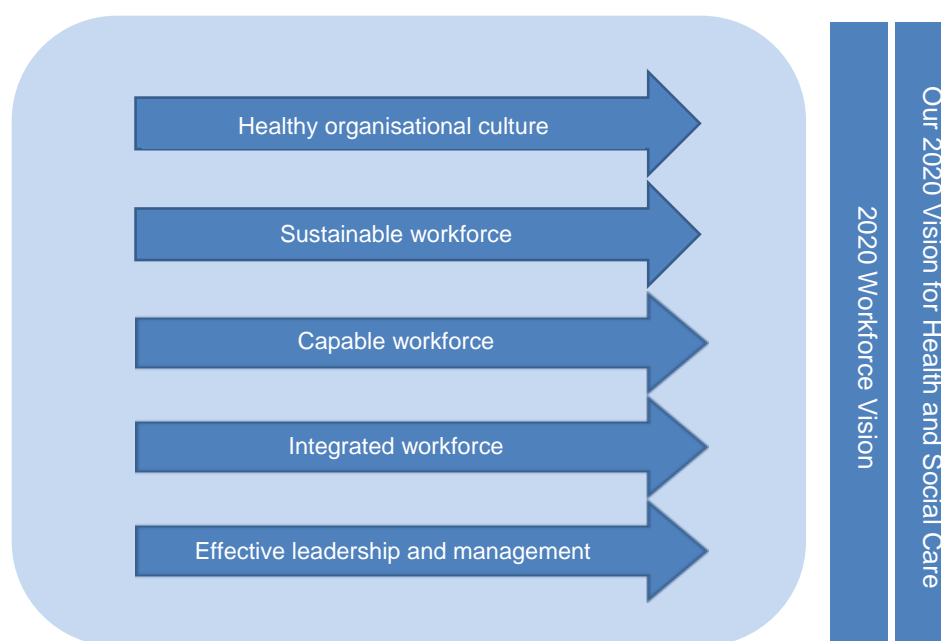
This first implementation plan is for the 2014-15 financial year. The actions in this plan support delivery of the commitments in *Everyone Matters*. This plan sets out the minimum actions that need to begin during 2014-15; some will take longer than one year to complete. Boards are encouraged to start this work as soon as possible. It is essential that progress is made as the next implementation plan will introduce new, additional actions. Progress will be monitored through Local Delivery Plans and Annual Reviews.

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When *Everyone Matters: 2020 Workforce Vision* was published in June 2013, Boards were asked to make early progress in embedding the core values. Progress against this commitment will be reviewed as a priority.

Many of the relevant systems and processes for delivering the priorities for action are already in place. The challenge we face is ensuring the actions are implemented and used in ways that reflect our shared values and support the commitments in *Everyone Matters: 2020 Workforce Vision*.

The priorities for action in 2014-15 focus on the following:

- developing and sustaining a healthy organisational culture to create the conditions for high quality health and social care. The focus this year is on embedding the shared values in everything we do.

- changing the health workforce to match new ways of delivering services and new ways of working; ensuring that people with the right skills, in the right numbers, are in the right jobs; promoting the health and well-being of the existing workforce and preparing them to meet future service needs. Strengthening workforce planning is identified as one of the early actions.

- ensuring that all staff are appropriately trained and have access to learning and development to support the *Quality Ambitions* and *2020 Vision for Health and Social Care*. The focus this year is on ensuring that development reviews/appraisals are meaningful, providing fair access to learning and development for support staff, and building capacity and capability to improve the quality of what we do.

- ensuring that the workforce is more joined-up across primary and secondary care, across Boards and with partners across health and social care. The focus this year is on developing the right conditions for an integrated workforce.

- ensuring that managers and leaders are valued, supported and developed. Managers and leaders are part of the workforce and have a key role to play in driving service and culture change. The focus this year is on supporting and developing line managers, particularly their people skills.

5.2   Guidance

This section provides guidance to NHS Boards on the implementation process and what is expected of them when working together and with partner organisations.

a) Considerable work is already being carried out locally and nationally which supports *Everyone Matters*. This plan focuses on the additional work that is needed to ensure the workforce vision becomes a reality.

b) Although responsibility for delivery rests mainly with NHS Boards, they will be supported by work taken forward at a national level, for example through the development of good practice guidance and national policy standards.

c) It may not be possible to complete some of the actions within the timeframe of this plan and additional work may be required in subsequent years.

d) An overview of progress against this first plan will be made in 2015.

e) The next implementation plan will build on this first set of actions, review the priorities and make any adjustments that are needed.

f) NHS Boards are expected to:

- make use of performance information and sources of intelligence, such as staff and patient survey results, to inform the work they do and how they prioritise local actions

- engage with staff, stakeholders and partner organisations in planning this work, building on the collaborative approach adopted so far

- ensure that the way they take this work forward reflects the NHSScotland core values and the Staff Governance Standard

- adopt a flexible approach to delivery to avoid duplication and ensure that ongoing work is sufficient and fully aligned to this implementation plan

- make connections when developing local programmes of work recognising that many of the actions in this plan are cross-cutting and support more than one priority

- ensure that effective arrangements are in place locally to monitor progress

- provide assurance, through Local Delivery Plans, that appropriate improvement work is being planned and carried out in support of the *Everyone Matters* commitments generally, and that progress is being made against the priorities and specific actions set out in this plan.

6. Priorities for action

> **Healthy organisational culture** - creating a healthy organisational culture in which NHSScotland values are embedded in everything we do, enabling a healthy, engaged and empowered workforce.

Why this matters

There is a compelling case in support of a healthy organisational culture and we know from evidence[5] that staff who are valued and treated well improve patient care and overall performance. We also know from the engagement feedback[6] with NHS staff that this as an area of concern to them. Recent reports[7] on service failures have also focused on culture, values and behaviours. However, culture change is complex, difficult and unlikely to be achieved quickly or easily, and the challenges will differ within and between organisations.

A healthy organisational culture is not about what we do, it's about how we do it. By developing and sustaining a healthy organisational culture Boards will create the conditions for high quality health and social care. **The focus this year is on embedding the shared values in everything we do.**

What we are doing

In recent years considerable work has been carried out within Boards to develop local values and a healthy organisational culture. Boards are expected to continue to take appropriate local action to support culture change as it provides a robust foundation for the developments set out below.

Actions for 2014–15

Scottish Government and others will:
Develop guidance on the core NHSScotland values and the process of embedding values
Encourage the use of NHSScotland core values to support selection onto relevant further and higher education programmes
Develop a plan for the roll-out of the *iMatter* Staff Experience continuous improvement model
Develop guidance on creating a healthy organisational culture and improving well-being.

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[5]MacLeod & Clarke (2009) Engaging for Success: Enhancing Performance Through Employee Engagement; West & Dawson (2012) Employee Engagement & NHS Performance; Boorman (2009) NHS Health & Wellbeing

[6]Scottish Government (2013) Everyone Matters: 2020 Workforce Vision, Summary of Engagement and Consultation Responses

[7] Francis (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry; Berwick (2013) Improving the safety of patients in England

NHS Boards will:
Take action to ensure that everyone is clear about the values and behaviours expected of them
Incorporate behavioural competencies (which reflect our core values) within recruitment and development reviews/appraisal processes
Roll out the *iMatter* Staff Experience continuous improvement model
Ensure that local feedback and monitoring arrangements (from patients, staff, service users etc) inform how well the core values are embedded
Engage and involve staff in decisions that affect them.

> **Sustainable workforce** – ensuring that the right people are available to deliver the right care, in the right place, at the right time.

Why this matters

Our health service is facing many challenges: growing demand, health inequalities, increasing public expectations, an ageing workforce, recruitment challenges, budget pressures and the integration of health and social care. To meet these challenges NHSScotland is changing how services are delivered. The health workforce will need to change to match these new ways of delivering services and new ways of working. We need to ensure that people with the right skills, in the right numbers, are in the right jobs. We need to promote the health and well-being of the existing workforce and prepare them to meet future service needs. **Strengthening workforce planning is identified as one of the early actions.**

What we are doing

Work is progressing to develop new service models and enhance roles in the priority areas identified in the *2020 Route Map*. These include early years, unscheduled and emergency care, and care for people with multiple and chronic illnesses. Shared services are being developed locally, regionally and at a national level to increase efficiency and ensure that resources are being invested in front-line services.

Progress is also being made in supporting healthy working lives and providing employment opportunities for young people.

Actions for 2014-15

Scottish Government and others will:
Identify and agree high impact workforce actions to support new and emerging service delivery models and ensure a more joined-up approach
Implement a national programme of work to ensure that the quality of regional and local workforce data is of the highest standard
Extend the risk assessment model of workforce planning to ensure risks are identified and mitigating actions are taken
Develop a Scottish Investment Plan to set the strategic direction for investing in the health care workforce now and in the future.

NHS Boards will:
Review their workforce planning arrangements to ensure a joined-up, consistent approach so that all services are included and benefit from the process
Demonstrate that workforce planning includes a long-term perspective and supports new and emerging service delivery models
Identify workforce risks and use this information to inform local workforce plans
Put in place measures to provide high quality workforce data and identify a lead officer with responsibility for workforce data
Ensure that workforce plans include an analysis of future education and training needs and that this is reflected in local learning and development strategies
Implement the Good Practice principles recommended by Audit Scotland in their *Early Departures* report[8] to ensure that early release schemes are driven by the needs of the Board and their workforce plans.

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[8] Audit Scotland (2013) Managing early departures from the Scottish public sector

> **Capable workforce** – ensuring that all staff have the skills needed to deliver safe, effective, person-centred care.

Why this matters

Over 150,000 people work for NHSScotland and the majority of the 2020 workforce already work here or are in training. All staff need to be appropriately trained and have access to learning and development to support our Quality Ambitions and 2020 Vision for Health and Social Care. **The focus this year is on meaningful development reviews/appraisals, providing fair access to learning and development for support staff, and building capacity and capability to improve the quality of what we do.**

Systems and processes are already in place locally to support staff development and people management, and there is much good practice. Development review/appraisal is one of the tools available. The engagement feedback shows that not all development review/appraisal discussions are meaningful, difficult issues are often avoided and that staff want this to change. The challenge is for all appraisals to be carried out effectively and reach the standard of the best.

Although support staff[9] make up over one-third of the NHSScotland workforce, their development needs are not always recognised and supported. Recent high profile events and reports highlight the important role of support staff in providing safe, effective, person-centred care. The staff engagement feedback shows that not all staff have fair and appropriate access to learning and development. This needs to change.

Going forward, more people with the right skills and knowledge will be needed to spread good practice and support service improvements across NHSScotland. We need to build capacity and capability to continually improve and meet current and future challenges. Leadership and management capabilities are dealt with later in this plan.

What we are doing

All Boards are required to have a learning and development strategy which is developed in partnership, includes mandatory training, reflects the outcomes of development reviews/appraisal discussions, and identifies actions for implementation, monitoring and evaluation. NHS Education for Scotland supports Boards with their education, training and development needs. The Scottish Government is working with partners and stakeholders to agree the future shape of the medical workforce.

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[9] More than 60,000 people work in support roles in NHSScotland, providing a wide range of services, including: direct or indirect clinical care and support to patients and service users; administrative and business services; and estates and facilities services.

Actions for 2014-15

Scottish Government and others will:
Review guidance on development reviews/appraisals to ensure they are effective and meaningful
Develop a quality improvement capacity and capability plan
Agree and develop education pathways for support workers to increase capability and support career progression
Develop guidance and provide support to help Boards make best use of national educational systems and learning resources that are available for support workers.

NHS Boards will:
Ensure that appraisers and those being appraised understand the purpose of development reviews/appraisals, their individual and mutual responsibility for ensuring it is meaningful and that conversations review whether behaviours, decisions and actions reflect our shared values
Improve the confidence, capability and capacity of everyone involved in leading and practising quality improvement
Provide fair and appropriate access to learning and development for support staff
Ensure that their Learning and Development Strategy is developed in partnership and addresses longer-term learning and development needs up to 2020.

> **Integrated workforce** - developing an integrated health and social care workforce across NHS Boards, local authorities and third party providers

Why this matters

The integration of health and social care is a key part of the Scottish Government's commitment to public service reform. The goals are to: improve the quality and consistency of services; provide seamless, joined-up, quality health and social care services; and ensure resources and staff are used effectively and efficiently to deliver services. To provide integrated services, there is a need for an integrated workforce, and joined-up working within and across primary and secondary care, across NHS Boards, local authorities and third party providers.

This implementation plan focuses only on the health service in Scotland and creating the conditions for an integrated workforce. Once legislation for health and social care integration has been enacted, the focus will extend beyond health and include social care. **The focus this year is on developing the right conditions for an integrated health and social care workforce.**

What we are doing

The Public Bodies (Joint Working) (Scotland) Bill[10] provides the framework that will improve the quality and consistency of health and social care services through integration. It is likely to be enacted around spring 2014. Work is going on to support the integration of primary and secondary care through the Primary Care Modernisation Programme.

Actions for 2014–15

Scottish Government and others will:
Develop practical guidance to support the creation of effective governance arrangements for an integrated workforce
Identify HR/workforce issues for integration to anticipate challenges and risks, and ensure that appropriate action is taken.
NHS Boards will:
Use the guidance provided to inform the appointment of Chief Officers and other joint appointments
Continue local actions and development work to support integration of primary and secondary care
Make better use of existing mechanisms, such as community planning partnerships, to identify opportunities to share resources, including workforces[11].

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[10] Scottish Parliament (2013) Public Bodies (Joint Working) (Scotland) Bill
[11] Audit Scotland (2013) Scotland's public sector workforce

> **Effective leadership and management** – leaders and managers lead by example and empower teams and individuals to deliver the 2020 Vision.

Why this matters

We know from recent events and reports[12] that the quality and kind of leadership and management we have affects how services are delivered, how staff feel about their work, and how organisations perform. The *Staff Governance Standard*[13] sets out the rights and responsibilities of staff and NHS employers to ensure fair and effective management of staff.

Delivering services that are fit for the future requires leaders and managers, at all levels across the public sector, who are visionary, work seamlessly with partners who deliver care, can make change happen, empower teams and individuals to innovate and make things better, and lead by example. They also play a key role in creating a culture of organisational learning and ensuring compliance with regulation and legislation.

Managers and leaders are part of the workforce and have a key role to play in driving service and culture change. They need to be valued, supported and developed. As we move towards 2020, investment is needed in leadership and management at all levels. This includes investing in emerging managers and leaders, as well as NHS Board Chairs and Non-Executive Directors who have a role in leading by example and demonstrating the shared values. **This year, the focus is on supporting and developing line managers, particularly their people skills.**

What we are doing

Work is ongoing locally and nationally to support leadership and management development though high quality programmes, management training schemes, toolkits, resources, expert advice, and consultancy support. This work is being taken forward in partnership with trades unions and professional organisations. Work is also planned to support the development of NHS Chairs and Non-Executive Directors.

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[12] Francis (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry; Berwick (2013) Improving the safety of patients in England; http://www.kingsfund.org.uk/topics/leadership-and-management; MacLeod & Clarke (2009) Engaging for Success: Enhancing Performance Through Employee Engagement

[13] Scottish Government (2012) Staff Governance Standard

Actions for 2014–15

Scottish Government and others will:
Develop a policy statement setting out the kind of leadership and management needed to deliver the 2020 Vision
Ensure that guidance and development support for NHS Board Chairs and Non-Executive Directors aligns with the leadership and management statement
Create a portal for information about leadership and management support, tools and resources
Ensure that national development programmes relating to leadership, management, leading quality improvement and so on reflect the leadership and management statement
Develop guidance and support for leaders and managers at all levels on people management skills

NHS Boards will:
Plan to build local leadership and management capacity and capability as part of their workforce plan to deliver the 2020 Vision
Ensure that line managers at all levels are clear about their people management responsibilities and are held to account for how they carry out these responsibilities
Identify the development, training and support needs of line managers at all levels, particularly in relation to people management, and ensure these needs are met
Ensure that leaders and managers at all levels understand and demonstrate the values and behaviours expected of them as well as their responsibilities in relation to the *Staff Governance Standard* and Quality Ambitions
Ensure that leaders and managers are aware of and abide by national governance arrangements/structures
Ensure that the approach to ongoing leadership and management development supports *Everyone Matters: 2020 Workforce Vision* and the Quality Ambitions, and reflects the leadership and management policy statement
Ensure that managers and leaders identify and focus on the strategic workforce actions needed to deliver *Everyone Matters: 2020 Workforce Vision*.

Appendix 1: Indicative timeline

Actions for Scottish Government and others	2014-15	2015-16
Healthy organisational culture		
Develop guidance on the core NHSScotland values and the process for embedding values	———————→	
Encourage the use of NHSScotland core values to support selection onto relevant further and higher education programmes	———————→	
Develop a plan for the roll-out of the *iMatter* Staff Experience continuous improvement model	——→	
Develop guidance on creating a healthy organisational culture and improving well-being	———————→	
Sustainable workforce		
Identify and agree high impact workforce actions to support new and emerging service delivery models and ensure a more joined-up approach	———————→	
Implement a national programme of work to ensure that the quality of regional and local workforce data is of the highest standard	——→	
Extend the risk assessment model of workforce planning to ensure risks are identified and mitigating actions are taken	——→	
Develop a Scottish Investment Plan to set the strategic direction for investing in the healthcare workforce now and in the future	——→	
Capable workforce		
Review guidance on development reviews/appraisals to ensure they are effective and meaningful	——→	
Develop a quality improvement capacity and capability plan	——→	
Agree and develop education pathways for support workers to increase capability and support career progression	——→	
Develop guidance and provide support to help Boards make the best use of national educational systems and learning resources that are available for support workers	——→	
Integrated workforce		
Develop practical guidance to support the creation of effective governance arrangements for an integrated workforce	——→	
Identify HR/workforce issues for integration to anticipate challenges and risks, and ensure that appropriate action is taken	———————→	
Effective leadership and management		
Develop a policy statement setting out the kind of leadership and management needed to deliver the 2020 Vision	——→	
Ensure that guidance and development support for NHS Board Chairs and Non-Executive Director members aligns with the leadership and management statement	——→	
Create a portal for information about leadership and management support, tools and resources	———————→	
Ensure that national development programmes relating to leadership, management, and leading quality improvement and so on reflect the leadership and management statement	———————→	
Develop guidance and support for leaders and managers at all levels on people management skills	———————→	

Actions for Boards	2014-15	2015-16
Healthy organisational culture		
Take action to ensure that everyone is clear about the values and behaviours expected of them	⟶	
Incorporate behavioural competencies (which reflect our core values) within recruitment and development review/appraisal processes	⟶	
Roll-out the *iMatter* Staff Experience continuous improvement model	⟶	
Ensure that local feedback and monitoring arrangements (from patients, staff, service users etc) inform how well the core values are embedded	⟶	
Engage and involve staff in decisions that affect them	⟶	
Sustainable workforce		
Review their workforce planning arrangements to ensure a joined-up, consistent approach so that all services are included and benefit from the process	⟶	
Demonstrate that workforce planning includes a long-term perspective and supports new and emerging service delivery models	⟶	
Identify workforce risks and use this information to inform local workforce plans	⟶	
Put in place measures to provide high quality workforce data and identify a lead officer with responsibility for workforce data	⟶	
Ensure that workforce plans include an analysis of future education and training needs and that this is reflected in local learning and development strategies	⟶	
Implement the Good Practice principles recommended by Audit Scotland in their *Early Departures* report to ensure that early release schemes are driven by the needs of the Board and their workforce plans.	⟶	
Capable workforce		
Ensure that appraisers and those being appraised understand the purpose of development review/appraisal, their individual and mutual responsibility for ensuring it is meaningful and that conversations review whether behaviours, decisions and actions reflect our shared values	⟶	
Improve the confidence, capability and capacity of everyone involved in leading and practising quality improvement	⟶	
Provide fair and appropriate access to learning and development for support staff	⟶	
Ensure that their Learning and Development Strategy is developed in partnership and addresses longer-term learning and development needs up to 2020.	⟶	
Integrated workforce		
Use the guidance provided to inform the appointment of Chief Officers and other joint appointments	⟶	
Continue local actions and development work to support the integration of primary and secondary care	⟶⟶⟶	
Make better use of existing mechanisms, such as community planning partnerships, to identify opportunities to share resources, including workforces.	⟶	
Effective leadership and management		
Plan to build local leadership and management capacity and capability as part of their workforce plan to deliver the 2020 Vision	⟶	
Ensure that line managers at all levels are clear about their people management responsibilities and are held to account for how they carry out these responsibilities	⟶	
Identify the development, training and support needs of line managers at all levels, particularly in relation to people management, and ensure these needs are met	⟶	
Ensure that leaders and managers at all levels understand and demonstrate the values and behaviours expected of them as well as their responsibilities in relation to the *Staff Governance Standard* and Quality Ambitions	⟶	
Ensure that leaders and managers are aware of and abide by national governance arrangements/structures	⟶	
Ensure that the approach to ongoing leadership and management development supports *Everyone Matters: 2020 Workforce Vision* and the Quality Ambitions, and reflects the leadership and management policy statement	⟶	
Ensure that managers and leaders identify and focus on the strategic workforce actions needed to deliver *Everyone Matters: 2020 Workforce Vision*	⟶	

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For more information see
www.workforcevision.scot.nhs.uk
or call 0131 244 2478

EVERYONE MATTERS:
2020 WORKFORCE VISION

Implementation plan 2015-16

NHS
SCOTLAND

healthier
scotland
SCOTTISH GOVERNMENT

Contents

2020 workforce vision and values

This implementation plan is for 2015-16. It builds on the actions in the first plan and emphasises the need to take a 'once for Scotland' approach where possible. The actions for 2015-16 will help to deliver the 2020 vision for health and social care.

NHSScotland aims to provide safe, effective and person-centred care. Our work will increasingly focus on preventing and detecting health problems and keeping people well in their own homes and in the community.

To support this overall vision, the Cabinet Secretary for Health and Wellbeing published *Everyone Matters: 2020 Workforce Vision*[1] in June 2013. It recognises the role that the workforce play in responding to the challenges that NHSScotland is facing in delivering sustainable services and in improving patient care and overall performance. All Boards are expected to deliver the commitments in *Everyone Matters*.

In December 2013, the Cabinet Secretary published the first *Implementation framework and plan*[2] which set out the arrangements for delivering *Everyone Matters.* The implementation framework has not changed. Resources giving a review of progress to date are available at www.workforcevision.scot.nhs.uk

The 2020 Workforce Vision for NHSScotland is:

> We will respond to the needs of the people we care for, adapt to new, improved ways of working, and work seamlessly with colleagues and partner organisations. We will continue to modernise the way we work and embrace technology. We will do this in a way that lives up to our core values.
>
> Together, we will create a great place to work and deliver a high quality healthcare service which is among the best in the world.
>
> *Source: Everyone Matters: 2020 Workforce Vision*

Everyone Matters: 2020 Workforce Vision makes a commitment to putting people at the centre of everything we do, and using our shared values to guide the work we do, the decisions we take and the way we treat each other.

The values that are shared across NHSScotland are:

> • Care and compassion
> • Dignity and respect
> • Openness, honesty and responsibility
> • Quality and teamwork.
>
> *Source: Everyone Matters: 2020 Workforce Vision*

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[1] Scottish Government (2013) Everyone Matters: 2020 Workforce Vision
[2] Scottish Government (2013) Everyone Matters: Implementation framework and plan 2014-15

Implementing the 2015-16 plan

This implementation plan sets out the minimum actions that need to begin during 2015-16; some will take longer than one year to complete. Boards are encouraged to start this work as soon as possible, building on their progress with the 2014-15 actions.

It is essential that progress is made on all of the actions as the next implementation plan will introduce additional actions. Progress will be monitored mainly through Local Delivery Plans.

In implementing the actions in this plan, and those carried forward from 2014-15, NHS Boards are expected to:

- make use of performance information and sources of intelligence, such as *iMatter*, staff and patient survey results, to inform the work they do and how they prioritise local actions

- engage with staff, stakeholders and partner organisations in planning this work, building on the collaborative approach adopted so far

- ensure that the way they take this work forward reflects the NHSScotland core values and the Staff Governance Standard

- adopt a flexible approach to delivery to avoid duplication and ensure that ongoing work is sufficient and fully aligned to this implementation plan

- make connections when developing local programmes of work recognising that many of the actions in this plan are cross-cutting and support more than one priority

- ensure that effective arrangements are in place locally to monitor progress

- undertake tests of change in relation to new ways of working and delivering services

- ensure that all learning and development programmes reflect the vision, values and five priorities in *Everyone Matters.*

Support for NHS Boards in implementing *Everyone Matters,* including case studies and links to relevant policies, is available on the workforce vision website (www.workforcevision.scot.nhs.uk).

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Priorities for action 2015-16

Healthy organisational culture – creating a healthy organisational culture in which our NHSScotland values are embedded in everything we do, enabling a healthy, engaged and empowered workforce. **The focus this year is on ensuring behaviours consistently live up to expectations.**

Scottish Government and others will:
Provide organisational development support and tools to NHSScotland Boards.
NHS Boards will:
Promote and recognise the behaviours of individuals and teams at all levels which reflect our values.

Sustainable workforce – ensuring that the right people are available to deliver the right care, in the right place, at the right time. **Strengthening workforce planning continues to be the focus this year.**

Scottish Government and others will:
Collaborate to make better use of analysis, intelligence and modelling of education and workforce data to inform longer-term planning
Refresh workforce planning guidance taking a three-year approach which takes account of the challenges of a multi-disciplinary workforce
Develop an integrated workforce planning approach across the wider workforce with other partners.
NHS Boards will:
Use high quality workforce data and contextual information to inform local workforce plans
Ensure that recommendations from the Working Longer Review around occupational health, safety and wellbeing are fully implemented and that flexible approaches are taken.

Capable workforce – ensuring that everyone has the skills needed to deliver safe, effective, person-centred care. **The focus this year is on developing a more consistent, Scotland-wide approach to learning and development**.

Scottish Government and others will:
Develop a learning and development framework and career pathways taking account of prior learning, particularly for support workers
Provide ongoing investment in developing Quality Improvement[3] capability across the workforce to meet the growing demand for these skills.
NHS Boards will:
Ensure that everyone has a meaningful conversation about their performance, their development and career aspirations
Develop the skills and behaviours required for working collaboratively and flexibly across primary and secondary care, and across health and social care.

Integrated workforce – developing an integrated health and social care workforce across NHS Boards, local authorities and third party providers. **The focus this year is on working with colleagues and partner organisations to implement integrated health and social care workforce arrangements.**

Scottish Government and others will:
Develop a shared approach to Quality Improvement and skills development across health and social care.
NHS Boards will:
Work with partners toward the Health and Wellbeing Outcomes[4] developing a shared culture, values and ways of working through effective teams and local partnerships
Provide leadership to continue to support the integration of primary and secondary care recognising the role of GPs, dentists, pharmacists and others as part of the workforce.

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[3] NHS Education for Scotland (2011) The Administrator's Guide to Quality Improvement
[4] Scottish Government - Health and Wellbeing Outcomes

Effective leadership and management – leaders and managers lead by example and empower teams and individuals to deliver the 2020 Vision. **This year, the focus is on ensuring effective leadership for change.**

Five priorities have emerged that will guide this work:

- Cross sector working
- Adopting values driven approaches
- Making space for honest dialogue to improve performance, sustain good performance and tackle poor performance
- Strengthening management at all levels but with a particular focus on middle management, talent management and succession planning
- Leading teams and engaging people.

Boards should ensure that the way they take this work forward reflects the NHSScotland core values and the Staff Governance Standard.

Scottish Government and others will:
Support the delivery of work on the five leadership and management priorities.
NHS Boards will:
Build leadership skills to lead/drive Quality Improvement
Ensure leaders at all levels and in all professions have the skills to support the workforce through change.

Appendix: Indicative timeline

The table below gives an indicative timeline for Scottish Government and others to complete the new actions for 2015-16 and the actions carried forward from 2014-15. The arrows indicate the start and completion times. Actions for completion during 2014-15 are not included.

Actions for Scottish Government and others	2014-15	2015-16	2016-17
Healthy organisational culture			
Provide organisational development support and tools to NHSScotland Boards		→	→
Develop guidance on the core NHSScotland values and the process for embedding values	→	→	
Encourage the use of NHSScotland core values to support selection onto relevant further and higher education programmes	→	→	
Develop guidance on creating a healthy organisational culture and improving wellbeing	→	→	
Sustainable workforce			
Collaborate to make better use of analysis, intelligence and modelling of education and workforce data to inform longer-term planning		→	
Refresh workforce planning guidance taking a three-year approach which takes account of the challenges of a multi-disciplinary workforce		→	
Develop an integrated workforce planning approach across the wider workforce with other partners		→	→
Identify and agree high impact workforce actions to support new and emerging service delivery models and ensure a more joined-up approach	→	→	
Capable workforce			
Develop a learning and development framework and career pathways taking account of prior learning, particularly for support workers		→	
Provide ongoing investment in developing Quality Improvement capability across the workforce to meet the growing demand for these skills		→	→
Integrated workforce			
Develop a shared approach to Quality Improvement and skills development across health and social care		→	→
Identify HR/workforce issues for integration to anticipate challenges and risks, and ensure that appropriate action is taken	→	→	
Effective leadership and management			
Support the delivery of work on the five leadership and management priorities		→	→
Create a portal for information about leadership and management support, tools and resources	→	→	
Ensure that national development programmes relating to leadership, management, and leading quality improvement and so on reflect the leadership and management statement	→	→	
Develop guidance and support for leaders and managers at all levels on people management skills.	→	→	

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The table below gives an indicative timeline for Boards to complete the new actions for 2015-16 and the actions carried forward from 2014-15. The arrows indicate the start and completion times. Actions for completion during 2014-15 are not included.

Actions for Boards	2014-15	2015-16	2016-17
Healthy organisational culture			
Promote and recognise the behaviours of individuals and teams at all levels which reflect our values		→————————→	
Sustainable workforce			
Use high quality workforce data and contextual information to inform local workforce plans		→——→	
Ensure that recommendations from the Working Longer Review around occupational health, safety and wellbeing are fully implemented and that flexible approaches are taken		→——→	
Capable workforce			
Ensure that everyone has a meaningful conversation about their performance, their development and career aspirations		→————————→	
Develop the skills and behaviours required for working collaboratively and flexibly across primary and secondary care, and across health and social care		→————————→	
Integrated workforce			
Continue local actions and development work to support the integration of primary and secondary care	→——→		
Work with partners toward the Health and Wellbeing outcomes developing a shared culture, values and ways of working through effective teams and local partnerships		→——→	
Provide leadership to continue to support the integration of primary and secondary care recognising the role of GPs, dentists, pharmacists and others as part of the workforce		→——→	
Effective leadership and management			
Build leadership skills to lead/drive Quality Improvement		→————————→	
Ensure leaders at all levels and in all professions have the skills to support the workforce through change.		→————————→	

Dear Colleague

REVISED WORKFORCE PLANNING GUIDANCE 2011

Purpose

1. To provide NHS Boards (and their component services) with a consistent framework to support evidence based workforce planning. The key aims of this framework are to ensure the highest quality of care for patients by ensuring NHSScotland has the right workforce with the right skills and competences deployed in the right place at the right time.

2. This guidance is designed to support and assist those responsible for leading on workforce planning, in particular the development of workforce plans at service, NHS Board and regional level. The guidance will also be of assistance to those in other areas of planning, most notably within financial and service planning functions, and in integrating health and social care planning.

3. This guidance supersedes HDL (2005) 52.

Background

4. Workforce planning is a statutory requirement and was established in NHSScotland (NHSS) in 2005 with the issuing of HDL (2005)52 "National Workforce Planning Framework 2005 Guidance"[1], which provided NHS Boards with a base for establishing workforce planning as a key element of the wider planning systems within NHSS.

5. The original HDL was developed at a time when workforce planning was a new development in NHSScotland. There has been discussion at NHS Board level for some time about the need to refresh the workforce planning guidance and to ensure that the methodology could be used by other areas of planning, most notably within financial and service planning. Particularly as we are seeing significant changes in the skill mix of staff groups and consequences of changes in one staff group on other groups it is crucial that NHS Boards use the evidence available to them to develop their workforce plans and workforce projections.

6. This refreshed guidance was drafted by a Drafting Group which included NHSScotland colleagues, partnership representation and Scottish Government.

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[1] http://www.scotland.gov.uk/Publications/2005/08/30112522/25230

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Healthcare Quality Strategy

7. This guidance sits within the Healthcare Quality Strategy for NHSScotland (published in May 2010)[2] which aims to build upon quality healthcare services in Scotland and ensure all work is integrated and aligned to the Quality Ambitions[3] with measurable improvements which include patients' experience to deliver the highest quality healthcare services to people in Scotland and in doing so provide recognised world leading quality healthcare services. This guidance will help NHS Boards to demonstrate in their Workforce plans how they contribute to better quality of care and outcomes for patients and deliver the Quality Ambitions.

Six Steps Methodology Format

8. The format of the guidance reflects the 6 Step Methodology[4] to Integrated Workforce Planning and contains workforce planning checklists at each step of the process and sign-posts to other data and information sources that will be of particular help in ensuring that workforce plans are evidence based.

9. This guidance (provided in Annex A) should be used by NHS Boards as part of the service improvement methodology to identify key workforce issues that support future models of care/ service delivery and how they will ensure the highest quality of care for patients. It also provides a tool to:

- Ensure closer integration between NHS Boards and social care providers in planning the wider workforce.
- Identify the key learning and educational needs of the existing and future workforce, the evidence of which will inform national education and training requirements.
- Reference the evidence and material that will support the wider planning agenda (including finance and service planning).
- Ensure that in developing workforce plans they support corporate goals and objectives.
- Take account of the guiding principles of workforce planning (as set out in Annex B).

Workforce Projections

10. The guidance and six steps methodology refer to workforce projections as part of the wider workforce planning process and you will be aware that SGHD has required NHS Boards to submit projections annually for several years, in part to enable us to develop a national picture of likely trends across all staff groups but specifically to inform annual student intake to the "controlled" groups (medical, dental and nursing and midwifery). You will also be aware that the projections exercise in 2011 raised a number of issues around the challenges of making meaningful projections for year 5 in current circumstances. We have reflected on that and will make changes to the process from next year. We will continue to issue a template for workforce projections, which will include specific guidance on coverage and completion, but will require detailed projections for most staff groups for a 3 year period only. This will align the projections exercise with the normal Spending Review period which provides a higher degree of planning certainty than could be offered for the longer term. The longer term continues to be important. However, in terms of SGHD setting undergraduate numbers for the "controlled" staff groups of medical, dental and nursing and midwifery. Medical and dental are already subject to separate longer term planning processes from which undergraduate intake is derived and those groups have therefore been excluded from the longer term element of workforce projections in recent years. For next year and beyond, we will similarly undertake a

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[2] http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/NHSQuality/QualityStrategy

[3] http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/NHSQuality/qualityambitions
[4]
http://www.healthcareworkforce.nhs.uk/resource_library/latest_resources/six_steps_refresh.html

parallel review of nursing and midwifery workforce over the longer term in order develop more robust recommendations to Ministers on student nurse and midwifery intake.

Summary

11. Significant progress has already been achieved and workforce planning has demonstrated a flexible, integrated approach with service and financial planning arrangements to meet the demands of NHSS. This revised guidance will not only help support those involved in developing workforce plans and projections but will also support workforce planning capability by providing of a consistent framework, and lead to a further step change in workforce planning across NHSS and social care providers.

Timing

12. This guidance should be used for the development of NHS Board Workforce Plans from 2012. NHS Boards should publish their Workforce Plans on their NHS Board's website by 30 June of each year and submit their workforce projections to Scottish Government on the agreed template, which will be issued in due course, by the same date.

Action

13. NHS Chief Executives are asked to ensure that the framework provided is used to develop their Board Workforce Plans from 2012 and specifically to ensure:

- **That integrated workforce planning is effectively undertaken to meet local, regional and national requirements.**

- **Workforce planning leads are identified to co-ordinate workforce planning and the development and reporting of workforce plans within NHS Boards.**

- **NHS Board Workforce Plans identify how they contribute to the highest quality of care for patients as set out in the Quality Strategy.**

- **That NHS Boards have systems in place to support the provision of quality workforce data, and the delivery of the National Data Quality Standard.**

- **NHS Board Workforce Plans have been developed in line with local partnership and staff governance arrangements as well as reflect an integrated approach with other planning agendas at local, regional or national levels. This is particularly important in demonstrating the integration with social care providers.**

- **For the nursing and midwifery workforce, professional validated workload measurement and workforce configuration tools should be used. NHS Boards should reference the national nursing and midwifery workload and workforce planning tools (as appropriate) used in deriving the nursing numbers for each clinical area (as appropriate). These tools should be used as part of the triangulated approach incorporating professional judgement with quality measures.**

Yours sincerely

Ricky Verrall

RICKY VERRALL
Deputy Director for Workforce Planning and Development

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REVISED WORKFORCE PLANNING GUIDANCE 2011 – REFRESH OF HDL 52 (2005) WORKFORCE PLANNING FRAMEWORK

Background

1.   Workforce Planning has progressed significantly since 2005 and now supports a strategic and longer term portfolio encapsulating core elements of service and financial planning, identifying education and training needs, socially responsible recruitment and issues around workforce sustainability. This allows for factors influencing developments within the public sector, particularly in areas such as service redesign, the appropriate deployment of staff and the achievement of productivity and efficiency targets.

Why we workforce plan

2.   Effective workforce planning ensures that services and organisations have the necessary information, capability, capacity and skills to plan for current and future workforce requirements. This means planning a sustainable workforce of the right size, with the right skills and competences, which is responsive to health and social care demand and ensures effective and efficient service delivery across a broad range of services and locations. This is particularly important as an increasing amount of service is moving towards community based care.

3.   The constantly changing dynamics of service provision and a mobile labour market make it challenging to achieve perfect alignment of workforce supply and demand. However, by applying a systematic and consistent approach to workforce planning, NHS Boards can anticipate and respond proactively to changes in workforce supply and demand. Workforce planning also relates to the preparation of our existing workforce to meet future service need through education and development pathways.

4.   The collection and analysis of this workforce evidence and information at national level (including the staff projections exercise using the agreed template) enables the Scottish Government and education providers to have a comprehensive picture of skill requirements across the NHSScotland workforce. This process also identifies a national picture of workforce availability, identifies any hard to recruit to posts and covers all staff employed in NHSS. The process also covers the non-clinical workforce and will be used to support the national commissioning processes for medical, dental and nursing and midwifery training.

5.   The term *Workforce Planning* can be used to describe a number of different yet related activities, these being:

Designing the future workforce
This is not just about service redesign and workforce alignment, but understanding and influencing the impact that redesigned and new services will have on the current or future workforce - ensuring that these workforce implications are considered as part of the service and financial planning process.

Developing the future workforce
This is about understanding what skills and competences will be needed to deliver service redesign and new services, where these skills and competences will come from and making provision to develop these skills and competences if they are not already available within the current workforce. This includes education commissioning, staff development, plus the recruitment and retention process.

Delivering the future workforce
This is about the management actions which are needed to ensure that the workforce is engaged, that new ways of working are achieved, that workforce development plans are delivered and that best practice is shared and adopted.

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NHS Board Workforce Plans

6.　　Although workforce planning is an ongoing process, NHS **Board Annual Workforce Plans should signed off by the NHS Board Chief Executive and formally published on NHS Board's websites by 30 June of each year.** The structure of these workforce plans should reflect the steps provided in this guidance.

7.　　NHS Boards should ensure that the workforce planning principles lie at the heart of their approach, in particular applying the tests, where possible, of **affordability, availability and adaptability** in developing sustainable and robust outcomes (definitions included in Glossary).

8.　　Changes to the economic climate may also impact on the wider population in relation to the health of the population. Workforce plans should therefore make reference to local labour markets and describe strategies that support socially responsible recruitment, which underpins local economies and the health inequalities agenda.

Regional Workforce Planning

9.　　The methodology and process provided in this refreshed guidance (CEL 32 (2011) can be used at local, regional or national level and the NHS Board Workforce Plans developed using it will support and inform regional workforce planning.

NHS Board Workforce Projections

10.　　Workforce projections (part of Step 3) only present part of the picture in predicting workforce requirements. With advances in medicine, new technology and drug treatments, and new ways of delivering services, medium to long term numerical projections are challenging. However, the majority of the future workforce is the current workforce, therefore projected workforce planning needs to allow for the development of the existing workforce to meet future predicted population and service need. It is the skills the workforce possesses, that will support the quality and governance agenda. Workforce education priorities can be identified through population and service profiles, and used to inform workforce personal development planning and education and training.

11.　　Detailed NHS **Board Workforce Projections should be submitted to the Scotish Government on the agreed template, which will be issued separately, by 30 June of each year.** The detailed narrative contained within the NHS Board Workforce plans will inform the completion of the template. Completed templates will be signed off by the NHS Board Chief Executive. In the case of the Nursing & Midwifery workforce projections, the Board Nurse Director should have professional oversight of the numbers and endorse these as part of the NHS Board Workforce Plan. NHS Boards should provide details of the workload/workforce planning tools used (where available) in the planning of their nursing and midwifery workforce.

12. SGHD will issue a template for workforce projections annually, which will include specific guidance on coverage, time horizons and completion. NHS Boards' projections, alongside the actions identified in workforce plans, should be informed by consideration of the short, medium and long terms (see Step 5 at Annex A) but detailed projections for most staff groups will be required for a 3 year period only, to align with the usual Spending Review period. Longer term workforce trends for the groups for which student intake is "controlled" (medical, dental and nursing and midwifery) will take into account the 3 year projections and other elements of NHS Boards' workforce plans, but will be considered further in more detailed parallel processes from which annual student intake numbers will be derived.

Workforce Data Quality

13.　　The quality of workforce data impacts on all workforce related organisational decisions, including the measurement of performance, for example sickness absence and workforce productivity and efficiency. A great deal of progress has been made in relation to

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data quality both at local and national level, but it is imperative that NHS Boards have in place adequate structures to effectively produce, manage and maintain data quality. NHS Boards need to be able to demonstrate implementation of the National Data Quality Standard, and have robust systems in place to provide assurance that all staff involved in the workforce data coding are working to the required standard. NHS Boards should also have systems to identify and rectify data inaccuracies.

14.   To ensure the continued improvement in the quality of workforce information and the delivery of the National Data Quality Standard, it is important that NHS Boards make sure provisions are in place to ensure the accurate capture of workforce information. Each NHS Board should have an identified lead to ensure data quality and workforce information, is monitored, and accurately captured on an ongoing basis.

15.   NHS Boards will be required to establish information systems which allow for benchmarking across NHSS. In addition, NHS Boards will utilise consistent national data sources to align population and labour market information to inform workforce planning and education and training priorities.

Staff Governance and Partnership Arrangements

16.   Workforce Planning is a key component of the NHSS Staff Governance Standard[5] in terms of underpinning the delivery of efficient and effective patient centred services across NHSS. Boards should evidence how workforce planning has been embedded in the partnership working agenda and demonstrate workforce and partnership engagement in the development of workforce plans.

17.   NHS Board and Committee papers should include ongoing assessments of any workforce implications as part of core business to ensure workforce demand and supply profiles remain reflective of organisational developments. This should also include an ongoing assessment of education and training needs.

18.   In line with Equality and Diversity requirements, NHS Boards should ensure a Rapid Impact Assessment/Planning for Fairness Process is applied prior to the publication of workforce plans.

Drivers for Change

19.   Workforce plans should articulate the drivers for change and 'levers' and the impact these will have on the future workforce and ultimately on the provision of future services. These drivers for change and 'levers' will have an impact on the levels of demand for future workforce numbers and skills as well as the ability to ensure a ready supply of workforce resources.

20.   Everything that happens in NHSS should be in line with the ambitions of the Quality Strategy and should contribute to measureable improvement. NHS Boards should consider how their workforce plans acknowledge the Quality Strategy Quality Outcomes that in turn represent the key outcomes we expect to achieve in pursuit of the three Quality Ambitions. NHS Boards should articulate how these may impact on future services identifying workforce solutions that ensure:

- People have the best start in life and are enabled to live longer healthier lives
- People are supported to live well at home or in the community
- Everyone has a positive experience of healthcare
- All staff feel supported and engaged
- Healthcare is safe for every person, every time
- Best possible use is made of available resources

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[5] http://www.staffgovernance.scot.nhs.uk/what-is-staff-governance/staff-governance-standard/

21.   As a companion document to the Quality Strategy, the Efficiency and Productivity Framework[6] for SR10 (published February 2011) provides the direction of travel for NHSS to improve   quality   while   reducing   overall   cost.

Demographic Influences

22. The changing pattern of Scotland's future demographic profile will play a pivotal role in shaping the number and type of health services required as well as how and where these will be delivered. It is imperative that in developing fit for purpose workforce plans, NHS Boards are able to demonstrate how changes in future service demand and workforce supply based on population need can be managed. Annex D provides some suggested data sources.

Education and Training

23.   A core element of NHS Board workforce planning function is the identification of organisational education and training requirements to ensure the workforce has the capability and competency to meet current and future service and population need. The national aggregation of this data will influence commissioning and provide a regional picture of supply variances and education requirements.

24.   An appropriately skilled, competent and deployed workforce is essential to achieve performance targets and meet local, regional and national objectives. Therefore integration with service and financial planning systems is essential to ensure that the workforce impact is accounted for as an integral component of integrated service planning.

Workforce Planning Capacity and Capability

25.   Investment in workforce planning education has been made at NHS Board and national level. This has embedded workforce planning within NHSS and enabled the sharing of responsibility across a range of services and professions, thereby ensuring a step change in workforce planning capacity and capability across NHSS.

26.   More specifically workforce planning will:
*   Ensure corporate ownership and support organisational goals and objectives.
*   be consistent and evidence-based
*   Operate out-with traditional boundaries and across NHSS and other public sector partners.
*   Support service re-design, new ways of working and achieving key targets. .
*   develop and deploy the workforce based on population need
*   Focus on future staffing requirements linked to issues of productivity and efficiency.

6 Steps Methodology

27.   The 6 Steps Methodology sets out a consistent, practical framework that outlines the elements that should be contained in workforce plans whether they are at service, NHS Board or Regional level. The guidance provided in Annex A describes the components which should be included in each part of the NHS Board Workforce Plan.

December 2011

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[6] http://www.scotland.gov.uk/Resource/Doc/341668/0113614.pdf

6 Steps Methodology Guidance

The following guidance outlines the components that should be included in each step of the NHS Board Annual Workforce Plan.

Step 1 - Defining the Plan

This is the first step in any planning process. NHS Boards should stipulate why a workforce plan is necessary and how it will support the achievement of wider corporate goals and objectives. The purpose, scope and ownership of the workforce plan should be made explicitly clear within this section. To support this, the following information/ data should be considered/ acknowledged at this stage.

Within this section, NHS Boards should provide:

- An overview of the organisation, including, the geography and lay out of the NHS Board area. In addition information on the number and type of services provided along with information on the overall size of the workforce should be provided.

- A clear statement on the purpose and objectives of the workforce plan should be outlined at this stage. This must reflect how the workforce plan links to the achievement of the main goals and objectives of the organisation and in turn supports consistent corporate communication.

- A description of the agreed outputs to be achieved from developing the workforce plan and how these will impact across other service areas within the NHS Board should be highlighted.

- A description of the workforce engagement and partnership working and consultation which supports the Workforce Planning function.

- A description of the Workforce Planning process adopted including reference to agreed governance arrangements and details of workforce engagement and Partnership involvement.

- An update on the actions identified from the previous year's Workforce Plan, indicating any timeframes set against those actions that are being carried forward.

Step 2 - Service Change

This section should indicate the goals and benefits of change, the future context for how services will be delivered, identify the options for future service delivery, the drivers for and/or constraints against future changes and what any preferred option(s) might look like.

This step is an excellent way of ensuring appropriate engagement with a range of stakeholders in the planning process. From here is it possible to determine the specific benefits, goals and objectives of any future service delivery. It is also possible to begin to create a range of service scenarios for the future and how this may specifically impact on the workforce.

Care must be taken not to unduly replicate information that is available in other plans such as the Local Delivery Plan (LDP), finance plan, service plans etc. The intention is not to duplicate reams of information but to ensure that underpinning information and context is taken into consideration.

Within this section, NHS Boards should:

- Describe what the future population profile may look like and highlight the comparison with the current configuration. Reference any data and information gathered from sources such as the General Register for Scotland (GRO). A list of helpful key data sources is provided in Annex D. Need to be mindful that demographic intelligence may vary considerably between NHS Board, regional and national boundaries.

- Make specific reference to any population priorities and/or disease profile for their NHS Board area making reference to appropriate data sources such as the Director of Public Health Annual Report, Scotpho and ISD Scotland (Annex D).

- Describe any known current financial issues facing the organisation as well as those anticipated in the medium to long term. This should already be reflected as part of the Finance Plan and the Local Delivery Plans.

- Describe any major service changes or changes resulting from service redesign which will or are likely to be taken forward in the future, articulating the impact these may have on the future workforce configuration.

- Describe any additional drivers and constraints on the delivery of future services. These would include issues such as economical environment, the political landscape, therapeutic advancements, patient attitudes/expectations, care/service pathways, changes in service location etc.

- Describe the corporate goals and/or targets that will impact on the workforce planning agenda and vice versa. Examples should include Health Efficiency, Access and Treatment (HEAT) targets[7], LDP, the Quality Measurement Framework and any agreed workforce productivity and efficiency targets.

- Describe the key strategies which are influencing service demand and configuration.

- Describe the workforce implications from strategic projects/developments already agreed by the NHS Board – set out in an action plan with short, medium and longer term timescales.

- Consider any integrated services with key partners including for example links with social care.

- Highlight any local issues being resolved across NHS Board boundaries with partner agencies and/or on a regional basis, e.g. Managed Clinical or Obligate Networks.

Step 3 – Defining the Required Workforce

This step should outline the workforce required to meet the predicted service needs and requires all of the key issues local and national which will impact on workforce design and deployment to be taken into account.

Within this section, NHS Boards should:

- Describe the required skills and competencies respond to predicted population and service need, with the objective of establishing a responsive competency based workforce.

- Highlight any workforce reporting requirements as well as any agreed workforce projections.

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[7] http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/17273/targets

- Describe the need for changing skill sets influenced by, for example, further shifts towards neighbourhood based care, demographics, changes in treatment pathways and technical and medical advances. The geography of service provision should also be accounted for as these may have an impact on the design of the workforce, the availability of the required skills with the local area, the availability of training provision, and the adaptability and retention of staff.

- Use modelling tools such as the Workforce Modelling Tree approach provides a useful planning tool that can be used to visualise and model the current and future shape and size of the workforce, showing ratios and cost.

- Ensure there is parity across the Career Framework in describing vocational and professional qualifications and development needs of staff. The Scottish Credit Qualification Framework[8] will act as the central framework to establish the required level of education for staff.

- Describe the requirements for new roles. The declaration of this within NHS Board Workforce Plans allows for alignment with other NHS Boards undertaking similar work, it also allows NHS Education Scotland (NES) to be informed of development need.

- Workforce projections are part of this Step and will be collected by completing the template agreed by Scottish Government. The use of professional validated workload measurement and workforce configuration tools should be used to assist the calculations. For the nursing and midwifery workforce NHS Boards should reference the National Nursing and Midwifery workload and workforce planning tools (as appropriate) used in deriving the nursing numbers for each clinical area (as appropriate). The tools should be used as part of the triangulation approach incorporating professional judgement with quality measures.

- Describe the systems and forums they have in place to establish data quality standards and to resolve identified data quality issues.

- It is important to acknowledge that projections do not just relate to numerical or short term affordable projections. The projections should also relate to the preparation of existing workforce to meet future service need through education and development pathways.

Step 4 – Workforce Capability

This section should describe the characteristics of the current workforce (i.e. baseline data), how any supply data can inform workforce forecasting and to identify what options can be implemented in managing future supply.

Within this section, NHS Boards should:

- Describe the provision of available workforce data to inform the development of the workforce plan. NHS Boards should also share what data quality measures have been put in place along with local governance arrangements that allow for robust workforce planning outcomes.

- Undertake to present a profile of the workforce covering individual staff/ professional groups. One of the options at this stage would be to present the profile of the workforce in the form of a Workforce Tree model.

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[8] http://www.scqf.org.uk/The%20Framework/

- Highlight any trend data on vacancies outlining any known recruitment hotspots as well as an indication as to whether this is a local, regional or national issue.

- Provide an outline on the expenditure and usage associated with supplementary staffing. This would include analysis on Bank, Agency and Locum deployment.

- Highlight the expenditure made against overtime, excess and part-time hours; and enhanced hours.

- Outline the breakdown of contracted sessions for the Consultant workforce, with particular reference to Direct Clinical Care (DCCs), Extra Programmed Activities (EPAs), Supporting Professional Activities (SPAs) etc. Further information stemming from the Consultant Job Planning process should also be highlighted at this stage (at data level which does not identify individuals).

- Review the local economy, in particular the available labour market, making reference to any labour market statistics including issues such as youth unemployment.

- Describe socially responsible recruitment practices being undertaken/ proposed that may support the appropriate supply of workforce in the future. Examples would include Work Experience placements, Modern Apprenticeships and local initiatives such as the Health Academy model where clear, structured and supported pathways have been developed to enable people from marginalised groups to access employment opportunities.

- Describe any known or projected skill gaps across service/ staff group boundaries making reference to the NHS Career Framework. This has the potential to be aggregated by Scottish Government to present a Scotland wide picture that would support the need for any specific education and training initiatives to be deployed at a local or national level.

Step 5 – Action Plan

Developing your NHS Board action plan is a high priority in the process because it identifies the actions and sets out how these will be progressed and managed by the NHS Board.

Within this section, NHS Boards should:

- Set out actions indicating whether they are short, medium or longer term, relating to the following time periods:

> Short Term – up to 1 year
> Medium Term – 1-3 years
> Long Term – 3-5 years +

- Describe NHS Board progress on Actions from the previous Workforce Plan (also covered in Step 1). The template for the NHS Board action plan is provided in Annex C.

- Describe the Education & Training priorities. An integrated education and training plan should be part of the NHS Board Workforce Plan; this allows for education and development priorities to be established and understood both at local and national level.

- Describe the detail of the NHS Board Workforce Data Quality Plan and describe the structures which are in place to support the provision of data quality.

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INVESTOR IN PEOPLE

- Demonstrate workforce planning capability by describing the Board Workforce Planning structure to demonstrate the credibility, capability and competence of workforce planning function to the Scottish Government.

- Include a Knowledge and Skills/Gap analysis across the career framework aligned to the Scottish Credit Qualifications Framework (SCQF), Career Framework[9], KSF and national occupational standards to determine the different education levels required.

- Highlight hard to fill posts or any workforce issues that could be progressed at national level. This will enable the Scottish Government to establish an accurate picture of workforce challenges across NHSScotland.

- Describe the NHS Board intervention to support socially responsible recruitment helping line with tackling health inequalities and supporting local economies and infrastructure.

- Outline the NHS Board skills registers/redeployment lists to ensure that the available workforce resource is able to contribute to its potential. The majority of staff for redesigned services will already be in NHSS employment and will be matched to meet service need with the requisite skills and competences required being delivered through training and support.

- Describe future workforce shape and size of the workforce through the use of the agreed projections template (collected by Scottish Government).

- Ensure that actions and progress on stated actions are described each year, so that no actions can be removed without description of progress or amendment. This will demonstrate ongoing iterative workforce planning.

- Highlight that the NHS Board recognise the importance of outlining education requirements in a consistent way that enables NES, Skills for Health and the wider educational sector to aggregate need and develop responsive education solutions.

- Describe the risks associated with the NHS Board Annual Workforce Plan and any steps taken to mitigate or remove these risks.

Step 6 – Implementation and Monitoring

Step 6 is the monitoring process for plans, it also allows for reflection on actions and taking account of any new drivers and any unintended consequences of developments.

The NHS Board Action Plan should be iterative, therefore the actions that are described as short, medium and long term should progress in relation to the immediacy as each year's action plan is developed e.g. medium term, will progress to short term. The monitoring process will be through the agreed NHS Board Committee structure and through Scottish Government monitoring and reporting.

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[9] http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/nhsworkforce/Framework

Guiding Principles of Workforce Planning – operational

Workforce Planning will:

- Use the 6 steps approach to ensure it is efficient and effective

- Will normally be led by Workforce/HR in NHS Boards.

- Integrate with service and financial planning, as well as other planning systems such as educational and training planning.

- Apply the tests of Affordability, Availability and Adaptability.

- Designing, Developing and Delivering the future workforce

- Improve the balance and alignment of demand and supply, by ensuring that an evidence based approach is used to inform workforce planning.

Dimensions:

- Is an ongoing process

- Is part of the service improvement methodology

- Involves partnership colleagues, finance and service colleagues from across the NHS Board supported by the Chair, Chief Executive and Director of Finance.

- Takes account of any workforce targets

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Action Plan Template (see Step 5)   **Annex C**

	Description of Action	Lead	Timescale for implementation (Short, Medium or Long term)	Description of Potential impact on Workforce	Financial resources required	Progress towards implementation
1						
2						
3						
4						
5						
6						
7						
8						

INVESTOR IN PEOPLE   POSITIVE ABOUT DISABLED PEOPLE

Key Sources of data

Scotpho **-** http://www.scotpho.org.uk/home/home.asp

Community Benchmark Tool -
 The tool can be accessed by NHS staff via the following web link;

www.show.scot.nhs.uk/workforce

Projected Population of Scotland (2008 Based) - General Register for Scotland
http://www.gro-scotland.gov.uk/statistics/theme/population/projections/scotland/2008-based/index.html

ISD Scotland (www.isdscotland.org)

NHS Education for Scotland (www.nes.scot.nhs.uk)

Labour Market Statistics (www.scotland.gov.uk/Topics/Statistics/Browse/Labour-Market)

Skills for Health (www.skillsforhealth.org.uk)

Centre for Workforce Intelligence (www.cfwi.org.uk)

Scottish Public Health Observatory (www.scotpho.org.uk)

SHOW (www.show.scot.nhs.uk)

Higher Education Statistics Agency (www.hesa.ac.uk)

Office of National Statistics (www.statistics.gov.uk)

Annual Survey of Hours & Earnings (www.statistics.gov.uk/statbase/product.asp?vlnk=13101)

Key Drivers for Change

On consultation with some NHS workforce planners, we have provided a list of drivers for change which may be relevant when producing your workforce plan and projections. The list is by no-means exhaustive, rather some basic guidance on what to consider when compiling the return. Full guidance is provided in HDL 52 (2005) (Step 2)

Driver	Description
Activity	Demographics, epidemiology, population projections, local & national health issues/aims
Local Service Changes	Proposed changes to delivery e.g. opening hours, location, required workforce
Retirements & Age Profile	Changes to legislation e.g. average retirement age, projections for staff behaviour & likely retirement ages
Service Sustainability	If no changes planned, what is the requirement to deliver a sustainable level i.e. backfill for attrition, increase in activity, potential difficulties in recruitment
Forthcoming Projects	Will any have a direct impact on workforce e.g. new build, significant redevelopment
Service Redesign	Skill mix changes, changes to service delivery e.g. Junior doctors being replaced with nurse specialists
Affordability	Efficiency savings impact, effect of

	incremental drift, internal savings targets, capital projects etc
Shrinkage	Items which will reduce the on-floor time e.g. sickness absence, training, secondments, annual leave etc.
Gender	Affect on contributory hours where applicable e.g. career breaks, maternity etc
Productivity & Efficiency	Changes to productivity, reducing requirement.
New guidance	Professional/Government guidance on minimum staffing levels, changes to skill mix, responsibilities etc
Targets	New targets from Government, internal aims affecting the required workforce e.g. 25% reduction in management
Advances & New Technology	Changes to procedures/processes affecting required staff, improvements in technology reducing staffing requirement
Turnover	Slowing/accelerating/static, affect on workforce
Benchmarking	Is your NHS Board's workforce trend in-line with other boards, are there reasons why it may be different, does it highlight any workforce issues?

Definitions/Glossary

Affordable, Adaptable and Available –

- Affordable: Workforce planning projections are affordable and offer value for money.
- Adaptable: The planned workforce is trained and supported, and plans fit with those for service redesign.
- Available: There are adequate sources of supply for the planned workforce.

All medical specialties – All medical specialties include hospital, community and public health medical specialties, but exclude dental hospital, community and public health specialties. Associate Specialist – A medical practitioner appointed to the Associate Specialist grade will have worked a minimum of four years as registrar, staff grade, clinical medical officer or senior clinical officer. Two of those years are in the relevant specialty. In total, the Associate Specialist will have 10 years of medical experience since graduating from medical school.

Capability and competency - Ability and knowledge or skill to do something successfully or effectively.

Certificate of Completion of Training (CCT) – A CCT confirms that a doctor has completed an approved training programme and is eligible for entry onto the General Practice Register or the Specialist Register http://www.gmc-uk.org/doctors/aboutcct.asp

Employment – An employee may hold more than one appointment in NHSS. Their appointments may be in more than one NHS organisation, in more than one region, in more than one specialty, or in more than one grade. The 'Employment' variable will count the employee under each organisation/region/specialty/grade they work i.e. the same employee may be counted more than once.

Establishment – Number of funded posts irrespective of whether the posts are filled or not. Establishment is calculated adding the number of staff in post and the number of vacancies at a point in time. It can be measured in WTE or headcount.

Full-time – A full time employee works the full weekly conditioned hours for the grade. This will be 37.5 hours per week under Agenda for Change. Under the New Consultant Contract, the 10 Programmed Activities or 40 hours are the conditioned hours for medical staff. Note that prior to the New Consultant Contract, those working a 'maximum part time contract' with 10 sessions and those working 11 sessions were recognised as 'full time'.

Headcount – Refers to the count of individuals, allowing some to hold more than one post in different organisation. When converting Whole Time Equivallent (WTE) to headcount using average WTE, decimals are rounded up to reflect that contribution will be delivered by one individual. For example, 1.2 converted headcount would be rounded to 2 individuals. Total headcount for NHSScotland will not be equal to the sum of the headcount working in the various NHS organisations. This reflects that some individuals work in more than one organisation.

Integrated Workforce Planning – Workforce Planning means having the right people, with the right skills, in the right place at the right time. An integrated workforce plan requires workforce planners to work closely with service and financial planners and takes account of the Local Delivery Plan. This will ensure a workforce plan, which meets the needs of the population and is affordable.

Joiners – The number of employees that join a substantive post, from another staff group, another NHS Board, someone who is new to NHSScotland or someone showing as having not worked in NHSS in the last 10 years would be classed as a 'joiner'. Someone showing up 9 years ago would count as a re-joiner.

Leavers – The number of employees that leave a substantive post to move to another staff group, another NHS Board or leave NHSS.

Local Delivery Plan (LDP) - LDPs provide details of:

- risks and risk management;
- planned levels of performance for each key performance measure;
- provides financial Templates

Models of care - Model of care is a multidimensional concept that defines the way in which health care services are delivered

National Data Quality Standard - National Data Standards are essential in order for the health and healthcare data held by ISD Scotland to be of high quality. They ensure that the data are collected throughout Scotland according to the same classifications and rules and the data is interchanged between systems consistently, robustly and securely.

NHSS – National Health Service Scotland

Out of Hours – The out-of-hours period is 18.30-08.00 on weekdays, all weekend and bank and public holidays.

Part-timer – A part time employee works less that the full weekly conditioned hours for the grade.

Rejoiners – The number of employees that worked in NHSS, had a minimum break of one year and then came back into NHSS.

Socially responsible recruitment – Poverty is the greatest determinant of ill health. Socially Responsible Recruitment is about interventions to support breaking the links between poverty and ill health, these include Healthcare Academies, and inclusive and equitable recruitment to ensure we have a workforce which reflects the population we service.

Staff groups

- Clinical Staff group: This group includes Hospital doctors and dentists, General Practitioners, General Dental Practitioners, nursing and midwifery staff, Allied Health Professionals, ambulance staff, scientific, professional, and technical staff.
- Non-clinical Staff group: This group includes staff in the Administrative & Clerical, Ancillary, Senior Management, Trades and Works groups.

Stock - The headcount of individuals in a particular year.

SWISS – Scottish Workforce Information Standard System.

Turnover Rate– The number of 'leavers' during a defined period, e.g. 2009 and 2010 divided by the average number of staff in post over the period concerned. For the 2009/10 time period, the denominator is calculated as: (staff in post at 30 Sept 2009 + staff in post at 30 Sept 2010)/2.

Vacancies – Any unfilled post for which funding is agreed and a decision has been made to fill it; action to fill the post may or may not include advertising the vacancy.

Waiting Times – The difference in days from the date the decision was made by the referring person (General Practitioner, Consultant) that the patient should be admitted to the actual date of admission.

Whole Time Equivalent (WTE) – Calculated as contracted hours/conditioned hours. A widely accepted method of counting staff based on contracted hours taking into account part time working. If evaluating the overall contribution of a team of individuals who have different terms and conditions, it is necessary to measure contribution in term of contracted hours. This approach was required for the Out of Hours case study given that General Practitioners and the other staff involved (Nurses, Paramedics, and Allied Health Practitioners) had different conditioned hours.

Workforce Supply and Demand – Supply is defined as the population seeking employment in NHS. Demand is defined as the Boards requirement for a particular staffing group.

Workforce Tree – Workforce trees provide a visual representation of the NHS workforce based on the NHS career framework.

Sustainability and Seven Day Services Taskforce

Interim Report

March 2015

Introduction

In late 2013 the previous Cabinet Secretary for Health and Wellbeing set out a vision for sustainable seven day services. It focussed on providing round the clock care for those who need it the most, with a genuinely seven day service for acutely ill patients. It also stressed the importance of patients receiving the support required to move through hospital and be discharged whatever the day of the week. He recognised that the NHS had already adapted to operate on a seven day basis, but said that more needed be done to remove inappropriate variation in how care is provided at weekends. A programme was established headed by a Taskforce to drive forward progress towards that vision.

The Taskforce met for the first time in April 2014 and this interim report provides you with an update on the work undertaken to date and suggests the next steps that are required to deliver the programme.

Context for the programme

The Scottish Government's ambition is to consistently deliver high quality care, whenever patients need it.

There is a broad consensus that the delivery of appropriate seven day services will improve patient care and clinical outcomes. It is about responding to the needs of patients and ensuring that the whole system works more cohesively and effectively. It is also ensuring that patients receive the same quality of care irrespective of the day of the week.

The overall context of this work is the Healthcare Quality Strategy for NHSScotland and the 2020 vision for Health and Social Care. In the context of quality this means a recognition that the model for the services provided must reflect the needs of patients and their families, and be delivered at the right time and in the right place for that patient. We need to develop health and social care systems to meet the significant demographic and financial challenges faced by our health and social care services. NHSScotland's approach to this is articulated in the 2020 vision and we note the recent announcement from the Cabinet Secretary for Health, Wellbeing and Sport that she will work with stakeholders to develop a refreshed routemap to 2020 and beyond by summer 2015. In developing a programme to deliver sustainable seven day services, we cannot just focus on hospital care. The complex interdependencies of the healthcare system mean pressures on one part of the system will inevitably impact on another. Designing an overall service that is sustainable is crucial.

In common with all healthcare systems in the developed world, NHSScotland faces a challenge with regard to sustaining a suitably trained workforce over the next 5-10 years. The Taskforce has been asked to identify the optimal service models and consider what is needed to deliver them. We recognise that the NHS Workforce already deliver services across seven days and as the programme develops the workforce implications of it will be considered carefully in partnership with the Scottish Government, NHS Employers and Staffside. This work will link with the vision for the NHS Workforce which is set out in *Everyone Matters: 2020 Workforce*

Vision[1]. The sustainability work stream, which aims to ensure that the right people are available to deliver the right care, in the right place, at the right time, is particularly relevant. All NHS Boards are working to deliver the commitments in *Everyone Matters* and this will support the delivery of our aims around sustainability and seven day services.

We recognise the challenges which NHSScotland faces, including an increase in patients, with more complex illnesses, the rising costs of expensive new drugs and the impact of inflation. While we need to make best use of our existing resources, we recognise that there is likely to be a financial impact to this work – both in terms of costs and benefits. As part of the next stage we will require to fully assess options and financial impact.

Approach to taking forward this work

The approach we are taking to this work is to:

- Define what we mean by seven day services
- Baseline/map current service levels across a number of clinical areas
- Define the requirements for seven day services in those areas
- Identify the steps needed to ensure sustainable seven day services across NHSScotland.

The work of the Taskforce to date has focussed primarily on the first two tasks. Drawing on those findings we now propose to consider the remaining tasks and develop a programme of work to support this.

Defining seven day services

Building on the vision set out, there has been substantial discussion in the Taskforce and its supporting groups about what is meant by a sustainable, seven day service. We have agreed the following as a definition of seven day services.

"The aim of the Sustainability and Seven Day Services Programme is to ensure that people requiring healthcare have timely access to high quality, person-centred, safe and effective care when they need it, regardless of the time or day of the week, and on a basis which is sustainable in the long term. Achieving sustainability and seven day services will require a whole system approach. This will focus on:

- Ensuring that all patients requiring clinically urgent or emergency healthcare have timely access to an appropriate clinical team who can determine and deliver their care.
- Ensuring that all such patients have access to appropriate investigations and tests when they are required.
- Ensuring that all patients have continuity of care including the capacity to be discharged and supported in their discharge from hospital seven days per week.

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[1] Everyone Matters: 2020 Workforce Vision

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- Achieving the best possible outcomes and experience for patients by using available resources in a sustainable manner."

Baseline/mapping of current service levels

Given the complexity and the potential scope of this work, we are taking a phased approach. In the first phase we have chosen to focus on a number of clinical areas where patients need a seven day service. That does not indicate that other clinical areas are less important and they may be included in future phases of work. The Phase One clinical areas are as follows:

- Major Trauma
- Critical care
- Acute Surgery
- Acute Medicine
- Coronary Care
- Maternity and Neonates
- Diagnostics and Investigations
- Primary care.

To gain an understanding of the service currently provided and what the delivery models are in each of the Phase One areas, we are gathering together data and intelligence on these areas. We are also mapping the policy landscape in terms of:

- the national work which sets out the policy direction for those services
- whether the expectation of what a quality sustainable service for these areas has been articulated, and if so the stage implementation has reached.

Grounding our work in a strong evidence base will continue to be crucial in supporting the programme and we have highlighted that in our next steps.

Recognising the particular challenges of designing and delivering sustainable seven day services in remote and rural areas we are looking specifically at this aspect.

Patient and Service User Involvement

Core to the development of the Sustainability and Seven Day Services programme is ensuring that the intended outcomes are based on what is important to patients and service users, alongside their clinical outcomes. This is aligned with the strategic aim of the Scottish Government's Person-Centred Health and Care Portfolio which plans that by December 2015, health and care services are focussed on people.

The key aims of the patient and service user involvement are to:

- find out peoples' views and experiences of using services and what matters most to them, recognising that this will impact on their clinical outcomes and their ability to lead and manage their own health and care
- ensure the issues that are important to service users inform the vision for sustainable seven day services

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- ensure that people with an interest have the opportunity, and are encouraged and supported, to help shape the future of services
- comply with national participation policy and good practice in health and social care.

As part of our baseline assessment we have also reviewed what we already know about patient experience of NHSScotland, using patient and service user information and intelligence sources including data from the national Inpatient Survey and Health and Care experience survey.

To deliver our aims for patient/service user involvement we will have a patient/service user workstream. We are discussing how this might be achieved with the national Person-Centred Steering Group.

Governance

In addition to the Taskforce, a number of supporting workstream groups have been established – an Evidence and Analysis Group, a NHS Board Leads Group and a Remote and Rural Group. We have established working groups for two of the phase one areas – Acute Surgery and Neonates and Maternity to drive forward work on behalf of the Taskforce.

We also recognise the importance of linking to the range of national workstreams underway to deliver the 2020 vision and the quality ambitions, including the Unscheduled Care Programme and the Review of Out of hours primary care services.

Central to the success of the programme is the consensus which has been achieved on the need for sustainable seven day services. NHS Employers, Staffside and professions are engaged with the programme through representation on the Taskforce and supporting workstream groups. The membership of the Taskforce at time of publication is listed in Annex A. There has also been engagement with a wide range of stakeholders to share the vision on sustainable seven day services and seek their input and expertise to the programme.

The sections below describe our interim assessment of the phase one areas and some of the work being taken forward by the Taskforce and its sub-groups. This is followed by a summary and some proposed next steps.

Major Trauma

Around 1000 people per year in Scotland sustain major trauma such as severe burns or major head injuries. We know that a key factor in their outcome is the time it takes from sustaining the injury to receiving definitive care by a specialist multi-disciplinary team.

Following a review by the National Planning Forum, the Scottish Government announced plans for an enhanced network of care for major trauma patients in Scotland which could save up to 40 lives a year[2]. The plans include the setting up of four new specialist major trauma centres in Aberdeen, Dundee, Edinburgh and Glasgow. From 2016, these centres will operate as hubs within a national major trauma network designed to improve trauma care across all hospitals that deal with such cases, with all the surgical specialities and support services to provide consultant led care, 24 hours a day, 7 days a week. Patients will be taken directly to one of these centres to be assessed and treated. If the patient cannot be taken to one of these centres within 45 minutes, they will be taken to a local hospital, with advice and support provided by the Major Trauma Centre as required. Implementation of the Major Trauma network is underway and is being led by the National Planning Forum's Major Trauma Oversight Group. Good progress has been made in a range of areas, with regional major trauma working groups now well established.

We note this work which will make a valuable contribution to the provision of a sustainable seven day service and will wish to remain closely linked to its implementation.

Critical Care

Critical Care units across Scotland deal with approximately 43,000 of the most seriously ill patients a year, in Intensive care units (ICU), High Dependency units (HDU) or combined Units. Of these admissions around 14,000 are into ICU or combined units and around 28,000 are into HDUs[3]. There is strong demand for these services in the evening and at weekends, with around 20% of admissions happen on a Saturday or Sunday and a third happening overnight (between 8pm-8am).

While there is no national Quality Framework for Critical Care, there are relevant standards from a number of UK wide professional bodies – such as the Intensive Care Society. In addition, the Scottish Intensive Care Society have an agreed set of Quality Indicators[4].

Patients with clinically urgent or emergency care needs have access to Critical Care units 24 hours a day, 7 days a week at present. However available data such as that from the Scottish Intensive Care Society Audit Group suggests a degree of variation in the way care is provided across the week

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[2] Trauma patients 10% of data assumed for Scotland
[3] Audit of critical care in Scotland 2014, reporting on 2013
[4] Quality Indicators for critical care in Scotland

The National Planning Forum has recently considered the current critical care position and whether further action is required to ensure the sustainability of the service on behalf of NHS Board Chief Executives. Following consideration of an initial Critical Care Stocktake report Board Chief Executives have asked for its findings to be taken into account through the Scottish Government's work on the development of a National Clinical Strategy. We will wish to link to this work as it develops.

Acute surgery

Acute surgery covers a range of surgical specialties. Initially we are focussing on emergency general surgery, vascular surgery, urology and orthopaedics and have established an Acute Surgery Group to support this work.

Our mapping exercise has shown that acute general surgery services are currently provided on 29 sites; acute urology is provided on 21 sites[5]. In the next phase of work we will consider whether the current configuration of these services provides all the agreed components of a high quality service.

Increasingly the components of a high quality service are being described for a range of clinical services. Taking Vascular Surgical Services as an example the Quality Framework developed by the National Planning Forum in 2011 set out optimal models of care. For vascular surgery this included a population base of 800,000 and access to intensive care and complex interventional radiology. This has necessitated the development a model whereby multi-disciplinary teams provide complex vascular surgical care on a regional/cross boundary services in support of local hospitals who direct patients to such specialist units when it is required. Implementation of this framework is underway through the NHS Board regional planning structures. In some areas such as the West of Scotland implementation requires service reconfiguration, while in the North of Scotland, they are setting up an integrated vascular service for NHS Grampian and NHS Highland, delivered through a clinical network. Few would disagree that this is the correct approach to the delivery of a complex service such as vascular surgery. The implications of the requirement for safe surgery to be undertaken by large integrated teams will require to be considered in planning for a sustainable seven day service in other clinical areas.

We are also exploring the quality of decision-making and access to investigations at weekends in surgical wards across Scotland. As part of this we are undertaking a review of ward rounds at weekends in order to measure their effectiveness. Effective ward rounds improve patient care by providing an opportunity for the clinical team to:

- establish, refine or change clinical diagnoses
- review the patient's progress against the anticipated trajectory on the basis of history, examination, early warning scores and other observations, access to and the interpretation of tests and radiological investigations

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[5] http://www.isdscotland.org/Health-Topics/Finance/Costs/File-Listings-2014.asp

- make decisions about future investigations and options for treatment, including do not attempt resuscitation and any ceilings of care
- formulate arrangements for discharge
- communicate the above with the multidisciplinary team, patient, relatives and carers
- carry out active safety checking to mitigate avoidable harm.[6]

As well as emergency patients, such interactions can have a positive impact on the on-going management of non-emergency patients, enabling their care to be progressed.

While we are exploring this through our Acute Surgery Group, it is applicable across a number of the Phase One areas. Once we have gathered a picture of current practice we will wish to consider whether guidance, a checklist or some advice for NHS Boards on this issue is required.

Acute medicine

Acute medical units provide care for patients who present as medical emergencies or who develop an acute medical illness while in hospital. They play a crucial role in deciding the correct clinical pathway for such patients – whether that is discharge, transfer to a specialist ward or for the most severely ill patients transfer to a High Dependency Unit or Intensive care.

There is already considerable work underway in this area under the banner of the Unscheduled Care programme. The Scottish Government are working with NHS Boards to ensure that they have sustainable systems and processes for unscheduled care pathways which optimise patient care and satisfaction across the week. Having assessed their current services, each NHS Board has developed a Local Unscheduled Care Action Plan which identifies their priority areas for improvement. A number of the deliverables within the Unscheduled Care programme will support delivery of the sustainability and seven day services programme and are consistent with our focus on access to appropriate decision makers and timeous diagnostics. For example, there is a stream of work on Pro-active Discharge Management which seeks to eliminate unnecessary waits and delays both on the day of discharge and across seven days. Key to this is morning and weekend discharges, which require engagement with senior decision makers to provide daily ward rounds and with the range of other key clinical services such as Allied Health Professions (AHP), pharmacy, and diagnostic services, as well as transport and other support services. Communication across acute services and with community partners is key to ensuring patient flow and many initiatives to improve this are being implemented.

Similarly a number of Boards are carrying out work to better manage flow through their Accident Emergency Departments. This work focusses on appropriate assessment and diagnostics services being available to manage demand across time of day and day of the week.

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[6] Ward rounds in medicine: Principles for best practice

As the Unscheduled Care programme moves into its next phase of activity, it will adopt a collaborative approach to leading improvement and building sustainability. It will do this by focussing on six essential actions to improving safety and patient flow across unscheduled care pathways. Seven day services has been identified as key across the essential actions.

With regard to pharmacy, the Scottish Government is considering the pharmaceutical care support and follow-up patients' needs either before discharge or post discharge. This would include, for example, medication reviews by pharmacists to ensure that patients are able to manage their medicines and get the optimum outcomes from their medicines whilst minimising harm, so that readmissions due to medication related causes are avoided. While this is relevant for Acute Medicine it is equally applicable to acute surgical discharge arrangements.

The Scottish Government and the Royal College of Physicians of Edinburgh are also undertaking a research project to evaluate Acute Medical care in Scottish hospitals which will help to inform our work. The project will consider the physical, process, procedural and personnel factors in each of 28 Acute Medical Units in Scotland. It will then analyse how the differing organisational factors relate to outcome data such as mortality rate, boarding/queuing rate, length of stay, readmission rate and direct discharge rate. It will also describe the current provision for seven day services within these medical units.

In addition, The Scottish Government is engaged on a national programme to improve patient flow, working initially on 4 pilot sites across Scotland (NHS Borders, NHS Tayside, NHS Forth Valley and NHS Greater Glasgow and Clyde). This includes identifying how existing weekday capacity can be better used to deliver services including elective surgery. It is seeking to identify how we can reduce any artificial variation that can have negative effects on how patients flow through the system and the quality and experience of care provided.

As we move forward we will wish to ensure that we link closely to these pieces of work.

Coronary Care

The Scottish Government issued a Heart Disease Improvement Plan in August 2014 which sets six priority areas which will contribute to the overall aim of improving the experience and clinical outcomes for patients living with heart disease[7]. The priorities include improving secondary and tertiary care cardiology. They stress the importance of patients with heart disease receiving the right investigation and treatment, administered by skilled staff in a timely, equitable and evidence-based manner. Actions being taken forward include improved patient-centred flow into, through, between and out of hospital for patients with chest pain and the development of local and regional pathways including strategy for cardiac investigation and intervention. We will link to the implementation of this Improvement Plan as it develops.

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[7] Heart Disease Improvement Plan 2014

Also of note is the Resuscitation Rapid Response Unit – 3RU, which provides a 24/7 on scene resuscitation service for patients in cardiac arrest[8]. It was piloted in Lothians as a joint project between the Scottish Ambulance Service and the Resuscitation Research Group at the University of Edinburgh. The 3RU team – a small team of paramedics, supported by doctors, nurses, dispatchers, medical students and a resuscitation officer – has shown significantly increased survivability rates for out of hospital cardiac arrests in Edinburgh - 33% as compared to the Scottish figure of 15-20%[8]. The Scottish Government is supporting a wider roll out of this scheme with funding of £200,000 in 2014.

Maternity & Neonates

Maternity

Births in a hospital setting in Scotland, generally take place in one of 38[9] maternity units, which may be consultant led or community maternity units. In addition women may give birth outside a hospital setting such as at home or in a private hospital.

The national Framework for Maternity Care in Scotland was refreshed by the Maternity Services Action Group on behalf of the Scottish Government in January 2011[10]. It sought improvements in maternal and infant wellbeing by supporting the planning and provision of high quality outcome focussed services. A key driver for the Framework was to ensure that women and their babies were cared for by the right team of people, with the right skills in the right place. The provision of high quality maternity services is also supported by the Maternity & Children Quality Improvement Collaborative (MCQIC) which was launched nationally in March 2013 and also encompasses neonatal and paediatric activity.

All NHS Boards have adopted the framework and have integrated it into their planning for Maternity Services, prioritising and adapting the principles and service standards to reflect existing local practices and particular service requirements in their area. Scottish Government funded Maternity Champions are in place in each NHS Board area to drive and co-ordinate improvement activity associated with the Framework and the MCQIC.

Given that the Maternity Framework and MCQIC already exist and describe a high quality seven day maternity service, our next steps will be to review the implementation of the framework and the programme and identify areas where further actions might be needed to support a sustainable seven day service across Scotland. In light of the changing pattern of demand for maternity service - with an increase in the age of average mother, more multiple births and more caesareans - we will wish to consider whether the current acute care model is supporting women and their babies to be cared for by the right team of people, with the right skills in the right place.

To take forward this strand of work a Neonates and Maternity Working Group has been set up, which will report to the Taskforce. In light of the recent Scottish

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[8] Resuscitation Research Group
[9] http://www.isdscotland.org/Health-Topics/Finance/Costs/File-Listings-2014.asp
[10] Framework for Maternity Care in Scotland

Government announcement of an assessment and refresh of the model of care for maternity and neonatal services, we will consider how best to link these two pieces of work together.

Neonates

Specialist neonatal services are provided across 16 sites in Scotland[11]. The level of service each neonatal unit provides is categorised into three levels:

- Special Care / Level One
- Local Neonatal Level Two - High dependency care and short-term intensive care
- Neonatal Intensive Care / Level Three.

The Scottish Government published *Neonatal Care in Scotland: A Quality Framework* in February 2013[12]. This Framework defines the approach and the requirements for delivering high quality care for newborn infants who require care at a level greater than standard perinatal care. It describes a service model which includes regional collaborative working to implement agreed patient pathways, maximising the use of available clinical expertise and supporting units to provide the right level of care.

NHSScotland is committed to the delivery of the Framework and while each Board is responsible for implementing the Framework, the three regional Managed Clinical Networks (MCNs) are facilitating co-ordination for their regions. The Units and MCNs are now implementing plans to drive forward improvements and working on delivery of the Framework.

Given that such a framework already exists, our next steps in this phase one area will be to review the implementation of the framework and identify areas where further actions might be needed to support a sustainable seven day service across Scotland. Areas we will consider include the availability of appropriate decision makers and supporting diagnostics across seven days, ensuring that preterm babies are being cared for in the most appropriate level of facility and looking at the national and local transport arrangements that support the return of babies and their mothers, when it is clinically appropriate, to their local units.

As described above we will consider how best to link this work with the recently announced assessment and refresh of the model of care for maternity and neonatal services.

Diagnostics & investigations

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[11] [Review of Neonatal Care Services in Scotland](#)
[12] [Neonatal Care In Scotland: A Quality Framework](#)

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Diagnostic services underpin an estimated 80% of all models of care irrespective of setting and clinical pathway[13]. Delivering sustainable services across seven days will require successful diagnostic services to be at the centre of service transformation.

Our initial baseline work has focused on diagnostic imaging and interventional radiology services. There has been a notable expansion in demand for such services in recent years. For example, in 2013/14 NHSScotland performed over 200,000 MRI, 450,000 CT and 550,000 Ultrasound examinations[14]; these numbers have increased by 30%, 25% and 20% respectively since 2010/11[15].

Interventional radiology also has an important and increasing role in managing critically ill patients. We are working with the Scottish Clinical Imaging Network to review the current provision of services in out of hours periods, building on previous research that suggested that out of hours provision was variable[16]. In the next phase of work we will consider this issue in more detail.

We are also aware of new models that are being developed to provide sustainable diagnostic imaging services, such as the out of hours diagnostic imaging model being implemented in NHS Greater Glasgow and Clyde and the improvement programme to underpin the roll out of radiography plain film reporting across Scotland. We are keen to explore these further with Boards.

We will also link to work being taken forward by the Scottish National Blood Transfusion Service to review the blood banks held in laboratories across the NHS in Scotland and identify opportunities to support the sustainability of the service. This work will be supported by the Healthcare Science National Delivery Plan, due for publication in spring 2015.

Our next phase of work will consider the other Healthcare Science services, that contribute to the delivery sustainable services across seven days.

Primary care

For most people contact with NHSScotland begins and ends outwith a hospital environment. Community based healthcare services, which encompass a wide range of professional roles are a key part of the unscheduled care landscape and a sustainable seven day service cannot be delivered without them. As well as the direct treatment and care such services provide, these services play a crucial role in avoiding unnecessary admissions to hospital and supporting appropriate discharge arrangements and moving forward we will consider what further contribution community based nurses and AHPs can make to the development of sustainable services.

In out of hours periods NHS 24 is the first point of contact for most people requiring care. They receive around 1.5 million calls from patients across Scotland every year.

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[13] Health Care Science National Delivery Plan
[14] http://www.isdscotland.org/Health-Topics/Finance/Costs/File-Listings-2014.asp
[15] http://www.isdscotland.org/Health-Topics/Finance/Costs/File-Listings-2011.asp
[16] Zealley, I.A; Gordon, T.J; Robertson, I; Moss, J.G; Gillespie, I.N; Provision of out of hours interventional radiology services in Scotland – Clinical Radiology 67 (2012) 855-861.

NHS 24 receive advice over the telephone or are redirected to another service, including the Scottish Ambulance Service, the local General Practice Out of Hours service or the nearest Accident and Emergency Department. Responsibility for the provision of GP out-of-hours services rest with the 14 territorial NHS Boards.

Another option for referral or access to care is through community pharmacies. There are some 1,240 community pharmacies[17] located in our towns and communities across Scotland. Most are open 6 days a week, and NHS Boards operate a rota for out of hours which includes evenings, Sundays and public holidays. As part of the community pharmacy based NHS Minor Ailment Service (MAS), pharmacist in the community can also treat eligible patients for common and minor self-limiting conditions without the need to see a doctor. There are currently over 890,000 patients registered for MAS[18]. In addition, under Patient Group Directions, pharmacists in the community may dispense a drug, before receiving a prescription form, where the conditions for urgent supply are met and if the pharmacist is satisfied that it is appropriate to do so.

The recently announced Primary Care Out-of-Hours Services Review will review the current delivery landscape and recommend action to ensure primary care out-of-hours services:

- Are sustainable, high quality, safe and effective
- Provide access to relevant urgent care where needed
- Deliver the right skill mix of professional support for patients during the out-of-hours period. [19]

The review will look at all territorial NHS Boards' out-of-hours service models and profiles of access, demand and delivery. The range of primary care services are diverse and whilst the Review does not strictly exclude any specific service, its initial focus will be on how primary care services are provided to patients when their GP surgeries are closed. It is expected to provide recommendations by late summer 2015 and its outcome will inform the steps that are necessary to support sustainable seven day services.

Remote and rural

In recognition of the particular challenges facing the delivery of sustainable services in remote and rural areas, we have established a Remote and Rural Group sub-group to consider this issue. The Group immediately recognised that a range of initiatives have been implemented over the past decade and that much good work continues to be undertaken. In order to avoid repetition, in the first instance a review of all the existing work was undertaken and compiled as a register.

The range of existing initiatives/projects include:

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[17] Practioners Services
[18] ISD Minor ailments service publication summary
[19] Review of Out of Hours Primary Care Services

- Being Here – Scottish Government/NHS Highland programme of work to test new approaches to delivering healthcare in remote and rural areas of Scotland.
- The *Supporting Remote and Rural Healthcare* report that describes current NHS Education for Scotland (NES) initiatives to support the educational needs of the remote and rural healthcare workforce[20].
- *Being Rural* Policy and Action Plan from the Royal College of General Practitioners[21].
- The Strategy for Attracting and Retaining Trainees in Scotland (START) programme being jointly led by NES and the Dean of the West of Scotland focussing on attracting and retaining trainees, in which remote and rural issues feature strongly.
- Bespoke rural-track GP specialty training programme in the North region / NES GP rural fellowships.
- Health and social care transport pilots.

The last comprehensive review of remote and rural services *Delivering for Remote and Rural Healthcare* was published in 2008[22]. This report made a number of recommendations. These have been reviewed in order to identify those that have been successfully implemented and those areas where challenges remain. The implemented recommendations from that report that have been highly successful include the development of the Specialist Transport and Retrieval (SCOTSTAR) retrieval service and the creation of community hospitals utilising extended skill practitioners. The development of educational facilities to meet the specific needs of the remote and rural workforce has also been a notable success.

Emergency Medical Retrieval Service

A robust, rapid and effective retrieval service is an important component of any strategic plan for the delivery of sustainable remote and rural services. For the Islands and areas of rural Scotland this needs to be by air. The Scottish Government has already invested in the Scottish Ambulance Service's Air Ambulance Service, which undertakes around 3,500 missions each year. In April 2014, ScotSTAR was launched as a national service for the safe and effective transport and retrieval of Neonates, Children and Adults in Scotland. ScotSTAR has brought together three existing services (Scottish Neonatal Transport Service, Emergency Medical Retrieval Service, and Transport of Critically Ill and Injured Children) under one umbrella. This provides a vital road and air service for critically ill patients across Scotland, taking skilled clinicians directly to the patient thereby ensuring the best possible pre-hospital care.

A central base for this service is currently being constructed at Glasgow Airport and will open in summer 2015. From spring 2015 all retrievals will be centrally coordinated by a Specialist Services Desk. Draft quality standards and indicators have been developed and the outcomes for patients will be audited.

Rural General Hospitals

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[20] Supporting Remote and Rural healthcare
[21] Being Rural Policy and Action Plan from the Royal College of General Practitioners
[22] Delivering of Remote and Rural Healthcare

The Group identified that a key remaining area of challenge was the recruitment and retention of staff to work in Scotland's six Rural General Hospitals (RGHs)[23]. The NHS is not unique in this, living and working in a rural area doesn't appeal to everyone and remote and rural recruitment challenges exist at all levels and in many industries in rural areas.

For medical staff, the Taskforce have agreed to explore the establishment of formal links between individual RGHs and urban Hospitals. This will build on the current obligate networks that have successfully provided visiting specialists to RGHs for the provision of elective care. This could provide a number of benefits - patients in rural areas would have access to clinicians with skills maintained in hospitals with a high volume of cases, there could be greater opportunities for collaborative working between visiting and local staff, it could support the out of hours and emergency rota in the RGH, reduce reliance on locums and increase the number of patients treated close to home.

Several models as to how this would work in practice are being discussed. The simplest of these models has been progressed for the RGH in Fort William whereby a link for continuing professional education / development has been developed between NHS Lothian and the surgeons in Fort William. As a result two experienced surgeons have recently been recruited to positions that in the recent past attracted no suitable applicants. Surgical services in Fort William are now sustainable with three full time surgeons in position. We intend to coordinate further work with key stakeholders to consider innovative solutions to sustain the RGHs and this and other models are being explored with other NHS Boards with a view to developing further pilots. While this initial work has focussed on medical staff, this provides a model that could be used for other staff such as nurses and AHPs.

The Group have also been reviewing examples of excellent and innovative practice from rural services that may be suitable for wider implementation. A particularly interesting example is the provision of the GP out of hours Accident and Emergency /acute admissions service in Stornoway. In this model[24] GPs staff the Emergency Department overnight, supported by extended role nurses both in the hospital and in the community. This includes managing acutely ill children and neonates as well as adults. In addition to providing stainable service it is of note that in the pilot period from May 2012 to May 2013, overnight hospital admissions fell by 17% when this model was introduced. There were also marked reductions in the requests for laboratory tests (10%) and radiological examinations. A key component of the success of this model is in utilising the skills of the GPs in making judgements based on clinical examination combined with investment in developing the skills of paramedics, community nurse practitioners, emergency nurse practitioners and clinical support nurses.

Summary and Next Steps

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[23] Gilbert Bain Hospital, Lerwick; Balfour Hospital, Kirkwall; Western Isles Hospital, Stornoway; Caithness General Hospital , Wick; Belford Hospital, Fort William; Lorn and the Isles Hospital , Oban
[24] Data and information on Out Of Hours Project Pilot provided by NHS Western Isles.

The Taskforce was convened to consider the implications of delivering a sustainable seven-day clinical service across NHSScotland and to offer proposals as to how that could be achieved.

Delivering sustainable services

NHSScotland already delivers a seven-day service across a range of clinical areas. Emergency patients are admitted to hospitals across the country seven days per week and 24 hours a day. Similarly elective patients within hospitals receive care out-with the normal working day. Some NHS Boards also undertake elective operations at weekends and we note that the first allocation from the Scottish Government's Performance Fund includes an allocation to NHS Highland to support them in providing elective procedures at weekends.

While we have been considering how access to appropriate decision makers, tests and treatments can be provided when required in out of hour periods, we recognise that this cannot be considered in isolation of the service provided during the rest of the week. Improvements to care provided at weekends must be built on a sustainable workforce supported by appropriate infrastructure across the week. So while we recognise the importance of making best use of the resources we have, we need to look at new models of care rather than just stretching our existing resources across seven days.

A strong theme that has emerged is that services should be configured to ensure that people receive the care they need in the most appropriate location to deliver that care. This does not always happen at the moment. Too often, older people are admitted to hospital when a package of assessment, treatment and support in the community might have better served their needs, and maintained their independence[25]. Surveys conducted in Scotland and elsewhere, indicate that approximately a quarter of patients in acute beds in a morning no longer require healthcare in an acute setting. Approximately half of these patients are there due to healthcare related issues and many of them are waiting for a clinical decision to allow them to go home.[26] It is also important to recognise that towards the end of their lives people often move in and out of hospital, so a significant proportion of acute care patients require palliative and end of life care. A study of inpatients in Scottish hospitals suggested that almost 1 in 10 patients in teaching or general hospitals at any given time will die during that admission. Almost 1 in 3 patients will have died a year later, rising to nearly 1 in 2 for the oldest groups.[27] Models such as Anticipatory Care Planning can support conversations with patients, their families and carers and help people to think ahead and have greater control and choice over their care and support. A Palliative and End of Life Framework for Action will be published later this year and we will want to ensure that we reflect that in our work. The scale of this challenge will only increase as the service deals with the growing number of people with longer term and often complex needs, many of whom are older. The work that is being progressed to deliver the 2020 vision, including health and social care integration and the range of initiatives to avoid unnecessary hospital

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[25] Reshaping Care and Integrating health and social care in Torbay

[26] Patient flow through day of care survey

[27] Clark, D; Armstrong, M; Ananda, A; Graham, F; Carnon, A; and Isles, C; Imminence of death among hospital inpatients: Prevalent cohort study – Palliative Medicine (2014), Vol. 28(6) 474 – 479.

admissions and enable appropriate discharge from acute care are supporting the necessary change in the balance from acute care to community and primary care.

As the new integrated partnerships begin their work from April 2015, it will be important for us to engage with them on how their integrated strategic commissioning role of preventing admission and supporting appropriate discharge can support improvements in the continuity of care for patients across seven days.

Acute Care

The principle of delivering care the patient needs in the most appropriate place also applies within the acute hospital sector. Clinical care in acute hospitals is increasingly dependent on multi-disciplinary teams supported by the availability of complex technology. All of these components require to be sustainable in order to deliver a high quality service across seven days. Acute general surgery exemplifies the challenges to be faced. It is currently delivered on 29 sites but the complexity of the surgery varies. Increasingly it is recommended that surgical teams have access to an intensive care unit and interventional radiology services.

In the lead up to the implementation of the 48 hour working week for junior doctors, various work streams were undertaken looking at how to run safe and sustainable rotas. *WTD – The Implications and Practical Suggestions To Achieve Compliance*, a report done jointly by the Royal College of Anaesthetics and the Royal College of Surgeons England published in 2009, identified the minimum staff required to run a safe and sustainable rota, while providing a good work life balance was eight. The work done also shows that the number of staff needed in any workforce is dependent on the amount of cover required, how many staff are needed at certain times of the day, and the skills that are required at any particular time[28]. Therefore minimum staffing numbers covering rotas can vary significantly between different specialties and sites. Importantly they require a sufficient population base/case load to ensure that the health professional can maintain their skills.

This dilemma has been addressed for vascular surgery services by focusing the intervention components of the treatment in fewer centres while ensuring that some non-invasive components of the vascular service are delivered in local hospitals. Such a model provides optimal clinical care for patients as they are able to access the majority of services through their local hospital and if they require more complex acute care this is delivered by sustainable teams on a seven day basis.

In moving forward we will look to develop models that bring sustainable teams together in secondary care while maintaining access for patients to appropriate care in their local hospital.

Primary care

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[28] WTD – The Implications and Practical Suggestions To Achieve Compliance

The recently announced review into out of hours primary care services will be important in supporting our progress towards sustainable seven day services. Also of relevance to our work is the UK Shape of Medical Training Review which considered how doctors' training could enable them to better meet the changing needs of patients, society and health services. One of the review findings was that patients need a different kind of doctor in the future whose training equips them to work across the interface between primary and secondary care. This means enhancing the skills of general practitioners and preparing hospital doctors to undertake duties in community settings. UK Health Ministers have welcomed the report and approved development activity to explore how medical training can be adapted to meet future patient and service needs. This will be taken forward in a planned way, and overseen by a Scottish Implementation group.

Drawing on these pieces of work where appropriate we will wish to consider new and emerging models of community based care that could enhance the local services for patients, while enabling acute hospitals to focus on their core activity; namely the treatment of seriously ill patients or those that require specific interventions. There are a range of options that could be considered from hubs to extended hubs and greater use of community hospitals.

Delivering a sustainable workforce

Sustainable services cannot be delivered without a sustainable workforce and we will consider carefully the workforce implications of this work as we move forward.

The solutions to sustainable seven day services require us to maximise the contribution from all healthcare professions in acute and primary care, working to the top of their professional capability.

In addition to the contribution from the medical profession, there are also numerous examples in the past of how nursing has taken on new or expanded roles across acute and community services, which has improved patient care. This can be seen in the introduction of nurse prescribers, hospital at night teams and minor illness advanced practice. As part of this programme we are keen to explore whether more can be done to empower and enable advance nurse practitioners to operate as senior-decision makers including in out of hours periods. Advance nurse practitioners already work in a wide variety of roles. In community settings they may be part of an enhanced primary care team or connected to GP services. Increasing numbers also work in secondary and tertiary care settings, such as Accident and Emergency, minor injury units, medical assessment units and hospital at night teams. They also work within specialities, such as paediatrics, neonatal care, cancer care, ophthalmology and orthopaedics.

The particular expertise of such nurses lies in their ability to operate both in specialist areas but also as a 'generalist', with a wide range of skills, a broad knowledge base and the ability to deliver specific aspects of care which complements the role of medical colleagues and other members of the health and social care team.

We would also propose as part of this programme to undertake a review of district nursing which looks at the current and future role of district nurses, ensuring that the available education and training supports this.

Allied health professionals (AHPs) also make a significant contribution to the care of patients in out of hours periods. While historically the majority of AHP services have operated on a five day basis, over the last two years the established AHP delivery pattern has been shifting and is now increasingly different across Scotland. This is primarily in response to service need, but also patient preference. Most recently the targeted use of AHP staff over weekends and out of hours periods in areas of service pressure has been making a significant contribution to patient flow, weekend (and earlier) discharge as well as the prevention of unnecessary admissions to hospitals through AHPs working in Accident and Emergency Departments, Admission Units, Frailty Teams, hospital at home, including community paramedics and other out of hours services. AHPs have also expanded their roles as prescribers, Advance Practitioners and AHP consultants across a range of specialties, working across hospital and community settings. We will build on this work, focussing on allied health professions that will make the most significant contribution to sustainable services across seven days.

It is crucial that we recruit the staff we need but also that we retain the staff we have and support them through providing them with good quality work, a good work life balance with working patterns designed to facilitate this, attractive working conditions and recognised career pathways.

Next Steps

From our work to date we have identified a number of actions which we would propose to take forward in the next phase of the programme.

- We will review the services provided in the 29 sites that undertake acute surgery to ensure that the models of care are sustainable while maintaining appropriate care in local hospitals.

- We will consider how the effectiveness of ward rounds at weekends can be improved to provide better patient care.

- We will consider further opportunities for nurses, AHPs and healthcare scientists to contribute to developing sustainable services, including how they can operate as senior decision makers in acute and primary care and by undertaking a review of district nursing.

- We will consider new models for reviewing and reporting diagnostic imaging and the provision of interventional radiology.

- We will co-ordinate further work to support the sustainability of Scotland's six Rural General Hospitals.

- We will continue to link to the range of national activity that is supporting the development of sustainable seven day services, including contributing to the

review of out of hours primary care and the refresh of maternity and neonatal care.

- To enhance local services, while protecting acute care resources, we will explore new models of care such as community hubs and the greater use of community hospitals with a view to developing pilots.

- We will use a strong evidence base to support us in progressing these next steps.

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Sustainability and Seven Day Services Taskforce Membership

Shirley Rogers (Chair)	Director of Health Workforce, Scottish Government
Anne Aitken	Programme Director, Sustainability & Seven Day Services, Scottish Government
Jennifer Armstrong	Medical Director, NHS Greater Glasgow and Clyde
John Burns	Chief Executive, NHS Ayrshire & Arran and Chair of Diagnostics Steering Group
Stuart Burnside	Unite
Robert Calderwood	Chief Executive, NHS Greater Glasgow and Clyde
Jim Cannon	Director of Planning, NHS Tayside
Chris Dodds	Health Analytical Services, Scottish Government
Ian Finlay	Senior Medical Officer, Health Workforce, Scottish Government
Alan Gray	Finance Director, NHS Grampian
Rosemary Hill	Scottish Health Council
Alan Hunter	Deputy Director Performance Management and National Programme Director for Unscheduled Care, Scottish Government
Aileen Keel	Acting Chief Medical Officer, Scottish Government
Jacqui Lunday Johnston	Chief Health Professions Officer, Scottish Government
Daniel MacDonald	Workforce Advisor, Health Workforce, Scottish Government
Hugh Masters	Acting Deputy Chief Nursing Officer, Scottish Government
Alan McDevitt	British Medical Association
Fiona McQueen	Acting Chief Nursing Officer, Scottish Government
Liz Porterfield	Head of Strategic Planning/Clinical Priorities, Healthcare Quality and Strategy Unit, Scottish Government
Helen Richens	Royal College of Nursing
Ian Ritchie	Scottish Academy of Royal Colleges
Claire Ronald	Chartered Society of Physiotherapists
Anne Thomson	Royal College of Nursing
David Thomson	Deputy Director Primary Care, Scottish Government
Nikki Thompson	British Medical Association

Sustainable 24/7 NHS Update

Innovative ideas in interim report welcomed

Enhancing the services provided in the community and empowering the whole healthcare team will help the NHS deliver more sustainable services 24 hours a day, seven days a week.

These are part of a range of proposals in an interim report of the Sustainability and Seven Day Services taskforce set up by the Scottish Government, which brings together stakeholders and experts on the health service.

The update finds that Scotland's NHS already operates on a 24/7 basis across a range of services, but outlines next steps that will help further progress this agenda, and make it sustainable for the long term – including:

- Diagnostics and interventions – exploring new models and improvements to out of hours diagnostic services, to enable more to happen at weekends and evenings, including more effective discharging of patients

- Enhancing local services – exploring new models of care such as community hubs and greater use of community hospitals, with a view to developing pilots.

- Empowering all members of the healthcare team to work to the full extent of their skills and capability, for example, supporting advance nurse practitioners to employ all their skills to make decisions on treatment and/or discharge to prevent hold ups in the system and allow it work more effectively and reviewing the role of district nurses.

- Supporting the sustainability of our Rural General Hospitals by establishing formal links with urban hospitals around staffing – for example allowing medical staff in rural hospitals to maintain skills and continue professional development at larger urban centres in order to aid retention and recruitment.

Shona Robison, Cabinet Secretary for Health welcomed the report and said the Scottish Government had already made progress on the providing more 24/7 services, including through investments from the £31 million NHS performance fund.

This will enable increased diagnostic and elective work during the evenings and weekends through the first awards made to NHS Lothian and NHS Highland.

Ms Robison said:

"This is an important update from the experts we have brought together on the 24/7 taskforce.

"The work being done by the Taskforce is invaluable, substantial and will deliver real sustainable improvements for patients in Scotland.

"It is encouraging that the group find Scotland's NHS already operates many services 7 days a week, 24 hours a day.

"The challenge is now is to progress this work to ensure that services out of hours are accessible, high quality and sustainable, both for those who require care in those periods and also for those in hospital who need support to move through their patient journey.

"While this is an interim report, on what is a complex and significant area, we are already making good progress. The link up between rural and urban hospitals, increasing diagnostics out of hours and the primary care out of hours review, all demonstrate our commitment to work towards a sustainable, 24/7 NHS in Scotland.

"We all know our NHS is facing considerable challenges of increased demand, with more patients with more complex illnesses. That is why we have increased health spending to beyond £12bn for the first time, but we need to use these resources as effectively as possible and also look at delivering new models of care. That is exactly what the work of the taskforce is considering and I look forward to seeing further progress."

John Burns, Chair of NHSScotland's Chief Executives, who sits on the taskforce said:

"The work of the Taskforce is giving a longer term perspective on how we may be able to use our resources even more effectively and efficiently at all times of the day and week to deliver the very best possible care for patients.

"It is important and valuable work, which I am sure will have benefits for patients across Scotland."

Ian Ritchie, Chair of the Academy of Medical Royal Colleges in Scotland, and a member of the Taskforce said:

"It is important we think and discuss seriously the long term future of our NHS, as demand rises. On that basis, we understand that services and models of care need to evolve and change to improve the care people receive across the week.

"The work of the Taskforce is making a valuable contribution to this process. Sustainable 7 day services will require new and innovative models of care across a range of areas, and the Academy welcomes the opportunity to work with the range of stakeholders on the taskforce to deliver these solutions."

Background:

The Taskforce is made up of senior leaders from the NHS and Scottish Government along with representatives from Staffside, professional organisations and patient representatives. It met for the first time in April 2014 and has had 4 subsequent meetings. A number of supporting workstream groups have also been established to support the programme.

Link to the report: : http://www.gov.scot/Publications/2015/03/7764

UNISON NOTE OF EVIDENCE TO THE ASSEMBLY COMMITTEE FOR HEALTH, SOCIAL SERVICES, AND PUBLIC SAFETY

COMMITTEE MEETING 29 APRIL 2015

WORKFORCE PLANNING IN THE CONTEXT OF TRANSFORMING YOUR CARE

Context

1. The recent decision of HSCB to second the TYC responsible officer to NHSCT without replacement; review the future of the TYC Unit; and 'mainstream' TYC into the general commissioning function of HSCB creates a changed dynamic in which the TYC project appears to be losing identity and focus.

2. 'New' direct investment 2015-2016 appears to be only £9m, following a cumulative and recurrent investment of £25m over the last years. 'Shift left' after 3 years has only moved £44m out of the projected £83m in Trust budgets. The current HSC/NHS financial position reported to HSCB Board is that there are no monies for service developments of any description.

3. HSCB have announced that they are to produce an update on progress with the 99 proposals in the original TYC report.

4. At a recent meeting of HSCB Board, there was confirmation from officers that GP practice funding did not translate into knowledge of the numbers of GPs and related health professionals per practice.

5. There are now two reviews of domiciliary care as a key component of TYC; the ongoing HSCB review, and the imminent workforce review as reported to your committee (which is ambiguous on the substantial and generally exploited workforce in the independent/private provider sector). The Committee should also note the DHSSPS/HSC/DEL collaboration on domiciliary care skills under the Connected Health and Prosperity Board. There is no trade union participation in this.

6. The current workforce is demoralised by ongoing pay restraint; under-resourcing; excess vacancy control which compromises

service delivery and performance targets; and a false reliance on agency staffing at exorbitant fees and rates.

Specific Issues raised

7. UNISON does not have representation on the RPWG, and no invitation has been issued to date. We have confirmed that no invitation has been issued to the Health Committee of NIC-ICTU, which is chaired by UNISON. To date we have had very limited involvement in discussions at Trust level which could be characterised as 'TYC workforce planning' or 'workforce modelling'. There is a lack of a 'central steer' for these processes.

8. The critical area of resourcing for any effective implementation of TYC is District/Community Nursing. The commitment to 'normative staffing' for this made by the previous Minister in his 2014-15 Direction has entirely disappeared from the recently published 2015-16 Direction. There is a contradiction, and lack of clarity, between statements at HSCB that there is 'no investment', and indications of funding at Trust level.

9. Workplace planning participation requires confidence from union membership. ICP's are an essential ingredient of TYC. The original ICP document included a commitment to evaluation of pathways, including 'conversion to social enterprise'. UNISON has demanded the withdrawal of this on a number of occasions, but has received no response. The tainting of TYC with the ethos of privatisation is a roadblock which could easily be removed.

10. Your committee's scrutiny at previous meetings demonstrated the unsoundness and false premises within the assumption of '-3%' in workforce numbers under TYC. Meeting perceived needs when demand is increasing at exponential rates and demonstrable

underfunding remains (e.g. in mental health) could be at best be about containment of growth in costs and numbers, not reductions. No Commissioning Plan to date has cited a 'dividend' from TYC.

11. The gender mix of the HSC/NHS workforce is substantially female. There should be no stereotypes relating this to part-time work.

12. UNISON has endorsed and supported for many years resettlement, and is actively engaged in workforce discussions at e.g. Muckamore to progress this. In respect of day centre facilities for learning disability clients, UNISON is promoting the concept of day centres as the local 'hub', and challenging Trust savings plans to remove client expenses and 'wages' for production activity.

Conclusion

13. Any workforce planning approach, including for TYC, needs a sustainable medium-term platform for delivery. To adopt a management cliché, 'the platform is burning'. UNISON will bring our skills and member insight to the table if invited, but will seek underlying and radical reform of the current structures and funding for health and social care as the precondition for inclusive workforce planning.

APPENDIX 3

DEPARTMENTAL BRIEFING PAPERS AND CORRESPONDENCE
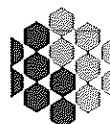
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Our Ref: AGY/87/2015

Date: 18 February 2015

Dear Ms McLaughlin

Thank you for your letter of 5 February regarding Workforce data on GP Practices.

I can advise that reports are no longer compiled publishing statistical information on GP Practices. This work was labour intensive and often out of date by the time of publication and as a result of budgetary pressures this work ceased after the 2007/08 report. However, the Business Services Organisation (BSO) continues to respond to ad hoc requests for statistical information on GP Practices. There is some information relating to the 350 practices within Northern Ireland readily available on the BSO website.

The Department currently does not collect data in relation to treatment room nurses and practice nurses. GPs are independent contractors and are therefore not required under the current GMS contract to provide data on their employees to the Department. However, proposals are being developed for a data warehouse facility capable of collating and analysing all the information from GP systems on issues such as referral patterns and prescribing and nursing data.

The Department is responsible for commissioning the education and training places for nursing and midwifery. As GP practice nursing is not a specific training programme, the Department does not produce workforce planning recommendations specifically for this area. However the Department's regular assessments of the provision of pre-registration nursing numbers take account of the requirements of the independent sector which includes practice nurses and treatment room nurses.

Jim Wells MLA
Minister for Health Social Services and Public Safety

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Our Ref: AGY/98/2015

Date: 5 March 2015

Dear Ms McLaughlin

WORKFORCE PLANNING

My officials, representing the HSC's Regional Workforce Planning Group are scheduled to appear before the Committee on 11 March 2015 to provide evidence on the Committee's Review of workforce planning in the context of Transforming Your Care.

In advance of that meeting, I enclose a briefing paper which has been prepared to assist members for this discussion.

I trust you will find this helpful.

James M. Wells

Jim Wells MLA
Minister for Health Social Services and Public Safety

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WORKFORCE PLANNING

Departmental Briefing Paper for the Committee for Health,

Social Services and Public Safety

1.   The purpose of this paper is to provide the Committee for Health, Social Services and Public Safety with briefing on progress on workforce planning in support of the implementation of *Transforming Your Care* (TYC), in advance of the evidence session scheduled for **11 March 2015.** Officials attending the evidence session will be:

- Mrs Heather Stevens, *Director of Workforce Policy and Chair of the Regional Workforce Planning Group;*
- Dr Carolyn Harper, *Public Health Agency and member of the Regional Workforce Planning Group; and*
- Mr Damian McAlister, *HR Director Belfast HSC Trust and member of the Regional Workforce Planning Group.*

The paper has been structured to respond to the specific questions notified by the Committee.

Progress To Date On Workforce Planning In Support Of The Implementation Of Transforming Your Care

2.   The Transforming Your Care (TYC) Review (December 2011) provided a vision of the health and social care (HSC) services that would be needed to meet future health and social care demands of the people of Northern Ireland. Those demands identified included:
- a growing ageing population;
- an increase in patients with long term conditions;
- a growing demand for services with an over reliance on hospital services;

- an increasing drive for greater productivity and value for money; and

- the changing profile of the available workforce.

3. The Review highlighted that the roles of health and social care professionals would need to change over time, as the new model of service delivery was implemented. However, whilst the Review examined potential changes in how existing staff worked, *it was not prescriptive* in how those changes should be brought about.

4. A ***Regional Workforce Planning Group*** was established in August 2012 to consider the implications of TYC for workforce and ensure that this was appropriately reflected in the workforce planning programme.   The workforce planning specific elements within TYC are proposals 79, 95 and 97A:

   i. **Recommendation 79**: Make necessary arrangements to ensure critical clinical staff are able to work in a manner which supports the new arrangements;

   ii. **Recommendation 95**: development of new workforce skills and roles to support the shift towards prevention, self-care, and integrated care that is well co-ordinated, integrated and at home or close to home; and

   iii. **Recommendation 97A**: More formal integration of workforce planning into the commissioning process to drive the financial transformation.

5. As part of its work the RWPG commissioned 'Skills for Health' to carry out an assessment of their workforce planning capacity and capability across the HSC – a 'Diagnostic' report.   The RWPG also commissioned and led the roll out of a training programme by Skills for Health, to train HSC staff and raise awareness in workforce planning. The Diagnostic Report (November 2013) recommended that a Framework was needed to define an integrated approach and process for workforce planning which would include the definition of the roles and responsibilities for each of the HSC stakeholders in the workforce planning process.

6. The Regional Workforce Planning Framework is now at final draft stage and will shortly be submitted for formal approval by the Department; however it is considered to be a living document which will be revised as necessary as the approach to workforce planning is taken forward.

7. The Draft Framework envisages that the organisational roles and responsibilities are as follows:

DHSSPS is responsible for:

- Setting the strategic vision;
- Securing commitment to a high level workforce strategy to underpin the Department's wider policy objectives;
- Providing regional workforce information and trends;
- Ensuring that a regional approach is taken to workforce planning; facilitating capacity building within the HSC trusts; and
- Making decisions on the commissioning of pre- and post-registration education and training across the HSC.

HSCB/PHA, as commissioners, their role is to:
- agree the models of service delivery;
- Be assured that HSC Trusts and independent practitioners have considered and identified the workforce needs for service delivery, through, for example, demand/capacity analysis;
- Exercise a challenge function where appropriate;
- Identify to the Department areas where intervention is required; and
- Lead or contribute to workforce reviews as required.

HSC Trusts are responsible for:

- Ensuring that they have an appropriate and skilled workforce to deliver the services commissioned from them;
- Utilising both qualitative and quantitative information to inform operational workforce plans (to include information on projection and risk) which are reviewed annually;
- Regularly liaise with other stakeholders (including local commissioners) to determine priorities and overcome challenges; and
- Agree courses of action and implementation of workforce change.

8.   The Draft Framework aims to deliver a future workforce that not only maintains safe staffing but supports the service transformation necessary to improve quality of care. Specifically it seeks to:

- Provide an adaptive HSC workforce of the right size with the right skills deployed in the right way;
- Provide an understanding of how organisations and individuals can contribute effectively in a mixed economy;
- Encourage partnership working both within and between organisations;
- Better inform education commissioning decisions.

The Draft Framework also endorses the *NHS Six Step Model* as the primary model for workforce planning which can be complemented by other regionally agreed methodologies where appropriate. Subject to approval, the Framework will be published and widely disseminated throughout HSC organisations. A primary implementation step is to pilot a *service area review* within a Programme of Care approach. It has now been agreed that the initial focus will be on the domiciliary care service area within the Older People Programme of Care.

Progress Made On Evidence Based Workforce Planning At Regional And Trust Level

<u>**Regional Level**</u>

9.   As a key driver of healthcare policy, the imperatives of TYC are now mainstreamed into workforce planning across the HSC in all disciplines. Accordingly, the workforce implications of future re-configuration of service delivery and changes in the skills mix of teams, in response to the "shift left" is a fundamental component for consideration in workforce reviews.

10.   Overseen by the RWPG, a range of uni-professional reviews are currently at various stages of completion. These will provide significant workforce intelligence on supply and demand; age profiles; areas of positive development; areas of concern; projected needs in line with service development; and emerging trends within workforce, albeit from the perspective of a single profession. Whilst an alternative approach, focusing on programmes of care, has been under discussion, it is

important that the existing work on workforce planning has continued and therefore the following are underway:

(i)   Medical Workforce Planning

Mouchel, an organisation linked to the Centre for Workforce Intelligence has been commissioned to deliver a review of the general medical workforce. The Review is being delivered in three phases: Phase 1 - a workshop for key stakeholders was held in May 2014 following which a scenario report was generated; Phase 2 – a data collection and analysis exercise is currently underway; and Phase 3: a follow up virtual workshop with key stakeholders building on information collected in Phases 1 and 2. It is expected that the review will be completed in the early part of 2015, subject to provision of data from stakeholders.

(ii)   Medical Specialty Workforce Planning

A series of specific reviews are being taken forward, led by PHA:

(i)   **Paediatrics including community services and neonatal care** – this work has been completed, and a report has been submitted to the Department;

(ii)   **Emergency Medicine** – this Review is a top priority. The Review will take into consideration the paper entitled 'The attractiveness of a career in Emergency Medicine: A survey of UK trainees' published by the College of Emergency Medicine in December 2014. An initial assessment has been sent to the Department;

(iii)   **Primary Care** – an interim Report of the General Practice Workforce Planning Group has been submitted to DHSSPS, and is currently being considered. Work continues on a final General Practice Report;

(iv)   **Trauma and Orthopaedics** – it is expected that this work will be completed in the early part of 2015;

(v)   **Urology** – this will commence following completion of the HSCB Review of Urology;

(vi)   **Radiology**

A Workforce Planning Sub-group has been convened as part of the Review of Imaging Services. A baseline data collection exercise is under way, the results of which are expected to be presented to the

Review of Imaging Services Project Board at their next meeting later this month.

The Public Health Agency, following consultation with Trust Medical Directors and NIMDTA, has set out an anticipated next phase of workforce reviews for 2015 and 2016:

Table 1

The	Jan – Jun 2015	Apr – Oct 2015	Jul – Dec 2015
Geriatrics	×		
Acute Medicine	×		
Haematology	×		
Intensive Care		×	
Neurology			×
Ophthalmology			×
Psychiatry			×
Dermatology			×
Occupational Health	×		
Anaesthetics		×	

For 2016, the specialities currently under consideration for the following phase of workforce planning are: Anaesthetics, ENT and Obstetrics & Gynaecology.

(iii)   Nursing and Midwifery

The Nursing and Midwifery Workforce Plan was presented to the DHSSPS Top Management Group in January and is currently being costed prior to consultation. Subject to necessary approvals, DHSSPS Central Nursing and Midwifery Advisory Committee (CNMAC) Workforce and Education Sub-Committee will be charged with overseeing and supporting the implementation of the recommendations with timely reports to CNMAC on progress and annual reviews.

(iv)   Domiciliary Care

Following a decision of the RWPG to undertake a workforce review within a Programme of Care approach, the first area of focus has been agreed as the *domiciliary care* service area within the *Older People* Programme of Care. Work is beginning to scope this review. This will feed into the work of the Workforce Partnership group which was established under a working group to take forward the Economy and Jobs Initiative Task and Finish report,

recommendation six - "DHSSPS and HSC to create strategic partnerships with DEL to align future skill-sets of HSC sector and the current provision through Universities and FE Colleges in NI". The aim of the Workforce Partnership, in the first instance is to align the future skill-sets of the domiciliary care sector workforce with service user need. It is intended that workforce planning in the area of domiciliary care will build on the regional project to determine the future service model for domiciliary care which is being led by HSCB and is due to be completed by the end of March 2015.

(v)   Unscheduled Care

Workforce issues identified under the Review of Unscheduled Care are being taken forward through existing workforce channels and project strands.

Trust Level

11.   The following information has been provided by Belfast Health and Social Care Trust as an example of workforce planning activity at Trust level.

12.   The Belfast Health and Social Care Trust delivers integrated health and social care to 340,000 people in Belfast and are the Regional Trauma Centre to the 1.8 million population of Northern Ireland.   Their Clinical services are provided within a directorate structure:

- Adult Social and Primary Care
- Children's Community Services
- Specialist Hospitals and Women's health
- Unscheduled and Acute Care
- Surgery and Specialist Services.

13.   The Trust's Emergency departments, at the Royal and Mater are among the busiest in Northern Ireland, treating around 150,000 patients each year. They currently employ a total of 20,509 staff equating to 17,541.31 whole time equivalents across a range of occupational family groups as indicated in **Table 2** below:

Table 2

Occupational Group	H/C	WTE
Admin&Clerical	3418	2948.03
Estates	234	233.8
Generic	4	4
Medical & Dental	1685	1589.15
Nursing & Midwifery	7288	6287.85
Professional & Tech.	3048	2672.66
Senior Executives	10	10
Social Services	2628	2163.83
Support Serv/User Exp.	2193	1631.32
Total	**20509**	**17541.31**

14. The Trust, along with representatives from other Trust's, the Public Health Authority and the Board has worked with the Department in developing a Regional Framework document on workforce planning for the Northern Ireland health economy and indeed already has developed a suite of training materials using the Skills for Health Six Step Approach to Workforce Planning and would endorse this methodology. The Trust accepts and supports the need to adopt a wide variety of resources and toolkits that are already in existence to support the development of a workforce plan, for example Lean, BEST, Keith Hurst's toolkit, Christmas Trees, Maximising Opportunities, Resources and Efficiencies (MORE), Quality Improvement Cost Reduction (QICR), all of which are key in the development of a workforce plan.

15. The Trust would also acknowledge the wealth of activity across the organisation that is already in place and would look to build on this to compile a workforce plan in the first instance in two priority areas, namely the Unscheduled Care Directorate and Adult Social and Primary Care Directorate. The first Directorate wide workforce plan is due for completion by 31 March 2015 covering the 5 year period April 2015 to March 2020 for the Adult Social and Primary Care Directorate. To date over 300 Trust staff have attend training on the Skills for Health Six Step approach to Workforce Planning.

Investment Made In Training / Re-Training Of Staff To Achieve Appropriate Skills Mix

16. The TYC Review highlighted that the new model of care would require a strong re-orientation away from the provision of acute and episodic care towards prevention, self care and co-ordinated, integrated care provided at home or close to home. The

Review noted that the proposed changes would require staff to develop different skills and capacities. In particular it highlighted opportunities for up-skilling (eg: GPs with Special Interests or specialist long-term condition nurses); extended GP leadership; opportunities for more outpatient follow up appointment to be carried out by GPs and nurses and extended GP leadership roles.

17.   The 'TYC: Vision to Action' consultation document provided further detail on expected changes, for example it is envisaged that some staff, currently working in hospital may in the future undertake their role more often in a primary/community care setting. Some staff will be asked to adapt to a change of role – but will receive training and support to do so.

Trust examples: BHSCT

Nursing & Midwifery Workforce

18.   In support of the reform and modernisation of the Nursing & Midwifery workforce the Trust has developed a ten day programme delivered four times a year for new staff. One Hundred and sixty programme places are provided each year.

19.   Nursing support staff are now recruited in Induction "cohorts" every twelve weeks. Staff attend the programme before they start work in our wards and departments. To support this group of staff to understand their roles and responsibilities within the Trust, the programme introduces staff to the Trusts values, purpose and objectives, provides key aspects of mandatory training and an introduction to the Activities of Daily Living and Person Centred Care. This supports newly appointed staff to enter the service with the necessary basic level of knowledge and skills required for their post, and supports the provision of safe effective compassionate care.

20.   The Trust also delivers Vocational Programmes - These eighteen week programmes start in February and September each year, and provide eighty programme places each year.

21.   The programme consists of relevant mandatory training, a QCF Certificate level qualification, and an Essential Skills Communication qualification, if required.

22.   The programme is available to staff after they have completed at least six months in post (probationary period). The programme provides staff with up dated Mandatory training, in depth information on duty of care and person centred approaches to care and provides all staff with a relevant qualification for their post, and supports the provision of safe effective compassionate care.

Generic Support Workforce

23.   The Trust has developed a multi-skilled AHP Support worker in the community to support the registered staff in carrying out their Home Treatment plans. The Trust currently employs 95 of these staff. Previously each of the professional groups would have had their own support staff.

Domiciliary Care Workforce

24.   The Trust has also provided our Homecare workers, in November last year, with Contracts of Employment detailing their contracted hours per week to improve the continuity of care provided to service users in the community, participating in scheduled rotas. Previously this workforce worked on a variable hours contract.

Investment In Leadership And Capability Development

25.   The **HSC Knowledge Exchange** - set up by the HSC Leadership Centre over a year ago, provides space (online and in person) for individuals to discuss, debate and tackle emerging and current trends in health and social care and share their knowledge and expertise about reform. It provides access to resources, good practice, leading thinking and up to date news and events across local, national and international systems to everyone in the HSC system – both statutory and independent sectors. Very positive feedback has been received.

26.   The HSC Board has invested in the following to support the Integrated Care Partnerships being developed under TYC:
- Clinical leadership programme for over 50 doctors and pharmacists.
- Organisational development and coaching for ICP chairs and committee members.
- Training and support for the service users and carers who are members of the committees.

- A third sector co-ordinator to support integration across the Voluntary and Community Sector representatives on ICP committees.

27. The **Delivery and Sustaining Change Programme,** complements the wide range of skills development on offer to all employees through the HSC Leadership Centre. Over 100 managers and clinicians have been through this programme.

28. The Belfast Trust is an accredited Investors in People Organisation. It has Learning and Development as one of the 5 core Values of the Trust. In regard to specifically Leadership and Capability the Trust has in place Leadership and Management Development programmes developed and delivered in accordance with our Trust values and have undertaken training needs analysis and evaluation. This is at all levels within the organisation and includes:

- Living Leadership, Leading with Care, a high level bespoke Leadership Development Programme for Co Directors/ Associate Medical Directors, Senior Managers and Clinical Directors.
- An Institute of Leadership Accredited Middle Manager Development Programme.
- An Institute of Leadership First Line Manager Development Programme.

29. The Trust also assess' capability and development needs through its Personal Contribution Framework. The Trust also provides training in regard to a wide range of other areas, on Workforce Planning, Service Improvement and a range of skills and development training.

Information On The Extent To Which The Impact On The Workforce Of Shifting £83m From Hospital Based Services To Primary / Community Based Services Has Been Modeled And Planned For, And The Impact On Staff To Date Of Money Shifted In Accordance With This Aspect Of Transforming Your Care

30. The formal implementation period for TYC commenced in March 2013. Steady progress is being made in its implementation across Northern Ireland. For example:

    a. Integrated Care Partnerships – all ICPs have agreed action plans in place and have submitted investment proposals to LCGs for service changes. Up to the end of this financial year, investment in this key TYC initiative will be almost

£6m over the last three years. Further information about the work of ICPs is attached at **Appendix A**.

b. NIAS Alternative Care Pathways 'See, Treat, Leave' – work is underway to implement alternative care pathways to provide treatment and support without unnecessary Emergency Department admissions where safe and appropriate to do so. Next implementation steps include embedding of the diabetes pathway, training sessions for paramedics, and continued engagement with integrated care partnerships.

c. Reablement – a regional audit of services has been undertaken and work is underway to secure full coverage of reablement in geographical services.

d. Domiciliary care – a review of the service delivery model for domiciliary care (linked to the work on reablement) is also underway.

e. Day opportunities for adults with learning disabilities – implementation groups have been set up in the 5 LCG areas and each group is currently benchmarking the agreed day opportunities model against services in their locality.

f. Primary care infrastructure development is progressing under three hubs (Banbridge, Ballymena, Omagh) currently under construction and two currently in procurement (Newry and Lisburn).

Information On The Extent To Which Workforce Planning In Support Of The Implementation Of TYC Is Taking Account Of Recruitment Issues For Particular Geographic Areas, The Desirability Of Seven-Day Working, And The Composition Of The Workforce In Terms Of Gender Mix And Associated Work Patterns.

Seven day Services

31. At regional level, a mandate has been provided to both the Doctors and Dentists Review Board and the NHS pay Review Body to make observations in relation to the barriers and enablers to seven day services. The Department awaits their reports which are expected in July 2015.

32. All Trusts have been developing seven day working particularly to respond to the demands in the unscheduled care area, with examples in the Allied Health professions contributing to reducing length of stay and facilitating earlier discharge through commensurate seven day working in social care to respond to the care

needs of those being discharged. Laboratories are also an area where shifts are now being introduced to cover what was traditionally on call arrangements.

33.   The Belfast Trust, when recruiting new staff does consider the need for providing 24/7 services and incorporates this into contracts of employment and job descriptions where necessary with a view to including in all relevant documentation in the future. To date a number of services e.g. Physiotherapy and Occupational Therapy in a number of areas have extended the working day and increased provision at weekends. This is mainly in areas such as ED, BCH Direct and will be required to provide such cover on the implementation of the Acute Care at Home service. Most of this is provided in the first instance on an on-call/ad hoc basis due to resources.

34.   The Trust is currently working towards the introduction of a 7 day service across a number of the Allied Health Professions in order to support early discharge and enhanced services within the community.

Gender mix and work patterns

35.   Within the Belfast Trust, 78% or 16,015 of the total workforce are female and of those 51% (8,130 headcount) work full time. 22% or 4,494 headcount of the workforce are male and 82%, 3,708 headcount of the male workforce work full time.

36.   Under modernisation of services, in many areas the Trust is working to ensure services are delivered, based on service need and where identified in consultation with all relevant stakeholders, extending the working day and where necessary week to improve the service delivery. Some examples include:

- enhanced senior doctor presence in the Trust's Emergency Departments to provide approximately 18 hours of senior cover each day of the week,
- extended Pharmacy Services opening hours,
- Allied Health Profession services being provided across 7-days of the week in hospital and community settings,

- enhanced Social Work and Social Care services to ensure patients are both discharged from hospital 7 days a week and where possible hospital admissions are prevented in the first place.

Information On The Department's Assumption That The Implementation Of TYC Will Require A Reduction In The Overall Workforce Of 3%, And The Proposed Mechanisms To Achieve This Objective

37. The "TYC: Vision to Action' consultation document provided detail on expected changes as follows:

- Some staff, currently working in hospital may in the future undertake their role more often in a primary/community care setting;

- Some staff will be asked to adapt to a change of role – but will receive training and support to do so;

- There would be a reduction of overall workforce of around 3% over the next 3-5 years (approximately 1,620 WTE of total workforce of 54,000 WTE). It was envisaged that this would be supported by a Voluntary Redundancy/Voluntary early Retirement (VR/VER) scheme and/or re-training support.

- A growth in employment in the non-statutory sector.

38. In relation to VR/VER, a total of 164 wte staff left the service through availing of VR/VER opportunities provided by investment of £10.17m of Invest to Save funding (2012/13 funding). The 2012-13 savings were £0.465m in 2012-13, £3.528m in 2012-13, and will be £4.514m in 2014-15.

Information On The Department's Approach To Involving Staff, Professional Bodies And Staff Side Organisations On Workforce Planning In Support Of The Implementation Of Transforming Your Care

39. Staff side and professional bodies were involved in workshops and discussions during the development of the Regional Workforce Planning Framework. A Stakeholder Engagement Group is in the process of being established to ensure the full engagement of staff side organisations and professional bodies going forward. HSC Trusts will also fully involve staff side in the local implementation of Programme of Care- related reviews.

40.   In relation to those medical uni-professional reviews underway, NIMTDA and the relevant Royal College or professional organisations are automatically involved in each uni-professional review. For example, the Royal College of Paediatrics and Child Health in paediatrics; and the Royal College of General Practitioners in respect of General Practice.   Nursing colleagues have also been closely involved in the Nursing and Midwifery Review. Such engagement has been extremely positive with staff willingly contributing their views and giving time.

Information On Any Examples Of Best Practice In Relation To Workforce Planning In Support Of A "Shift Left" In Services, Which The Department Is Drawing On In Terms Of The Implementation Of Transforming Your Care

41.   Specific examples of workforce planning within the Belfast Trust in two areas – Unscheduled and Acute Care; and Adult and Social Primary Care – as examples of best practice, are set out in **Appendix B.**

Integrated Care Partnerships

Integrated Care Partnerships (ICPs) are a key element of Transforming Your Care and a new way of working for the health service in Northern Ireland to transform how care is delivered. Seventeen Integrated Care Partnerships have been established and are implementing service improvements in across clinical priority areas.

ICPs are collaborative networks of care providers, bringing together doctors, nurses, pharmacists, social workers, hospital specialists, other healthcare professionals and the voluntary and community sectors, as well as service users and carers, to design and coordinate local health and social care services.

They focus on the clinical priority areas of frail elderly, respiratory, diabetes and stroke, and end of life care as it relates to the other conditions. They have developed Care Pathways and have a series of service development projects underway, as well as undertaking proactive care management for those people identified most at risk within the clinical priority areas.

The investment in ICPs to date has allowed these partnerships to be established and supported to work effectively and has included investment in a range of projects promoting care in primary and community care settings, such as:

Table 1

Area	Clinical Priority Area	Summary
Belfast	Frail Elderly	Implementation of the Acute care at home model
	Respiratory	Implementation of the COPD pathway, and a range of service developments for those with COPD
	Stroke	Primary Prevention through Chronic Disease Hubs, Enhanced Inpatient Rehabilitation, Early Supported Discharge
Northern	Respiratory	Home oxygen service. Enhanced community respiratory service 7 days a week.
	Frail Elderly	Nursing Home in – reach pilot programme

	Diabetes	Structured patient education, multi-disciplinary foot care team
South Eastern	Frail Elderly	Falls prevention pilot
	Respiratory	Home oxygen
Southern	Frail Elderly	Extended rapid response hours, advanced access to diagnostics. Pilot of Pharmacist support for SHSCT rapid response team. Transport Services to support access to Dementia Service or Rapid Response Teams
	Diabetes	Diabetes and pre diabetes case finding and management in primary care; educational training and awareness for GP on diabetic podiatry and for those newly diagnosed with diabetes; Out of Hours Diabetic Specialist Nurse
	Respiratory	Pilot Rapid Access Respiratory Clinic
	Pilot monies	Short term project manager posts - rapid response and directory or services, community pharmacy FE and COPD pilot, pilot rapid access respiratory clinics
Western	Frail Elderly	Community navigator to support older people after discharge and streamline access to C&V sector services; Community Pharmacy and Hospital Pharmacy Lead Case Management Reviews; Falls Specialist
	Respiratory	Home oxygen service to support care at home for COPD patients; Ensuring access to community specialist respiratory team and physiotherapy support for the respiratory early supported discharge team.
	Diabetes	Review of patients 'at risk' of developing diabetes; Implementation of a comprehensive diabetes foot care pathway and structured education programmes for those at risk, and GPs & practice nurses.
	Stroke	Access to orthoptists and specialist visual assessment and follow up after stroke, OT technical instructors
	Cardiology	Implementation of an integrated cardiac ambulatory care model
	End of Life	Day Hospice; end of Life GP facilitator providing advanced care planning education and training to GP practices

These initiatives are at varying stages of implementation with some delivering change on the ground and others only recently approved with implementation just getting underway.

Workforce modelling at Belfast Health and Social CareTrust

Unscheduled and Acute Care

Our largest directorate is Unscheduled and Acute Care employing 23% or 4792 headcount, 4199.65 whole time equivalents, of our total workforce. The Directorate has undertaken considerable work to address the backlogs faced within our emergency departments and over recent months we have re-located our wards on our Royal Victoria site. Twelve wards and six clinics, totalling 308 beds. This was a determined effort to put patient safety and experience first by co-locating specialisms; to aide cutting down on patients outlying from their specialism; and to ensure the beds we need for our patients are in the right place and cared for by the right team. For example, we now have the whole of fractures service in one area; cardiology, respiratory and cardiac surgery are all on the one floor. And, we have a newly re-profiled respiratory ward in the Royal to ensure the patient experience is enhanced.

The Trust has launched an IMPACT programme Improving Patient Experience and Accessing Care through Team work. An Unscheduled Care service which delivers a timely, quality experience to patients/clients, carers and staff is the number one Trust priority and essential to our goal of becoming one of the best performing Trusts in the UK in terms of patient safety, patient experience, and patient outcomes.

The IMPACT project, will empower seven clinical teams, supported by experienced managers, to design and deliver the necessary changes across the Trust. Each team has specific objectives, based on the Berwick Principles, focused on reducing Waste, Harm and Variation. The Belfast Project will be part of a Regional Project designed to establish better regional co-ordination, better information sharing between Trusts and better planning across and between Trusts.

The seven clinical teams include the following:-
- Frail Older People
- Respiratory
- Emergency department
- Flow and Take
- Ambulatory Care

- Resource profiling
- Diagnostics

Frail Older People

The team opened the BCH Direct Unit for the direct assessment and admission, if required, of frail older people in October 2014 on the City Hospital site. The unit has reduced the number of older people being admitted through RVH ED and has addressed complex discharge arrangements to support patients to be able to go home once medically fit. The team also has a focus on developing and implementing pathways to support people to remain at home and, if needed, ensure direct admission to the right specialty.

Respiratory

As part of specific RQIA recommendations on respiratory services, the team are initially focussed on reviewing arrangements for the assessment and admission of patients, for developing a direct assessment and admission arrangement at BCH to reduce LOS. The Trust is committed to ensuring that more respiratory patients will be cared for by a respiratory consultant in a designated respiratory bed as indicated above.

Emergency Department

Within the 2:1:1 Trust focus (2 hours for decision for Speciality assessment: 1 hour Specialty decision: 1 hour Admission achieved (if required)), the Workstream have identified changes to the triage, assessment and liaison roles of the ED teams, separating minor injuries, increasing the number of patients directly triaged to the appropriate specialty and aligning the staff team to attendance patterns.

The Emergency department has also invested in upskilling our existing workforce to become Emergency Nurse Practitioners and also enhanced the number of Advanced Nurse Practitioners in this area. The Trust is leading the way in Northern Ireland with the appointment of two Advanced Nurse Practitioners, in January of this year. The new appointees are based at the Royal site Adult Emergency Department.

Although a very well established role across the UK, this is an exciting first for Northern Ireland.

Flow & Take

This workstream's initial focus is on identifying the specialties that have the greatest unscheduled care responsibilities, analysing the patient flow arrangements in each of these specialties and identifying the barriers to effective patient flow, recognising that they are likely to be different for each specialty. Once these specific barriers have been identified the group will look to these specialties to propose and implement solutions.

Ambulatory Care

The Team initially focused on identifying patients' top five admitted medical conditions which could safely be diverted through the use of virtual clinics, PTU or OPD, increasing the Trust capacity for urgent outpatient appointments and associated diagnostics, increasing the number of patients directly discharged from ED to an alternative ambulatory care pathway and to ensure the spread of good practice across the Trust.

Resource Profiling

The Team initially worked to agree a bed re-profile which looked to ensure the numbers of patients outlying from the speciality areas is reduced by 90% compared to 2013/14 and support the delivery of the 2:1:1 model. The group will also review current capacity and working arrangements to optimise clinical input for patients and to co-ordinate the assessment and admission arrangements for direct admission by specialties at BCH.

Diagnostics

The diagnostics group works closely with several of the Workstreams to ensure timely access to diagnostics as part of the unscheduled care pathway, to improve the patient's length of stay by delivering diagnostics on an outpatient basis within the same time frame as an inpatient stay and to support new ambulatory models of care.

Adult and Social Primary Care

Our Adult Social and Primary Care Directorate is our second largest Directorate employing 22%, 4547 headcount, 3820.55 wte and again considerable workforce planning and modernisation has taken place within this service area. The Directorate comprises four key service areas namely:-

- Mental health services
- Learning disability services
- Older People services
- Psychology service

Mental Health Services

The Trust has reduced the number of acute mental health in-patient beds by almost 50% since 2008 from 160 to 82 and plan to further reduce over the next few years, subject to commissioner approval. The new purpose built in-patient unit is due to open in 2017 and will have single room accommodation for 74 mental health beds and 8 psychiatric intensive care beds. The Trust has enhanced our community Mental health teams and opened a new Home Treatment House on the Antrim Road. It has also introduced a new Peer Support role and would plan to further develop this in the future. The Trust has developed our Acute Day Treatment Model with a team based in the Antrim Road but outreach to other facilities such as Dunluce and Woodstock.

Our ethos is to resettle patients from the acute setting into the community, in to better facilities and under the premise that no-one should have to spend their days in a hospital, unless absolutely necessary. Our plans into the future will continue this ethos and our community teams will be enhanced and new roles identified and staff redeployed from our acute settings into the community where necessary.

Older People Services

Within Older People Services and in collaboration with colleagues in our Unscheduled Care directorate as mentioned above, the BCH Direct Unit opened in October 2014. This created a direct access assessment unit for GPs who refer frail elderly patients via ambulance, allowing them to by-pass ED.

The aim of BCH Direct is to assess patients on arrival and either discharge them with a full treatment and review appointment, or admit them to an appropriate ward. This approach aims to greatly improve services for older people, while reducing pressures on the Emergency Departments. BCH Direct aims to ensure that patients go to the right place first time.

Staff working on BCH Direct have been up-skilled to meet the demands associated with this new service linking in and shadowing colleagues in the Adult Emergency departments. An Assistant Nurse Practitioner role has also been introduced with staff skilled in taking bloods and carrying out ECG's.

The unit accepts level 3 – 5 patients who would have previously attended the Emergency Departments at the Royal and Mater Hospitals. Patients also once admitted remain on the City site and are not transferred to other sites.

Reablement Service

The Trust has introduced a Reablement Service to improve the discharge process whereby patients are now discharged from Hospital to home on a short term care package up to six weeks duration. During this six week timeframe the permanent care package is assessed. This has shortened the length of stay in hospital and reduced the number of permanent home care packages that are required.

As a result of this modernisation, the Trust has merged the Social Work Rapid Response Team and the Reablement Team into one holistic service improving our patient outcomes.

District Nursing

Within in the Trust a review of the District Nursing service (which also includes 24HR Nursing teams, Rapid Response Team, Twilight Service, Night Service etc.), highlighted a number of recommendations to be taken forward which will provide a more robust infrastructure in the community to support the Trust strategic direction and enhance services to the communities we serve. These include:

- Standardisation across the organisation's 8 Integrated Care Teams (ICT's) with 24/7 responsibility

- Extended days which include flexible start and finishing times

- Enhanced range of services building on existing skills and up-skilling staff where required

- Enhanced case management role to prevent hospital admissions and facilitate early discharge

- Clear communication pathways with interfacing teams including rapid access to Community Acute Care at Home Team.

Social Work/Social Care

A review of Social work/Social care is now completed which will set out recommendations to enhance the following:

- Better integration across teams

- Enhance development and promotion of Social Work role both within Hospital and community

- Standardise processes, systems etc.,

- Enhance co-ordination/collaboration approach within a multi-disciplinary/integrated service

- Create a seamless service through improved in-reach/out-reach processes to support the organisation to improve patient discharge etc.

Learning disability

Muckamore Abbey Hospital has and continues to resettle patients into the community in line with the ministerial priority that no-one should live in a hospital but instead have a place to call home in the community.

The multidisciplinary team explores the alternatives to hospital care with the patient and their families to find an appropriate community placement that meets the assessed needs of the patients being resettled.

This work has led to a shift in skill mix. In April 2012 we had a compliment of 323.76 wte which compares to 280.63wte, a reduction of 43.13 wte or 13.32% in January 2015. As we continue with our resettlement programme a further reduction to 249.23 wte is planned.
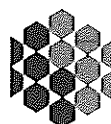
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Our Ref: AGY/188/2015

Date: 1 3   April 2015

Dear Ms McLaughlin

WORKFORCE PLANNING IN THE CONTEXT OF TRANSFORMING YOUR CARE

Thank you for your letter of 12th March 2015 seeking clarification on a number of points arising from the Department's evidence presented on 11 March 2015.

The response to the queries raised, dealt with in the order raised, is as follows:

- **The paper that the RWPG submitted before the meeting states that "Skills for Health" published a Diagnostic Report in November 2013. What is "Skills for Health"? Where was this report published? To who was it circulated? How much did it cost?**

Response: Skills for Health is a not for profit organisation and the Sector Skills Council for the whole of the UK health sector. They specialise in workforce and organisational development in this sector and provide employers with workforce solutions designed to improve healthcare, raise quality and improve productivity and financial performance.

Skills for Health provided the Department with a Diagnostic Report (copy attached at Appendix 1) in November 2013 which was used to inform a workshop held in July 2014 which focused on the development of a new Regional HSC Workforce Planning Framework. The workshop was well attended by relevant HSC stakeholders.

At the time of the report (November 2013), Skills for Health were in receipt of funding on a 4-country basis, the Northern Ireland contribution for which was £52k. The report was produced within this overall cost envelope which also covers the support they provide such as provision of online tools and resources.

- **Officials confirmed that the Regional Workforce Planning Framework (RWPG) will be finalised in the coming weeks and agreed to share the document with the Committee when it is available.**

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Response: The Regional Workforce Planning Framework has now been agreed by the RWPG and a copy is attached at Appendix 2.

- **Can the Department quantify how much has been spent across all the Trusts since TYC was published in terms of re-training staff to meet the shift left requirement?**

Response: The Department is unable to provide such a disaggregation of Trust training expenditure.

- **In relation to the £25m already shifted from hospital services to community/primary services in the areas of learning disability and mental health re-settlements, can the Department provide any detail of the impact that has had on staff who work in those areas? Have staff who work in those areas moved location because of the £25m shift (e.g. are workers in those areas now in community-based settings versus hospitals?)**

Response: Over the last eight years during the resettlement programme, there has been some change in the staffing model and profile of those who worked in long stay institutional care settings. Some staff have chosen to work in a community setting, while others remain working in the modernised hospital setting where there is enhanced therapeutic care. This means the staffing ratio is higher than it had been in the previous long stay institutional care settings. Over this period there has also been the normal turnover of staff, including retirement.

- **Officials stated that the 3% reduction of workforce to implement TYC is inapplicable and that is not a target for workforce numbers. If this is correct, when was this decision made and who made this decision? Is there a new target?**

Response: The position, as set out by officials, is correct. The Review of Health and Social Care in Northern Ireland - Transforming Your Care, when it was published in December 2011, did not state there would be a reduction of staff numbers by 3%. When the Health and Social Care Board consulted on how it proposed to implement elements of Transforming Your Care through operational change across our HSC system, the Vision to Action document outlined some dependencies and possible implications of implementing the changes it was proposing.

As with any change in how we deliver services there will inevitably be impacts on our workforce but it was highlighted in Vision to Action that the exact impacts were not known at that time. Implications therein, including any reduction in the statutory workforce due to the implementation of TYC, were working assumptions at that time. The same document highlighted that there is likely to be a growth of employment in the non-statutory sector. Vision to Action did not set a target in relation to staff reduction, and there has never been a target as part of the Transforming Your Care programme. The strategic objectives and associated measures for the HSCB's TYC programme remain those articulated in previous communication to the Health Committee.

The context of our health and social care system is a different to the context in 2012, and as we have always acknowledged, the pace of change and implementation of TYC is influenced by our financial circumstances and has been slower than anticipated.

- **Can the Department clarify how many GP training places will be funded in 2015/2016?**

Response: The number of GP training places being funded in 2015/16 is currently 65. Any in –year increase will depend on wider funding decisions still to be taken.
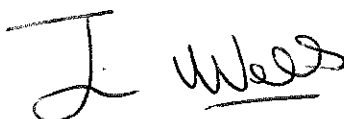
- **An update on the scoping exercise for the workforce review of domiciliary care for older people, following the RWPG meeting scheduled for 30 March 2015.**

Response: The RWPG has recently discussed arrangements for taking forward a regional workforce review of domiciliary care for older people and has agreed the composition of a Steering Group comprising key stakeholders and a Project Group to drive the review forward. Initial steps will include development of terms of reference and a project plan with indicative timescales. The Steering Group will report progress to the RWPG.

- **The membership of the Regional Workforce Planning Group (RWPG).**

Response: A copy of the membership of the Regional Workforce Planning Group (RWPG) is attached. A separate virtual Stakeholder Engagement Group is also in the process of being developed to ensure engagement with a wider range of interested stakeholders.

I hope this is helpful.

Jim Wells MLA
Minister for Health Social Services and Public Safety

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Skills for Health Workforce Planning Diagnostic Report for DHSSPS

November 2013

Summary

The workforce planning diagnostic process was an investigative project and it would have been easy to jump to conclusions without fully understanding the underlying issues. Many of those interviewed believed solutions to implementing workforce planning practices were possible, but accepted without buy-in from managers organisation-wide, at all levels, it may be challenging to instigate any lasting change. Additionally, support and coordinated planning across Northern Ireland was seen as a key requirement.

The general consensus from those interviewed as part of the diagnostic is that overall the approach to workforce planning across Northern Irish Trusts has:

- Been reactive and short term.
- Been traditional i.e. replacing like-with-like.
- Made use of historical models based on trends.
- Shown little evidence of the use of workforce planning tools and methodologies.
- Not been systematic
- Made little use of horizon scanning beyond 1-2 years.

Many of those interviewed understood the relationship between workforce, service and financial planning, however that understanding was not believed to be widespread across the organisations and that in practice these links were not consistently factored into the planning process.

Many recognised the drivers for workforce planning such as:

- 'Transforming Your Care' (TYC) and the greater emphasis on community based services
- The need for revised service delivery models to meet patient/clinical need in the wide ranging geography of Northern Ireland.
- The recognition of the changing nature of healthcare needs and the link to demographic changes in local populations
- Patient safety and quality of care
- Affordability of services given the challenging financial context for all organisations
- Linkages with the overall strategies of the organisations

It was not entirely clear where the roles and responsibilities lay within the organisations for workforce planning. Additionally, whilst some staff had the skills required to workforce plan effectively, there was an identified need to build workforce planning capacity and capability into the organisations.

Interviewees did express a number of challenges to implementing a systematic workforce planning methodology, not least the use of "workforce planning" terminology. However, many felt that the challenges were

outweighed by the opportunities that a co-ordinated approach would bring. Many believed the time was ripe for a change of practice and armed with knowledge, skills and competences in workforce planning could envision a route to a workforce fit to meet both their own service and strategic needs and TYC.

It is important to note that while there are recommendations to improve workforce planning within this document some good practice does occur across Trusts. There were a number of examples of innovative practice but these tended to be linked to major changes in service provision (e.g. a new build hospital or unit, a new service being developed) rather than a consistent approach adopted to ensure on-going development of the workforce.

Northern Ireland Workforce Planning Diagnostic

Workforce planning happens at many levels within organisations from whole organisation planning to front line service level. However, the organisational framework within which such planning happens is crucial to ensuring effective integrated planning is seen as a core element of the organisation's approach to service delivery.

In order to understand the Trusts workforce planning processes and culture a comprehensive diagnostic was carried out by Skills for Health during 2013. The aim of the diagnostic was to explore, through a series of staff interviews, how workforce planning currently operates within the organisation, identify key barriers, and highlight areas of good practice. The information gathered feeds into this report which outlines the findings of the diagnostic process and provides key recommendations as to how to support and embed effective workforce planning across organisations. In addition, key themes that emerged from the delivery of the wider Skills for Health development programme also fed into this report.

Diagnostic aims

1. Development of an effective evaluation framework and interview schedule

2. Interviews with up to 15-20 key stakeholders drawn from each Trust and representative of:

    a. Executive Team members

    b. Human Resource managers

    c. Finance managers

    d. Divisional/Directorate managers

    e. Service Managers

> f. Key clinical service staff

> 3. Development of a report setting out key issues and recommendations for improved workforce planning across Northern Ireland

Diagnostic research approach:

The researcher made use of an effective evaluation framework developed by Skills for Health, with the schedule for interviews arranged by each Trust. Trusts nominated a number of appropriate staff so that they could be interviewed and contribute to the process. Sessions were a mixture of one-to-one and small group interviews. All of the interviews were face to face and lasted roughly one hour.

Findings and Analysis

It is important to note that qualitative research is often associated with an interpretive philosophy because of the need to make sense of the subjective meanings expressed by those taking part in the research. Meanings are therefore dependent on individual's understanding of the events occurring around them. Consequently for interpretation, analysis and understanding of the data there is a need to be mindful of real or inferred meaning(s).

In addition, the report highlights key themes that are relevant for all Trusts. However, it is important to note that the Trusts taking part in this process were all at differing levels of development in terms of their workforce planning processes, reflecting differing organisational approaches and staff with divergent experience and expertise. As a result, while it is judged that all recommendations will be relevant for all organisations it will inevitably be the case that the relevant priority placed on these recommendations will vary by organisation.

Diagnostic research approach:.

Validity of the findings is based on the interviewees' perceptions, beliefs and feelings about the organisations and how they operate in respect of empowerment. Occasionally responses were contradictory, but it was acknowledged that what is/was "real" for individuals may not be "real" for others. Responses to the questions were open, honest, frank, truthful and sometimes hard-hitting. It is important to recognise the comments contained in this report are intended to highlight areas where workforce planning could be improved and are not intended to be critical of individuals or organisations. It is recognised that workforce planning is complex and that the vast majority of people act with the best of intentions – therefore this report supports areas of good practice which already exist and aims to ensure such good practice can be embedded as widely as possible.

In order to explore the interim findings the broad framework for the interviews is used, drawing on themes outlined in the diagnostic framework, i.e. **Workforce Planning Culture; Knowledge and Skills; Systems and Processes.**

i. Culture

The issue of culture as regards workforce planning is intended to encapsulate a range of issues which can be seen as indicative of the organisations' maturity in undertaking effective planning. It captures a range of 'soft' information which highlights organisations' views of workforce planning and how this is perceived by those involved.

Was workforce planning a priority for the organisation?

There was a mixed response to this issue, with responses dependent on where the interviewee sat within the organisation. At a more operational level some felt that workforce planning was not a priority, whereas many at a more strategic level felt that workforce planning was seen as priority. This is probably due to workforce planning as a system being less visible at the operational end of Trusts rather than at a strategic level.

However, even where respondents indicated that workforce planning was a priority many stated that it was prioritised in the 'wrong' way. By this was meant a perception that workforce planning was driven by short term issues and challenges, seen often through the prism of 'cost-cutting' or 'efficiencies'. There was a consistent minority view that workforce planning was driven largely by the need to achieve savings, and didn't take proper account of a wider range of issues.

In general respondents felt that the organisations' approach to co-ordinating workforce planning in a systematic way was not cohesive. Many believed it was reactive to operational need but that there was little time for "future gazing" or "planning for the future" in a co-ordinated way. It was felt that there was a reliance on HR and management information to ignite and do the planning and expectancy that HR would align workforce with corporate and finance plans.

Many recognised and understood the importance of good workforce planning i.e. "it's definitely there, but small cohort at the moment". Overall it was felt that while there tended to be a small number who recognised the need for good workforce planning, others continue with no common understanding.

Was it clear what was meant by workforce planning across the Trust?

A number of people alluded to the lack of clarity across organisations regarding the distinction between workforce planning and rostering. Many felt that what was seen as 'workforce planning' was more accurately characterised as rostering or rota management. This was predominantly seen as short term workforce management, whereas planning was seen as a longer term process that looks across a wider range of issues to articulate what *kind* of workforce is required, not just what *numbers* are required to ensure a service is deliverable in the short term.

A number of delegates recognised that there was a need for greater clarity regarding this distinction, by what is meant by workforce planning and that there was a need to clarify that going forward.

Is workforce planning undertaken in an integrated way?

It was recognised or assumed that the workforce, operational and financial plans all feed into the strategic planning process. However it was believed that there was a lack of detailed understanding of how the elements fitted together, expressed as "there's a bit missing from strategic to operational"; "lack of clarity at strategic level" and "strategically there's a good understanding, lower levels not so good". Up until this point workforce planning has tended to be in silos using historical approaches, i.e. based on what has gone before.

A common issue identified by interviewees was the need for linkages to be strengthened between strategic planning, both within and across Trusts, and operational planning. There was felt to be a gap between strategic aims and objectives and how they impacted and were accounted for in operational planning. This was expressed as 'we have a good sense of what the strategic aims are, but the question is how we get from where we are now to where we need to be'.

In addition, it was often felt that workforce issues were considered late in the wider service change process. A number of individuals felt that workforce was considered 'late in the game' in terms of service change and as result opportunities were missed which could have resulted in more effective and efficient services.

Is workforce planning seen as a predominantly long term process?

The view that came up most often was that planning was carried out on a short term basis and was reactive to operational need, rather than looking to future models of service delivery and identifying the skills required to deliver services over the next 2-3 years and beyond. It was commonly felt that much time was spent 'fire fighting' and 'keeping the wheels turning' which limited the ability of staff to plan and proactively prepare for challenges/issues identified in the future.

Longer term planning did happen in some cases, but this tended to be linked to strategic planning for the organisation and didn't necessarily focus on operational change.

Is it clear who is responsible for workforce planning?

Many individuals across all organisations were often unsure as to who in the organisation 'does' the workforce planning. Where people offered a view they tended to identify Human Resources, Education and Training or individuals who had specific responsibility for uni-professional workforce planning (e.g. Lead Nurse workforce planner).

Those who had more knowledge of where workforce planning happened tended to be those at a more strategic level or those more directly involved in the process, with more operational staff showing least ability to identify key roles, which indicates a disparity in knowledge and understanding across organisations regarding who undertakes workforce planning.

A number of people indicated that they believed that this lack of clarity was widely shared across the organisations, with few confident that many people would be able to identify key roles in the workforce planning process.

Is workforce planning service led, involving relevant service staff?

Most commonly it was felt that workforce planning was centrally driven, with a relatively small cohort within organisations responsible for the process. For many workforce planning wasn't seen as part of the 'day job' for operational managers, except in a relatively short term, reactive way.

A number of operational interviewees expressed the view that workforce planning felt as though it was something that was 'done to them' rather than them having any real influence or effect on the process or its outcomes.

It was recognised that there is an essential role for organisational planning ('top down') but that this was often focused on to the exclusion of operational planning ('bottom up') and that a better balance should be sought in order to effectively use the knowledge and experience that exists across organisations.

ii.   Knowledge and Skills

This section focuses on the key issue of whether the Trusts have both the capability and capacity to undertake effective planning. It focuses on the skills and knowledge required to undertake effective planning as well as whether that knowledge and skill is appropriately distributed within organisations.

Is there a general and consistent understanding of what is meant by workforce planning and what is involved in the process?

As regards knowledge, many felt that staff within their Trusts would potentially struggle to articulate what workforce planning was in its simplest form. Alternatively, if there was an understanding it was felt that this would tend to focus on short term rostering/rota management and day to day management of the workforce rather than an integrated, proactive, longer term approach.

Where understanding of workforce planning was more developed this tended to be based on previous experience either in current or previous roles. A number of interviewees indicated that a number of people would be involved in workforce planning to some degree, and that they may have a narrow understanding of workforce issues, but wouldn't be able to articulate their role in the wider process or how what they do links to other processes.

Do staff have the appropriate knowledge and skills within their organisations to undertake workforce planning?

There was some recognition of expertise in workforce planning but this tended to be located in small groups within Trusts, although much of this was developed through 'learning on the job' with very few indicating that they had had any development/training in workforce planning.

Some highlighted a general lack of confidence among staff regarding their ability to workforce plan, and that in some cases staff were undertaking 'what was felt to be the right approach but without any real confidence or assurance that this was correct'. It was noted that there was a need to adapt and enhance workforce planning skills across organisations as there were gaps in capacity & capability, and in the interpretation of data. It was suggested that the organisations would benefit from a learning package, template or some form of consistent system & process to build a "consistency of approach".

One key gap in knowledge was how to translate proposed service changes into practical workforce changes, for example developing new or amended roles, changing skill mix, or ensuring clinical staff are able to operate in different environments (e.g. a move from acute to community based service provision). Underpinning this is a widespread lack of awareness of the variety of tools and resources which support this process.

Is this knowledge spread widely enough in the organisation to ensure good planning?

The general response was that while some knowledge was contained within key roles in each organisation this was usually restricted to small centralised groups who currently led the workforce planning process. It was recognised that a wider group of staff would need to be involved in workforce planning, in a variety of ways, for the process to work more effectively. It was noted on a number of occasions that a key group who should be involved in workforce planning but were currently underutilised were service managers. However, it was raised a number of times that how people should be involved in workforce

planning depends on their role and that organisations shouldn't fall into the trap of assuming that 'everyone should be an expert in workforce planning'.

iii. Systems and Processes

This section focuses on the systems and processes that support workforce planning. Particularly it explores whether proactive workforce planning was enabled by current processes or hindered by them.

Who leads the development of workforce plans? Who has ownership of the process?

With regard to workforce planning responsibilities and ownership of workforce planning at strategic, directorate and service levels across the Trusts, the general consensus was that it was "not really clear, collectively", "not clearly defined" and "not clear who takes responsibility". Others seemed to be clear about the responsibilities for workforce planning, although this tended to be those who were involved in the current process. There was an identified need "to clarify ownership of levels of workforce plans" and ensure that this was widely understood within Trusts.

A number of interviewees indicated that those best placed to lead on the development of service level workforce plans were service managers, that this responsibility was not widely understood or embedded within organisations, and that this issue should be explored in more detail.

Does the planning system incorporate any feedback mechanisms? i.e. when staff submit information into the workforce planning process is there communication with them regarding what happens next?

Many of those interviewed believed that there was a tendency to "feed up to HR" in a traditional way when asked about how the workforce plans are aggregated up through the organisation. It was expressed that there was a need for a better picture as to how the impact of information provided fed upwards in organisations, but planning at the moment tended to be downwards. This contributed to a feeling that the workforce planning process which, while important, had little practical relevance to service managers and the development of services.

Is planning encouraged that focused on the multi-professional workforce rather than individual professions?

Generally the workforce was seen in silos with on-going work at an organisational level to anticipate and predict changes within professional groups. This was reflected in the fact that many organisations had identified individuals responsible for uni-professional workforce planning (e.g. nursing or medical staffing). While this is an important part of workforce planning there

was little systematic thought about how these staffing group changes might impact on each other or other parts of the workforce.

Given the increasing diversification of the workforce it was recognised that workforce planning had to incorporate the fact that services will increasingly be delivered by a combination of clinical and non-clinical roles and that workforce planning had to take account of this fact. However, it was felt that there had been some improvement in multi professional planning in some areas, but that this was on an ad hoc basis at service level and generally not consistent across organisations.

Does workforce planning link to and inform the training and education provision provided by the organisation or outside bodies?

Many responses indicated that although there is a formal link between workforce planning and education and training it was again felt to be primarily at a strategic level and not necessarily linked to operational need or reflective of the changes required in the future.

It was felt that the education that was commissioned was not as strongly linked to service and organisational need as it could be.

Was there a strong link in the planning process to service commissioners?

A recurring issue that was raised during the interviews was a lack of clarity regarding service commissioners' intentions and the impact this had on the ability of individuals to plan effectively. There was a lack of clarity regarding who was best placed to lead discussions with commissioners within organisations, with some feeling that it should be service managers whereas others felt it should be undertaken at a more strategic level.

However, it was clear that this was felt to be an important issue given the potential impact commissioning decisions have on the future direction of services, how they are delivered and therefore the workforce required in the future. A number of interviewees indicated that although this could be a role for service managers there was a need for organisations to develop relationships with commissioners in a strategic way.

Was the workforce planning process seen as on on-going process, with a need to review plans on a regular basis?

Most respondents felt that workforce planning was seen as a yearly 'one-off' event with little encouragement or expectation that workforce plans would be regularly reviewed and updated where appropriate. This was linked to a view of workforce planning as a process that was undertaken primarily to 'tick the box' in terms of organisational requirements (i.e. 'feeding the beast').

It was felt that for workforce planning to become a live process that is cyclical there needed to be a greater emphasis on planning on an on-going basis.

Do the data and information systems available support effective planning?

Many interviewees noted that the data and information relied on for workforce planning was not as robust as it could be. Accuracy of the data provided was a recurring concern with many feeling that data and information systems were not as robust as they could be. In addition, it was reported that the information that was available was limited and that there was a gap in terms of workforce planning information (e.g. current skills and competences held by the workforce).

In addition, many felt that the data was not always easily accessible or intelligible. This prompted a number of interviewees to indicate that Trusts could usefully explore what key workforce information is provided, in what format, and how it is distributed.

Recommendations

The recommendations below are drawn from the information gathered from the delivery of the programme undertaken by Skills for Health. Although couched in terms of areas of improvement it is important to recognise that organisations are at different points in their development, and that there are pockets of good practice in all organisations. Therefore, the recommendations are likely to be more relevant to some Trusts then others, but it is intended that all the recommendations below will have some relevance for all organisations.

1. **In order to drive engagement in workforce planning Trusts should ensure that workforce planning reflects the values and aims of the organisation and its staff. To avoid the impression that workforce planning is primarily a process of realising cost savings, links to service improvement, quality, and risk management should expressly be made as central to the purpose of workforce planning. This should also feed into communication and visibility of workforce planning within organisations.**

2. **Trusts should clarify the workforce planning process utilised within their organisation, describing what happens at different stages as part of an end to end process. There should be a particular focus on ensuring a consistent approach which can be applied organisation wide and that it is widely understood.**

3. **There is an urgent need for Trusts to clarify workforce planning roles and responsibilities across the organisation. This should**

include a clear distinction between those who are expected to lead and contribute to the development of workforce plans at different levels within the organisation (e.g. service level, directorate/divisional, organisational), as well as those roles that support the planning process (e.g. Human Resources, Education & Training, Organisational Development etc.). There is a further need to then embed such responsibilities within the organisations' systems and processes to ensure clarity and adoption.

4. Trusts should explore the possibility of ensuring there is a recognised and appropriately skilled team who are responsible for leading and supporting workforce planning at an organisational level. Currently, responsibilities are allocated on an ad hoc basis with little consistency.

5. Trusts should undertake a process of identifying the knowledge and skills required across the organisation in order to undertake workforce planning effectively. This would link to and naturally follow on from the role clarification work described above (i.e. in particular roles what knowledge and skills would be required?). Identification of key knowledge and skills required should be mapped to the current workforce to identify key gaps.

6. Utilising the information above Trusts should ensure the development of key staff through a tailored programme of training and support which provides targeted development appropriate to their role. Given the range of roles involved in workforce planning this would require a multi-faceted programme which should, where appropriate, be linked to practical service based projects.

7. Any workforce planning process adopted should place greater emphasis on the need for innovative thinking. In particular the process should encourage flexibility by ensuring that workforce change is led by future service need not historical staffing models.

8. All systems and processes should be future focused. This would involve encouraging staff to become proactive in longer term workforce planning in order to reduce the pressure on, and the need for, reactive responses to short term workforce crises.

9. Trusts should ensure that integration is central to the planning process in order to promote a more effective model. This issue has a number of dimensions but integration should focus on the following areas:
   a. The link between service, financial and workforce planning

b. The link between operational pressures and strategic aims and objectives

c. A more multi-professional approach that formally links planning across both clinical and non-clinical roles

10. There is a need to consider what could be effectively undertaken at an organisational level to support operational planning and how that information could be shared internally (e.g. high level summaries, horizon scanning that is relevant for all, tools and templates and the use of key data and information). Again, this is an issue that can be explored within organisations but might usefully prompt examination across organisations.

11. Some issues affecting workforce planning are relevant at a strategic level across Northern Ireland, for example some aspects of education commissioning and linking strategic aims to operational change. As a result Trusts, together with the DHSSPS, should explore how to coordinate and improve such processes, and determine which elements of workforce planning are best dealt with in a coordinated and strategic way.

12. Ensure and communicate a common understanding of new ways of workforce planning to staff and partner groups using a range of communication methods. This includes the need to clarify within the organisation the difference between shorter term 'transactional' workforce planning (e.g. rostering, filling vacancies, etc) and 'transformational' workforce planning (e.g. challenging the organisation's culture ensuring that workforce planning is integrated and strongly linked to service development over the long term, including how workforce planning operates across the organisation).

Regional HSC Workforce

Planning Framework

March 2015

better **skills**   better **jobs**   better **health**

Contents

Section 1

Introduction

- Effective workforce planning is complex and challenging but is essential in order to contribute to ensuring services across Northern Ireland are both sustainable and delivered to the appropriate standard. The range of challenges faced by the health and social care system has reinforced the need to ensure that the workforce is balanced correctly in terms of numbers and skills.

- There are many **drivers** for workforce planning, such as:

  a. The recognition of the changing nature of health and social care needs and the link to demographic changes in local populations; (greater emphasis on preventative approach and supporting people)

  b. The need for revised service delivery models to meet the needs of patients and clients and health and social care staff and in meeting the career needs of the health and social care workforce in the wide ranging geography of Northern Ireland;

  c. Patient safety and quality of care;

  d. Affordability of services given the challenging financial context for all organisations; and

  e. The need to connect workforce issues with the overall strategic direction as set out in documents e.g. Programme for Government Transforming Your Care, , Making Life Better, HSC Quality Strategy 2020 and the annual Commissioning Plan Direction.

- This Framework aims to support the following **outcomes** for the workforce planning process:

a. An adaptive Health and Social Care workforce of the right size with the right skills deployed in the right way.

b. Developing a shared understanding of the core elements of effective workforce planning;

c. Providing greater clarity of roles and responsibilities, process, structures and governance;

d. Providing an understanding of how organisations and individuals can contribute effectively in a mixed economy; and

e. Encouraging partnership working both within and between organisations;

f. Better informed education commissioning decisions.

Section 2

Workforce Planning: A Working Definition

- At its simplest, effective workforce planning ensures a workforce of the right size, with the right skills, organised in the right way, delivering services to provide the best possible care for patients and clients within available resources

- The approach to workforce planning as set out in this Framework Document is designed to:

    a. *Be centred around the needs of patients and clients;*

    b. *Embrace complexity;*

    c. *Recognise uncertainty;*

    d. *Be open and transparent;*

    e. *Be flexible and responsive to change;*

    f. *Whole system approach to workforce planning taking into account impact on changes to one part of the system on another (taking a Programme of Care approach where possible);*

    g. *Recognise that workforce planning is not just about the numbers but also the competence and deployment of the workforce;*

    h. *Enable the HSC to anticipate where possible, and respond to, Departmental and Ministerial directions and policies;*

    i. *Set out the NHS Six Step Model and its underlying principles as the primary model for workforce planning (Annex A), which can be complemented by other regionally agreed methodologies where appropriate;*

    j. *Make a clear linkage between workforce data, intelligence and projections with decisions on the commissioning of education and training;*

k. *Engage with key stakeholders including employers and staff;*

l. *Ensure timely, robust and accurate workforce information and analysis is available.*

Organisational Roles and Responsibilities

- Effective workforce planning demands a collaborative, consistent, integrated and proactive approach across multiple stakeholders. No individual, group or organisation can undertake the process unilaterally and as a result, there is a range of responsibilities that lie within and between organisations that contribute to effective workforce planning.

- This section sets out the core roles and responsibilities involved in the HSC workforce planning process. Not every organisation with a role in workforce planning is included in this overview however key stakeholders will be included in the process as appropriate.

- The Framework focuses on the core elements deemed necessary to support effective workforce planning.

Department of Health, Social Services and Public Safety (DHSSPS)

- The DHSSPS has a range of statutory responsibilities regarding the effective functioning of health and social care service provision across Northern Ireland. As part of these responsibilities, the DHSSPS should ensure that key core responsibilities regarding workforce planning are delivered both in terms of leadership and ensuring effective functioning of the process. It is responsible for:

a. setting the strategic vision;

b. securing commitment to a high level workforce strategy which will underpin the Department's wider policy objectives;

c. providing regional workforce information and trends;

d. ensuring a regional approach is taken to workforce planning;

e. facilitating of capacity building within the HSC Trusts; and

f. making decisions on the commissioning of pre- and post-registration education and training across the HSC.

Health and Social Care Board/Public Health Agency

- The commissioning of health and social care services is a crucial function within the wider health and social care economy. The Health and Social Care Board, through Local Commissioning Groups, and the Public Health Agency have a duty to ensure, through the commissioning process, that they are able to:

  o meet the current and future health and social care needs of the population of Northern Ireland;

  o secure value for money and ensure the appropriate quality of service provision; and

  o utilise appropriate processes to develop and reform services.

- In relation to workforce, the commissioners' role is to:

  a. agree the models of service delivery;

  b. be assured that HSC Trusts and independent practitioners have considered and identified the workforce needed for service delivery, through for example demand/capacity analysis;

  c. exercise a challenge function where appropriate;

d. identify to the Department areas where intervention is required; and

e. lead or contribute to workforce reviews as required.

The Public Health Agency has an additional specific role in providing professional advice across the HSC and to the Department

Health and Social Care Trusts

- HSC Trusts are responsible for:

    a. ensuring that they have an appropriate and skilled workforce to deliver the services commissioned from them;

    b. utilising both qualitative and quantitative information to inform operational Workforce Plans (to include information projection and risk) which are reviewed annually;

    c. regularly liaise with other stakeholders (including local commissioners) to determine priorities and overcome challenges; and

    d. agree courses of action and implementation of workforce change.

Regional Workforce Planning Group

- The Regional Workforce Planning Group, chaired by the Director of Human Resources, DHSSPS, will:

    a. act as the hub for all workforce planning activity within Health and Social Care;

    b. provide expert advice to the Department regarding workforce planning matters;

    c. inform the overall strategic direction for workforce planning;

    d. agree a programme of workforce reviews; and

    e. receive, comment on and endorse commissioned Workforce Reviews.

- The Table below describes the key roles and responsibilities in relation to regional workforce planning:

DHSSPS	HSCB/ PHA	Trusts	Regional Workforce Planning Group
Set the strategic vision	Agree models of service delivery	Ensure Trusts have an appropriate and skilled workforce to deliver the services commissioned from them	Act as hub for HSC workforce planning activity
Secure commitment to a high level workforce strategy which will underpin the Department's wider policy objectives	Be assured that HSC Trusts have considered and identified the workforce needed for service delivery, through demand/capacity analysis	Utilise both qualitative and quantitative information to inform operational Workforce Plans, which are reviewed annually	Inform overall strategic direction
Ensure a regional approach is taken to workforce planning	Exercise a challenge function where appropriate	Regularly liaise with other stakeholders to determine priorities and overcome challenges	Agree a programme of workforce reviews
Facilitate capacity-	Identify to the	Agree courses of action	Receive comment on

building within HSC Trusts	Department areas where intervention is required	and implementation of workforce change	and endorse commissioned workforce reviews
Take decisions on the commissioning of pre- and post-registration education and training across the HSC	Lead and contribute to workforce reviews as required		

Diagram to Illustrate Workforce Planning process
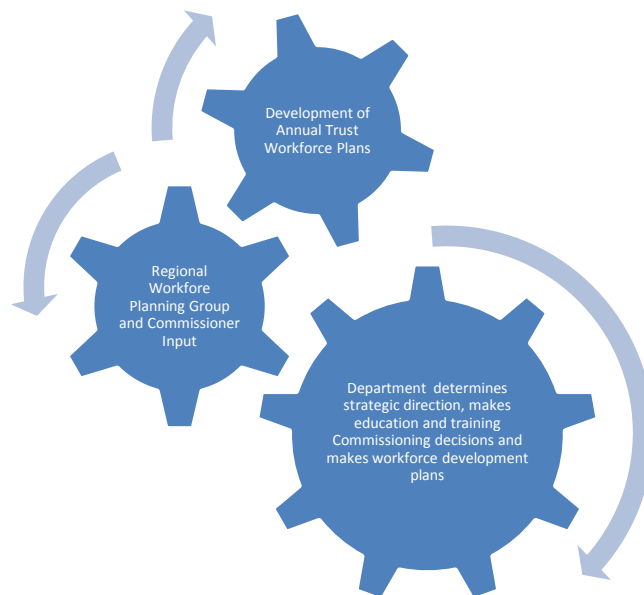
Governance Arrangements

- This Framework Document has been developed under the aegis of the Regional Workforce Planning Group (RWPG). This Group will be re-purposed to oversee the next phase of workforce planning within Health and Social Care. It will have a revised Terms of Reference (including membership), which will be formally submitted by the Chair of the RWPG for approval by DHSSPS.

- Membership of the RWPG will include core representation from the DHSSPS, HSCB, PHA and HSC Trusts, at Senior Executive level as well as other key stakeholders. A list of the members is attached at the Annex B.

- Additional members will be co-opted on an agenda-specific basis or as the work programme dictates.

- Processes will be put in place to ensure that wider stakeholder engagement is facilitated.

Section 5

Next Steps

- This version of the Framework articulates the regional roles and responsibilities envisaged for HSC workforce planning; however it is 26ecognized that this is an evolving process. In view of this, the Framework will be subject to ongoing review and refinement as appropriate.

- Implementation of the framework will be led by the DHSSPS, and primarily taken forward through the RWPG. The primary implementation steps shall be:

    a. Development of revised Terms of Reference for the RWPG for approval by DHSSPS;
    b. Reconstitution of the membership of RWPG to fulfill the Terms of Reference;
    c. To pilot a service area review within a Programme of Care (POC) approach;
    d. Further development of workforce planning capability and capacity across the region.

For further information regarding this Framework please contact
wpu@dhsspsni.gov.uk.

Adapted from the Six Step Model to Integrated Workforce Planning
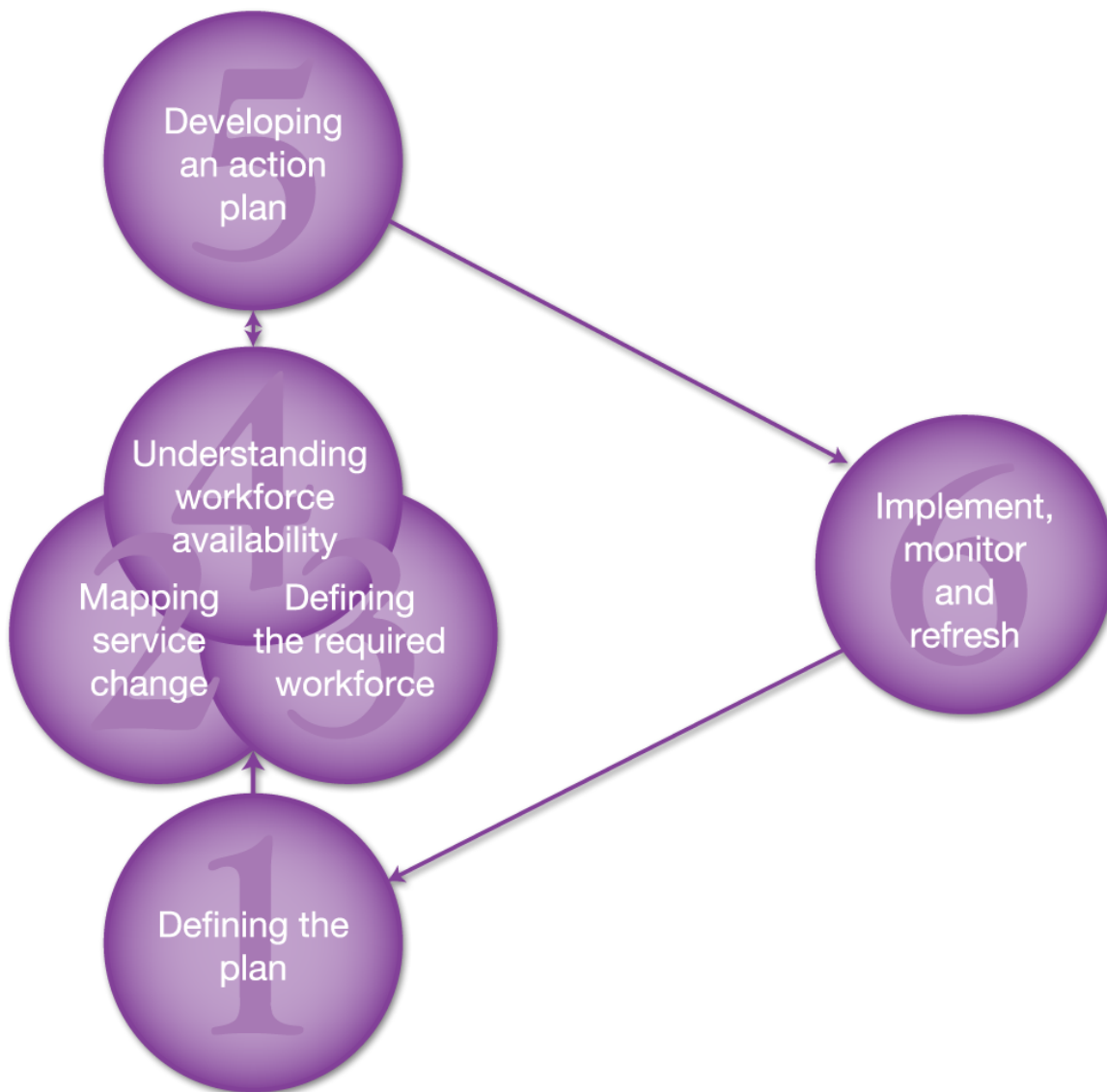
Step 1 – Defining the Plan

Identify why a workforce plan is needed and for whom it is intended:

• Purpose;

• Scope;

• Ownership.

This is the critical first step in the planning process. It is important to be clear why a workforce plan is required and what it will be used for. The scope of the plan should be determined, for example, whether it will cover a single service area, a particular patient pathway or a whole health economy; responsibility for ensuring the plan is delivered and other parties who will need to be involved in the planning process should be clearly stated.

Step 2 – Mapping Service Change

Identify the purpose and shape of any proposed service change that will impact upon future workforce requirements:

• Goals / benefits of change;

• Current baseline;

• Drivers/constraints;

• Option appraisal;

• Working models.

This is the first of three interrelated steps. It is the process of service redesign in response to service user choice, changes in modes of delivery, advances in care or financial constraints. It is important to be very clear about current costs and outcomes and to identify the intended benefits from service change. Those factors that support the change or may hamper it, should be identified. There must be a clear statement about whether the preferred model better delivers the desired benefits or is more likely to be achievable, given anticipated constraints.

Step 3 – Defining the Required Workforce

Identify the skills required and the type / number of staff to deliver the new service model (workforce demand):

• Activity analysis;
• Types / numbers;
• Productivity / New ways of working.

This step involves mapping the new service activities and identifying the skills needed to undertake them and the types and numbers of staff required. This will involve consideration of which types of staff could best carry out particular activities in order to reduce costs and improve the service user experience even where this leads to new roles and new ways of working.

Step 4 – Understanding Workforce Availability

Identify current and future staff availability based on current profile and deployment (workforce supply):

• Understanding the current workforce;
• Workforce forecasting;
• Demographics;
• Supply options.

This step involves describing the existing workforce in the areas under consideration, its existing skills and deployment, plus assessing any particularly challenging areas arising from its age profile or turnover. It may be the case that the availability of staff with particular skills, or, alternatively, the shortage of such staff itself contributes to service redesign and steps 2 and 3 will need to be revisited. Consideration should be given to the practicalities and cost of any retraining, redeployment and / or recruitment activities that could increase or change workforce supply.

Step 5 – Developing an Action Plan

Plan to deliver the required workforce (new skills in new locations) and manage the change:

• Gap analysis;
• Priority planning;
• Action planning;
• Managing change.

This step involves reflecting on the previous three steps and determining the most effective way of ensuring the availability of staff to deliver redesigned services, even if this means some further service redesign. A plan for delivering the right staff, with the right skills in the right place needs to be developed with milestones and timescales. An assessment of any anticipated challenges and how the momentum for change will be created, including staff engagement should be included in the plan.

Step 6 – Implement, Monitor and Refresh

Implement the plan, monitor progress and refresh the plan as required.

• Implementation;
• Measuring progress;
• Revisiting Six Steps.

As the plan is being implemented, it should undergo periodic review and adjustment as appropriate. This should be done by monitoring the agreed indicators of success and by identifying any unintended consequences of the changes.

REGIONAL WORKFORCE PLANNING GROUP (RWPG) MEMBERSHIP	
Name	**Organisation**
Heather Stevens	DHSSPS – Workforce Policy Directorate **(Chair)**
Peter Barbour	DHSSPS – Workforce Policy Directorate
Catherine Donnelly	DHSSPS – Workforce Policy Directorate
Erin Montgomery	DHSSPS – Information and Analysis Directorate
Caroline Lee	DHSSPS – CNO GROUP
Linda Johnston	DHSSPS SSO
Paddy Woods	DHSSPS – CMO Group
Damian McAlister	Belfast HSC Trust
Clare Duffield	Northern HSCT – HR Director
Eamonn Molloy	South Eastern HSCT – HR Director
Kieran Donaghy	Southern HSCT – HR Director
Anne McConnell	Western HSCT – HR Director
Roisin O'Hara	NIAS Trust – HR Director
Hugh McPoland	BSO – HR Director
Gill Smith	HSCB
Dean Sullivan	HSCB
Carolyn Harper	PHA
Patricia Higgins	NISCC

FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY
Jim Wells MLA
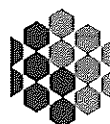
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Our Ref: AGY/187/2015

Date: 2o April 2015

Dear Ms McLaughlin

2015/16 BUDGET

Thank you for your letter of 13 March 2015 requesting additional information following the evidence session on 11 March.

Shift left of £83 million

Transforming Your Care (TYC) aims to implement a new model of care which is organised around the individual rather than institutions or hospitals. This transformation requires an accompanying 'shift left' of resources, the key elements of which are:

- the **re-provision of services from a hospital into a community** (non-hospital) **setting**. This 'shift left' element equates to the £28.46m figure most recently discussed at the Health Committee session of 11 March 2015;
- the **avoidance of hospital activity** through the provision of alternative, community based services which avoid the need for either existing or new hospital care. This 'shift left' element equates to the £0.57m figure which is discussed in more detail below; and
- the **re-direction of new investment into community based transformational services**. This 'shift left' element equates to the £16.31m figure which is also discussed in more detail below.

As was discussed at the Health Committee on 11 March, together some £45.34m is expected to have "shifted left" by 2015/16 through the three elements set out above. Forecasts in respect of both anticipated spend and the shift left value for each of these three elements continue to be kept under review.

Avoidance of hospital activity

In respect of the avoidance of hospital activity the Committee asked for clarification about:

(i) How much have these new services cost themselves, and what Programme of Care they have been funded under;

(ii) Where the funding for these new services has been sourced from; and

(iii) Whether the funding for these services is recurrent or non-recurrent?

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The HSCB has advised that there are two key initiatives which contribute to the £0.57m figure identified in respect of shift left, namely NI Ambulance Services Alternative Care Pathways (NIAS ACPs) and the Respiratory Virtual Pathway.

Based on anticipated spend to date of £410k in NIAS ACPs, the recurrent forecast shift left by the end of 2015/16 is £293k.

Based on anticipated spend to date of £290k for the respiratory virtual pathway, the recurrent forecast shift left by the end of 2015/16 is £277k.

The source of funding for these initiatives is non-recurrent TYC transitional funding.

Re-direction of New Investment

The Committee had also requested details in respect of the re-direction of new investment into community based transformational services which are an alternative to hospital investment and activity. The table in **Appendix 1,** which sets out details provided by the HSCB, offers the response to each of the Committee's queries, namely:

(i)   Details of the services being provided;
(ii) What Programme of Care they have been funded under;
(iii) Where the funding for these new services has been sourced from; and
(iv) Whether the funding for these services is recurrent or non-recurrent.

DHSSPS Capital Investment 2015/16
The capital projects that are proposed to be taken forward or continued in 2015/16 are as follows:
- RVH - Maternity New Build
- RVH - Critical Care Block
- RVH - Cath Lab
- RBHSC MRI Scanner
- BCH Mental Health Inpatient Unit
- Shared Services Accommodation – Construction – Belfast
- BCH - Centralisation of Endoscopy Decontamination
- RVH - Regional Children's Hospital, Enabling and Energy Centre - Enabling
- Ballymena Health and Care Centre
- Ballee Children's home
- Northern Adult Orthodontics
- AAH replacement MRI Scanner
- AAH 2nd MRI scanner
- AAH PFI - Replacement Renal Contract
- Ulster Hospital Phase B - General Ward Block - Main Build
- Ulster Hospital Infrastructure new High Voltage Electrical Supply
- Ulster Hospital Phase B - Acute Services Block (incl. Enabling)

- Ulster - Decentralisation of Boilers
- LVH Emergency Dept co-location/GP Out of Hours
- LVH Site Demolition
- Banbridge Health & Care Centre Main Build
- CAH High Voltage Electrical Infrastructure
- CAH Mechanical Infrastructure
- Additional Main Theatre at CAH

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- CAH 2nd MRI scanner
- CAH Paediatric ward and Ambulatory Care Unit
- DHH Paediatric Centre of Excellence
- North West Radiotherapy (Cancer Service) - Project Team Costs
- North West Radiotherapy (Cancer Service)
- Omagh Local Hospital - Phase 1 - Core Hospital
- Omagh Local Hospital Internal Project Costs
- Altnagelvin 5.1 Tower Block Development
- Erne Decommissioning
- Omagh Cranny
- Additional Theatres at Altnagelvin
- Shared Services Accommodation – Construction - Western
- Enniskillen Ambulance station
- Ballymena Ambulance Station
- Ulster - Decentralisation of Boilers
- NIFRS - Logistics and Support Centre - One Stop Shop

It is not possible at this stage to provide a list of unconfirmed projects that may be progressed if money becomes available in-year. There are a considerable number of projects at the planning and development stage across the Department's ALBs, which vary considerably in size and scale. As part of the process of finalising the capital plan for 2015/16, the Department is working with HSCB to prioritise which projects might be progressed in 2015/16 and further information on proposed capital bids for in year spend will be provided to the Committee in the Department's briefing paper on June Monitoring.

Pilot in South Eastern Trust on self-management of diabetes

As part of TYC, the HSCB is continuing to support a pilot project in the South Eastern HSC Trust which uses an innovative Diabetes Insulin Guidance Service.

The device, which is also supported by nursing support, provides people with quick and easy access to advice if they need it. The device is the size of a mobile phone and uses a simple finger print blood test combined with smart technology to help people regulate their own insulin dosage. This enables people to use it at home, on the move, and without having to wait for the next visit to a healthcare professional. 270 diabetes patients in the South Eastern HSC Trust Area are currently benefitting from this innovative project.

The HSCB will shortly be considering its suitability/applicability for the region, although funding would have to be found for a regional expansion.

I trust that this is helpful.

Jim Wells MLA
Minister for Health, Social Services and Public Safety

## Shift Left Value Associated with New Recurrent Investment of £16.31m by end of 2014/15 onwards

Service	Detail of service provided	(i) Recurrent Investment and Shift Left Value	(ii) Programme of Care	(iii) Source of Funding	(iv) Status of Funding
Community Nursing - to Support Early Discharge	To support earlier discharge from hospital and promote recovery in the community.	£0.39m	Primary Health & Adult Community	HSCB Demography Funds	Recurrent
Reablement	To support older people to re-enable them to undertake personal care tasks.	£4.83m	Elderly	HSCB Demography Funds	Recurrent
Glaucoma Services in Primary Care	To enable delivery of the service to move to a primary care based service utilising an integrated model.	£0.22m	Primary Health & Adult Community	HSCB Demography Funds	Recurrent
Specialist Foster Carers	To provide additional specialist foster care places, for those children who are hardest to place, which helps avoid admissions to long term care in Children's Residential Homes.	£0.25m	Family & Childcare	HSCB Demography Funds	Recurrent
Community based COPD Team	To provide capacity for extended hours to avoid unnecessary hospital admissions & support patients at home.	£0.13m	Primary Health & Adult Community	HSCB Demography Funds	Recurrent
Telecare & Telemedicine	To enable management of a range of long term conditions through health monitoring technology.	£2.93m	Elderly and Primary Health & Adult Community	HSCB Demography Funds	Recurrent
Stroke	To enable early supported discharge and early intervention to initiate a recovery based pathway.	£0.15m	Acute	HSCB Demography Funds	Recurrent
Children's Services	To support technology dependent children in their homes and provide an enteral feeding team to avoid	£0.62m	Family & Childcare	HSCB Demography Funds	Recurrent

Service	Detail of service provided	(i) Recurrent Investment and Shift Left Value	(ii) Programme of Care	(iii) Source of Funding	(iv) Status of Funding
	interventions at hospital.				
Palliative Care Services in the Community	To provide medical, nursing and AHP professional support to enable those patients approaching their last few weeks of life to be discharged from hospital where it is appropriate to do so or maintained appropriately at home.	£0.67m	Primary Health & Adult Community	HSCB Demography Funds	Recurrent
Mental Health	To provide a range of services including crisis response home treatment, community addiction teams and psychological therapy for alcohol related brain injury to reduce demand for psychiatric inpatient beds and hospital attendances.	£0.38m	Mental Health	HSCB Demography Funds	Recurrent
Elderly	To support a range of services including pre-admission assessment and access to enhanced rapid access services Domiciliary Care, Reablement, OPAL, Early Supported Discharge, Rapid Response Nursing and District Nursing to reduce hospital lengths of stay and prevent unnecessary unscheduled admissions and readmissions to secondary care.	£1.71m	Elderly	HSCB Demography Funds	Recurrent
Dementia Strategy & Memory Services	To further develop dementia home support services and re-designed care pathways allowing patients and clients to be cared for at home as an alternative to hospital admission.	£1.31m	Elderly	HSCB Demography Funds	Recurrent
All Other Investments	To improve Community Access for those	£2.70m	Various	HSCB Demography	Recurrent

Service	Detail of service provided	(i) Recurrent Investment and Shift Left Value	(ii) Programme of Care	(iii) Source of Funding	(iv) Status of Funding
	with a Physical Disability, Nursing Support for those with an Eating Disorder, 7 day working, Day Opportunities, Diagnosis and intervention for adults with an Autistic Spectrum Disorder			Funds	
TOTAL		£16.31m			

Note: The £16.31m represents the annual recurrent investment and the shift left value in these service developments by end of 2014/15 onwards.
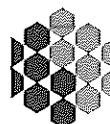
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Our Ref: AGY/257/2015

Date: 29 April 2015

Dear Ms McLaughlin

WORKFORCE PLANNING

Thank you for the Committee's letter of 16 April in which you seek further clarification on a number of points relating to current workforce planning issues.

The response to each query is detailed below.

Q1: *If the recently announced £300,000 to go towards recruitment and retention of GPs is not going towards training places, where is it going? Are there any plans in the near future to make a decision on increasing the number of GP training places for 2015/2016?*

Response: A range of measures are being considered in relation to the recruitment and retention of GPs. These include: how GPs wishing to return to practice in Northern Ireland can be facilitated to do so on a timelier basis; the trialling of incentives for GPs close to retirement to remain in practice; and those newly qualified, to practice in areas of greatest demand within Northern Ireland.

There are also a number of strands of medical workforce planning under way at present. The Centre for Workforce Intelligence (CFW) has been appointed to review the medical workforce including undergraduate intake levels. In addition, the Health and Social Care Board are currently undertaking some work specifically on GP workforce planning (eg examining initiatives to improve the recruitment and retention of trained GPs and including areas such as part time working and child care arrangements). No final decision will be taken until the Department has considered the findings of these reviews.   However, any increase to the number of GP trainees would require increased funding and any decisions would need to take account of the overall funding position for health.

Q2: *Regarding the issue that the 3% reduction of staff was a possible implication of implementing TYC, how was this figure reached and is there a new possible implication within the current framework?*

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Response: In the public consultation paper, published in 2012, on the proposed service changes following consideration of the proposals set out in the Transforming Your Care Report published in 2011, a working assumption was included on the possible impact to the directly employed workforce. As the Committee has been previously advised, **this was not a target and was subject to change**. It was based on calculations and assumptions in relation to Voluntary Redundancy and Voluntary Early Retirement as a result of potential changes to the required skills mix and services models, as well as taking account of natural wastage over the period. The document also said that it was likely that there would be a growth of employment in the non-statutory sector. Going forward, no overall target for either an increase or decrease is being set for the HSC workforce as that would be arbitrary and would serve no useful purpose.

Q3: *Does the Department intend to open the NICS Voluntary Exit Scheme to the wider HSC, and if so, how will this be coordinated with the work in relation to workforce planning?*

Response: In common with all other parts of the public sector, work is ongoing to develop a Voluntary Exit Scheme specifically for the HSC in order to contribute to the delivery of organisational savings plans and a bid for funding will be made to the Public Sector Transformation Fund. It is expected that the impact on front line staff will be minimal

I hope this information is helpful.

Jim Wells MLA
Minister for Health Social Services and Public Safety

Northern Health and Social Care Trust

HSC

14 May 2015

Dr K Aiken
Clerk
Committee for Health, Social Services and Public Safety
Room 284, Parliament Buildings
Stormont
Belfast
BT4 3xx

Dear Dr Aiken

Thank you for your letter dated 22 April 2015 regarding Workforce Planning activity in the Trust.

By way of an overview, to date the Trust has approached Workforce planning through an informal and devolved model with plans developed and delivered at a local service and Directorate team level. This is reflected in Directorate Management Plans and Service improvement initiatives. The use of workforce information and data supports local managerial and clinical knowledge of skill mix requirements and resource supply and demand need to the extent that this informal and local management and planning of resources has become a sound business as usual activity.

More recently the Trust is in the process of developing a comprehensive strategic Reform and Modernisation Plan which will provide a future roadmap for service change and improvement and remains in keeping with the objectives of TYC. Implementation of this Plan will be supported by a wider people-centric model for Transformation. This will include delivering Transformation through cultural change, organisational development and people based initiatives. It is required to be embedded by the development of a formal organisational model for workforce planning to support the delivery of a locally transformed model of service provision. We recognise that delivery of our strategic plan will be reliant on further investment and development of the mechanics and tactical aspects of workforce planning across the organisation given that currently there is insufficient internal capability to co-ordinate or lead this important area of work from a strategic perspective.

Involvement in regional service review working groups and the RWPG provide the platform for the Trust to request greater momentum and proactivity from education providers and training bodies to address skills gaps, as this is a significant dependency in addressing skills shortages in certain clinical professions as well as sufficient numbers of such staff to meet the demand for professionals to deliver a transformed service model.

In your correspondence you have referred to the Trust's responsibilities for Workforce Planning. I will address the three responsibilities that you have outlined in turn and hope that this provides you with an overview and some examples of the on-going work, plans and capability within the Northern Trust in this area.

1. An appropriately skilled Workforce

- The provision and analysis of workforce data helps to shape and informs operational workforce plans. Central Information produced and analysed includes: labour turnover, reporting on use of fixed term contracts, agency and locum usage, vacancy and recruitment data, absence data. This complements local productivity, skill gap and forecasted training need knowledge to inform supply and demand of people resources.
- The Trust has commenced work to develop its employment brand and employee engagement strategy to ensure the attraction and retention of sufficient and appropriately skilled and capable employees.
- The Trust has a learning and development plan which is strategically aligned and informed by service requirements.
- The Trust adopts volume and targeted recruitment campaigns for key roles when required.
- Each Directorate has a management plan with objectives and deliverables on the use of resources and workforce plans.
- There is specific skill within the Trust in the development and delivery of workforce plans for Nursing. Some initiatives in this area have included:
    - Implementation of Normative Nursing
    - Shift consolidation review

2. Development of Operational Workforce Plans

The Trust has an on-going programme of service improvement and development, aligned to TYC. All initiatives are accompanied by a relevant and appropriate plan for People Change which will assess, plan and deliver changes to the workforce ranging from changes to working patterns, skills development, organisation of teams, recruitment and selection for new roles, and consultation on changes to existing roles. Support and expertise from an HR Business partner model and Directorate Planning and Performance managers help the development of these workforce plans.

Some recent examples include:

- The review and modernisation of Speech and language Therapy services
- On-going work to expand and up skill the domiciliary care workforce to address demographic trends and the increasing complexity of the roles.
- Developing locality based multi- disciplinary community teams to support care and rehabilitation closer to home.

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- A regional approach to recruitment for certain roles e.g. Allied Health Professionals
- A review of Management structures with the objectives of financial efficiency and effective management of Services through a new Divisional Service model which will improve patient pathways.

The Trust recognises the particular recruitment and succession challenges to fill medical vacancies in certain specialities. The resourcing challenge within the medical workforce is heightened by the insufficient number of trainees in certain key areas. Within the Northern Trust the geographic position of Causeway Hospital also makes recruitment more difficult. The Trust is proactive in addressing gaps through the use of flexible, agency and locum staff. Collaboration with neighbouring Western Trust in how Urology services are delivered is a recent example of how service reconfiguration and workforce challenges can be addressed.

The Trust is also currently undertaking a significant piece of work to review Consultant Job planning in the spirit of ensuring an effective use of resources, value for money, alignment to performance and delivery of SBA volumes and to improve clinical leadership capabilities through a refreshed divisional medical director and clinical director leadership model.

3. Make changes to the Workforce to implement TYC

As previously stated, we are in the process of developing a strategic Reform and Modernisation Plan for 2015-2020 in partnership with our stakeholders. This strategic plan will set out our ambition and will enable us to pursue our vision "*to deliver excellent integrated services in partnership with our community*" and will provide a roadmap for the implementation of TYC.

From a workforce perspective this will include the further development of integrated teams, integrated management and governance arrangements and integrated pathways of care.

Our ambition is that this will not only be delivered through Service Reform but will be underpinned by a People-centred model for Transformation; performance optimisation through a highly engaged workforce and which will include investment in skill and capability development.

This strategic approach to Workforce Planning will encompass:

- Development of leadership and management capabilities to deliver change and modernisation.
- Investment in practionner and clinical leadership capabilities.
- A workforce plan for revised Nursing and Medical resource requirements for Causeway Hospital.
- A Workforce model for locality based multidisciplinary and integrate teams working in the community but with clear connection into and out of the main Acute and intermediate care facilities.

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- A workforce plan to expand the skill and capability of employees within the main Acute hospital sites to support increased demand and continuously improve in the areas of quality and safety.

In addition to the approach described above, the Trust is represented on the Regional Workforce Planning Group. The development of the Regional Workforce planning framework in early 2015 has been helpful in clarifying roles and responsibilities and in connecting the wider range of activity across HSC.

The Trust is aware of the existence of other groups which have Workforce Planning remits and which have the aim of contributing to Workforce Planning from a particular professional or occupational angle. The Trust is also represented on these but has encouraged streamlining these under the RWPG:
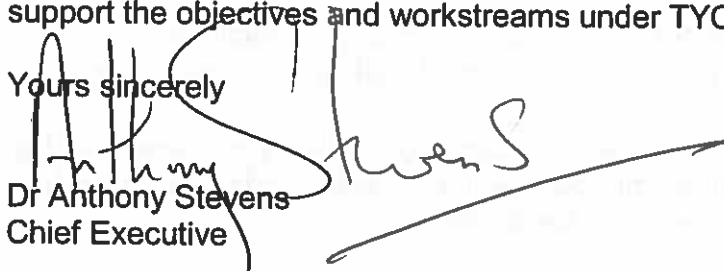- Steering Committee for Workforce Planning in Nursing and Midwifery
- Medical Workforce Review and work under taken by Mouchel
- Medical Speciality Review being led by PHA.

Given the importance of workforce planning to our developing strategic plan, we have identified the following opportunities going forward, both for the Trust, and for which we will request wider support and collaboration:

- Support to develop the Trust's resource and specialist capability in workforce planning and labour productivity.
- Adoption of the 6 step methodology as a central framework and organisational awareness to translate this into a practical operational model.
- Greater leverage in managing the interdependencies and complexity of workforce planning in areas such as Primary care and pharmacy for example.
- Strategic partnership with education to align HSC skill requirements to training.
- Making a greater contribution and provision of evidence in relation to medical specialties shortages to increase momentum to have these areas addressed.
- Creating a more flexible solution to address gaps in medical training posts in discussion with our Commissioner and the training bodies.

I hope that the information provided demonstrates that we have both an operational approach to workforce planning which is embedded in Service delivery management plans as well as a longer term strategic plan which we are developing in pursuit of our vision for the Northern Trust and which will naturally support the objectives and workstreams under TYC.

Yours sincerely

Dr Anthony Stevens
Chief Executive

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Ref: DMAO 15/65

14 May 2015

By email

Dr. Kathryn Aiken
Clerk
Committee for Health, Social Services and Public Safety
Room 284, Parliament Buildings
Ballymiscaw
Stormont
Belfast

Dear Dr. Aiken

Review of Workforce Planning within the Context of Transforming Your Care (TYC)

I refer to your letter of 22nd April 2015 to the Trust Chief Executive, Dr Michael McBride, requesting information in regard to the above. I am responding on Dr McBride's behalf as he is currently out of the office.

The Belfast Health and Social Care Trust has in place a number of initiatives across the organisation to ensure we have a highly motivated and skilled workforce, i.e. the right people at the right time in the right place to deliver safe, compassionate quality care and deliver the strategic vision of health and social care in the future.

The Trust promotes and supports managers in the development of workforce plans and has set out priorities to take this forward. The Trust continues to identify new ways of working, to improve the patient experience, and to build the capacity and capability of our managers.

A number of key reviews and projects are on-going within the Trust which inform workforce plans and create a community infrastructure to support patients/clients to remain at home and to reduce demand on acute services.

I attach an outline of the workforce planning initiatives that are underpinning a number of service reviews that are currently on-going within the organisation.

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I trust this information will be helpful to the Committee in their consideration of this matter.

Yours sincerely

Damian McAlister
Director of Human Resources and Organisational Development

Copy: Dr M McBride – Trust Chief Executive

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Review of Workforce Planning within the context of Transforming Your Care (TYC)
Belfast Health & Social Care Trust

1.   Context

The Belfast Health and Social Care Trust deliver's integrated health and social care to 340,000 people in Belfast and are the Regional Trauma Centre to our 1.8 million population of Northern Ireland.   Our Clinical services are provided within a directorate structure:

- Adult Social and Primary Care
- Children's Community Services
- Specialist Hospitals and Women's health
- Unscheduled and Acute Care
- Surgery and Specialist Services

The Trust's Emergency Departments, at the Royal and Mater are the busiest in Northern Ireland, treating around 150,000 patients each year.

We currently employ a total of 20,509 staff equating to 17,541.31 whole time equivalents across a range of occupational family groups as indicated in table 1 below.

Occupational Group	H/C	WTE
Admin & Clerical	3418	2948.03
Estates	234	233.8
Generic	4	4
Medical & Dental	1685	1589.15
Nursing & Midwifery	7288	6287.85
Professional & Tech.	3048	2672.66
Senior Executives	10	10
Social Services	2628	2163.83
Support Services/User Experience	2193	1631.32
Total	20509	17541.31

Table 1

The information outlined below is in response to the Health Committee's letter of 22nd April 2015. The Belfast Health & Social Care Trust has a number of initiatives ongoing across the organisation to ensure we have a highly motivated and skilled workforce to deliver the strategic vision of health and social care in the future. This response concentrates on those services directly affected.

The Trust promotes and supports managers in the development of workforce plans and has set out priorities to take this forward. The development of a workforce plan for Adult Social & Primary Care (AS&PC) Directorate is near completion. The draft workforce plan is due to be presented to the ASPC Modernisation Team meeting in June 2015.

A number of key reviews and projects are ongoing which will inform the workforce plan and create a community infrastructure to support patients/client to remain at home and to reduce demand on acute services. I have provided an outline below of on-going projects across a number of Directorates:

2.   Adult Social & Primary Care Directorate

The Adult Social and Primary Care Directorate is our second largest Directorate employing 4547 headcount, 3820.55 wte. Considerable workforce planning and modernisation has taken place within this service area. The Directorate comprises four key service areas namely:-

- Mental Health Services
- Learning Disability Services
- Older Peoples' Services/Physical & Sensory Support
- Psychology Service

2.1   Mental Health Services

The Trust has reduced the number of Acute Mental Health in-patient beds by almost 50% since 2008 from 160 to 82 and plan to further reduce over the next few years, subject to commissioner approval. The new purpose built in-patient unit located on the BCH site is due to open in 2017 and will have single room accommodation for 74 mental health beds and 8 psychiatric intensive care beds. The Trust has enhanced community Mental Health teams and opened a new Home Treatment House on the Antrim Road.   It has also introduced a new Peer Support role and would plan to further develop this in the future. The Trust has developed our Acute Day Treatment Model with a team based in the Antrim Road but outreach to other facilities such as Dunluce and Woodstock.

The ethos is to resettle patients from the acute setting into the community, into better facilities and under the premise that no-one should have to spend their days in a hospital, unless absolutely necessary. Future plans will continue this ethos with community teams enhanced and new roles identified.

2.2   Older People Services

2.2.1   BCH Direct Assess and Treat Unit

Within Older People Services and in collaboration with colleagues in Unscheduled Care Directorate, the BCH Direct Unit opened in October 2014. This created a direct access assessment unit for GPs and Northern Ireland Ambulance Service (NIAS) to refer frail elderly patients via ambulance and negate the need to present at the Emergency Department (ED).

The aim of BCH Direct is to assess and treat patients on arrival and either discharge them with a full treatment and review appointment, or admit them to an appropriate ward. This approach aims to greatly improve experience and service for older people, while reducing pressure on the Emergency Departments. BCH Direct aims to ensure that patients go to the right place first time.

BCH Direct staff have been up-skilled to meet the demands associated with this new service e.g. training on triage of patients and linking in to shadow colleagues in Adult Emergency departments. An Assistant Nurse Practitioner role has also been introduced with staff skilled in taking bloods and carrying out ECG's.

The Unit is multi-disciplinary and requires all professional groups within the unit to work over a 7 day period and extended working days. This includes Physiotherapy and Occupational Therapy staff.

2.2.2   Acute Care in the Community

The Trust Acute Care at Home Team aims to provide, for urgent conditions, a comprehensive, safe and efficient service for frail elderly patients. The teams' role will be to clinically assess all frail elderly patients over 75 (including adults with acute exacerbation of chronic conditions) referred to them from any 'home setting'.

Pivotal to a successful community based model for urgent care will be the rapid access to a community geriatrician to support acute care at home with access to appropriate step up beds, rapid assessment and diagnostics.

The Acute Care at Home service has currently been funded by Belfast LCG based on 5 day week. The service will be multi-disciplinary and consist of the following posts which are currently in the recruitment process.

- Acute Care at Home Co-Ordinator Band 8A x 1

- Consultant Geriatrician 10 sessions

- GP x 20 sessions

- Acute Care at home Band 7 x 4

- Nurses – Band 6x4.

- Nurses – Band 5 x 3.

- Rehabilitation/ Healthcare Assistant Band 3 x 5

- Social Worker Band 6 x 1

- Occupational Therapists Band 6 x 1.(5 day week x 52 weeks)

- Physiotherapist Band 6 x2.5 (7 day week x 52 weeks)

- Community Mental health Practitioner Band 6 x 1 (5 day week)

- Pharmacist Band 6 x1.

- Administrative Band 4 x 2.

- Admin Support – Band 3 x 1.

- Drivers Band 1 x 2. (7 day week.)

2.2.3 Reablement Service

The Trust has introduced a Reablement Service to improve the discharge process whereby patients are now discharged from Hospital to home on a short term care package up to six weeks duration. During this six week timeframe the permanent care package is assessed if appropriate. This has reduced the length of stay in hospital and the number of permanent home care packages that are required.

As a result of this modernisation, the Trust has merged the Social Work Rapid Response Team and the Reablement Team into one holistic service improving patient outcomes.

2.2.4 District Nursing Review

A recent review of the District Nursing service (which also included 24HR Nursing Rapid Response Team, Twilight Service, Evening &Night Service etc.), highlighted a number of recommendations for consideration which will provide a more robust infrastructure in the community, support the Trust strategic direction and enhance services to the communities we serve. These include:

- ➢ Standardisation of 8 Integrated Care teams across the organisation with 24/7 responsibility

- ➢ Extended days which include flexible start and finishing times.

- ➢ Enhanced range of building on existing skills and up-skilling staff where required.

- ➢ Enhanced case management role to provide alternatives to hospital admissions and facilitate early discharge.

- ➢ Clear communication pathways with interfacing teams including rapid access to Community Acute Care at home team.

- ➢ The review process is on-going and the above recommendations will require Trust approval and sign off.

- ➢ Improved communication & collaborative working with Primary Care.

2.2.5 Social Work/Social Care Review

A review of Social Work/Social Care was recently completed the report compiled is now awaiting sign off by the Directorate. The report sets out a number of recommendations to enhance the delivery of the Social Work/Social Care Service and provide for greater utilisation of resources to support TYC and provide greater integration between Acute and Community Services. Recommendations under consideration will result in the following:

➢ Better integration across teams.

➢ Enhance and promote the Social Work role within hospital and community

➢ Standardise processes and systems

➢ Enhance co-ordination/collaboration approach within a multi-disciplinary/integrated service

➢ Create seamless service through improved in-reach/out-reach process to support the organisation to improve patient flow etc.

2.2.6 Respiratory Services

Chronic Obstructive Pulmonary Disease (COPD)

The Trust has currently embarked on service developments required in Belfast to support the operation of a fully integrated care pathway for COPD. Many of the elements of the pathway are already in place across the Trust but gaps remain to be addressed if the benefits of an integrated service in terms of efficiency, effectiveness and quality of care are to be fully realized. The priority is to reduce acute admissions and hospital length of stay and to support patients at home with effective involvement of primary care. Inpatient care should only be required for patients with severe exacerbations who cannot be managed at home. These should be consistent with good practice guidance and the implementation of Transforming Your Care to ensure appropriateness of hospital admission and optimize the role of Primary and Community Care.

➢ **Discharge Planning**: a gap in effective discharge planning resources exists in respect of the South and East Belfast sector of the LCG area. The Trust should bring forward a proposal for an in-reach resource to focus on the COPD discharge care bundle which will inform the proposed commissioner quality performance monitoring for COPD and which enhances linkages with the pulmonary rehabilitation process.

➢ **Seven Day Respiratory Early Discharge and Community Support:** early discharge schemes are an evidence-based effective means of reducing the length of stay (LoS) of COPD patients by providing enhanced support at home. The Trust response should identify their approach to ensuring the delivery of a 7 day respiratory early discharge service to allow COPD patients within the three Belfast

hospitals to be assessed for the potential to be discharged home early and to permit more patients to be discharged at weekends.

➤ A seven day community service would permit an early discharge scheme for Belfast to operate over the whole week, as well as providing support to manage exacerbations and reduce admissions either by direct follow-up at home or direct discharge from A&E. It is envisaged that this service would involve GP with Special Interest in Resources (GPwSI) to ensure continuity of care, medical cover and governance. The role of the GPwSI would be to support complex patients at home, facilitate earlier identification of palliative needs, support patients to die at home where appropriate.

➤ The emotional and psychological wellbeing of patients will be supported through the addition of a Clinical Specialist Psychologist embedded within the community respiratory specialist team

➤ Full implementation of the home oxygen service assessment and review.

2.2.7 Stroke Services

The Trust continues to review stroke services across both the Acute and Community. To date the Trust has merged stroke wards from BCH to one single stroke unit on the RVH site. This has allowed for greater efficiency in the delivery of care with bed reduction and reduction in length of stay.

Work is now underway through Belfast ICP's to improve the management of Transient Ischaemic Attacks (TIAs) and enhance the level of rehabilitation support available to stroke survivors. There will be enhanced input from Allied Health Professionals (AHPs). This will assist more patients to be discharged from hospital at the earliest opportunity and receive specialist rehabilitation at home.

2.2.8 Home Care Workforce

The Trust in November last year provided approximately 400 Homecare staff the opportunity to move from an 'as and when' contract to permanent hours contract. This enhanced utilisation of the workforce and improved continuity of care provided to service users in the community. This change was conducted in partnership with Trade Unions

2.3   Learning Disability

Muckamore Abbey Hospital has and continues to resettle patients into the community in line with the ministerial priority and strategic direction to where possible provide care and support to patients/client within the community.

The multidisciplinary team explores the alternatives to hospital care with the patient and their families to find an appropriate community placement that meets the assessed needs of the patients being resettled.

This work has led to a shift in skill mix. In April 2012 we had a compliment of 323.76 wte which compares to 280.63wte, a reduction of 43.13 wte or 13.32% in January 2015. This work continues to be rolled out and staff affected will be redeployed within the organisation in line with the Trust's Redeployment Protocol.

2.5 Supported Living

A number of areas across AS&PC Directorate are reviewing the current service delivery in relation to residential care with a view to provide opportunities for clients to move to supported living within the community.

3.0 Unscheduled and Acute Care Directorate

Our largest directorate is Unscheduled and Acute Care employs 4792 headcount, 4199.65 whole time equivalents, of our total workforce. It is envisaged that work on developing a Directorate wide workforce plan will commence this year.

The Directorate has undertaken considerable work to address the backlogs faced within our emergency departments and over recent months we have re-located our wards on our Royal Victoria site. Twelve wards and six clinics, totalling 308 beds. This was a determined effort to put patient safety and experience first by co-locating specialisms; to aide cutting down on patients outlying from their specialism; and to ensure the beds we need for our patients are in the right place and cared for by the right team. For example, we now have the whole of fractures service in one area; Cardiology, Respiratory and Cardiac Surgery are all on the one floor. And, we have a newly re-profiled respiratory ward in the Royal to ensure the patient experience is enhanced.

The Trust has launched an IMPACT programme Improving Patient Experience and Accessing Care through Team work. An Unscheduled Care service which delivers a timely, quality experience to patients/clients, carers and staff is the number one Trust priority and essential to our goal of becoming one of the best performing Trusts in the UK in terms of patient safety, patient experience, and patient outcomes.

The IMPACT Project, will empower seven clinical teams, supported by experienced managers, to design and deliver the necessary changes across the Trust. Each team has specific objectives, based on the Berwick Principles, focused on reducing Waste, Harm and Variation. The Belfast Project will be part of a Regional Project designed to establish better regional co-ordination, better information sharing between Trusts and better planning across and between Trusts.

The seven clinical teams include the following:-

- Frail Older People
- Respiratory
- Emergency department
- Flow and Take
- Ambulatory Care
- Resource profiling

- Diagnostics

3.1   Frail Older People

(please see information above under Older People Services)

The team opened the BCH Direct Unit for the direct assessment and admission, if required, of frail older people in October 2014 on the City Hospital site. The unit has reduced the number of older people being admitted through RVH ED and has addressed complex discharge arrangements to support patients to be able to go home once medically fit. The team also has a focus on developing and implementing pathways to support people to remain at home and, if needed, ensure direct admission to the right specialty.

3.2   Respiratory

(please also refer to information above under COPD)

As part of specific RQIA recommendations on respiratory services, the team are initially focussed on reviewing arrangements for the assessment and admission of patients, for developing a direct assessment and admission arrangement at BCH to reduce LOS. The Trust is committed to ensuring that more respiratory patients will be cared for by a respiratory consultant in a designated respiratory bed as indicated above.

3.3   Emergency Department

Within the 2:1:1 Trust focus (2 hours for decision for Speciality assessment: 1 hour Specialty decision: 1 hour Admission achieved (if required)), the Workstream have identified changes to the triage, assessment and liaison roles of the ED teams, separating minor injuries, increasing the number of patients directly triaged to the appropriate specialty and aligning the staff team to attendance patterns.

The Emergency department has also invested in upskilling our existing workforce to become Emergency Nurse Practitioners and also enhanced the number of Advanced Nurse Practitioners in this area. The Trust is leading the way in Northern Ireland with the appointment of two Advanced Nurse Practitioners, in January of this year. The new appointees are based at the Royal site Adult Emergency Department.

Although a very well established role across the UK, this is an exciting first for Northern Ireland.

3.4   Flow & Take

This workstream's initial focus is on identifying the specialties that have the greatest unscheduled care responsibilities, analysing the patient flow arrangements in each of these specialties and identifying the barriers to effective patient flow, recognising that they are likely to be different for each specialty. Once these specific barriers have been identified the group will look to these specialties to propose and implement solutions.

3.5   Ambulatory Care

The Team initially focused on identifying patients' top five admitted medical conditions which could safely be diverted through the use of virtual clinics, PTU or OPD, increasing the Trust capacity for urgent outpatient appointments and associated diagnostics, increasing the number of patients directly discharged from ED to an alternative ambulatory care pathway and to ensure the spread of good practice across the Trust.

3.6   Resource Profiling

The Team initially worked to agree a bed re-profile which looked to ensure the numbers of patients outlying from the speciality areas is reduced by 90% compared to 2013/14 and support the delivery of the 2:1:1 model. The group will also review current capacity and working arrangements to optimise clinical input for patients and to co-ordinate the assessment and admission arrangements for direct admission by specialties at BCH.

3.7   Diagnostics

The diagnostics group works closely with several of the Workstreams to ensure timely access to diagnostics as part of the unscheduled care pathway, to improve the patient's length of stay by delivering diagnostics on an outpatient basis within the same time frame as an inpatient stay and to support new ambulatory models of care.

3.8   Extended Day & Weekend cover for AHP's

To date a number of services e.g. Physiotherapy and Occupational Therapy in a number of areas have extended the working day and increased provision at weekends. This is mainly in areas such as ED, BCH Direct and will be required to provide such cover on the implementation of the Acute Care at Home service. Most of this is provided in the first instance on an on-call/ad hoc basis due to resources.

The Trust is currently working towards the introduction of a 7 day service across a number of the Allied Health Professions in order to support early discharge and enhance services within the community. Communication and consultation with staff and their representatives has commenced to progress this issue. In the meantime steps have been taken to ensure newly appointed staff are contracted to deliver a 24/7 service.

4.   Community Children's Services Directorate (CCS)

CCS Directorate have a workforce of Headcount 1184 WTE 942.12. It is anticipated that work will commence this year to develop a Directorate wide workforce plan. There is currently a number reform and modernisation programmes within the Directorate which contribute to the ethos of delivering services closer to clients homes and providing support to help children remain within the family and out of institutional care.

On- going projects include the following:

- Re-provision of College Park Ave, Children's Home and creation of a resource centre to provide support to children and their families.

- Review of School Nursing Service to introduce a more effective skill-mix and includes clear distinction between the role of Band 5 and Band 6 School nurse role.

- Review of Children's Learning Disability Service

5. Training/retraining of staff

In support of the reform and modernisation of the Nursing & Midwifery workforce the Trust has developed a ten day programme delivered four times a year for new staff. One Hundred and sixty programme places are provided each year.

Nursing support staff are now recruited in Induction "cohorts" every twelve weeks. Staff attend the programme before they start work in our wards and departments. To support this group of staff to understand their roles and responsibilities within the Trust, the programme introduces staff to the Trusts values, purpose and objectives, provides key aspects of mandatory training and an introduction to the Activities of Daily Living and Person Centred Care. This supports newly appointed staff to enter the service with the necessary basic level of knowledge and skills required for their post, and supports the provision of safe effective compassionate care.

The Trust also delivers Vocational Programmes - These eighteen week programmes start in February and September each year, and provide eighty programme places each year.

The programme consists of relevant mandatory training, a QCF Certificate level qualification, and an Essential Skills Communication qualification, if required.

The programme is available to staff after they have completed at least six months in post (probationary period). The programme provides staff with up dated Mandatory training, in depth information on duty of care and person centred approaches to care and provides all staff with a relevant qualification for their post, and supports the provision of safe effective compassionate care.

The Belfast Trust is an accredited Investors in People Organisation. It has Learning and Development as one of the 5 core Values of the Trust.

In regard to specifically Leadership and Capability the Trust has in place Leadership and Management Development programmes developed and delivered in accordance with our Trust values and have undertaken training needs analysis and evaluation. This is at all levels within the organisation and includes:

- Living Leadership, Leading with Care, a high level bespoke Leadership Development Programme for Co-Directors/Associate Medical Directors, Senior Managers and Clinical Directors.

- An Institute of Leadership Accredited Middle Manager Development Programme.

- An Institute of Leadership First Line Manager Development Programme.

The Trust also assess' capability and development needs through its Personal Contribution Framework.

The Trust also provides Training in regard to a wide range of other areas, on Workforce Planning, Service Improvement and a range of skills and development training.

6.   Role redesign

The Trust has developed a multi-skilled AHP Support worker in the community to support the registered staff in carrying out their Home Treatment plans. The Trust currently employs 95 of these staff. Previously each of the professional groups would have had their own support staff.

7.   Review of work patterns

Under modernisation of services, in many areas the Trust is working to ensure services are delivered, based on service need and where identified in consultation with all relevant stakeholders, extending the working day and where necessary week to improve the service delivery. Some examples include:

- Enhanced senior doctor presence in the Trust's Emergency Departments to provide approximately 18 hours of senior cover each day of the week;

- Extended Pharmacy Services opening hours;

- Allied Health Profession services being provided across 7-days of the week in hospital and community settings;

- Enhanced Social Work and Social Care services to ensure patients are both discharged from hospital 7 days a week and where possible hospital admissions are prevented in the first place.

8.   Recruitment

The Trust has undertaken a number of measures to help attract and recruit medical staff into hard to fill posts. These have included:

- Advertising widely - in Europe, Australia and New Zealand in printed and on-line mediums and at targets universities.

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- Commenced the development of our website page – to help sell the Trust as an Employer of Choice.

- Staff testimonies included with the recruitment documentation for hard to fill posts – to provide a personal touch and to give potential applicants an opportunity to find out about our staffs personal experiences.

- Facebook/Linkedin – all Trust posts are now advertised on both facebook and linkedin. In addition, our printed advertisements ask readers to like us on facebook and linkedin to enable them to be advised of future vacancies.

- Developed closer links with Queens University Belfast – to explore the option of joint recruitment with QUB to help maximise resources and ensure maximum benefit for both organisation.

- Skills mix – within the Trust we have appointed to skills mix roles in areas that we have had difficulty recruiting medical staff. A recent example is the appointment of Advanced Nurse Practitioners (ANP's) within our Emergency Department. An ANP is a non-medical prescriber who works alongside a middle grade doctor whose education pathway is based on medical training. We continue to explore this option in other areas.

9.   Succession Planning

The Trust has identified through its workforce planning processes, reviewing for example recruitment and turnover trends and age profiles, a need to invest systematically in Succession Planning. This is a systematic process to:

➢ Identify key positions and hard to fill positions

➢ Identify the critical leadership, competencies, behaviours, expert/ specialist knowledge requirements for the future

➢ Identify and prepare a potential pool of applicants to ensure the continued ability of the organisation to meet its strategic goals and service delivery plans

➢ It is good practice, governance and Leadership.

The Belfast Trust has in place its Succession Planning Programme, *"Developing Our People Today for Tomorrow – Succession Planning the Belfast Way"*. The Trust has completed 3 cohorts at Senior and Middle Levels within the Trust. The evaluation of the model to date has evidenced real benefits, increasing the applicant pool and preparedness to fill positions.

10.   Quality 2020

The Trust is also taking forward the Department of Health Social Services and Public Safety Quality 2020 Strategy. This is a 10 Year Strategy to protect and improve quality in Health and Social Care. The implementation of the Strategy is being Led by the Medical Director

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and Director of Nursing. In particular the implementation of the Quality Attributes Framework is very relevant to the strengthening the workforce and in raising standards of care.

The examples mentioned above are all good examples of best practice within the Belfast Trust in relation to workforce planning in support of the Transforming Your Care programme. Our workforce plan for our Adult Social and Primary Care Directorate when completed will further demonstrate best practice in relation to workforce planning in support of TYC.

Dr Kathryn Aiken
Clerk
Committee for Health, Social Services and Public Safety
Room 284
Parliament Buildings
Ballymiscaw
Stormont
Belfast
BT4 3XX

14 May 2015   **Our Ref:**   EM/MW/ts   **Your Ref:**

Dear Dr Aiken

Thank you for your letter 22 April 2015, addressed to Mr Hugh McCaughey, Chief Executive. I can confirm that the South Eastern Trust has established a Workforce Reform group to ensure a comprehensive approach to workforce reform across all of the Transforming Your Care (TYC) workstreams. Part of the remit of this group is also to identify programmes of work to address future service need. This includes the use of workforce planning, role modelling and the formation of new approaches to service delivery including skill mix and deployment.

Membership of the group is comprised of representatives from each TYC workstream or directorate, Human Resources, Planning, Performance and Information, Finance and Trade Unions. The role of the group is:

- to ensure that workforce planning needs are integral to Reform projects
- to collate the information generated from all the workstreams into a composite workforce review including key challenges and successes
- to ensure the interdependencies associated with workforce change are properly elucidated and captured in an appropriate way
- to identify the appropriate approaches to workforce reform such as workforce planning, role modelling, skill mix and deployment
- to ensure that technologies are appropriately used to aid modernisation and reform processes

Some examples of work conducted are:

- The Trust have been developing 7 day working particularly to respond to the demands in the unscheduled care arena with good examples in AHP, Physios, OTs reducing length of stay and facilitating earlier discharge through commensurate 7 day working on the Social work side of the Trust to respond to the care needs of those being discharged.
- The Trusts has submitted IPTs to bring about the change necessary to further the core objectives of TYC in terms of managing chronic conditions in a different way to avoid hospital admission and provide more care closer to home. EG COPD/Respiratory Services, D-Nav for renal patients etc.

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Upper Newtownards Road, Dundonald, Belfast BT16 1RH Tel: 028 9055 3145 Fax: 028 9041 1307
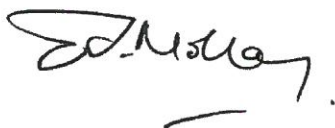
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- Domiciliary Care Review – Trustwide implementation of Regional Reablement Model.
- Mental Health Resettlement - resettlement of Mental Health long stay inpatients from one of the wards in the Downshire Hospital to a purpose focused community facility in Downpatrick.

Workforce planning training has been undertaken within the South Eastern Trust by Skills for Health on behalf of the DHSSPS. This training took place at two levels:

- Awareness training for TYC project teams
- One-day workforce planning skills development workshop for members of the Workforce Reform Group, including a follow-up on tools and techniques.

To assist workforce planning across the organisation and ensure a focused and consistent approach, the Trust has developed a Workforce Planning Template based on the Skills for Health Six Steps Model.

Yours sincerely

Mr Eamonn Molloy
Director of Human Resources & Corporate Affairs

Southern Health
and Social Care Trust

Quality Care - for you, with you

18 May 2015

Dr Kathryn Aiken
Clerk, Committee for HSSPS
e-mail: committee.hssps@niassembly.gov.uk

Dear Dr Aiken

DETAILS OF WORK UNDERTAKEN IN RELATION TO WORKFORCE PLANNING IN SUPPORT OF TRANSFORMING YOUR CARE

With reference to your letter dated 22 April 2015 regarding the above matter, please find attached the Southern Trust's response.

Please do not hesitate to contact me should you require any further information.

Yours sincerely

Paula Clarke (Mrs)
Acting Chief Executive

Att.

Southern Health & Social Care Trust Response to 22 April 2015 Letter from NI Assembly Committee for Health, Social Services and Public Safety (Dr Kathryn Aiken, Committee Clerk), requesting details of work undertaken in relation to workforce planning in support of Transforming Your Care (TYC)

The Transforming Your Care (TYC) Review (December 2011) set out a vision for health and social care (HSC) services that would be needed to meet future health and social care demands of the people in Northern Ireland. The demands identified included:

- A growing ageing population
- An increase in patients with long term conditions
- A growing demand for services with an over reliance on hospital services
- An increasing drive for greater productivity and value for money
- The changing profile of the available workforce

In order to support these growing demands the Trust carries out a range of workforce planning based around service delivery models, driven by commissioner requirements.

In order to response to the Committee's request this response has been structured into three main sections:

1. Regional Workforce Planning which supports Transforming Your Care, which the Trust participates in

2. General Local Workforce Planning Issues

3. Local Workforce Planning which supports Transforming Your Care

1. **Regional Workforce Planning which supports TYC**

As indicated by the Committee in its letter of 22nd April the Trust participates in a range of workforce planning activates.

Southern Trust is represented on a Regional Workforce Planning Group which was established in August 2012 to consider the workforce implications of TYC, and participates in a range of regional workforce planning initiatives.

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This section provides examples of regional workforce planning which supports TYC.

1.1 **Medical Workforce Planning:** Mouchel, an organisation linked to the Centre for Workforce Intelligence has been commissioned to deliver a review of the general medical workforce. The review is being delivered in three phases: Phase 1 - a workshop for key stakeholders was held in May 2014 following which a scenario report was generated; Phase 2 – a data collection and analysis exercise is currently underway; and Phase 3: a follow up virtual workshop with key stakeholders building on information collected in Phases 1 and 2.

1.2 **Medical Specialty Workforce Planning:** A series of specific reviews are being taken forward, led by the Public Health Agency:

- **Paediatrics including community services and neonatal care** – this work has been completed, and a report has been submitted to the Department
- **Emergency Medicine** – this review is a top priority. The review will take into consideration the paper entitled 'The attractiveness of a career in Emergency Medicine: A survey of UK trainees' published by the College of Emergency Medicine in December 2014. An initial assessment has been sent to the Department
- **Primary Care** – an interim Report of the General Practice Workforce Planning Group has been submitted to DHSSPS, and is currently being considered. Work continues on a final General Practice Report
- **Trauma and Orthopaedics** – it is expected that this work will be completed in 2015
- **Urology** – this will commence following completion of the HSCB Review of Urology;
- **Radiology** - a Workforce Planning Sub-group has been convened as part of the Review of Imaging Services.

1.3 **Nursing and Midwifery:** The Nursing and Midwifery Workforce Plan was presented to the DHSSPS Top Management Group in January 2015 and is currently being costed prior to consultation. Subject to necessary approvals, DHSSPS Central Nursing and Midwifery Advisory Committee (CNMAC) Workforce and Education Sub-Committee will be charged with overseeing

and supporting the implementation of the recommendations with timely reports to CNMAC on progress and annual reviews.

1.4 Domiciliary Care: Following a decision of the Regional Workforce Planning Group to undertake a workforce review within a Programme of Care approach, the first area of focus has been agreed as the *domiciliary care* service area within the *Older People* Programme of Care. Work is beginning to scope this review. This will feed into the work of the Workforce Partnership group which was established under a working group to take forward the Economy and Jobs Initiative Task and Finish report, recommendation six - "DHSSPS and HSC to create strategic partnerships with DEL to align future skill-sets of HSC sector and the current provision through Universities and FE Colleges in NI". The aim of the Workforce Partnership, in the first instance is to align the future skill-sets of the domiciliary care sector workforce with service user need. It is intended that workforce planning in the area of domiciliary care will build on the regional project to determine the future service model for domiciliary care which is being led by HSCB and DHSSPS.

1.5 Unscheduled Care: Workforce issues identified under the Review of Unscheduled Care are being taken forward through existing workforce channels and project strands.

1.6 Integrated Care Partnerships: Integrated Care Partnerships (ICPs) are a new way of working for the Northern Ireland health service to transform how care is delivered, and are a key element of TYC. Seventeen ICPs have been established across Northern Ireland, bringing together networks of care providers (including doctors, nurses, pharmacists, social workers, hospital specialists, other healthcare professionals and the voluntary and community sectors), as well as service users and carers, to implement service improvements. The partnerships focus on clinical priority areas of frail elderly, respiratory, diabetes, stroke, and end of life care relating to other conditions.

The following ICPs have been established by the Southern Trust:
- Frail Elderly
- Diabetes
- Respiratory

2. General Local Workforce Planning Issues

As the Committee states in its letter of 22nd April, Trusts have a responsibility to ensure they have an appropriate and skilled workforce in place, and to deliver operational workforce plans to adapt to what is being required.

The main focus of this paper is, as requested, is on Transforming Your Care. Section 3 below provides examples of workforce planning which specifically supports TYC. The Trust would also make the following general points regarding workforce planning.

2.1 Workforce Information / Indicators

The Southern Trust undertakes workforce planning using a range of workforce indicators to support local and regional workforce strategies.

Workforce indicators / data include:

- Skills Mix
- Turnover
- Sickness Absence Rates
- Maternity Leave Levels
- Age Profiles (estimated retirements)
- Recruitment and Retention
- Agency / Bank / Locum Usage

2.2 Critical Areas of Concern

The Trust would like to take this opportunity to highlight to the Committee some critical areas of concern regarding current and future availability of resources, in relation to the nursing and midwifery workforce and the medical workforce.

2.2.1 Nursing & Midwifery Workforce

The Northern Ireland Nursing and Midwifery Workforce Plan 2015-2025 recognises the increasing demand for services and the variety of factors affecting the nursing and midwifery workforce, for example '...*up to 46% [of the nursing and midwifery workforce are] eligible to retire over the next ten years...*'. All of these factors indicate the requirement for Southern Trust to consider the current and future needs in anticipation

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of the predicted shortages and for this reason this issue has been placed on the Trusts Corporate Risk Register.

At this stage the Trust is working towards staff retention and increasing ability to recruit staff in the Band 5 Nursing category. Actions in place / being taken include:

- Maintenance of Waiting lists for Band 5 Nurse Positions through regular recruitment drives. (The most recent drive closed on 9th April 2015 with 206 applicants.)
- Introduction of Rotational Programmes for newly qualified staff as a means of consolidating their learning and developing their skills and experience. Following a 12 month programme they will then be retained in an area of their choice aligned to service needs. One programme commenced on 13th April 2015 with further programmes now being planned around the next output from the universities in late September / early October 2015.
- Securing of temporary staff into permanent appointments where possible.
- Expansion of the current Open University programme by increasing numbers in the next round.
- Open registration to the Trusts Nurse Bank not only at Band 5 but for Nursing Students at Band 3 with a view to this securing a pool of suitable staff once they qualify.
- Establishment of a Nursing Workforce Planning Group to seek to address current and future anticipated challenges regarding the demand for and supply of Registered Nurses across all programmes of care. The first meeting of this group is planned for Tuesday 19th May 2015.
- Ongoing lobbying with the Chief Nursing Officer to increase pre-registration nursing numbers

2.2.2 Medical Training

There is a need to align medical training with service requirements, for example in relation to Emergency Departments where there is a critical need to increase numbers being trained.

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3. Local Workforce Planning which supports Transforming Your Care

Southern Trust produced a strategy document "Changing for a Better Future 2013-2015" which set out what implementing TYC would mean for local services. The plan summarised what the key areas of change were expected to be, describing them around four key themes that underpin the Trust's future model of care across its services:

- Promoting early intervention, prevention and wellness
- Enabling choice, independence and care within the local community
- Primary, hospital and community care working more closely together
- Optimising our hospital network.

The plan detailed a number of key local factors which would contribute to the need to change in how the Trust delivers health and social care:

- A growing and aging population - Southern Trust population:
  - Is projected to grow by 13.5% by 2020, compared to the NI average of 6.5%
  - Has high birth rates with a 12.6% increase in 0-17 population expected by 2020, compared to the NI average of 2.5%
  - Aged over 65 is estimated to grow by 33% by 2020, compared to the NI average of 27%
- Increased numbers of people with long term conditions
- Increased demand and over reliance on hospital services
- Ensuring safety and quality in service provision and meeting national standards and locally defined commissioning criteria
- Financial challenges with no growth in funding, at the same time as demand is increasing

The following are examples of Southern Trust workforce planning which is specifically in support of TYC, by Programme of Care.

3.1 Children & Young People's Services Programme of Care

3.1.1 New Advanced Paediatric Nurse Practitioners - Amulatory Services
Southern Trust Children's and Young People's Services Directorate has undertaken workforce planning in relation to Ambulatory Services in Craigavon Area Hospital and Daisy Hill Hospital, by introducing new

Band 7 Advanced Paediatric Nurse Practitioners. Seven nurse practitioners have already been trained, with a further four due to complete training this year (two Intellectual Disability and two Neonatal). Another two are to commence training in September 2015. Training is through a 12-18 month training course in England.

An existing Ambulatory Service in Southern Tyrone Hospital is also being further developed.

3.1.2 Community Paediatrics

Through service re-design the Trust has established an ADHD service and introduced skill mix within Community Paediatrics.

3.1.3 Looked After Children (LAC) & Children's Residential Services

A review of the care pathway for LAC, alongside the development of community based services and a re-configuration of the delivery of residential services has meant that the Trust has had to deal with a range of workforce issues, in relation to staff movement and redeployment.

3.2 Acute Services Programme of Care

3.2.1 Improving Emergency Department (ED) Flows

This covers three main areas:
- 7 day diagnostics for CT, Ultrasound and cardiac echo
- A dedicated Minor Injuries stream for ED
- Elements of 7 day working in ED including the current short stay Clinical Decision Unit (CDU) – this will involve arrangements in the community to facilitate discharges at weekends such as the provision of 7 day intermediate care including equipment delivery, the availability of memory liaison and the ability to commence new packages of care at weekends.

This is linked to the roll out of **Acute Care at Home (Rapid Response),** which will include the establishment of a 7 day fast turnover unit which will eventually replace the current CDU and will be community facing 7 days per week, with strong links to Acute Care at Home including dedicated Consultant Geriatrician sessions and the

establishment of a dedicated ambulatory care area alongside ED with a focus on preventing admissions and facilitating discharge following in depth clinical investigations – **see below 3.3.1 below, under Older People & Primary Care Programme of Care.**

This will involve piloting of 24/7 working arrangements, and is part of the Southern Trusts TYC 'shift-left' plans.

3.2.2 Acute – Emergency Practitioners

The current staffing model within the Minor Injuries Department comprises Emergency Nurse Practitioners (ENPs). ENPs are experienced Registered Nurses with a minimum of 5 years' experience in an Emergency Department who have undergone specialist training to gain the knowledge and skills to assess, diagnose and prescribe a management treatment plan for patients. The Southern Trust currently has 13.2 whole time equivalent ENPs working across Craigavon Area and Daisy Hill Hospitals Emergency Departments (EDs) as well as the South Tyrone Hospital Minor Injury Unit. All ENPs work to a set of clinical protocols and all patients triaged to this service are assessed, diagnosed and treated within 4 hours. Within the ED the ENP service makes a significant contribution to improving the flow of patients through the department, enhancing the patients experience by enabling them to be seen in a timely manner as well as assisting in the release of senior Emergency Department medical staff to provide timely emergency care to patients with a higher acuity. Trust is also working with commissioners to expand the scope of practice for Emergency Nurse Practitioners (ENPs) to enable them to see a wider range of conditions including patients presenting with minor illnesses, supported by medical staff working in the Emergency Department.

3.3 Older People & Primary Care Programme of Care

3.3.1 Acute Care at Home

The Trust is piloting a Consultant led multi-disciplinary Acute Care at Home Service to deliver acute care to patients over 65 years deemed critically unwell and residing in Nursing/Residential homes or their own home. The service is being piloted with a number of GP practices and nursing and residential homes in the Craigavon and Banbridge and

Armagh and Dungannon areas. It aims to prevent unnecessary attendance at Emergency Department and avoid the subsequent admission to hospital and the risk associated with this, such as falls, hospital acquired infection and delerium. The service is an excellent example of improving community service provision with the aim of reducing pressures in Acute Care and meeting the TYC objective of a "shift left". Patients who may otherwise have been admitted to an Acute hospital and assessed as appropriate for the service will receive care in their own home from a dedicated team who will provide a comprehensive geriatric assessment and provide care to meet their identified needs during the acute phase of their illness. The average length of stay on the service is 5 days.

The new service currently comprises a Consultant Geriatrician, Associate Specialist, Band 7 Specialist Nurses, Band 5 Nurses, Specialist Physio, Specialist OT, and Independent Supplementary Prescriber Pharmacist, Health Care Assistants and administrative staff. Staff have been redeployed into the service from acute and community settings.

The skill mix within the team is vital, the acute staff have experience working with patient at this level of acuity, the community staff have experience working in a community setting and all of the unique challenges that can pose. For staff coming from acute to community additional training was required in terms of lone working, environmental assessments, intermediate life support and anaphylaxis. Also training regarding links with existing community teams, ICTs, Specialist Services, domiciliary care agencies and Private Nursing/Care homes.

3.3.2 Specialist Community Teams
The Southern Trust has a range of specialist multi-disciplinary teams based in the community who provide a range of services to patients, including:
- Chronic Obstructive Pulmonary Disease
- Heart Failure
- Diabetes
- Intermediate Care
- Stroke and Palliative Care

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The teams aim to prevent unnecessary hospital admissions and to facilitate early hospital discharge. Currently these services are funded Monday – Friday, however the plan is to move to 7 day services when additional funding becomes available.

3.3.3 GP Out of Hours (OOH) Urgent Care Service

Within the GPOOH service the Trust has introduced a skill mix model to address the increased demand on the service and the difficulties experienced in attracting GP's to work in the service. The Trust has recently recruited nurse advisors to facilitate timely triage for patients contacting the service as well as nurse practitioners who as well as triage can provide face to face consultation. In partnership with the Commissioner the Trust has also implemented a pilot of Pharmacy Independent Prescribers to deal with minor ailments and medication/prescription issues.

3.3.4 Domiciliary Care Service

Part of the Trust strategy is to develop a mixed economy of providers so as to enable more older people to be cared for in their own homes and ensure all resources are used to best effect. In response to Transforming Your Care, the Trust's Population Plan includes a specific proposal to achieve a cumulative 12% shift to mixed economy providers over a 3 – 5 year period. These changes have raised a number of workforce issues, including the need to balance the increasing diversity of provision with demand and capacity issues across both statutory and independent sector providers. In support of the Trust's Population Plan, arrangements were agreed with trade union representatives to manage any adverse impact on the Trust's domiciliary care workforce. The Trust continues to experience workforce issues across the Trust and is currently assessing the need to offer an increased number of minimum guaranteed hours contracts in line with the need for increased staff flexibility. A range of approaches have been implemented to address continuity of care and stability in the domiciliary care workforce and service

Qualifications and Credit Framework (QCF) Strategy for Domiciliary Care: The Trust has a strategy to train 95% of Domiciliary Care Workers to Award level by March 2016, and 40% to be trained to

Certificate level by March 2017. The Certificate level covers palliative care and promoting independence.

3.3.5 Re-ablement Service

A new Re-ablement Service has been introduced to enable suitable patients, under the direction of an Occupational Therapist (OT), to have a short term targeted therapeutic OP led intervention for a period lasting usually 12 days on average (up to 6 weeks). This intervention supports individuals in regaining their independence in relation to the activities of daily living with the aim of reducing their need for mainstream domiciliary care. The Re-ablement Service is delivered by Occupational Therapists and Band 3 Re-ablement Support Workers (RSW) with the RSW's having undergone a bespoke training programme at QFC Level 3.

3.3.6 Access and Information Service

The Trust has developed an Access and Information Service, the purpose of which is to provide a single, centralised point of access and a single access strategy for referral for a range of social and health care services both within the OPPC Directorate and externally to supports within the wider statutory, community and voluntary sectors. In the first instance this service will focus on older people in the provision of a streamlined process for how referrals are received, administered and implemented; with consistent operational procedures and practice. The Trust has reorientated social work support staff and created additional posts to support the implementation and development of this service.

3.4 Mental Health & Disability Services Programme of Care

3.4.1 Review of Addiction Services

This involves a focus on development of the Community Addiction Service, with the aim of reducing need for inpatient care, consistent with TYC 'shift-left'. The regional review of inpatient services has concluded and been implemented within the Trust with the closure of the Inpatient Unit on the St Luke's site in Armagh, from which the remaining staff have been redeployed into community settings. Additional funding required for the preferred community model is:

- Consultant psychiatrist – 0.40 WTE
- Band 7 – 1.0 WTE
- Band 6 – 12.0 WTE
- Band 5 – 2.09 WTE

The funding streams for development of Tier 3 community services are not yet confirmed, therefore services remain filled on a temporary basis. This is being kept under review.

3.4.2 Mental Health Resettlement

This has now completed with the closure of Long Stay wards in St Luke's Hospital, Armagh and the centralisation of the Psychiatric Intensive Care Unit (PICU, Rosebrook) to the Bluestone Unit, Craigavon Area Hospital site. All staff have been redeployed to community settings or to the acute settings on Bluestone site. Additional workforce planning is ongoing to ensure the appropriate staffing levels are in place and to allow for future demand

3.4.3 Learning Disability Resettlement

This delivers the ongoing implementation of the Bamford resettlement programme, involving the closure of long stay beds. This has now completed with the closure of Long Stay wards in Longstone Hospital, on the St Luke's site, Armagh, and the opening of the new Granville Supported Living Scheme which is now operational within Dungannon. As part of this 60 staff were redeployed from the Long Stay wards to the new supported living facility.

The Learning Disability Assessment and Treatment Unit formally in Longstone site, Armagh, has now been centralised to the Bluestone Unit site, Craigavon Area Hospital, with bed level reduced to 10 beds in line with regional strategy. This has been supported by the creation of a new model of service delivery utilising the skills of experienced nursing staff in the creation of a Home Treatment Crisis Response Team which provides short term crisis intervention in the clients' home to reduce the need for hospital admission. Again this unit has been staffed from Longstone redeployments, enabling the utilisation of existing skills and experience.

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3.4.4 <u>Mental Health & Learning Disability Day Care - Reform of Day Time Activities</u>

The aim is modernisation of Day Services to ensure diversity of options which are age and need appropriate. The new service model will ensure the provision of buildings based day care which focuses on clients with complex healthcare needs and service users with significant challenging behaviours. It will also allow for the further development and enhancing of a range of options for day opportunities in a community setting. Workforce planning will include a review of current provision including numbers and skill mix required to deliver the new service and staff development to meet increased acuity levels of those accessing day care/day opportunities. The Community Access Service has been stood down and staff redeployed to alternative posts commensurate with their banding and skill set, whilst provision of this service has now been transferred back to the key worker on the Community Teams.

The Trust will of course continue with workforce planning at local and regional level.

We trust that this information and these examples are helpful in informing the Committee on the status of workforce planning within the Trust.

Paula Clarke
Chief Executive (Interim)

Western Trust Response to the letter of 22 April 2015 from the Northern Ireland Assembly Committee for Health, Social Services and Public Safety

This response details the work undertaken by Western Trust in relation to Workforce Planning in support of Transforming Your Care (TYC).

The two key workforce strands of TYC are to:

1. implement the specific workforce proposals; and

2. facilitate the workforce change required to deliver revised models of care emanating from the implementation of TYC.

REGIONAL WORKFORCE PLANNING GROUP (RWPG)

A Regional Workforce Planning Group (RWPG) was established to guide the development of a strategy to take forward the TYC workforce recommendations, provide a regional forum to facilitate the discussion of workforce developments required under TYC models of service delivery and provide a conduit for sharing workforce planning and development information across the region. The Western Trust has a representative who contributes to this Group.

Under the auspices of the RWPG, the Trust took part in commissioned workforce planning training on the Six Step Model to Integrated Workforce Planning to upskill HR staff, nursing workforce planners and service managers involved in redesigning services. The Trust has also contributed to regional workforce planning exercises to develop a Regional Nursing and Midwifery Workforce Plan and is currently contributing to Medical Workforce Review and a Domiciliary Care Review.

The Trust undertakes local workforce planning to recruit and retain a workforce that has the capacity, skills, diversity and flexibility to meet the demands of the HSC which are increasing in volume and complexity and to implement the changes required by TYC. The rurality of Western Trust means that it experiences unique workforce pressures, particularly in Medical and specialist posts, however attracting and retaining a skilled Nursing and Midwifery workforce is an emerging pressure. To this end, the Trust establishes internal workstreams to ensure the supply of appropriate staff, e.g. a working group to focus on attracting International Medical staff.

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Northern Ireland Assembly Committee for Health, Social Services and Public Safety

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WORKFORCE CHANGE TO IMPLEMENT TRANSFORMING YOUR CARE

CONTEXT

In March 2013, the HSCB launched *'Transforming Your Care – Vision to Action: A post Consultation Report'*. It described the requirement for the HSC system to reform if it is to effectively meet the changing health and social care needs of the population of Northern Ireland. The Western Trust established a dedicated Transforming Your Care team charged with implementing a suite of proposals over a 2-year period, ending in March 2015.

In April 2015, the Western Trust produced a comprehensive Reform Plan detailing a range of reform initiatives and projects that encompass the regional, Western area and Trust specific priorities which will secure the shift left reform required in Transforming Your Care.

The Reform Plan outlines 32 projects which the Trust will deliver. These projects include:

a) large scale, cross directorate shift left enabling projects which are crucial to establishing the necessary infrastructure for community based care provision, e.g., Reablement/Domiciliary Care and Acute Care in the community;
b) Service specific reform projects aimed at transforming care from an acute to a community based model, e.g., home based renal dialysis and remodelled Care pathways for the ICP Clinical priority areas.

All project plans outline the HR implication associated with successful delivery of the project. In addition, detailed implementation plans for each Reform Project outline the timescales for specific workforce actions to ensure workforce alignment and working patterns are consistent with the aim of each project.

Workforce modelling is undertaken in conjunction with relevant professional leads and key stakeholders and supported by the Trust workforce planners. The reconfigured workforce model takes account of best practice, NICE guidelines, professional regulatory requirements and regional models as well as using workforce planning tools e.g. skill mix, normative staffing, and staff turnover rates. The new workforce configuration is then assessed against existing workforce (and other resources) to identify skills and capacity required to achieve the change.   Before progressing to implement the reformed model, engagement with the Commissioner is undertaken. In certain instances transitional funding has been provided to create the capacity to change. The Trades Unions are consulted on all changes. We provide updates on Reform implementation to all quarterly meetings of our Joint Forum.

As part of the established project management structure a named project lead has been identified for each project and a HR representative attends all Service Directorate meetings at which accountability is provided.

Western Trust Response to the letter of 22 April 2015 from the Northern Ireland Assembly Committee for Health, Social Services and Public Safety

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Within the Reform Plan, it is made explicit for every project that monitoring of 'implementation of the HR elements of the project' is one of four components of overall all project monitoring. The other three are: that objectives are achieved on time; that non-financial benefits are delivered and that savings (where appropriate) are delivered.

WORKFORCE IMPLICATIONS TO DATE

1. ENABLING PROJECTS

1.1 Reablement/Domiciliary Care

There will be full roll out of Reablement across the Trust in September 2015. Effective roll out of this service has involved training and development of frontline staff to ensure a shift in their work focus from 'doing for' clients to empowering clients towards independence.

The findings from the recent Regional Audit on Reablement acknowledged the strength of the Western Trust's Reablement model. The considerable time spent in supporting and realigning staff to deliver our model has been acknowledged recently when the Trust's HR Department was shortlisted to the final three for a National Healthcare People Management Award for Innovation. Client feedback on the reformed service is overwhelmingly positive.

1.2 Acute Care in the Community

We are engaging with staff (Medical, Nursing, AHPs and Social Workers) to redesign how, where and when staff work to support the provision of Acute Care in the community where it is safe and effective to do so. This work will ensure that nursing care (District, Treatment Room, Rapid Response, Specialist Nursing) as well as Adult Social Care, AHP Services and Doctors' Job Plans are reformed and aligned in accordance with care pathway redesign. In particular, considerable work has been done on pathways for: Respiratory, Frail/Elderly, Cardiology, Diabetes and End of Life Care.

In addition to being and enabler for pathway redesign, the Acute Care in the Community project is crucial to our implementing our overall Acute Hospital Reform programme which includes unscheduled care redesign and the remodelling of beds in our hospitals.

1.3 Excellence in Community Care

As part of its commitment to Transforming Your Care, the Trust has established an Excellence in Community Care Project to overview all of the key functions that enable an effective community care structure to grow and develop. Emphasis will be placed on developing a social model of care, supported by (and within) each Directorate and also through professional structures.

Western Trust Response to the letter of 22 April 2015 from the
Northern Ireland Assembly Committee for Health, Social Services and Public Safety

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The Trust is in the process of establishing a group to provide leadership, co-ordination and planning to ensure the ongoing development of Excellence in Community Care.

Excellence in Community Care will focus on the following priority areas for professional practice development, accountability, risk, governance and related service design:

a) Personalisation:

- Self-Directed Support
- Direct Payment
- Young Carer)s)
- Carer Assessment
- Advocacy/Engagement

b) Training and Development:

- Preparation for Change
- Cultural Shift
- Resilience Building
- Lone Working
- Supervision

c) Adult Services Improvement:

- Care Management Forum
- Safeguarding
- Hospital Discharge
- Domiciliary Care
- Delegated Statutory Functions
- Regulated Services
- Caseload Weighting

As part of delivery of the Excellence in Community Care initiative, the Trust will review the readiness of Approved Social Workers to care for patients with complex Mental Health needs who are living in the community.

1.4 Pharmacy:

The Trust is in the process of reforming its Pharmacy provision to ensure that it is fully aligned with new service provision. We now provide: condition specific Pharmacy support for patients living with a variety of long-term conditions (including Respiratory disease); 7 day dispensing in both acute hospitals within the Trust and extending the Clinical Pharmacy service to all wards across the Trust (including Adult Mental Health wards). Pharmacy staff work with the multidisciplinary team to enable patients to take their medicines post discharge through implementing self-administration of medicines schemes in intermediate care and developing formal assessment of need for monitored dosage systems.

Western Trust Response to the letter of 22 April 2015 from the
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2. SERVICE AREA SHIFT LEFT REFORM PROJECTS

2.1 Increasing Provision of Renal Dialysis at Home

The Project, supported by transitional funding from the HSCB, aims to increase the percentage of patients of Peritoneal Dialysis from 10% (2013) to 20% (by 2016) when the last year the percentage has increased to 14.5% despite the fact that overall dialysis activity has also increased.

In order to support the reformed service, we have retrained three staff (2 WTE) to enable then to provide dialysis at home.

2.2 Respiratory Pathway

Within the last 18 months the provision of Respiratory Care within the Western Trust has been fundamentally reformed.

Supported by transitional funding from HSCB this includes:

a)   Additional Respiratory Consultant in SWAH

The outcomes associated with this include:
- An increase (by 32%) of patients seen in SWAH, however a 38% reduction in length of stay for Respiratory patients.
- Provision of 21 new Outreach Respiratory Clinics and Virtual Clinics, to which there were 152 new referrals, thereby avoiding Outpatient Review Appointments. 48 patients were discharged.
- 131 phone and 133 email consultations, resulting in an estimated 33 potential admissions and 89 Outpatient Appointments avoided.

b)   Home Oxygen Nurses

Two nurses have been retrained to provide home oxygen assessment. The outcomes include:
- A 10 month reduction in waiting times for home oxygen (this will undoubtedly have reduced hospital admission rates).
- Non-commencement or discontinuation of home oxygen services for 52 patients over a six month period. These patients were clinically judged as not/no longer requiring oxygen by the nurse specialist. Prior to implementation of the reformed services these patients may have been commenced on oxygen.

c)   Respiratory Pharmacist

Five of the top six drugs prescribed in the Western Trust area are for Respiratory conditions. Patients reviewed by the specialist Respiratory Pharmacist are more likely to have the right drug for the right duration. The Pharmacists liaise closely with local GPs to ensure co-ordinated patient care. To date, 377 patient care reviews have taken place.

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d) **Respiratory Physiotherapist**

The Physiotherapists provide community and home based care to reduce the likelihood of admissions for some patients. To date, they estimate that their work has prevented 98 hospital admissions.
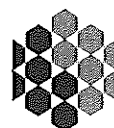
e) **Establishing a Community Respiratory Team**

The team will begin to operate in June and will be fully operational across the Trust from the Autumn of 2015. It will provide integrated and specialist care in the community for patients who live with chronic respiratory illness.

The new Respiratory pathway is ensuring more equitable and consistent provision of patient care with improved outcomes for patients. A recently conducted GP Survey on the Reformed Service found high satisfaction levels with the change. We are ensuring that GP feedback on future care is factored into our continued Respiratory Service redesign.

We trust that this information and these examples are helpful to inform the Committee on the progress and status of workforce planning within Western Trust.

ELAINE WAY, CBE
CHIEF EXECUTIVE
15 May 2015

Western Trust Response to the letter of 22 April 2015 from the
Northern Ireland Assembly Committee for Health, Social Services and Public Safety
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Our Ref: AGY/468/2015

Date: *12* August 2015

Dear *MAEVE*

INFORMATION ON THE NUMBER OF TRAINING PLACES FOR GPs AND THE ASSOCIATED COSTS

Thank you for your letter dated 2 July 2015 seeking, amongst other things, information on the number of training places for GPs and the associated costs.

The Northern Ireland Medical and Dental Training Agency currently recruits 65 GP trainees each year and there are currently a total of 224 GP trainees in the programme, reflecting the fact that for a variety of reasons, such as maternity leave and part-time training/working, some GP trainees take longer than 3 years to complete the 3 year programme. The amount spent on GP training in 2014/2015 was approximately £8m (£8,003,615).

In light of interim recommendations arising from a workforce review of general practice, led by the Public Health Agency in 2014, a bid has been submitted as part of June monitoring to fund the recruitment of an additional 15 GP training places and we await the outcome of that process.

The Committee will also be aware of a £15m package of additional investment in GP services which my predecessor announced on 1st April 2015 including the provision of up to £300,000 to recruit and retain GPs.

This package of investment will help to address some of the current difficulties and plan for future challenges in general practice.

Yours sincerely

SIMON HAMILTON MLA

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APPENDIX 4

RESEARCH PAPERS

Research and Information Service
Briefing Note

Dr Janice Thompson

Transforming Your Care (TYC) – Workforce Planning

1 Overview

In connection with 'Transforming Your Care' (TYC),[1] this briefing note summarises how the issue of HSC workforce planning has been dealt with in the series of official TYC publications[2]:

- Transforming Your Care, DHSSPS, December 2011;

- Transforming Your Care, Vision to Action, A consultation document, 9 October 2012 – 15 January 2013, Health and Social Care (HSC) Board;

- Transforming Your Care, Vision to Action, A Post Consultation Report, March 2013; HSC Board;

- Transforming Your Care, Strategic Implementation Plan, October 2013, Final Version, HSC Board;

- The Belfast, Northern, Western, Southern and South Eastern Local Commissioning Group Locality Population Plans.

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[1] Transforming Your Care, A Review of Health and Social Care in Northern Ireland, DHSSPS, HSCB, December 2011
[2] http://www.transformingyourcare.hscni.net/consultation/

The briefing also highlights some challenges to medical workforce planning as identified by the BMA and introduces the NHS Scotland *Everyone Matters: 2020 Workforce Vision* as a good practice example of workforce planning.

The new model of service delivery required by TYC requires a substantial move towards prevention, self-care, increased primary care and care that is provided at home or closer to home. This direction will have a substantial impact on the HSC workforce in a number of ways. There will be a 'shift left' of activity to the community and primary care setting, with a more integrated care focus, meaning a change in role/location for some staff. The development of acute hospital networks will also mean a change in working patterns for some staff.

Given the substantial 'shift left' of the TYC proposals and the resultant impact on staff in terms of numbers, location and training, the published information so far deals with workforce planning in a relatively high level manner. Although a new methodology of workforce planning is described in the Population Plans of the Local Commissioning Groups (see section 4.1), the workforce plans (staff reductions[3]) of the five HSC Trusts, as published in the Population Plans of the LCGs (see Appendix 1), do not appear to be well developed and are very indicative in nature.

2   Introduction to the Workforce Implications of TYC

2.1 Introduction

The Review of Health and Social Care (the Review) in Northern Ireland, culminating in the publication of TYC, concluded that there was "*an unassailable case for change*".[4] It identified key reasons which supported the need for change, including 'Reason 11' - "*Supporting Our Workforce*". Problems being experienced by staff delivering services within the Health and Social Care (HSC) system were highlighted in the HSC Staff Survey (2009) - 43% of staff reported that they could not meet all the demands on their time at work; 34% agreed that there were not enough staff in their organisation to do their job properly, and the most common reason for staff having been injured or unwell in the previous 12 months was due to work-related stress.[5]

The Review noted the willingness of staff to want to make changes and be closely involved in how the change should happen.[6] At the start of the consultation process on TYC (October 2012), the consultation document (*Vision to Action*) noted that there would be a three to five year implementation period and it would be during this period that "*more understanding and detailed plans would be developed about how relevant*

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[3] The consultation used the working assumption that moving to the new model of care would see a reduction in the overall workforce of around 3% (around 1,620 whole time equivalents)

[4] Transforming Your Care, DHSSPS, HSCB, December 2011, page 4

[5] As above, page 34

[6] As above page 34

proposals would be effected in practice".[7] So at the time of the consultation it was not clear what the exact impact on staff would be.

With regard to workforce planning, by the time of publication of the TYC Strategic Implementation Plan, the Health and Social Care Board (HSCB) had committed to[8]:

- Evidence based workforce modelling - to ensure that it is known what skills will be required to deliver services under TYC;

- Investment in the workforce – to ensure they have the right skills to support TYC and;

- Leadership and capability development – investment in and training of the people with the capacity to deliver change was proposed.

Despite the lack of detailed workforce proposals at that stage, the Review document and subsequent related documentation did identify certain issues around the impact on the HSC workforce as a result of the new care model and these are outlined in Section 2.2 in more detail.

The responsibility for workforce planning rests with the DHSSPS and it is anticipated that TYC transformation will involve the Regional Workforce Planning Group supporting the development of detailed workforce plans, including continuing engagement with staff, professional bodies and staff side organisations (a Joint Forum has been set up with staff side organisations).[9]

'*Finance and workforce planning'* is described as one of the Regional Enabler Workstreams (the regional workstreams are to enable other regional programmes or the local Population Plans to be delivered.[10]) The '*Finance and workforce planning'* workstream has been set up to[11]:

- Provide financial expertise to support the detailed work of other workstream plans;

- Ensure that the financial implications of all workstreams are reported accurately;

- Ensure financial stability is maintained during the implementation of TYC plans; and

- In addition to the finance aspects**, detailed workforce planning will be undertaken to ensure the correct skill mix exists in the new healthcare configuration**.

2.2 New Care Model – Workforce Implications

The new model of service delivery requires a substantial move away from the current emphasis on acute care towards prevention, self-care, increased primary care and care

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[7] Transforming Your Care, Vision to Action, A consultation document, 9 October 2012 – 15 January 2013, DHSSPS, HSCB, page 59

[8] Transforming Your Care, Strategic Implementation Plan, October 2013, HSCB, Final Version, page 9

[9] Transforming Your Care, Strategic Implementation Plan, October 2013, HSCB, Final Version, page 32

[10] As above, page 28

[11] Transforming Your Care, Strategic Implementation Plan, October 2013, HSCB, Final Version, page 63

that is provided at home or provided closer to home than in the current model. Health and social care will therefore need to harness the skills of professionals working together to provide the pace of change required.

The TYC Strategic Implementation Plan identified the following key groups as being impacted by TYC – HSC staff, including those in the HSCB and HSC Trusts, and other healthcare staff including GPs, dentists and pharmacists. The impact on these groups stems from[12]:

- A shift of activity from an acute to a community and enhanced primary care setting;
- Delivery of care in a more integrated manner across primary, secondary and community care - may mean a change in role/location for some staff;
- Enhanced role for some of the independent healthcare providers - may require enhanced training and regulatory frameworks; and
- Development of acute networks across an area - may mean a change in working patterns or organisational structures.

The HSCB confirmed in the Strategic Implementation Plan that[13]:

- It is committed to supporting the workforce through the transition;
- Workforce planning is integral to planning and delivering the reforms;
- The HSCB wants to engage in a meaningful way with staff, unions and the voluntary and community sector to ensure an integrated approach to workforce planning; and
- Training, retraining and capability development is a key enabler for making TYC successful.

In addition, workforce development is described as 'critical' to the establishment of the new network models of care through the creation of 5 to 7 hospital networks - it is planned that the role of some hospitals will change as they become part of one of the 5 to 7 hospital networks working together with partners in the network.[14] These networks have implications for the HSC workforce:

- More people will receive care in their own home, or close to home - with hospital clinicians working closely with GPs and other community staff to plan[15];
- Multi professional, community health and social care integrated teams will support patients in their own homes with increasing use of networks to coordinate care[16];
- Staff will be required to develop different skills and capacities in new and extended roles, for example, GPs with special interests in emergency medicine or paediatrics, specialist long-term condition nurses and emergency care practitioners. It is

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[12] Extracted from Transforming Your Care, Strategic Implementation Plan, October 2013, HSCB, Final Version, page 99
[13] Extracted from Transforming Your Care, Strategic Implementation Plan, October 2013, Final Version, HSCB, page 99
[14] Transforming Your Care, Strategic Implementation Plan, October 2013, HSCB, Final Version, page 40
[15] Transforming Your Care, DHSSPS, HSCB, December 2011, page 122
[16] As above, page 122

proposed that there will be an increase in outpatient follow-up appointments being carried out by GPs and nurses[17].

The Review document and subsequent consultation document did identify certain specific issues around the impact on the HSC workforce:

- **Workforce availability**[18] – It was likely that workforce availability over the three years following the Review would be lower than that required to sustain the current HSC model (for example, shortages of doctors within emergency care services);

- **Reduction in HSC workforce** - The consultation used the working assumption that moving to the new model of care would see a reduction in the overall workforce of around 3% (around 1,620 whole time equivalents). To enable this shift, the HSC "*will provide support for voluntary early retirement/voluntary redundancy and/or retraining support*"[19];

- **Training**:

  o The Review concluded that the current model is unsustainable in terms of the training experience required for junior doctors[20];

  o Some staff who currently work in a hospital, may find that, in the new care model, they will fulfil unchanged/very similar roles in the community or primary care setting, whereas others will be asked to adapt to a change in role and will be given "*appropriate training and support*"[21];

- **Workforce sustainability**[22] – future services models must be sustainable - "*while locum and agency staff may be used to support a services where necessary and appropriate, they should not be inextricably linked to a service's ability to remain*";

- **GP Leadership**[23] – the Review recognised that GPs would assume leadership roles in the new Integrated Care Partnerships.

The TYC Strategic Implementation Plan highlighted specific aspects of building the workforce capability to lead and to operate in the new models of care, including[24]:

- Skill development of leaders at all levels – to enable them to develop a vision and a strategy to make the changes real and see them through to implementation. There are three key target audiences for this:

  o Senior Leaders responsible for TYC;

  o Delivery teams (regional and local);

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[17] As above, page 122

[18] As above, page 123

[19] Transforming Your Care, Vision to Action, A consultation document, 9 October 2012 – 15 January 2013, DHSSPS, HSCB, page 59

[20] Transforming Your Care, DHSSPS, HSCB, December 2011, page 123

[21] Transforming Your Care, Vision to Action, A consultation document, 9 October 2012 – 15 January 2013, DHSSPS, HSCB, page 59

[22] Transforming Your Care, DHSSPS, HSCB, December 2011, page 41

[23] As above, page 123

[24] Transforming Your Care, Strategic Implementation Plan, October 2013, Final Version, HSCB, page 105

o   Clinical staff who will work alongside the delivery teams; and

▪   Support local teams and staff to develop change plans and training required to ensure staff have the abilities to operate in new ways of working.

3 HSC Workforce – Issues Highlighted During the Consultation Process

The TYC Post Consultation Report highlighted that a significant number of responses stated that the workforce was a key enabler to the success of TYC, including the need for[25]:

▪   Effective workforce planning to ensure sufficient skills where they are needed;

▪   Appropriate investment in training and skills development for staff impacted by changes to the model of care;

▪   Appropriate use of the current HSC workforce; and

▪   Understanding the impact of any change in staffing numbers.

Some specific workforce areas highlighted were as follows:

▪   A medical workforce strategy should be developed to keep acute facilities operational into the future[26];

▪   There should be investment in front line staff and a reduction in management costs[27] as there is a risk the proposals would result in a reduced access to acute care at a time when A&E services are already under pressure;

▪   Support for implementing seven-day-a-week services in acute hospitals as well as networking with other sites in the locality (with the Royal College of Nursing highlighting the need to clarify patient flow and staffing in such networks)[28];

▪   Staff side organisations[29]:

o   Lack of workforce planning has caused problems in the past and every effort should be made to ensure that the skills available matched those required; and

o   The proposed 3% reduction in the HSC workforce would put greater strain on the remaining staff and "*the agenda is one of cost saving rather than any meaningful service redesign*".

▪   Professional bodies[30];

o   The need to ensure the development of the workforce to support the provision of more services in the community;

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[25] Transforming Your Care, Vision to Action, A Post Consultation Report, March 2013, HSCB, Section 4.4, page 41
[26] As above, page 109
[27] As above, page 42
[28] As above, page 109
[29] As above, page 42
[30] Transforming Your Care, Vision to Action, A Post Consultation Report, March 2013, HSCB, pages 42, 56

o   Current skills should be put to good use, for example, the Pharmacy Forum highlighted that there was potential for Pharmacists to take on much more responsibility for care delivery, such as vaccination services and minor ailments; and

o   The BMA reflected that there could be an impact on the training of junior doctors by moving services from a hospital to a community setting.

In response to the comments from respondents, the HSC Board re-iterated the commitment made in TYC regarding the HSC workforce - "*one of the main reasons the way services are delivered needs to change is to ensure the best possible deployment of skills and staff and better networking between sites, to ensure support for the workforce in delivering services to patients and service users*".[31]

With regard to the responses received during the consultation, the HSC Board highlighted the following critical steps during implementation of TYC, the need to[32]:

- Develop detailed planning and modelling around service models and workforce to map the impact of TYC (including the call for more 7 day a week services[33]);

- Continue to engage with Staff Side organisations through a dedicated consultative forum to facilitate engagement with HSC Trade Union representatives;

- Continue to engage with professionals groups to understand the training needs and implications for professional development; and

- Design the HSC Board Programme projects and workstreams to ensure that workforce implications are a core element.

4 Workforce Planning Issues and Risks - Local Commissioning Groups (LCGs) Locality Population Plans 2012-15

The Population Plans are the "*local strategic articulation of Transforming Your Care*" and the proposed transformation in the workforce, in terms of skills development and realignment" is part of the delivery of TYC in each LCG locality.[34]

The Population Plans - "focus primarily on the nature of the services changes. The implications for the workforce in terms of skill mix would be developed following detailed operational planning in the workstreams, and as part of an overall strategic service planning exercise. Detailed discussions on nursing, midwifery, allied health professionals and doctors'

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[31] Transforming Your Care, Vision to Action, A Post Consultation Report, March 2013, HSCB, page 43
[32] Bullet points directly extracted from: Transforming Your Care, Vision to Action, A Post Consultation Report, March 2013, HSCB, page 44
[33] Transforming Your Care, Vision to Action, A Post Consultation Report, March 2013, HSCB, page 112
[34] Transforming Your Care, Strategic Implementation Plan, October 2013, Final Version, HSCB, page 66

requirements to support the initiatives will be required over the coming months."[35]

4.1 Workforce Planning – New Methodology

The LCGs have highlighted (through their population plans) that as a result of TYC and the QICR (Quality Improvement and Cost Reduction Savings Plan) [36] agenda they are moving towards a 'bottom up' workforce plan.[37]

A new common workforce analytics/service development methodology and approach is to be developed over the timeframe of the Population Plans. This "*will ultimately deliver detailed workforce and service change plans*".[38] The TYC Strategic Implementation Plan highlighted that the HSCB, together with the Business Services Organisation, DHSSPS and the HSC Trusts would "*procure the use of a workforce/service planning tool to inform and support future planning*".[39]

To move to the new workforce model, the LCGs will follow a number of core steps[40]:

- **Define strategic direction** (Population Plans) and identify the financial resource shift from hospital services into Primary Care/Community Services (£83m[41]);
  - o Services/organisations the plan will cover and the timescales.
- **Mapping service redesign**:
  - o Current position - Develop a baseline of the current workforce profile; and
  - o Option appraisal (costs and benefits) and selection of a preferred model (costs and benefits);
- **Future need** – Analysis of future activity, numbers and skills of the future workforce including a measurement of predicted productivity gains;
- **Supply** - Analysis of projected workforce supply;
- **Forecast Demand** - Forecast of workforce need by identifying skills needed in the future;
- **Gap Analysis** - Analysis of the gaps between the current and future workforce and a list of the most critical workforce changes needed;

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[35] As above, page 26

[36] QICR – Quality Improvement and Cost Reduction Savings Plan – developed by the HSC Trusts for the Population Plans which have been produced for TYC (informed by McKinsey, Appleby and PEDU Reviews). The QICR plans cover both cash releasing and productivity/cost avoidance initiatives which seek to improve efficiency whilst maintaining or improving quality outcomes.

[37] Belfast Local Commissioning Group Locality: Population Plan 2012-2015, page 69

[38] As above, page 69

[39] Transforming Your Care, Strategic Implementation Plan, October 2013, Final Version, HSCB, page 32

[40] Directly extracted from the Belfast Local Commissioning Group Locality: Population Plan 2012-2015, page 70

[41] TYC presented the methodology to make the necessary changes over a 5 year period. It initially describes a financial remodelling of how money is to be spent indicating that a 5% shift (which is approximately £83 million in the current budgets) from hospital services would need to be re-invested into primary and community and social care services by 2014/15, Transforming Your Care, Strategic Implementation Plan, October 2013, Final Version, HSCB, page 14

- **Design the workforce plan** needed to move from the current workforce to the future workforce - implement, monitor and review the workforce plan.

The following common workforce implementation issues have also been identified in the Population Plans[42]:

- Delivery of care in a more integrated manner across primary, secondary and community settings may mean a change in role and location for some staff;
- Enhanced role for some independent health care provider partners may require enhanced training and regulatory frameworks;
- Development of acute networks across an area may mean a change in working patterns or organisational structures; and
- New care pathways may mean staff work in different ways, and have enhanced interfaces with other parts of the service.

The LCGs envisage that any service change will address impacts of staff, including as a minimum:

- An understanding of the impact on the workforce, and the most appropriate skills mix to deliver the services;
- Meaningful involvement and consultation with Trade Unions as appropriate;
- Ensuring that staff transition and Human Resources activities are integrated with the project and workstream plans from the outset;
- An understanding of the capability needs of the staff, and detailed re-training plans to support implementation where such a need exists; and
- Where appropriate, provide support to the staff through voluntary redundancy and voluntary early retirement schemes.

As further work is undertaken "*greater understanding will be developed on the workforce skills mix needed to deliver the new models of care. This will support the identification of the training and capability needs for staff groups, and where any gaps and risks exist which could impact on the resilience of the service in later years*".[43]

Appendix 1 shows the *indicative* workforce implications (reductions) of the various HSC Trusts QICR plans as included in the local Population Plans.

4.2 Workforce Planning – Key Risks and Challenges

Key risks to the implementation of TYC with regard to the workforce have been highlighted in the Populations Plans. These include:

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[42] Directly extracted from the Belfast Local Commissioning Group Locality: Population Plan 2012-2015, page 71
[43] Transforming Your Care, Strategic Implementation Plan, October 2013, Final Version, HSCB, page 112

- Public or political insistence to maintain hospital services despite resource limitations – thus hindering the 'shift left' and making hospital services vulnerable due to safety concerns[44];

- Secondary care inflexibility in supporting the 'shift left' and the Integrated Care Partnerships, with the potential to undermine the 'shift left' and the Integrated Care Pathways[45];

- Inability to create the 'critical mass' of GPs needed to support the 'shift left' and the Integrated Care Partnerships – this could lead to uneven 'transformation' of care[46];

- Inability to attract the consultants required – therefore an inability to deliver acute specialties and sub-specialties[47]; and

- The capability of the workforce is not sufficient to deliver the TYC agenda i.e. staff do not have or are not re-trained with the relevant skills – leading to a failure to deliver changes to services or to make the changes at the required speed[48].

The BMA recently highlighted the main challenges to medical workforce planning across the UK as follows[49]:

- Training – the long duration of training (10 years to become a GP and 12-15 years to become a consultant), therefore effective national workforce planning is essential;

- Seven day services – The greatest demand for hospital doctors is in frontline positions, with the most advertised specialties being emergency, acute and geriatric medicine – moving to seven-day working would further increase demand in these areas;

- Consultant numbers – the Centre for Workforce Intelligence[50] has estimated that by 2020 the total number of doctors qualified to consultants level will have increased by 60% - this raises two issues – funding and the availability of consultants posts – a long term national workforce plan is crucial;

- GP numbers – concerns around a potential shortage of GPs and the BMA have called for an increase to GP training numbers to 3,250 by 2015;

- Regional Variation – there is considerable local and regional variation for GPs and hospital doctors, with workforce needs in Northern Ireland, Wales and Scotland needing to be considered as part of a national plan; and

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[44] Western Local Commissioning Group Locality Population 2012-2015, page110

[45] Western Local Commissioning Group Locality Population 2012-2015, page110

[46] As above, page110

[47] As above, page110

[48] Belfast Local Commissioning Group Locality: Population Plan 2012-2015, page 104, and South Eastern Locality Population Plan 2012-2015, page 114

[49] Medical Workforce, BMA Media Brief, September 2013, http://bma.org.uk/-/media/files/word%20files/news%20views%20analysis/press%20briefings%20new/bmabrief_medicalworkforce.doc

[50] The CfWI is a key contributor to the planning of future workforce requirements for health, public health and social care in England, www.cfwi.org.uk

- Part-time working – flexible and part-time working is essential for staff retention. In recent years there has been a 50% increase in the number of consultants working part time (from 12% to 18%), with 38% of female and 6% of male consultants working part time.

5 Recent Update from DHSSPS

On 13th May 2014, the Committee for Health, Social Services and Public Safety received a written update on the 99 proposals in TYC and several of these specifically concerned the HSC workforce under the heading 'Implications for the Service' and these are directly extracted below from the document received:

- Recommendation 95 – Development of new workforce skills and roles to support the shift towards prevention, self-care and integrated care that is well co-ordinated, integrated and at home or close to home – *The Department has established a regional workforce planning group to take forward TYC proposals 79,95 and 97' A'. The group is focusing on development of a regional framework for workforce planning which will aim to ensure there is an agreed process for identification of the development needs (training/education and skills) to deliver the TYC aim of providing greater care in the community.*

- Recommendation 96 – Development of GPs to assume a critical leadership role in the new integrated care teams:

  o *A clinical Leadership Development Programme for 51 clinicians (17 GPs, 17 Pharmacists and 17 Secondary Care Consultants) was launched on 20 September 2013 as part of the Integrated Care Partnerships;*

  o *Through the Integrated Care Partnerships, the HSCB have retained 17 GP Pharmacy leads on a sessional basis to provide a dedicated leadership capacity. An organisational development programme to support the partnership committees started in March 2014, and additional development support is in place for the Chairs of the ICP committees, many of whom are GPs.*

- Recommendation 97 – More formal integration of workforce planning and capital expenditure into the commissioning process to drive the financial transformation, with regard to workforce planning – *The Department is currently taking forward a project to develop a strategic framework for regional workforce planning which will seek, for the first time, to set out and agreed specific roles and responsibilities for each HSC organisation in terms of workforce planning. The aim will be to ensure we have the appropriate mechanisms in place to support robust planning at both organisational and regional level. The Department will be engaging with a wide range of stakeholders from across the HSC, in taking forward this important project.*

6 A Good Practice Model – NHS Scotland *Everyone Matters: 2020 Workforce Vision*

Research findings of a two-year project by the University of Nottingham[51] highlight post-devolution NHS Scotland as representing a "*groundbreaking*" approach to industrial relations and "*anyone wanting to understand how government, employers and staff should work together to deal with strategic and organisational challenges can learn from it*".

Dr Samuel from the University of Nottingham, highlighted how the policymakers of NHS Scotland concluded that the way to deliver better healthcare was to improve the way staff were engaged, which led to the establishment of structures at national and local levels to give staff more say in decisions affecting their working lives and healthcare provision, "*NHS Scotland has even passed into law a 'staff governance code' that compels all its health boards to engage and involve staff and their representatives*".[52]

Given these research findings NHS Scotland may provide a useful good practice model for workforce planning. Moving in much the same direction as TYC, Scotland's Health Service has the vision that "*by 2020 everyone is able to live longer, healthier lives at home or in a homely setting*"[53] and, as in Northern Ireland, this will necessitate many changes to the way that services are delivered.

The *Everyone Matters: 2020 Workforce Vision* (June 2013) recognises that it is "*people that make change happen and the support and contribution of the NHS Scotland workforce is crucial in delivering reform*" and it was developed with input from 10,000 people across NHS Scotland including trades unions, professional organisations and partners in the delivery of care.[54]

NHS Scotland makes clear that:

> Over the next seven years, all NHS Boards are expected to deliver the commitments set out in Everyone Matters: 2020 Workforce Vision. This will not be achieved through business as usual, compliance and a tick box culture. Real transformational change will be needed.[55]

The *Implementation framework and plan 2014-15* sets out the arrangements for holding NHS Boards in Scotland to account for delivering the commitments in *Everyone Matters* and sets out the minimum actions that that need to be carried out during 2014-15.

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[51] The study was carried out with the full co-operation of NHS Scotland

[52] NHS Scotland a role model for reform, says study, The University of Nottingham, http://www.nottingham.ac.uk/news/pressreleases/2012/february/nhs-scotland-a-role-model-for-reform,-says-study.aspx

[53] Everyone Matters: 2020 Workforce Vision, Implementation framework and plan 2014-15, NHS Scotland, page 2, http://www.scotland.gov.uk/Publications/2013/12/7263

[54] Everyone Matters: 2020 Workforce Vision, Implementation framework and plan 2014-15, NHS Scotland, page 2, http://www.scotland.gov.uk/Publications/2013/12/7263

[55] Everyone Matters: 2020 Workforce Vision, Implementation framework and plan 2014-15, NHS Scotland, page 9, http://www.scotland.gov.uk/Publications/2013/12/7263

NHS Scotland acknowledges that a "*great deal of work is needed over the next seven years to deliver Everyone Matters: 2020 Workforce Vision and it will require a continuous process of planning, implementation and progress reviews*". The table below is directly extracted from the *Implementation framework and plan 2014-15* and gives an overview of the framework[56]:

Implementation plans	**Priorities for action**
Annual implementation plans will build on each other up to 2020 and will encourage a continuous improvement approach. Some actions will be taken forward at a national level and others locally by Health Boards, through engagement and co-production with those who deliver or are involved in the delivery of health care.	Priority actions will be identified and will be supported by project plans with key milestones for delivery. The priorities are: • Healthy organisational culture • Sustainable workforce • Capable workforce • Integrated workforce • Effective leadership and management.
Monitoring and reporting arrangements	**Governance arrangements**
Progress will be monitored locally through relevant reporting arrangements. Progress will also be monitored nationally through the Local Delivery Planning (LDP) process, along with results from the staff survey and staff governance monitoring arrangements. Workforce Plans may also be used to help monitor progress. Progress will be reported to the Everyone Matters Implementation Group and the Health and Social Care Management Board.	The Everyone Matters Implementation Group will be responsible for producing the annual implementation plans. The Group will report to the Health and Social Care Management Board and this will contribute to the wider discussion about joined-up planning for workforce, finance, service, IT and capital infrastructure to deliver the 2020 Vision.

The five workforce priorities for NHS Scotland with specific actions for 2014-15 are as follows[57]:

1. **Healthy organisational culture** - By developing and sustaining a healthy organisational culture, Boards will create the conditions for high quality health and social care – *the focus this year is on embedding shared values.*

2. **Sustainable workforce** - The health workforce needs to change to match new ways of delivering services and new ways of working, with a need to ensure that people with the right skills, in the right numbers, are in the right jobs. There is also a need to promote the health and well-being of the existing workforce and prepare them to meet

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[56] Everyone Matters: 2020 Workforce Vision, Implementation framework and plan 2014-15, NHS Scotland, page 6, http://www.scotland.gov.uk/Publications/2013/12/7263

[57] Extracted and summarised from Everyone Matters: 2020 Workforce Vision, Implementation framework and plan 2014-15, NHS Scotland, page 4, http://www.scotland.gov.uk/Publications/2013/12/7263

future service needs - *Strengthening workforce planning is identified as one of the early actions*;

3. **Capable workforce** - All staff need to be appropriately trained and have access to learning and development to support the *Quality Ambitions and 2020 Vision for Health and Social Care* - *The focus this year is on ensuring that development reviews/appraisals are meaningful, providing fair access to learning and development for support staff, and building capacity and capability to improve quality*;

4. **Integrated workforce** - The workforce should be more joined-up across primary and secondary care, across Boards and with partners across health and social care - *The focus this year is on developing the right conditions for an integrated workforce*; and

5. **Effective leadership and management** - Managers and leaders as part of the workforce have a key role to play in driving service and culture change - *the focus this year is on supporting and developing line managers, particularly their people skills*.

Appendix 1 - *Indicative* workforce implications (reductions) of the various HSC Trusts QICR plans as included in the local Population Plans (2012 - 2015).

The tables below are directly taken from the Population Plans (2012-2015) and show the *indicative* workforce implications of the TYC plans of the five HSC Trusts TYC plans. For example, the Belfast HSC Trust describes its table as "*best estimates of future outcomes based on previous experience of savings plans and the profile of the current workforce. The actual workforce implications are heavily dependent on opportunistic turnover and workforce flows*".[58]

The workforce summary plans appear to be very high level in the Population Plans and Whole Time Equivalent figures (WTEs) are very indicative only and therefore, presumably, will be subject to more detailed refinement as plans are developed.

For four of the Trusts – Belfast, South-Eastern, Southern and Western – the tables are presented in each of the Population Plans in a standard format of two sections:

- Staff Group (Medical and Dental, Nursing, Admin and Clerical, Professional and Technical, Social Services and Ancillary and General); and
- Workstream (Reform Area, Acute Reform, Social Care Reform, Staff Productivity, Miscellaneous Productivity).

The Northern HSC Trust shows figures catagorised by staff Group only.

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[58] Belfast Local Commissioning Group Locality: Population Plan 2012-2015, page 90

Belfast HSC Trust Workforce Summary of QICR Plans

The indicative workforce implications of the Trust's Plans are outlined below:

Table 5	2012/13	
	Indicative Headcount impacted post backfill reduction (in WTEs)	Estimated Reduction in Backfill* Costs (in WTEs)
Medical & Dental	10	10
Nursing	230	45
Admin & Clerical	60	70
Professional & Technical	55	5
Social Services	45	5
Ancillary & General	50	45
Sub-Total	**450**	**180**
Workstream		
Reform Area		
Acute Reform#	200	
Social Care Reform		5
Staff Productivity**	250	95
Miscellaneous Productivity		80
Sub-Total	**450**	**180**
Less new investment	**25**	
Total Net of new investment	**425**	

*Backfill includes Bank, Agency, Overtime and Additional hours.
**Part of the Staff Productivity targets will be achieved by reducing the backfill costs associated with sickness absence . The Trust plans to reduce sickness absence by 0.5% pa as part of its QICR Plans.
#A number of Acute Reform initiatives will be delivered in the latter part of 2012/13. Although the majority of savings will be released in 2013/14, the workforce impacts are reflected in 2012/13.

The above table represents best estimates of future outcomes based on previous experience of savings plans and the profile of the current workforce. The actual workforce implications are heavily dependent on opportunistic turnover and workforce flows.

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Northern HSC Trust Workforce Summary of QICR Plans

The figures appearing in the year 1 and year 2 summary table below continue to be developed. They show the net impact of a number of the proposed planned developments contained within the Population Plan. The figures are net workforce impact i.e. the number of posts which it is anticipated will reduce as a result of implementing specific service plans. At this time the figures do not include the impact of ICP/Long Term Condition Service Transformation or any planned new service development workforce increases where it is anticipated that there will be significant opportunities for redeployment and re-training.

Trust workforce Summary of QICR Plans:

Workforce	Staff in post as at 31/3/12 (incl. career break)	As at 31/3/13	As at 31/3/14
Total staff numbers:			
•Admin & Clerical	1649.63	1624.71	1622.71
•Estate Services	118.64	118.64	118.64
•Support Services	854.26	842.79	833.57
•Nursing & midwifery	3011.10	3009.10	2965.39
•Social Services	2226.40	2194.88	2169.11
•Professional & Technical	1206.54	1206.54	1206.54
•Medical & Dental	521.99	521.99	521.99
Total	**9588.56**	**9518.65**	**9437.95**

(The above figures include ~VER/VR funding secured at 31 March 2012.)

South-Eastern HSC Trust Workforce Summary of QICR Plans

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Trust Workforce Summary Of QICR Plans

The indicative workforce implications of the Trust's Plans are outlined below:

Staff Group	2012/13 WTE
Medical and Dental	11
Nursing	25
Admin and Clerical	22
Professional and Technical	1
Social Services	31
Ancillary and General	15
Totals	**105**
Workstream	
Reform Area	
Acute Reform	36
Social Care Reform	40
Staff Productivity	5-45
Miscellaneous Productivity	6
Totals	**87-127**
Less new investment	**30**
Net WTE Impact	**57-97**

Mid point of the range of workforce reductions taken to estimate the impact by staff grouping. Agency/bank staff WTEs included in above numbers.

Southern HSC Trust Workforce Summary of QICR Plans

The indicative workforce implications of the Trust's Plans are outlined below:

Table 5

Staff Group	2012/13 WTE	2013/14 WTE	2014/15 WTE
Medical & Dental	(8)	(12)	(6)
Nursing	(49)	(75)	(38)
Admin & Clerical	(22)	(34)	(17)
Professional & Technical	(13)	(22)	(11)
Social Services	(26)	(40)	(21)
Ancillary & General	(11)	(17)	(9)
Totals	**(129)**	**(200)**	**(102)**
Workstream			
Reform Area			
Acute Reform	(18)	(29)	(15)
Social Care Reform	(9)	(13)	(7)
Staff Productivity	(89)	(137)	(70)
Miscellaneous Productivity	(13)	(21)	(10)
Totals	**(129)**	**(200)**	**(102)**

The Whole Time Equivalent (WTE) figures above are extremely indicative only and will be subject to much more detailed refinement as plans are developed in full. WTEs have been calculated on an average gross cost of £30k per annum

Western HSC Trust Workforce Summary of QICR Plans

Population Plan Net Workforce Implications

The indicative workforce implications of the Trust's Plans are outlined below:

Table 5

Staff Group	2012/13 WTE Inc/(Dec)
Medical & Dental	4
Nursing	(10)
Admin & Clerical	(19)
Professional	4
Social Services & Technical	(35)
Ancillary & General	50
Total QICR Workforce Implication	**(6)**
Workstream	
Reform Area	
Acute Reform	(36)
Social Care Reform	(18)
Staff Productivity	(115)
Miscellaneous Productivity	0
Total QICR Workforce Implication	**(169)**
Total Investment WTE - In House	**163**
Total WTE WHSCT Reduction	**(6)**

The above shows an indicative headcount impact.

Northern Ireland Assembly

Research and Information Service
Briefing Paper

Dr Janice Thompson and Dione Todd

Transforming Your Care (TYC) Workforce Planning 2 – Trends in HSC Staff Numbers

Contents

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Summary and Key Points

The TYC Strategic Implementation Plan identified the main impact on health and social care (HSC) staff as stemming from the shift of activity from an acute to a community and enhanced primary care setting.

The Committee for Health, Social Services and Public Safety has previously received a RaISe briefing summarising how HSC workforce planning has been dealt with in the series of official TYC publications to date.

This second RaISe briefing paper regarding workforce planning provides a baseline and an introductory review of HSC staff numbers and trends in a selection of staff groups likely to be impacted by TYC.

The aim of the briefing is to stimulate discussion around potential areas for further investigation by the Committee in terms of the numbers, work places and patterns of various staff groupings in line with the implementation of TYC.

Section 3 provides a series of trend graphs and analysis of selected HSC staff groups, using figures taken from the *Northern Ireland Health and Social Care Workforce Census.*[1]

The workforce census does <u>not</u> include independent contractors such as General Practitioners and General Dental Practitioners and information on these staff groups is covered in Section 4 of this paper:

Section 3 of the paper, shows that, overall, from 2000 onwards to the present the following HSC occupational 'families' show a general upward trend in numbers across Northern Ireland (NI):

- Qualified Nursing and Midwifery staff;
- Medical and Dental staff;
- Professional and Technical staff;
- Social Services Staff; and
- Ambulance Staff.

Administrative and Clerical Staff showed an overall general increase from 2000 to 2007/08 but numbers have since levelled off.

A closer look (over the period 2008 to 2014) at selected staff groups within these occupational 'families' shows variations within the general overall NI upward trends between staff groups and between Trusts.

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[1] DHSSPS, Health and Social Care Workforce Census , www.dhsspsni.gov.uk/index/statistics/workforce/staff-numbers.htm

According to figures from the *Northern Ireland Health and Social Care Workforce Census*, some of the main variations noted across the time period 2008 to 2014 are:

- **Qualified Nursing and Midwifery staff**:
    - District Nurses and Treatment Room Nurses show a general decrease across NI;
    - Acute Nurses show a mixed picture of increases and decreases across Trusts;
    - Health Visitors have decreased in the Belfast Trust; and
    - Mental Health Nurses have remained stable in numbers across NI but there are varying increases and decreases across Trusts.

- **Medical and Dental staff;**
    - Consultants – increases across all Trusts;
    - Specialty/Specialist Registrar/GP Trainee – general decreases across NI, small increase in the Northern Trust;
    - Foundation/Senior House Officer – increases across the Trusts but overall totals show main increase from 2008-2009; and
    - General/Hospital Practitioner – relatively small numbers of this staff group but general decreases across the Trusts.

- **Professional and Technical staff**;
    - General increases across Trusts (variations between Trusts) in all staff groups looked at – Dieticians, Occupational Therapists, Physiotherapists, Radiographers, Speech and Language Therapists and Pharmacists.

- **Social Services Staff;**
    - General increases across Trusts (variations between Trusts with some decreases) in all staff groups looked at – Social Workers for Child and Family Care, Hospital, Elderly, Learning Disability, Mental Health and Social Care Staff

- **Administrative and Clerical Staff**
    - Overall numbers of this occupational 'family' show an increase from 2000 to 2007, followed by a steady decrease;
    - There has been steady decline in total numbers in grades 1-4 across all Trusts from 2008; and
    - There has been an increase in total numbers in bands 5-6 since 2011 in all Trusts.

It should be noted that RaISe requested explanations from the DHSSP for some of the more notable or unusual trends for some staff groups. For some of the trends within Qualified Nursing and Midwifery, the DHSSPS statisticians advised that it was difficult to respond because Trusts re-coded some staff when new Agenda for Change grade codes became available and this occurred at different times.   Another explanation provided, with regard to a staff group within Medical and Dental Staff was that the

number of these staff will vary in each Trust according to the Trust's own service configuration and specialties delivered. Therefore, it may follow that these types of explanations also apply to some other trends that RaISe did not specifically pursue at this early stage of the HSSPS Committee's workforce planning review.

Looking at Section 4 of the paper it is evident that gathering recent/current information regarding staff numbers not covered by the HSC Workforce Census is difficult, for example, with regard to GP Practices.

The total number of GPs and GP surgeries is known but beneath that level to gather information about the number of nurses or administrators that these independent contractors employ does not appear possible without contacting individual GP practices.

However, Section 4 highlights that prior to the establishment of the Business Services Organisation, it appears that the Family Practitioner Services Directorate did publish more detailed information about General Medical Services, General Dental Services, General Ophthalmic Services and Pharmaceutical Services, with its last statistical report published in 2007/08.[2]

Reviewing trends in HSC Staff numbers across NI as a whole and across Trusts in primary and secondary care settings is, of course, only part of the story. The key to the success of implementing TYC will be in the changing roles and locations of certain staff groups with increasing HSC treatment occurring in primary care and community settings.

Pertinent questions may be:

- Do the increases and decreases in different staff groups support the policy direction and implementation of TYC?
- Is the current information collated by the DHSSPS on the workforce sufficient to monitor the implementation of TYC?

In order to provide the Committee with the most up to date position regarding HSC workforce planning in connection with TYC, RaISe requested an update on the work of the **Regional Workforce Planning Group** and the response is included at Section 5.

1   Introduction

In May 2014, the Committee for Health, Social Services and Public Safety (the Committee) received a RaISe briefing note (NIAR 277-14)[3] in connection with 'Transforming Your Care' (TYC) [4] – Workforce Planning. This summarised how HSC workforce planning had been dealt with in the series of official TYC publications,

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[2] http://www.hscbusiness.hscni.net/pdf/NI_FAMILY_PRACTITIONER_SERVICES_STATISTICAL_REPORT_2007-08.pdf
[3] NIAR 277-14 (unpublished)
[4] Transforming Your Care, A Review of Health and Social Care in Northern Ireland, DHSSPS, HSCB, December 2011

including the Belfast, Northern, Western, Southern and South Eastern Local Commissioning Group Locality Population Plans.[5]

That first briefing also highlighted challenges to medical workforce planning as identified by the BMA and introduced the NHS Scotland *Everyone Matters: 2020 Workforce Vision* as a possible good practice example of workforce planning.

The new model of service to be delivered by TYC requires a substantial move towards prevention, self-care, increased primary care and care that is provided at home or closer to home. This direction will have a substantial impact on the HSC workforce with a 'shift left' of activity to the community and primary care setting and a more integrated care focus, meaning a change in role/location for some staff. The development of acute hospital networks will also mean a change in working patterns for some staff.

The previous briefing noted the new methodology of workforce planning described in the Population Plans of the Local Commissioning Groups (LCGs) but the workforce plans (staff reductions[6]) of the five HSC Trusts did not appear to be well developed at that time and were indicative in nature.

The TYC Strategic Implementation Plan identified the impact on HSC staff as stemming from[7]:

- A shift of activity from an acute to a community and enhanced primary care setting;
- Delivery of care in a more integrated manner across primary, secondary and community care;
- Enhanced role for some of the independent healthcare providers. (May require enhanced training and regulatory frameworks); and
- Development of acute networks across an area. (May mean a change in working patterns or organisational structures.)

In addition, workforce development is described as 'critical' to the establishment of the new network models of care through the creation of five to seven hospital networks:

- More people will receive care in their own home, or close to home - with hospital clinicians working closely with GPs and other community staff[8];
- Multi professional, community health and social care integrated teams will support patients in their own homes[9]; and
- Staff will be required to develop different skills and capacities in new and extended roles, for example, GPs with special interests in emergency medicine or paediatrics, specialist long-term condition nurses and emergency care practitioners. It is

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[5] http://www.transformingyourcare.hscni.net/consultation/

[6] The consultation used the working assumption that moving to the new model of care would see a reduction in the overall workforce of around 3% (around 1,620 whole time equivalents)

[7] Extracted from Transforming Your Care, Strategic Implementation Plan, October 2013, HSCB, Final Version, page 99

[8] Transforming Your Care, DHSSPS, HSCB, December 2011, page 122

[9] As above, page 122

proposed that there will be an increase in outpatient follow-up appointments being carried out by GPs and nurses[10].

The TYC Review document and subsequent consultation document did identify certain specific issues around the impact on the HSC workforce:

- **GP Leadership**[11] – the TYC Review recognised that GPs would assume leadership roles in the new Integrated Care Partnerships.

- **Workforce availability**[12] – Workforce availability over the three years following the TYC Review was unlikely to be sufficient to sustain the current HSC model (for example, shortages of doctors within emergency care services);

- **Reduction in HSC workforce** – The TYC consultation used the working assumption that moving to the new model of care would see a reduction in the overall workforce of around 3% (around 1,620 whole time equivalents). To enable this shift, the HSC "*will provide support for voluntary early retirement/voluntary redundancy and/or retraining support*"[13];

- **Training**:

  o The TYC Review concluded that the current model is unsustainable in terms of the training experience required for junior doctors[14];

  o In the new care model some staff (currently hospital-based) will fulfil unchanged/very similar roles in the community or primary care setting, whereas others will be asked to adapt to a change in role and will be given "*appropriate training and support*"[15];

- **Workforce sustainability**[16] – future services models must be sustainable - "*while locum and agency staff may be used to support a services where necessary and appropriate, they should not be inextricably linked to a service's ability to remain*";

The responsibility for workforce planning rests with the DHSSPS and TYC transformation will involve the *Regional Workforce Planning Group* supporting the development of detailed workforce plans, including continuing engagement with staff, professional bodies and staff side organisations.[17]

In response to a Member's Question in 2014[18], the then Health Minister, Edwin Poots, responded that:

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[10] Transforming Your Care, DHSSPS, HSCB, December 2011, page 122

[11] As above, page 123

[12] As above, page 123

[13] Transforming Your Care, Vision to Action, A consultation document, 9 October 2012 – 15 January 2013, DHSSPS, HSCB, page 59

[14] Transforming Your Care, DHSSPS, HSCB, December 2011, page 123

[15] Transforming Your Care, Vision to Action, A consultation document, 9 October 2012 – 15 January 2013, DHSSPS, HSCB, page 59

[16] Transforming Your Care, DHSSPS, HSCB, December 2011, page 41

[17] Transforming Your Care, Strategic Implementation Plan, October 2013, HSCB, Final Version, page 32

[18] NI Assembly Oral Question, AQO 6669/11-15, asked on 11/09/14,
http://aims.niassembly.gov.uk/questions/oralsearchresults.aspx?&qf=0&qfv=1&ref=AQO%206669/11-15

The regional workforce planning group was established to take forward the specific proposals in 'Transforming Your Care' relating to workforce planning. The group is completing the development of a framework for workforce planning that will strengthen HSC workforce planning across the region and inform the basis for taking forward a programme of workforce reviews. Whilst the framework is being finalised, my Department continues to lead on regional workforce planning, and a number of workforce reviews are in progress in relation to nursing, medical specialists and medicine…

2 Overview

In connection with the Committee's scrutiny of TYC this second RaISe briefing paper regarding the workforce provides a starting point for the next phase of the Committee's work on TYC. The information in this paper is provided as an introduction to the Committee's wider review into workforce planning.

It is not intended as a full review of all HSC staff groups in primary and secondary care but includes a selection of staff groups that are among those impacted by TYC. The briefing seeks to stimulate discussion around potential areas for further investigation in terms of the numbers, work places and patterns of various staff groupings and the impact this will have on the implementation of TYC.

Section 3 of this paper provides a series of trend graphs and analysis of selected HSC staff groups[19], both totals[20] and broken down by Trusts, using figures taken from the *Northern Ireland Health and Social Care Workforce Census.*[21] The HSC staff groups covered in Section 3 are:

- Qualified Nursing and Midwifery staff;

- Medical and Dental staff;

- Professional and Technical staff;

- Social Services Staff;

- Ambulance Staff; and

- Administrative and Clerical Staff.

The workforce census does <u>not</u> include independent contractors also working in Health & Social Care such as General Practitioners and information on some of these staff groups is covered in Section 4.

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[19] Workforce figures exclude staff on career breaks, bank staff (due to the variable nature of their employment), Chairman/Members of Boards and staff with a whole-time equivalent of less than or equal to 0.03. For this 2014 edition, Home Helps/Domiciliary Care staff are also excluded as their recorded WTE does not accurately reflect their contributions to the service. Some historical figures have been revised to reflect methodological changes in order to maintain comparability. Data from the Northern Ireland Medical and Dental Training Agency were only available for 2014, so these staff have not been included in this comparison. They have been included in the main tables

[20] The totals include staff that are based within the HSC Board or Regional Services

[21] DHSSPS, Health and Social Care Workforce Census , www.dhsspsni.gov.uk/index/statistics/workforce/staff-numbers.htm

3   Numbers and Trends Within the HSC Workforce

Graphs within this section show **Whole Time Equivalent** (WTE). WTE is a method of aggregating full and part-time staff's hours effectively converting them into equivalent number of 'whole time' staff. This is done by calculating the aggregate of the total number of hours that staff in a grade are contracted to work, and dividing by the standard hours for that grade. As a result, part-time staff are converted into equivalent number of 'whole time' staff[22].

Figures used to prepare the graphs were taken as far as possible from the most recent published HSC workforce census[23] and then from the census of relevant years as applicable. According to the 2014 HSC workforce census, "*the main tables and discussion exclude Home Helps/Domiciliary Care Staff, bank/sessional staff and staff with a WTE of less than or equal to 0.03….Figures also exclude staff on career breaks and Chairs/Members of Boards*".[24]

The figures used for trend graphs of occupational families covering the years 2000-2014 are where universal definitions allowed figures to be compared[25]. Figures for 2005-2014 are taken from Table A of the 2014 HSC workforce census and figures for 2000-2004 are taken from Table A of the 2005 HSC workforce census.

Graphs in this paper which cover the period 2008-2014 (or parts thereof) are a result of earlier figures not being comparable due to changes in definitions of staff job titles or groupings.

RaISe requested explanations from the DHSSP for some of the more notable or unusual trends for some staff groups. For example, for some of the trends within Qualified Nursing and Midwifery, the DHSSPS statisticians advised that it was difficult to respond because Trusts re-coded some staff when new Agenda for Change grade codes became available and this occurred at different times.   Another explanation provided, with regard to a staff group within Medical and Dental Staff was that the number of these staff will vary in each Trust according to the Trust's own service configuration and specialties delivered. Therefore, it may follow that these types of explanations also apply to some other trends that RaISe did not specifically pursue at this early stage of the HSSPS Committee's workforce planning review.

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[22] DHSSPS (2001) Definition of Whole Time Equivalent, Available at http://www.dhsspsni.gov.uk/wf_2001_definitions.pdf

[23] DHSSPS, (2014) Northern Ireland Health and Social Care Workforce Census 2014. Available at: http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf
http://www.dhsspsni.gov.uk/ni_hpss_workforce_census_march_2005_no_cover.pdf

[24] 2014 HSC workforce census, page 5, http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

[25] Figures for 2005-2014 taken from the 2014 HSC workforce census and figure for 2000-2004 are taken from the 2005 HSC workforce census, http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf
http://www.dhsspsni.gov.uk/workforce_census_march_2005_exc_sec_11.pdf

3.1 Qualified Nursing and Midwifery Staff

Overall NI Trend for Qualified Nursing and Midwifery Staff[26]:

> **2000-2014: 27% increase (11,381.3 to 14,428.5 in WTE)**
> - **2005-2014: 8% increase (13,314.1 to 14,428.5 in WTE)**
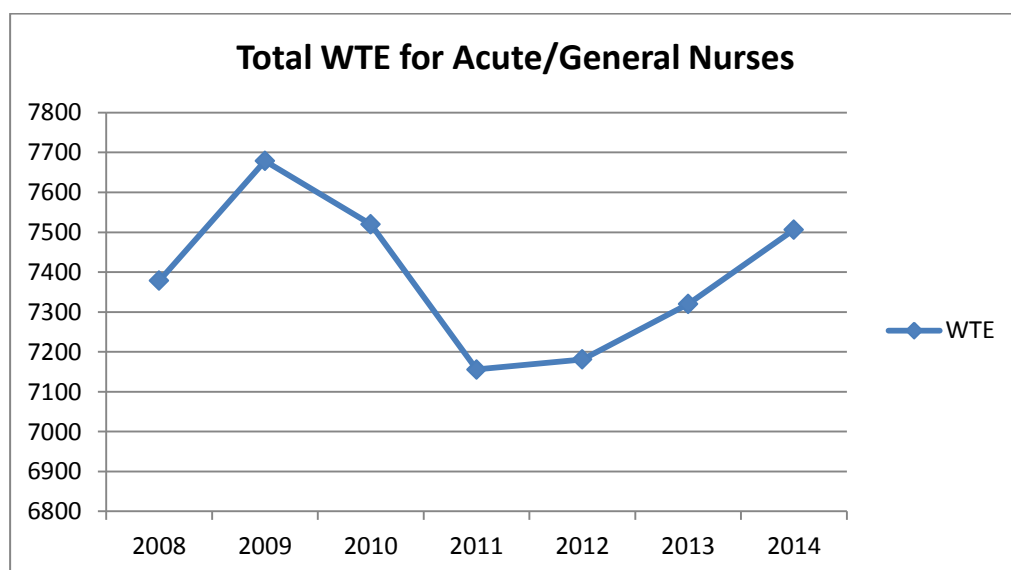> - **2009-2014: 4.0% increase (13,875.9 to 14,428.5 in WTE)**

Qualified Nursing and Midwifery Staff 2000-2014

Qualified Nursing and Midwifery Staff 2009-2014

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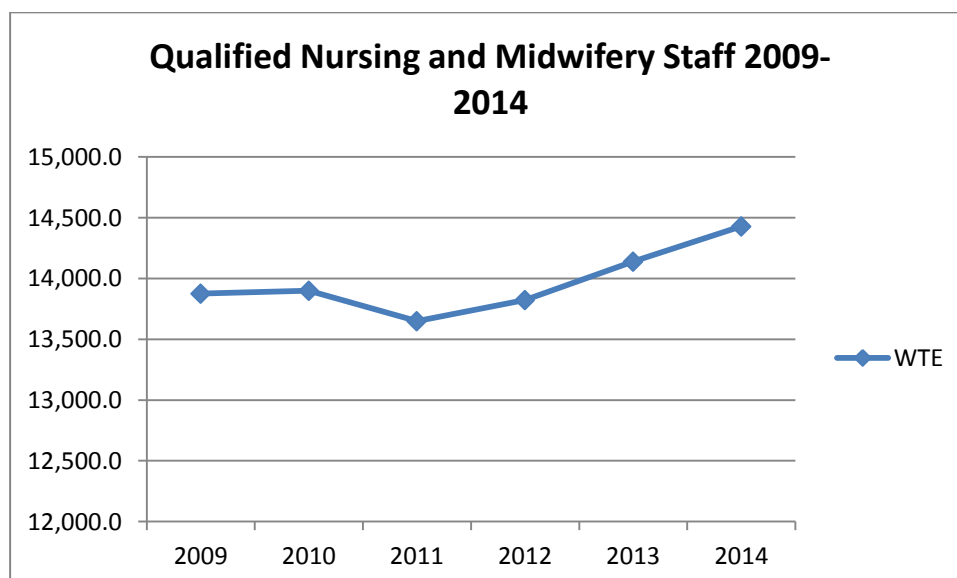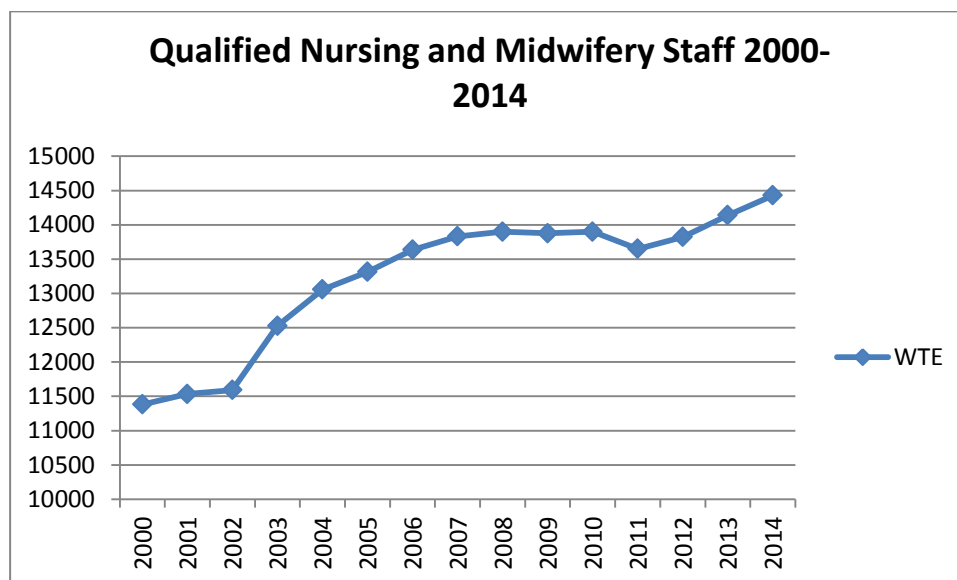
[26] As above

This section includes a more in-depth look at the figures for selected staff groups within *Qualified Nursing and Midwifery* staff:

3.1.1   Acute/General Nurses;

3.1.2   Mental Health Nurses;

3.1.3   Health Visitors;

3.1.4   District Nurses; and

3.1.5   Treatment Room Nurses.

3.1.1 Acute/General Nurses[27]

Overall Trust Totals for Acute/General Nurses

Overall 2% increase in WTE from 2008-2014

Total WTE for Acute/General Nurses

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[27] Figures for each year are extracted from the workforce census publication for that year. Available at:
 2008 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2008_web.pdf
2009 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2009_exc_sec_11.pdf
2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

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Trends across the Trusts 2008 to 2014:

Belfast:	**5% decrease**	**(3098.8 to 2930.7 in WTE)**
Northern:	**8% decrease**	**(1184.7 to 1088.7 in WTE)**
Southern:	**9% increase**	**(1021-1125.6 WTE)**
South Eastern:	**23% increase**	**(903-1114 WTE)**
Western:	**6% increase**	**(1172.0 to 1247.3 in WTE)**

Based on the above trend, RaISe asked the DHSSPS to explain the following: *since 2008, there has been a decrease in acute nurses in the Belfast (around 5%) and Northern (around 8%) Trusts, against increases in the other Trusts (WTE).*

The DHSSPS statisticians advised that it is difficult to respond to this question because Trusts re-coded some staff when new Agenda for Change grade codes became available and at different times e.g. from Acute Nurse to Specialist Nurse.[28]

3.1.2. Mental Health Nurses[29]

Overall Trust Totals for Mental Health Nurses 2008-2014:

Overall 2% increase in WTE from 2008-2014

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[28] Email reply received from DHSSPS DALO on 3rd February 2015

[29] Figures for each year are extracted from the workforce census publication for that year. Available at:
 2008 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2008_web.pdf
2009 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2009_exc_sec_11.pdf
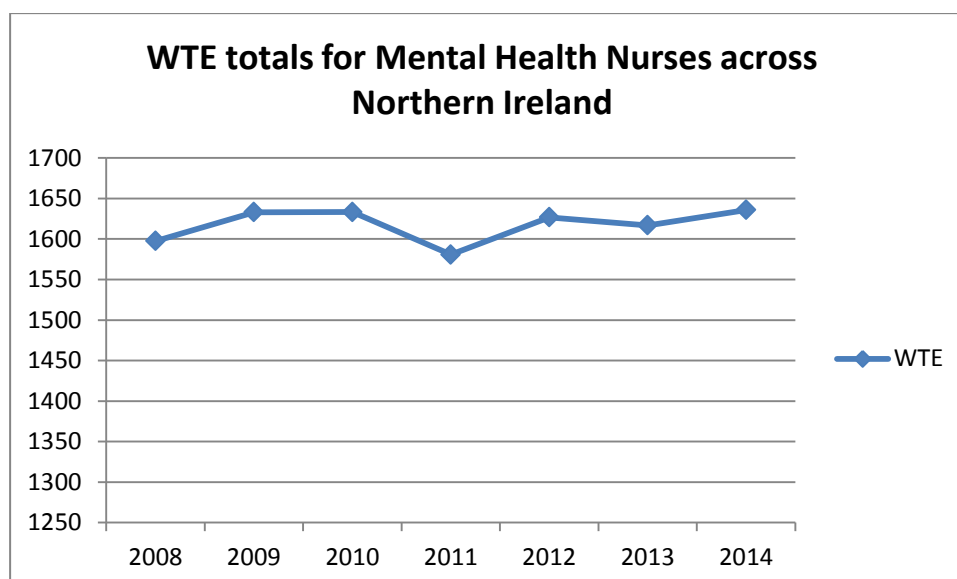2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf
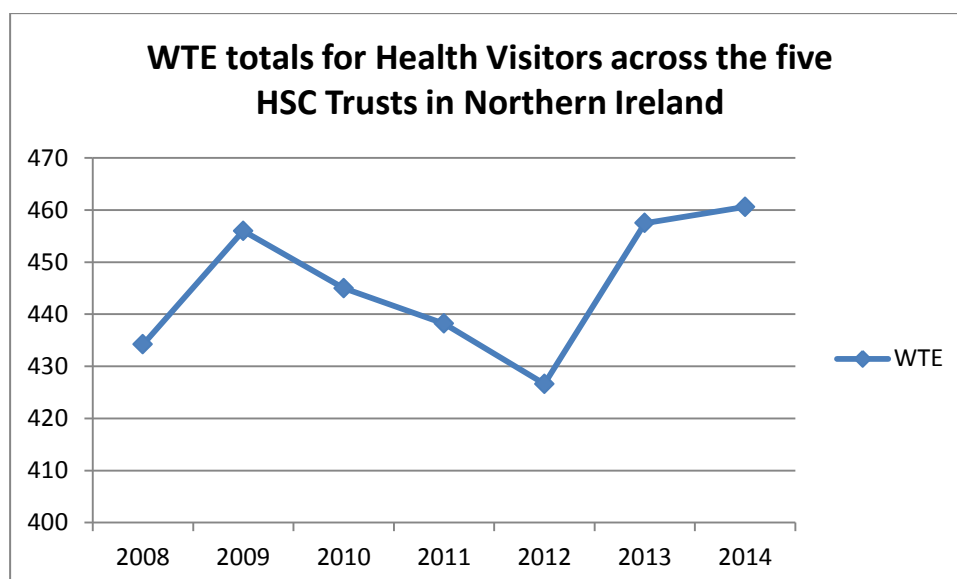
WTE totals for Mental Health Nurses across Northern Ireland

Trends across the Trusts 2008-2014:

Belfast:	**2% increase**	**(406.3 to 414.9 in WTE)**
Northern:	**2% decrease**	**(316.3 to 311.2 in WTE)**
Southern:	**9% increase**	**(262.7 to 289.9 in WTE)**
South Eastern:	**15% increase**	**(198.1 to 233.8 in WTE)**
Western:	**7% decrease**	**(414.2 to 386.1 in WTE)**

3.1.3. Health Visitors[30]

Overall Trust Totals for Health Visitors:

Overall 6% increase in WTE from 2008-2014

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[30] Figures for each year are extracted from the workforce census publication for that year. Available at:
 2008 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2008_web.pdf
2009 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2009_exc_sec_11.pdf
2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

WTE totals for Health Visitors across the five HSC Trusts in Northern Ireland

Trends across the Trusts 2008-2014:

Belfast:	**9% decrease**	**(80.5 to 73.1 in WTE)**
Northern:	**1% increase**	**(103.0 to 104.1 in WTE)**
South Eastern:	**20% increase**	**(73.6 to 88.7 in WTE)**
Southern:	**10% increase**	**(96.0 to 106.4 in WTE)**
Western:	**8% increase**	**(81.1 to 88.3 in WTE)**

Based on the above trend using figures from the HSC Workforce Census of that year, RaISe asked the DHSSPS to explain the following*: since 2008, there has been a decrease of around 9% in number of Health visitors in the Belfast Trust against a general NI increase (WTE).*

The DHSSPS statisticians advised that the figures noted in the query seem to have been derived by including Student Health Visitors in 2014 and excluding them in 2008 and that it is preferable to include them, as they are qualified nurses with their own caseloads. A direct comparison including students is presented in the table below. It should also be noted that there has been an increase in the number of Health Visitor Training places commissioned – 37 places in 2013-2014 and 61 places in 2014 - 2015[31].

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[31] Email reply from DHSSPS DALO 03/02/15

Staff in post graded as:	**Belfast**	**Northern**	**South Eastern**	**Southern**	**Western**	**All Trusts**
Health Visitor WTE 2008	86.7	112.4	79.1	103.9	85.6	467.6
Health Visitor WTE 2014	73.1	104.1	88.7	106.4	88.3	460.5
% change Health Visitor WTE	-15.7%	-7.4%	12.2%	2.4%	3.2%	-1.5%

Health Visiting Education Commissions 2008/09 – 2014/15

	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Commissioned Places	29	26	24	18	25	37	61

3.1.4. District Nurses[32]

Overall Trust Totals for District Nurses:

Overall 4% decrease in WTE from 2008-2014
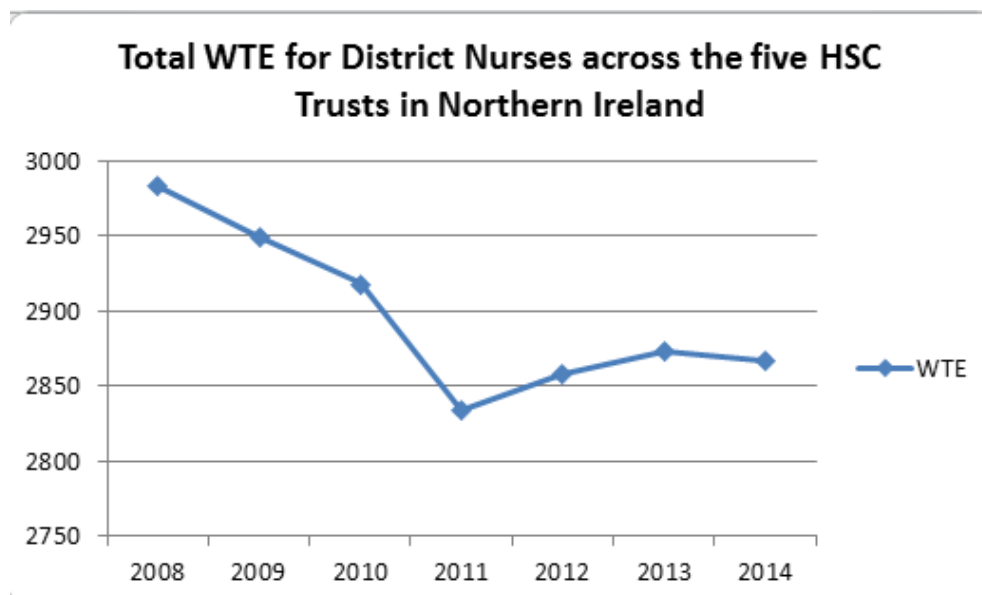
Trends across the Trusts 2008-2014:

Belfast:	**14% decrease**	**(197.2 to 170.4 in WTE)**
Northern:	**18% decrease**	**(211.3 to 172.4 in WTE)**
South Eastern:	**9% decrease**	**(189.2 to 172.1 in WTE)**
Southern:	**21% decrease**	**(187.4 to 148.2 in WTE)**
Western:	**0.3% decrease**	**(190.8 to 190.2 in WTE)**

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[32] Figures for each year are extracted from the workforce census publication for that year. Available at:
 2008 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2008_web.pdf
2009 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2009_exc_sec_11.pdf
2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

3.1.5. Treatment Room/Practice/Family Planning Nurses

Overall Trust Totals for Treatment Room/Practice/Family Planning Nurses 2008-2014:

Overall 11% decrease in WTE from 2008-2014

**Total WTE Treatment Room/Practice/Family Planning Nurses across the five HSC Trusts in Northern Ireland**
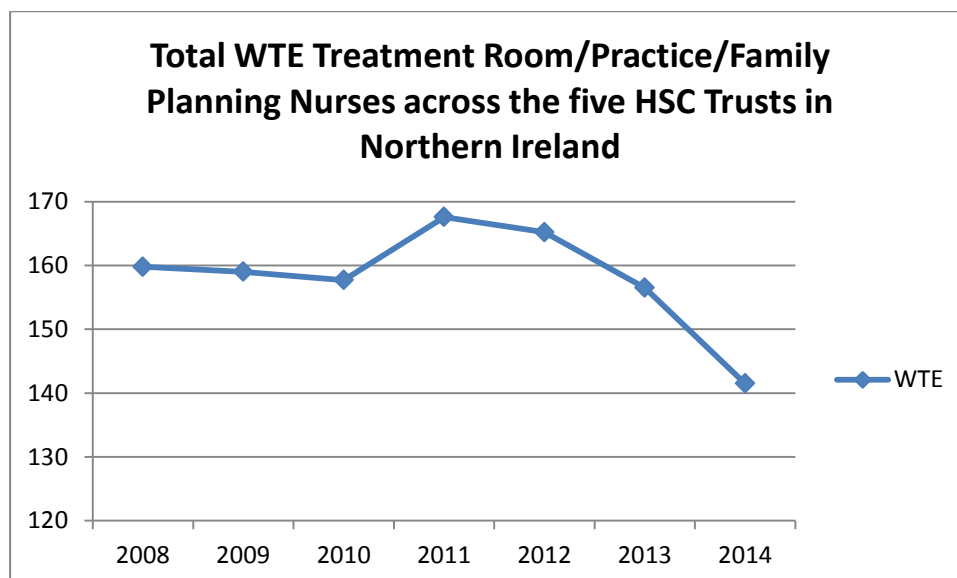
Based on the above trends using figures from the HSC Workforce Census of that year, District nurses and Treatment room nurses have experience a general decrease in numbers across the five HSC Trusts, therefore, RaISe put the following query was put to the DHSSPS: *Please explain the following: since 2008, there has been a general decrease in District Nurses and Treatment Room Nurses across all five Trusts (WTE).*

DHSSPS statisticians advised that it is difficult to comment on this query because Trusts have re-coded some staff when new Agenda for Change grade codes became available and at different times e.g. to the Specialist Nurse grade.

3.2 Medical and Dental Staff[33]

Overall NI Trend for Medical and Dental Staff[34]:

- **2000-2014: 53% increase (2,468.3 to 3789.5 in WTE)**
  - o **2005-2014: 22% increase (3098.8 to 3789.5 in WTE)**
  - o **2009-2014: 9% increase (3491.0 to 3,789.5 in WTE)**

Medical and Dental 2000-2014

Medical and Dental Staff 2009-2014

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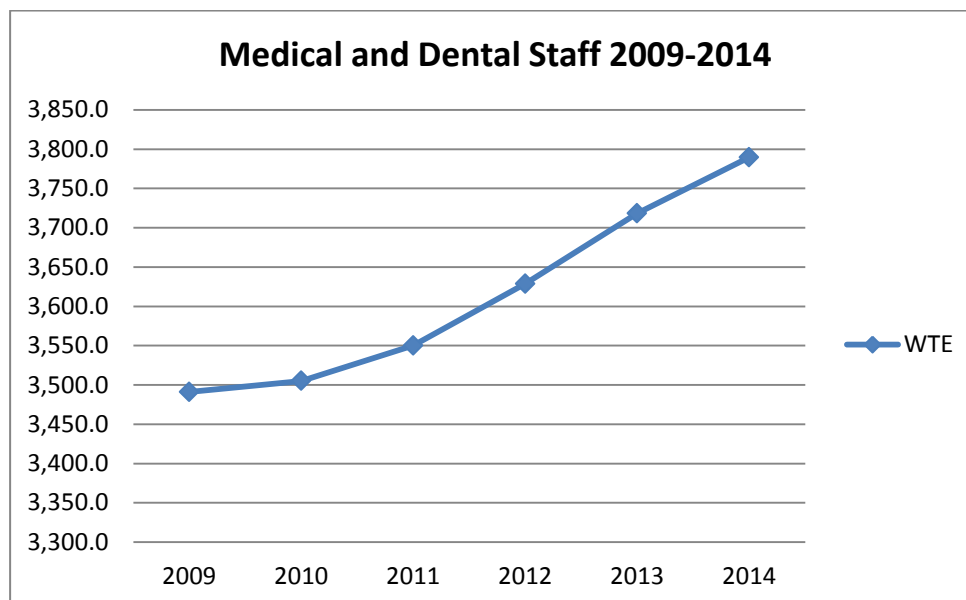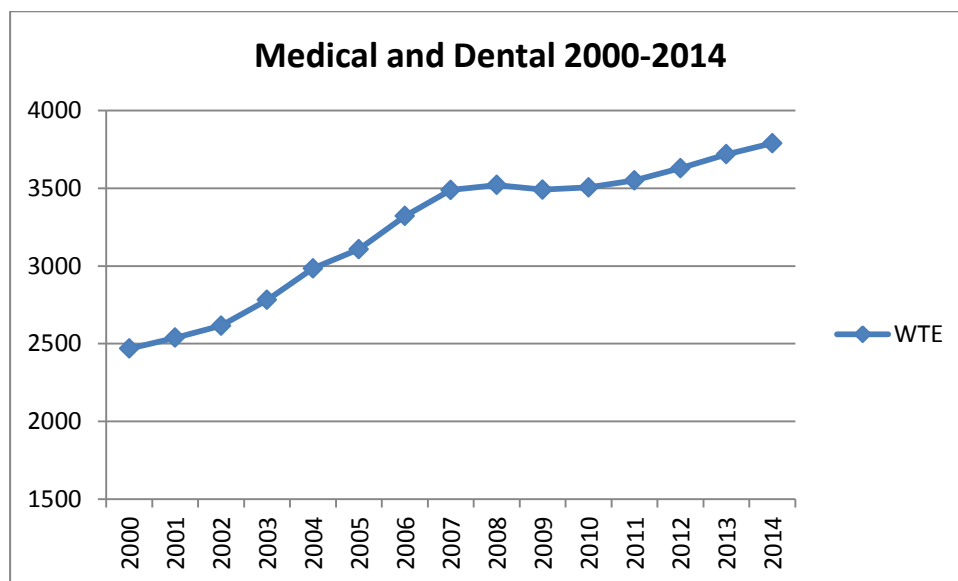
[33] 2014 figure includes Northern Ireland Medical and Dental Training Agency (NIMDTA)

[34] Figures for 2005-2014 taken from the 2014 HSC workforce census and figure for 2000-2004 are taken from the 2005 HSC workforce census, http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf
http://www.dhsspsni.gov.uk/workforce_census_march_2005_exc_sec_11.pdf

This section includes a more in-depth look at the figures for selected groups of Medical and Dental staff:

3.2.1 Consultants

3.2.2 Specialty Doctor/ Associate Specialist/ Staff Grade

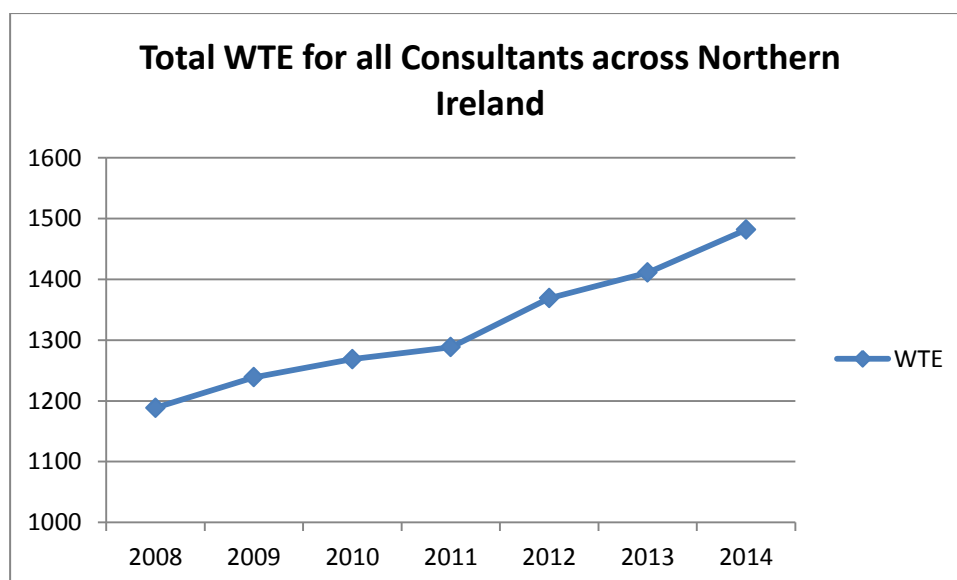3.2.3 Specialty/ Specialist Registrar/ GP Trainee

3.2.4 Foundation/ Senior House Officer

3.2.5 General/ Hospital Practitioner

3.2.1. Consultants[35]

Overall Trust Totals Trend for Consultants:
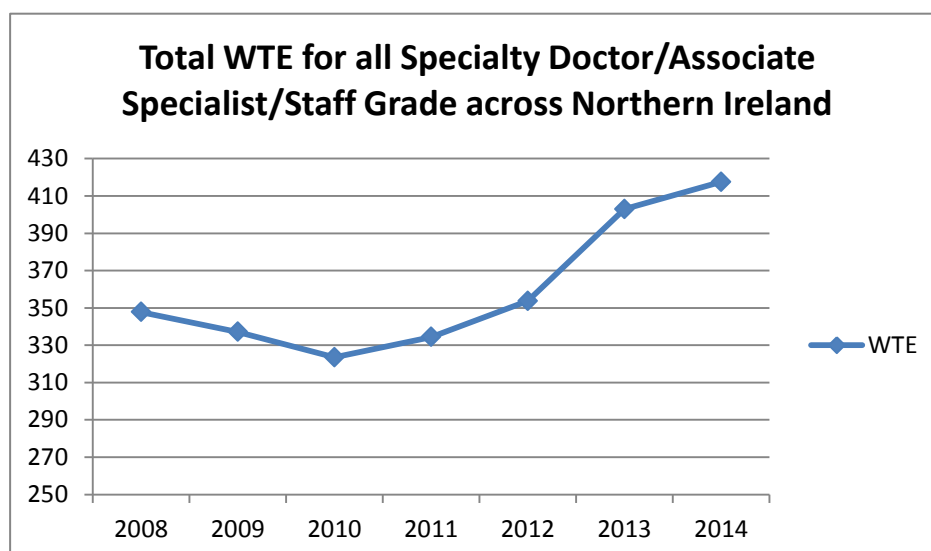
Overall 25% increase in WTE from 2008-2014

Total WTE for all Consultants across Northern Ireland

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[35] Figures for each year are extracted from the workforce census publication for that year. Available at:
 2008 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2008_web.pdf
2009 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2009_exc_sec_11.pdf
2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

Trends across the Trusts 2008-2014:

Belfast:	**25% Increase (521.4 to 657.7 in WTE)**
Northern:	**20% increase (165.7 to 199.2 in WTE)**
South Eastern:	**33% increase (160.6-212.5 in WTE)**
Southern:	**26% increase (157.8 to 199.2 in WTE)**
Western:	**16% increase (183.2 to 213.1 in WTE)**

3.2.2. Speciality Doctor/ Associate Specialist/ Staff Grade[36]

Overall Trust Totals for Specialty Doctor/ Associate Specialist/ Staff Grade:

Overall 20% increase in WTE from 2008-2014

Total WTE for all Specialty Doctor/Associate Specialist/Staff Grade across Northern Ireland

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[36] Figures for each year are extracted from the workforce census publication for that year. Available at:
 2008 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2008_web.pdf
2009 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2009_exc_sec_11.pdf
2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

Trends across the Trusts 2008-2014:

Belfast:	10% decrease	(116.4 to 104.3 in WTE)
Northern:	72% increase	(50.3 to 86.3 in WTE)
South Eastern:	37% increase	(49.6 to 68.1 in WTE)
Southern:	36% increase	(71.9 to 97.5 in WTE)
Western:	3% increase	(59.6 to 61.3 in WTE)

Based on the above trends using figures from the HSC Workforce Census of that year, a general increase in WTE is noted for Specialty Doctor/Associate Specialist/Staff Grade; however, the Northern and Western Trusts experience different trajectories. The DHSSPS was asked by RaISe to explain these differences. The response was[37]:

The number of these staff will vary in each Trust according to their own service configuration and specialties delivered. Trusts have indicated that additional posts have been created due to newly funded initiatives which optimise the skill mix within medical teams, hence increasing this level of doctor. Trusts have also indicated that additional doctors of these grades can be recruited due to vacancies at either training level or consultant level. There will also be an increase in this group of staff due to the Modernising Medical Careers initiative and it being an attractive career pathway since the introduction of the 2008 contract for Specialty Doctors and Associate Specialists. Furthermore, some staff on the old medical officer and hospital practitioner grades will have transferred to this contract.

[37] Email reply from DHSSPS DALO, 03/02/15

3.2.3. Speciality/ Specialist Registrar/ GP Trainee[38]

Overall Trust Totals for Speciality/ Specialist Registrar/ GP Trainee:

> Overall 7% decrease in WTE from 2008-2014

**Total WTE for all Specialty/Specialist Registrar/GP Trainee across Northern Ireland**
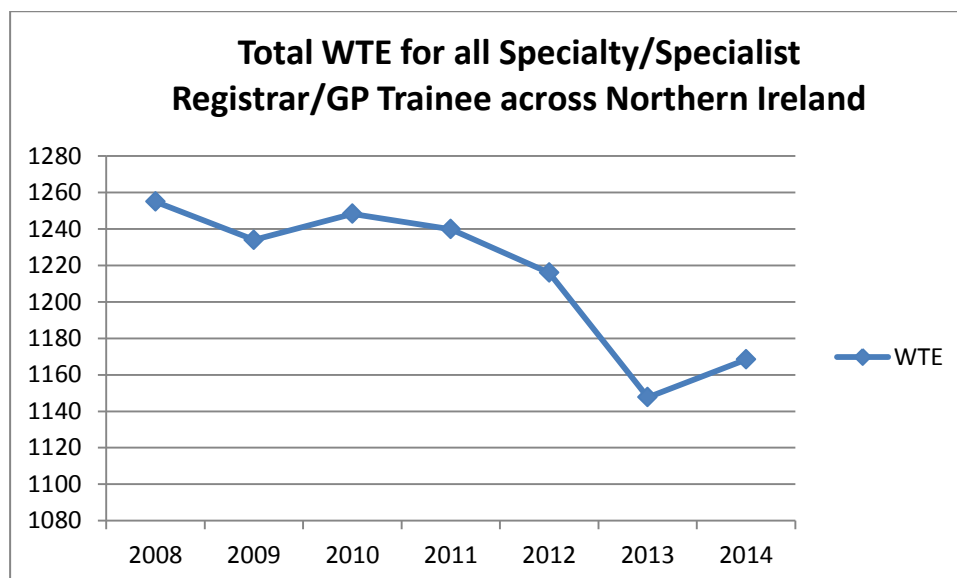
Trend across the Trusts 2008-2014:

Belfast:	11% decrease	(631.5 to 561.1 in WTE)
Northern:	7% increase	(153.1 to 165.1 in WTE)
South Eastern:	0.5% decrease	(150.6 to 149.9 in WTE)
Southern:	no change in WTE	
Western:	16% decrease	(171.6 to 144.2 in WTE)

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[38] Figures for each year are extracted from the workforce census publication for that year. Available at:
 2008 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2008_web.pdf
2009 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2009_exc_sec_11.pdf
2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

3.2.4. Foundation/ Senior House Officer[39]

Overall Trust Totals for Foundation/ Senior House Officer:

Overall 8% increase in WTE from 2008-2014

Total WTE for all Foundation and Senior House Officers across Northern Ireland 2008-2014
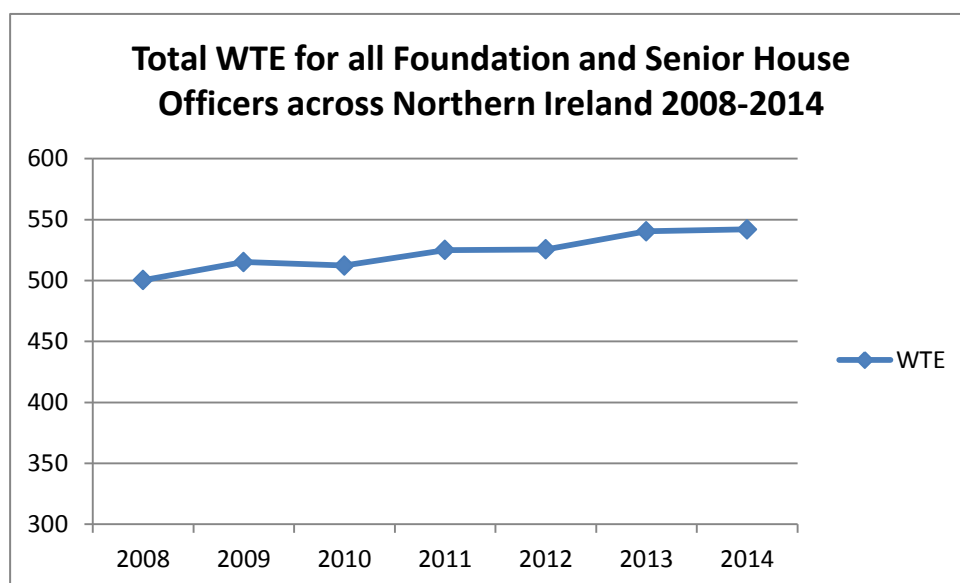
Trends across the Trusts 2008-2014:

Belfast:	**6% increase (212.5 to 224.6 in WTE)**
Northern:	**8% increase (79.8 to 87.0 in WTE)**
South Eastern:	**5% increase (83.2 to 87.3 in WTE)**
Southern:	**1% increase (69.1 to 70.0 in WTE)**
Western:	**30% increase (56.0 to 73.0 in WTE)**

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[39] Figures for each year are extracted from the workforce census publication for that year. Available at:
 2008 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2008_web.pdf
2009 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2009_exc_sec_11.pdf
2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

3.2.5. General/ Hospital Practitioner[40]

Overall Trust Totals for General/ Hospital Practitioners:

Overall 60% decrease in WTE from 2008-2014

Total WTE for all General/ Hospital Practioners across Northern Ireland
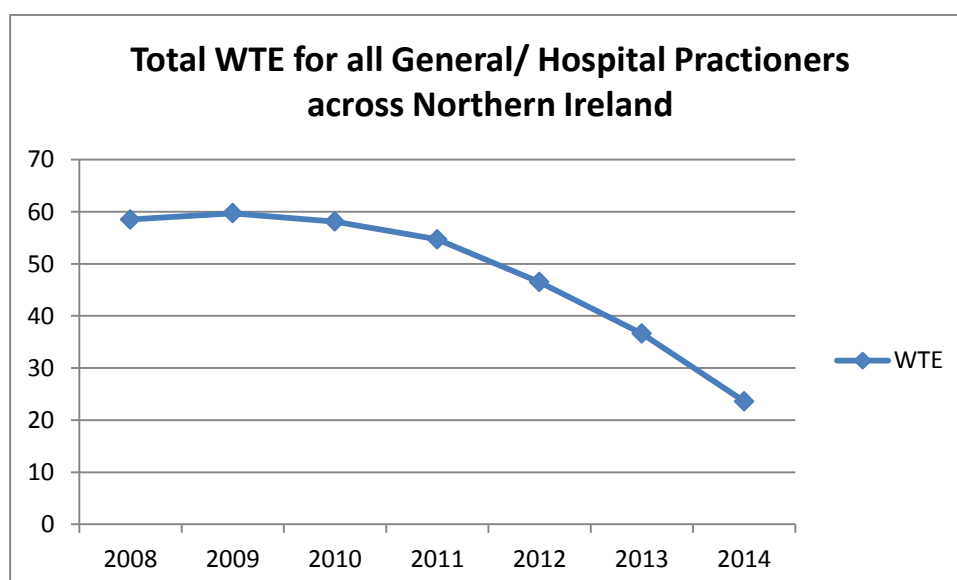
Trends across the trusts 2008-2014: (relatively small staff numbers reflected in large percentage changes):

Belfast:	89% decrease	(29.7 to 3.2 in WTE)
Northern:	14% increase	(5.6 to 6.4 in WTE)
South Eastern:	35% decrease	(9.1 to 5.9 in WTE)
Southern:	78% decrease	(38.1 to 8.1 in WTE)
Western:	100% decrease	(4.2 to 0 in WTE)

Based on the above trends using figures from the HSC Workforce Census of that year, there has been a consistent decline in General/ Hospital Practitioners.

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[40] Figures for each year are extracted from the workforce census publication for that year. Available at:
 2008 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2008_web.pdf
2009 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2009_exc_sec_11.pdf
2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

RaISe put the following query to the DHSSPS: Although the overall numbers in this staff group has never been high, since 2008 the number has decreased in all but the Northern Trust and there now appears to be none of this staff group in the Western Trust and a very large decrease in the Belfast Trust of around 90% - please advise what role this staff group play in the Trusts and the rationale for the decreases. The response received was as follows[41]:

The published HSC Workforce Census figures for staff graded as General/Hospital practitioner now exclude those working in the GP Out of Hours service, whereas the March 2008 HSC Workforce Census had included these doctors. This is the explanation for the bulk of the apparent decrease in this staff group. The hospital practitioner grade is also being phased out, hence the low level of current staff. These staff also work on a sessional basis, hence the low level of whole-time equivalent. As above, the number of staff on general/hospital practitioner grades has been decreasing since the introduction of the 2008 Specialty Doctors and Associate Specialist contract.

[41] Email reply from DHSSPS DALO, 03/02/15

3.3 Professional and Technical Staff

Overall NI Trend for Professional and Technical Staff[42]:

- **2000-2014: 70% increase (4251.0 to 7195.6 in WTE)**
  - ○ **2005-2014: 27% increase (5,675.9 to 7195.6 in WTE)**
  - ○ **2009-2014: 16% increase (6187.2 to 7195.6 in WTE)**
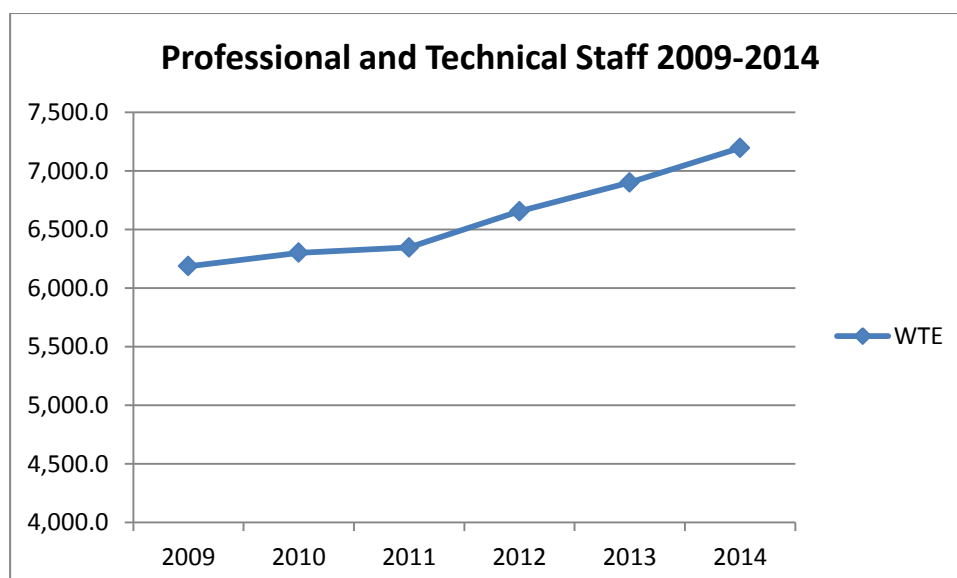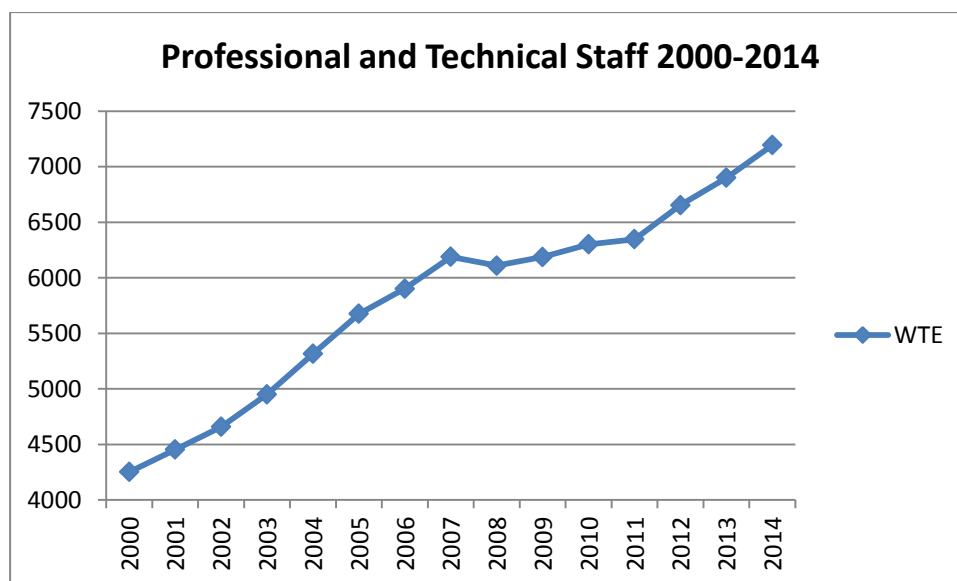
Professional and Technical Staff 2000-2014

Professional and Technical Staff 2009-2014

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[42] Figures for 2005-2014 taken from the 2014 HSC workforce census and figure for 2000-2004 are taken from the 2005 HSC workforce census, http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf
http://www.dhsspsni.gov.uk/workforce_census_march_2005_exc_sec_11.pdf

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This section includes a more in-depth look at the figures for selected Professional and Technical staff:

3.3.1 Dieticians

3.3.2 Occupational Therapists
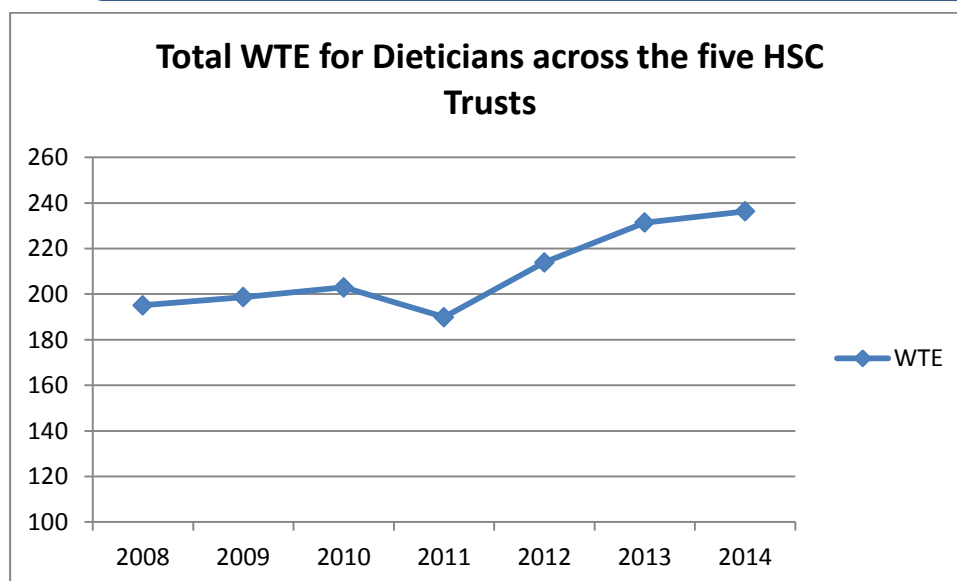
3.3.3 Physiotherapists

3.3.4 Radiographers

3.3.5 Speech and Language Therapists

3.3.6 Pharmacists

3.3.1. Dieticians[43]

Overall Trust Totals for Dieticians from 2008-2014:

Overall 21% increase in WTE from 2008-2014

Total WTE for Dieticians across the five HSC Trusts

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[43] Figures for each year are extracted from the workforce census publication for that year. Available at:
 2008 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2008_web.pdf
2009 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2009_exc_sec_11.pdf
2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
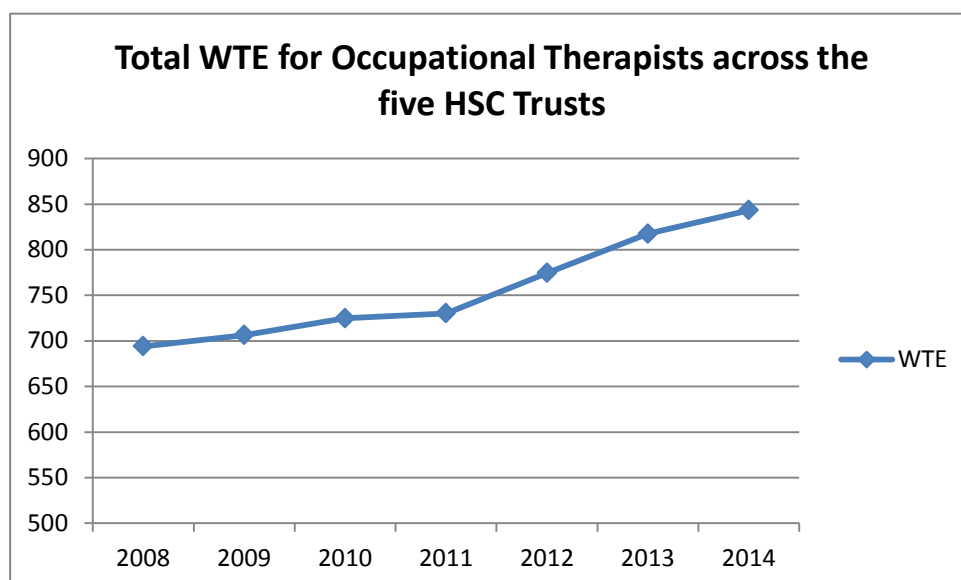2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

Trends across the Trusts 2008-2014:

Belfast:	**4% decrease**	**(77.0 to 73.8 in WTE)**
Northern:	**18% increase**	**(37.0 to 43.7 in WTE)**
South Eastern:	**77% increase**	**(26.4 to 46.7 in WTE)**
Southern:	**23% increase**	**(29.1 to 35.9 in WTE)**
Western:	**41% increase**	**(25.6 to 36.2 in WTE)**

3.3.2. Occupational Therapists[44]

Overall Trust Totals for Occupational Therapists:

Overall 21% increase in WTE from 2008-2014

Total WTE for Occupational Therapists across the five HSC Trusts

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[44] Figures for each year are extracted from the workforce census publication for that year. Available at:
 2008 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2008_web.pdf
2009 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2009_exc_sec_11.pdf
2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
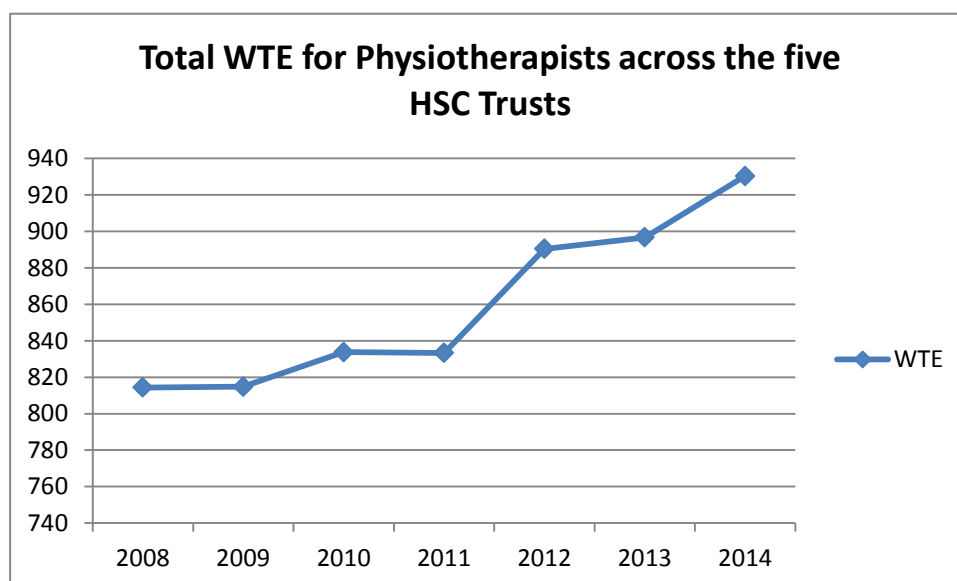2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

Trends across the Trusts 2008-2014:

Belfast:	**12% increase**	**(205.5 to 229.7 in WTE)**
Northern:	**15% increase**	**(169.8 to 194.8 in WTE)**
South Eastern:	**63% increase**	**(87.2 to 142.5 in WTE)**
Southern:	**23% increase**	**(133.4 to 164.1 in WTE)**
Western:	**14% increase**	**(98.2 to 112.2 in WTE)**

3.3.3. Physiotherapists[45]

Overall Trust Totals for Physiotherapists:

Overall 14% increase in WTE from 2008-2014

Total WTE for Physiotherapists across the five HSC Trusts

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[45] Figures for each year are extracted from the workforce census publication for that year. Available at:
 2008 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2008_web.pdf
2009 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2009_exc_sec_11.pdf
2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
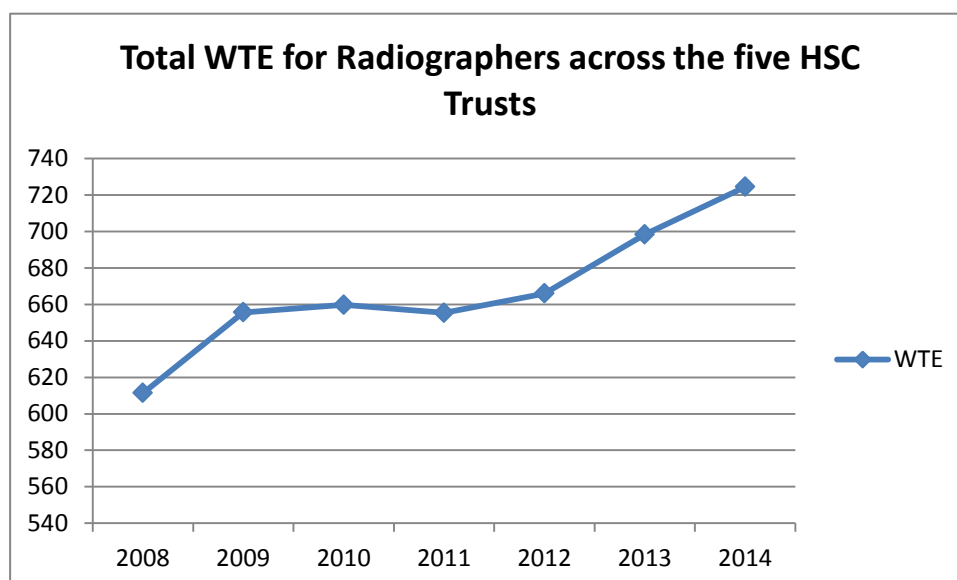2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

Trends across the trusts 2008-2014:

Belfast:	**less than 1% increase (292.8 to 293.4 in WTE)**
Northern:	**16% increase (142.9 to 165.9 in WTE)**
South Eastern:	**13% increase (141.8 to 159.9 in WTE)**
Southern:	**37% increase (139.7 to 190.7in WTE)**
Western:	**24% increase (97.2 to 120.5 in WTE)**

3.3.4. Radiographers[46]

Overall Trust Totals for Radiographers:

> Overall 18% increase in WTE from 2008-2014

Total WTE for Radiographers across the five HSC Trusts

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[46] Figures for each year are extracted from the workforce census publication for that year. Available at:
 2008 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2008_web.pdf
2009 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2009_exc_sec_11.pdf
2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
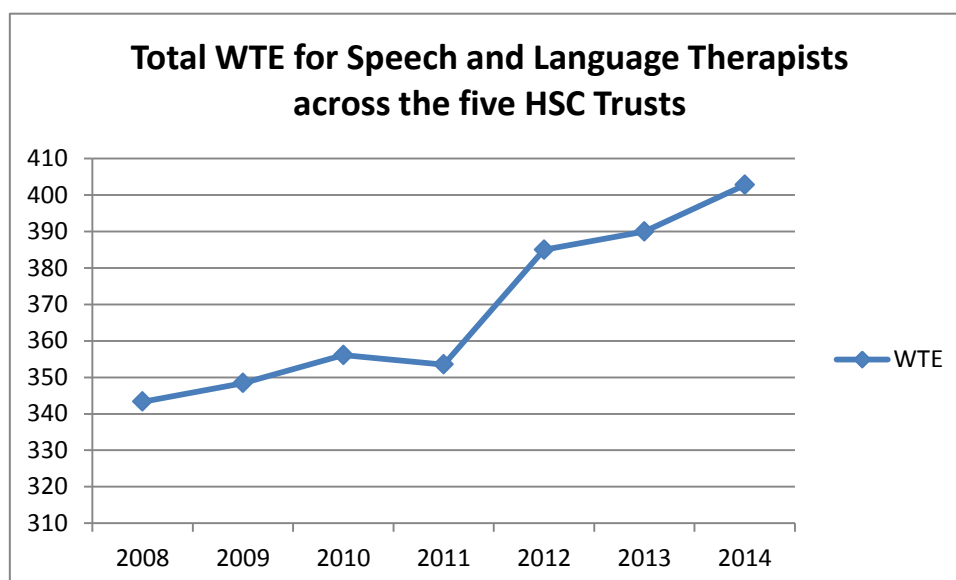2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

Trends across the Trusts 2008-2014:

Belfast:	**8% increase (273.0 to 295.9 in WTE)**
Northern:	**19% increase (86.3 to 103.0 in WTE)**
South Eastern:	**22% increase (75.1 to 91.8 in WTE)**
Southern:	**29% increase (88.7 to 114.6 in WTE)**
Western:	**35% increase (88.3 to 119.1 in WTE)**

3.3.5. Speech and Language Therapists[47]

Overall Trust Totals for Speech and Language Therapists:

Overall 17% increase in WTE from 2008-2014

Total WTE for Speech and Language Therapists across the five HSC Trusts

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[47] Figures for each year are extracted from the workforce census publication for that year. Available at:
 2008 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2008_web.pdf
2009 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2009_exc_sec_11.pdf
2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
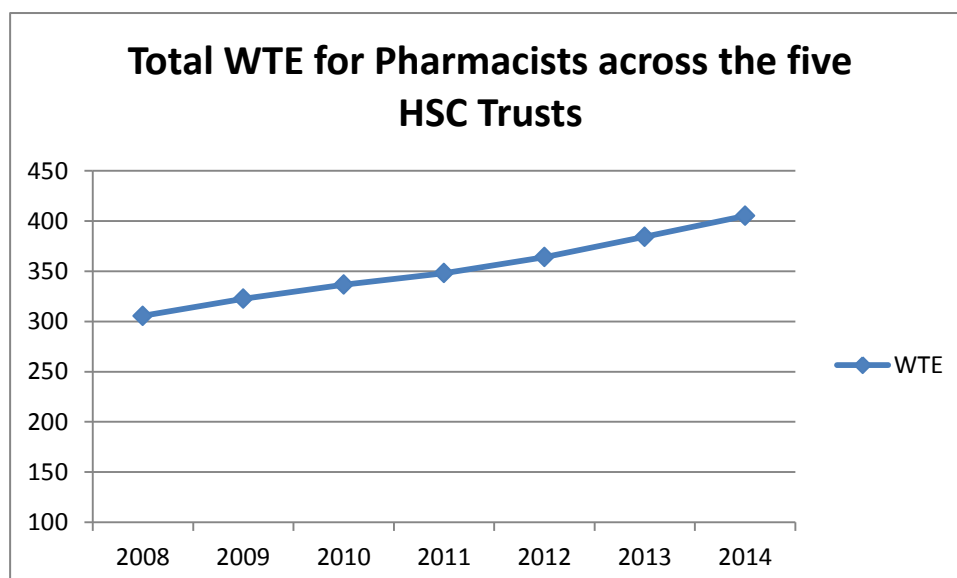2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

Trends across the Trusts 2008-2014:

Belfast:	**18% increase (98.5 to 116.7 in WTE)**
Northern:	**27% increase (77.3 to 97.9 in WTE)**
South Eastern:	**15% increase (57.3 to 65.7 in WTE)**
Southern:	**less than 1% decrease (60.7 to 60.5 in WTE)**
Western:	**25% increase (49.5 to 61.8 in WTE)**

3.3.6. Pharmacists[48]

Overall Trust Totals for Pharmacists:

Overall 33% increase in WTE from 2008-2014

Total WTE for Pharmacists across the five HSC Trusts

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[48] Trust figures for each year are extracted from the workforce census publication for that year. Available at:
 2008 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2008_web.pdf
2009 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2009_exc_sec_11.pdf
2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

Trends across the Trusts 2008-2014:

Belfast:	**17% increase (115.2 to 134.9 in WTE)**
Northern:	**42% increase (63.7 to 90.4 in WTE)**
South Eastern:	**51% increase (42.2 in 63.9 in WTE)**
Southern:	**32% increase (44.1 to 58.1 in WTE)**
Western:	**43% increase (40.4 to 57.9 in WTE)**

3.3.6. Other Professional and Technical

There was no further breakdown of the figures for Technical and Scientific Staff within the Workforce Census, yet they appear to make up nearly a third of this staff group (see Figure 4a below extracted from workforce census)[49]. The DHSSPS advised that this group covers - Clinical Scientists, Biomedical Scientists, Medical Technical Officers, Research Scientists and their support staff.

Figure 4a: Professional & Technical Staff by Job (% WTE)

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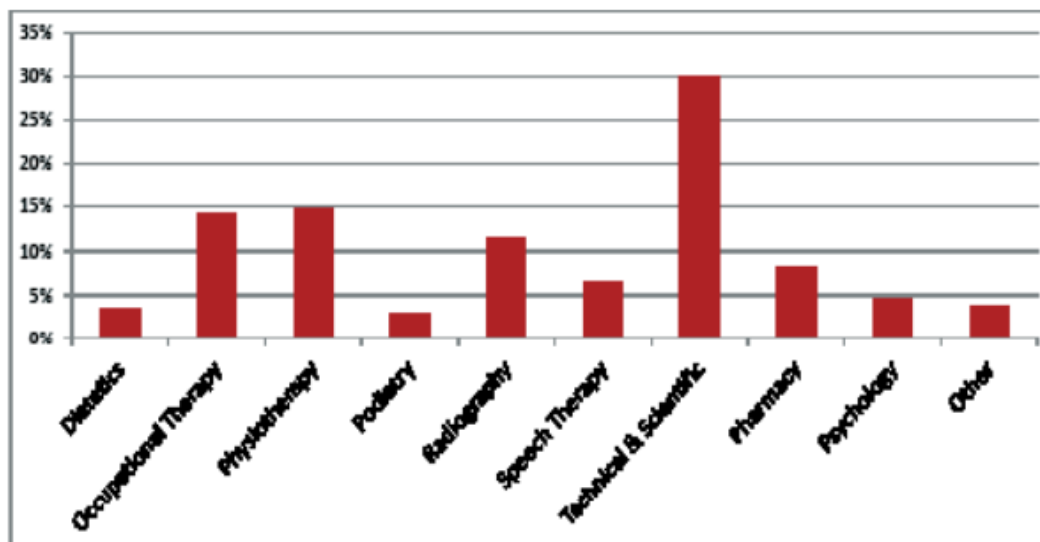
[49] DHSSPS, (2014) Northern Ireland Health and Social Care Workforce Census 2014, page 9. Available at: http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

3.4 Social Services Staff

**Overall NI Trends for Social Services Staff[50]:**

- **2000-2014: 94% increase (3466.3 to 6736.1 in WTE)**
  - **2005-2014: 47% increase (4587.6 to 6736.1 in WTE)**
    - **(2007-2008: 23% increase 5112.3 to 6268.5 in WTE)**
  - **2009-2014: 4% increase (6483.3 to 6736.1 in WTE)**
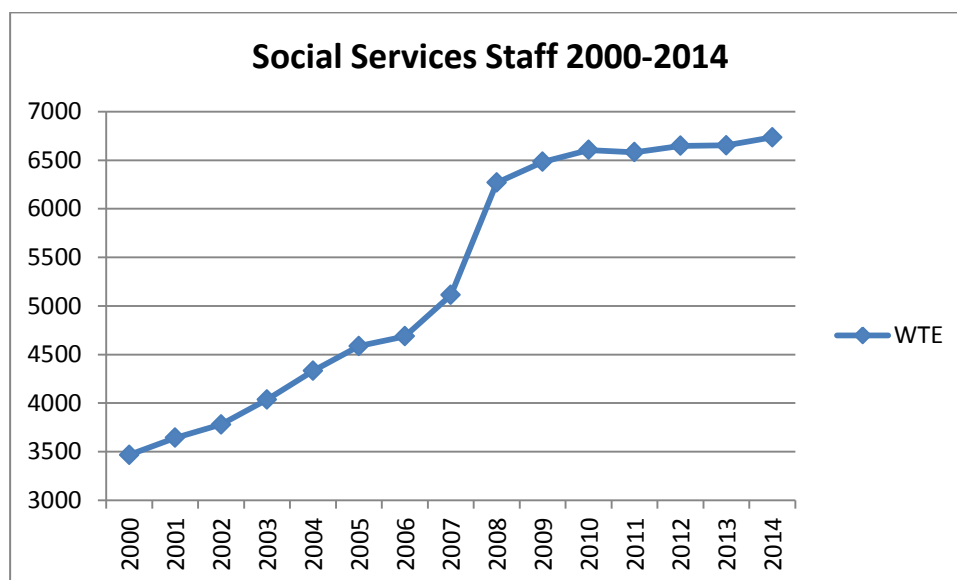
RaISe noted the increase of Social Services Staff between 2007 and 2008 and asked the DHSSPS to explain this increase. The DHSSPS advised:

This is attributable to two factors: firstly, the 2007 HSC Workforce Census did not include staff graded as Home Helps, but for the first time the 2008 HSC Workforce Census did. Secondly, due to Agenda for Change and re-grading of jobs, many workers who were previously coded to the Ancillary & General terms and conditions group were then re-coded to fall within the Social Services terms and conditions group (or Occupational Family as it is now known).

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[50] Figures for 2005-2014 taken from the 2014 HSC workforce census and figure for 2000-2004 are taken from the 2005 HSC workforce census, http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf
http://www.dhsspsni.gov.uk/workforce_census_march_2005_exc_sec_11.pdf

Social Services Staff 2009-2014
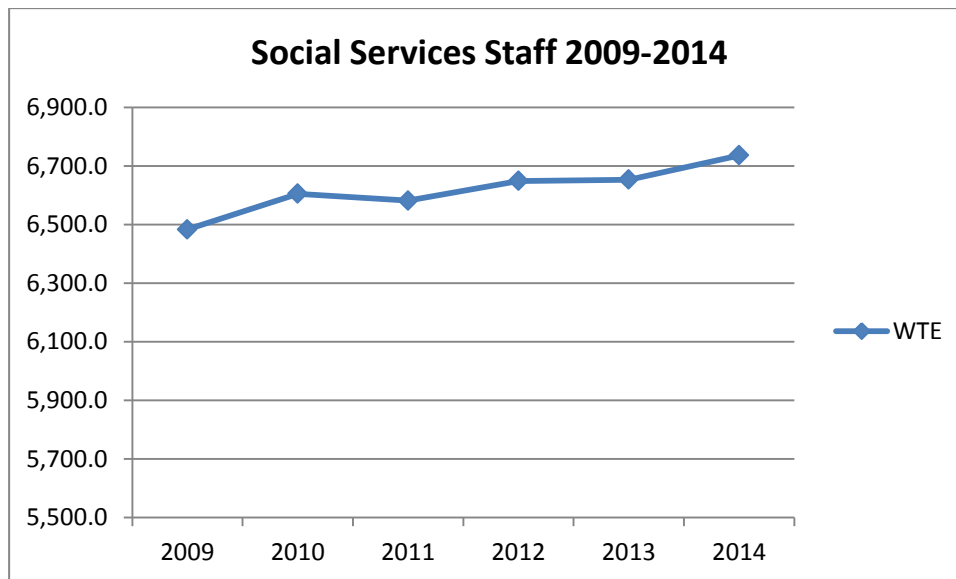
This section includes a more in-depth look at the figures for selected Social Services staff this includes:

3.4.1 Child/ Family Care Social Workers

3.4.2 Hospital Social Workers

3.4.3 Elderly Social Workers
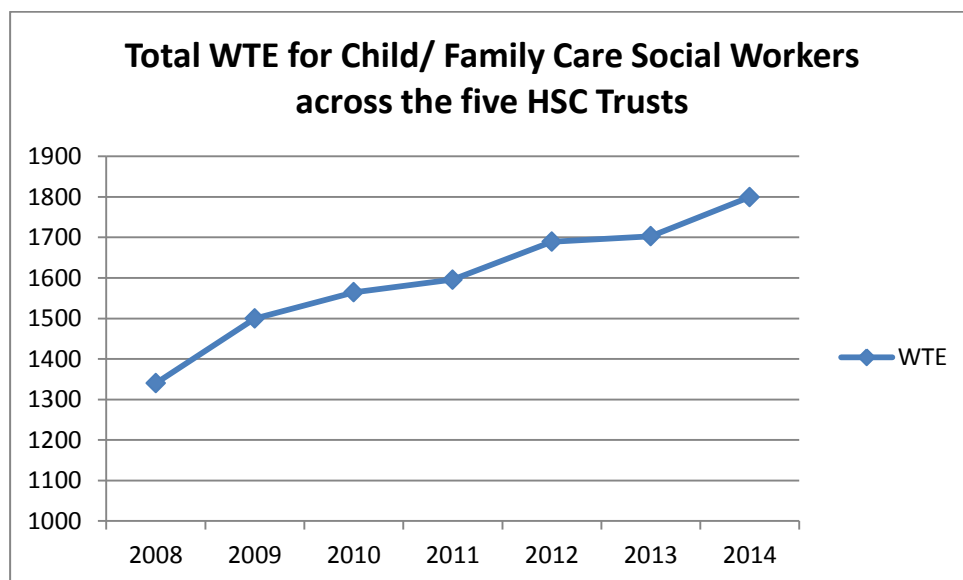
3.4.4 Learning Disability Social Workers

3.4.5 Mental Health Social Workers

3.4.6 Social Care Staff

3.4.1. Child/ Family Social Workers[51]

Overall Trust Totals for Child/ Family Social Workers:

Overall 34% increase in WTE from 2008-2014

Trends across the Trusts:

Belfast:	**45% increase**	**(298.3 to 431.1 in WTE)**
Northern:	**30% increase**	**(285.9 to 372.4 in WTE)**
South Eastern:	**101% increase**	**(171.0 to 343.0 in WTE)**
Southern:	**41% increase**	**(201.1 to 296.5 in WTE)**
Western:	**5% decrease**	**(374.9 to 356.7 in WTE)**

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[51] Figures for each year are extracted from the workforce census publication for that year. Available at:
 2008 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2008_web.pdf
2009 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2009_exc_sec_11.pdf
2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

3.4.2. Hospital Social Workers[52]

Overall Trust Totals for Hospital Social Workers:

Overall 12% increase in WTE from 2008-2014

Total WTE for Hospital Social Workers across the five HSC Trusts
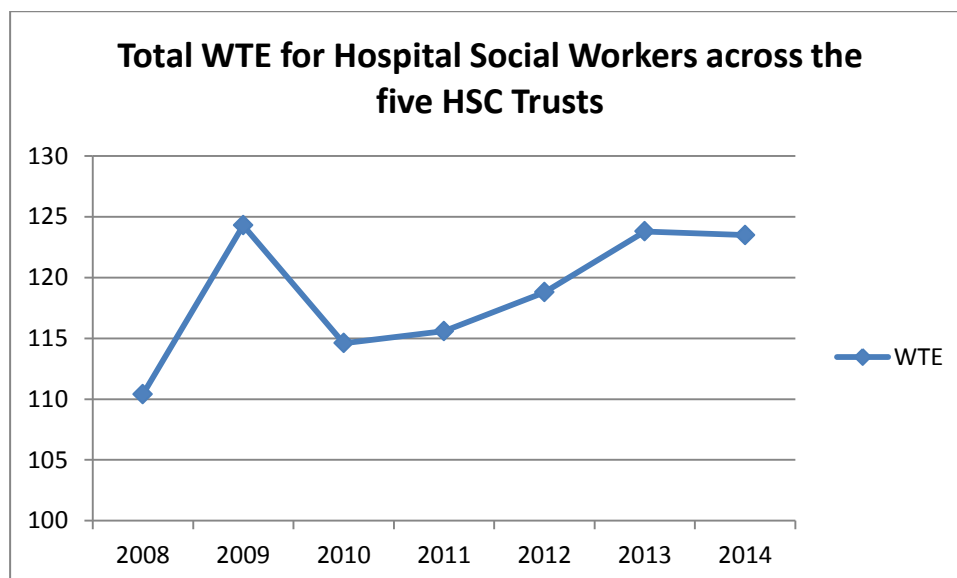
Trends across the Trusts:

Belfast:	**8% increase**	**(39.7 to 42.7 in WTE)**
Northern:	**12% decrease**	**(31.4 to 27.5 in WTE)**
South Eastern:	**96% increase**	**(11.5 to 22.2 in WTE)**
Southern:	**4% increase**	**(23.2 to 22.2 in WTE)**
Western:	**87% increase**	**(4.6 to 8.6 in WTE)**

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[52] Figures for each year are extracted from the workforce census publication for that year. Available at:
 2008 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2008_web.pdf
2009 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2009_exc_sec_11.pdf
2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

3.4.3. Elderly Social Workers[53]

Overall Trust Totals for Elderly Social Workers:


Overall 14% increase in WTE from 2008-2014

Total WTE for Elderly Social Workers across the five HSC Trusts
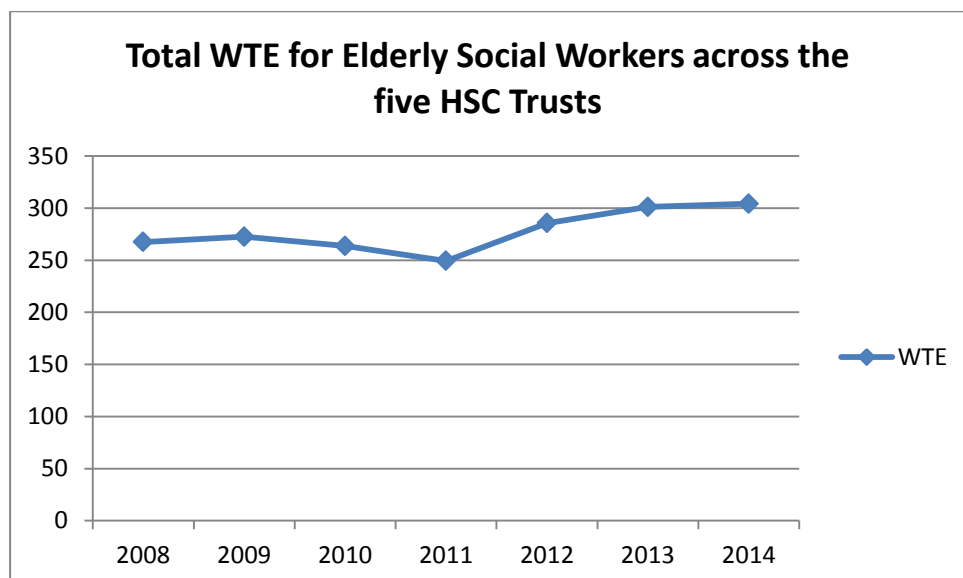
Trends across the Trusts:

Belfast:	**60% increase**	**(40.5 to 64.6 in WTE)**
Northern:	**3% increase**	**(55.0 to 56.5 in WTE)**
South Eastern:	**144% increase**	**(17.5 to 42.6 in WTE)**
Southern:	**12% increase**	**(43.7 to 49.0 in WTE)**
Western:	**18% decrease**	**(111.1 to 91.6 in WTE)**

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[53] Figures for each year are extracted from the workforce census publication for that year. Available at:
 2008 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2008_web.pdf
2009 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2009_exc_sec_11.pdf
2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

3.4.4. Learning Disability Social Workers[54]

Overall Trust Totals for Learning Disability Social Workers:

Overall 9% increase in WTE from 2008-2014

Total WTE for Learning Disability Social Workers across the five HSC Trusts
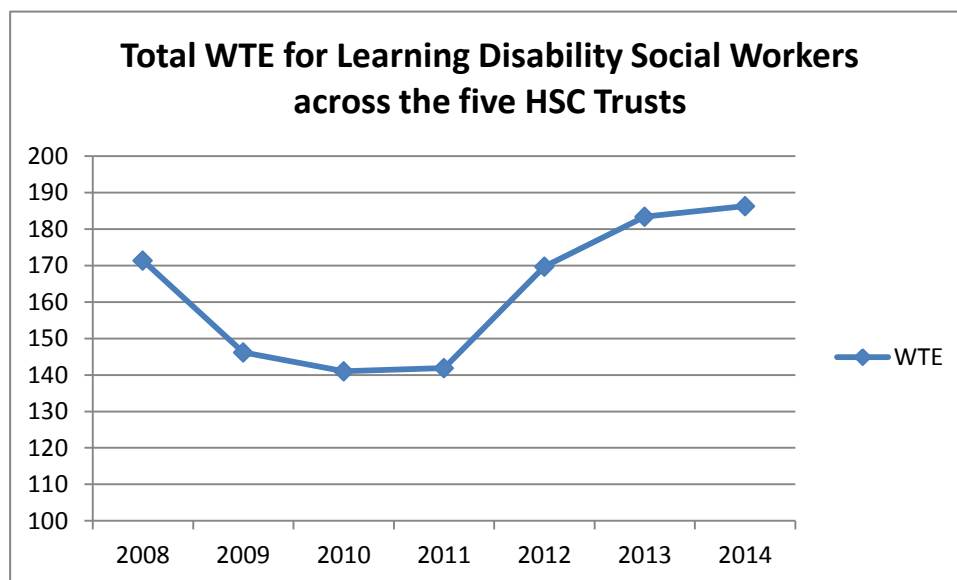
Trends across the trusts:

Belfast:	**143% increase**	**(27.1-65.9 in WTE)**
Northern:	**68% increase**	**(21.3-35.8 in WTE)**
South Eastern:	**152% increase**	**(10.6-26.7 in WTE)**
Southern:	**32% increase**	**(20.9-27.5 in WTE)**
Western:	**67% decrease**	**(91.5-30.4 in WTE)**

Based on the above trend using figures from the HSC Workforce Census of that year, there was an overall decrease of learning disability social workers between 2008 and 2011 followed by an increase. RaISe queried the *decrease in learning disability social workers between 2008 and 2009 of around 65% (WTE) in the Western Trust.*
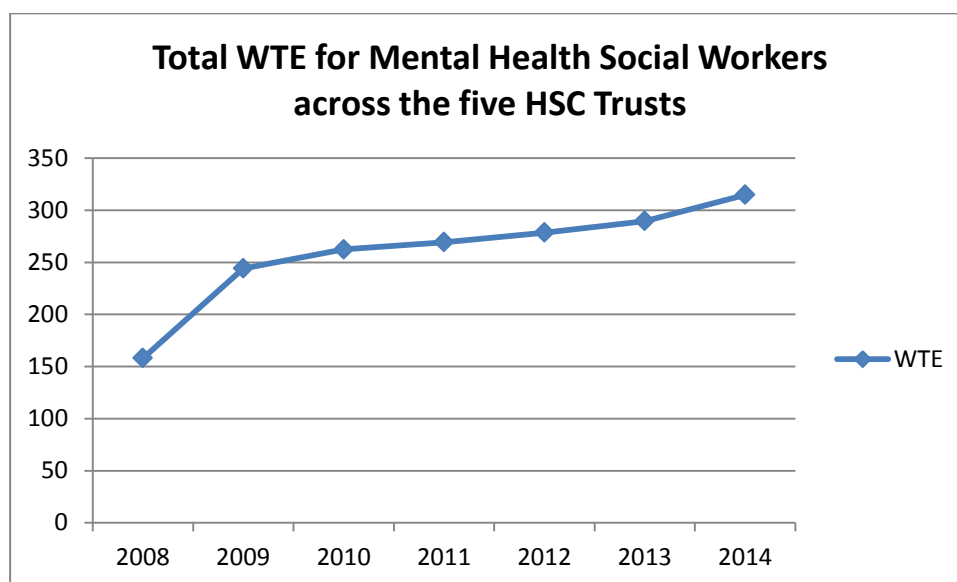
The response received was[55]:

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[54] Figures for each year are extracted from the workforce census publication for that year. Available at:
 2008 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2008_web.pdf
2009 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2009_exc_sec_11.pdf
2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

This query appears to relate to a recording issue during grade code assimilation, following the introduction of the new Agenda for Change grade coding. Some staff that had been coded to Learning Disability Social Worker Band 5 in 2008 were subsequently correctly moved to Learning Disability Social Work Support Band 5 by 2009.

3.4.5. Mental Health Social Workers[56]

Overall Trust Totals for Mental Health Social Workers:

Overall 99% increase in WTE from 2008-2014

Total WTE for Mental Health Social Workers across the five HSC Trusts

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[55] Email reply received from DHSSPS DALO, 03/02/15

[56] Figures for each year are extracted from the workforce census publication for that year. Available at:
 2008 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2008_web.pdf
2009 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2009_exc_sec_11.pdf
2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
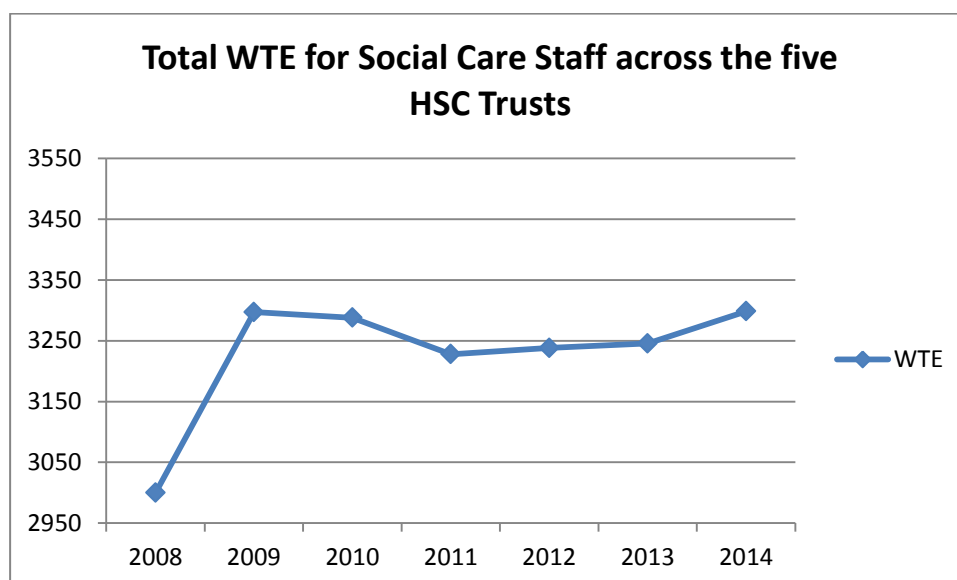2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

Trends across the Trusts (relatively small numbers reflected in large percentage changes):

Belfast:	**Increase of 80% (41.1-73.8 in WTE)**
Northern:	**Increase of 279% (23.7-89.7 in WTE)**
South Eastern:	**Increase of 423% (9.7-50.7 in WTE)**
Southern:	**Increase of 56% (32.4-50.7 in WTE)**
Western:	**Decrease of 1% (51.2-50.7 in WTE)**

3.4.6. Social Care Staff[57]

Overall Trust Totals for Social Care Staff:

Overall 10% increase in WTE from 2008-2014

Total WTE for Social Care Staff across the five HSC Trusts

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[57] Figures for each year are extracted from the workforce census publication for that year. Available at:
 2008 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2008_web.pdf
2009 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2009_exc_sec_11.pdf
2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
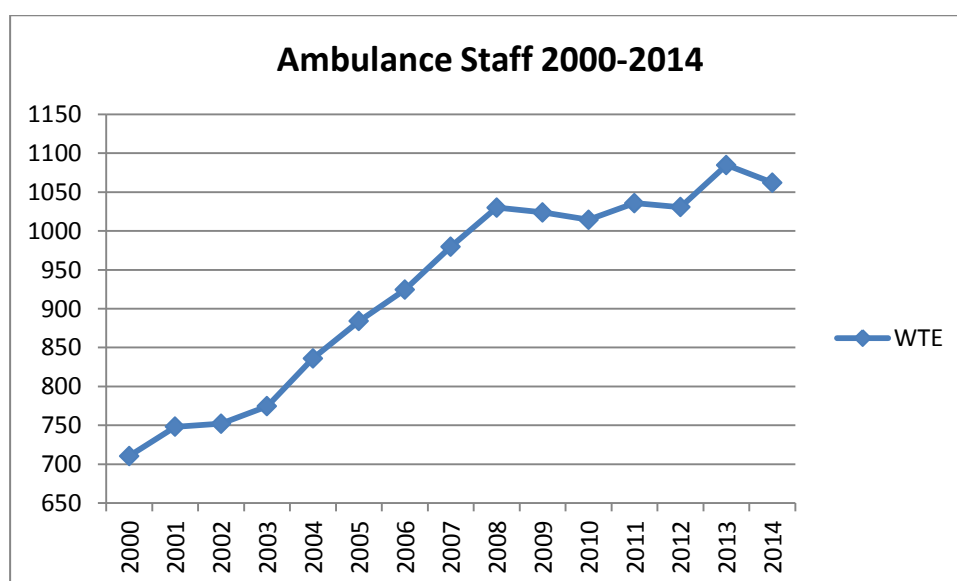2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

Trends across the trusts:

|	
Belfast:	**5% increase (838.4 to 881.4 in WTE)**
Northern:	**less than 1% increase in WTE**
South Eastern:	**1% decrease (595.4-589.2 in WTE)**
Southern:	**34% increase (398.7 to 533.3 in WTE)**
Western:	**29% increase (432.7 to 556.6 in WTE)**

3.5 Ambulance Staff

Overall NI Trend for Ambulance Staff[58]:

- **2000-2014: 50% increase (710.5 to 1062.2 in WTE)**
  - **2005-2014: 20% increase (884.1 to 1062.2 in WTE)**
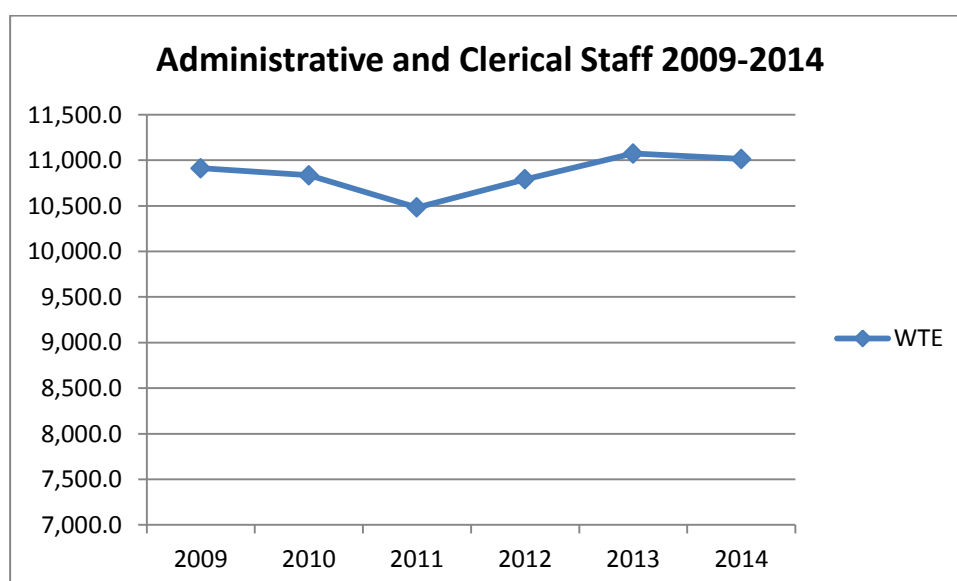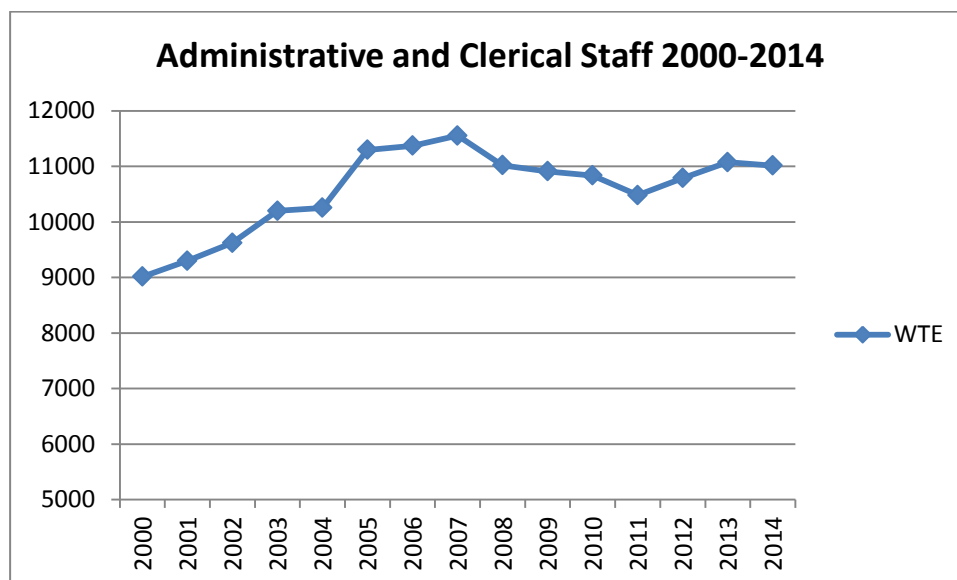 - **2009-2014: 4% increase (1023.9 to 1062.2 in WTE)**

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[58] Figures for 2005-2014 taken from the 2014 HSC workforce census and figure for 2000-2004 are taken from the 2005 HSC workforce census, http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf
http://www.dhsspsni.gov.uk/workforce_census_march_2005_exc_sec_11.pdf

Ambulance Staff 2009-2014
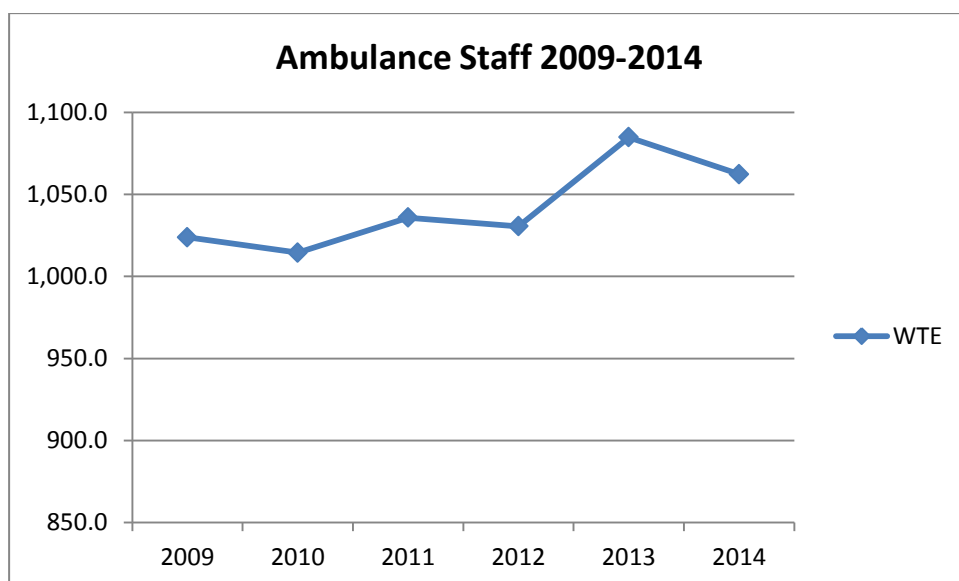
3.6. Administrative and Clerical Staff

Overall NI Trend for Administrative and Clerical Staff[59]:

- **2000-2014: 22% increase (9014.0 to 11,014.5 in WTE)**
  - **2005-2014: 3% decrease (11,296.2 to 11,014.5 in WTE)**
  - **2009-2014: 1% increase (10,912.2 to 11,014.5 in WTE)**

Administrative and Clerical Staff 2000-2014

Administrative and Clerical Staff 2009-2014

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[59] Figures for 2005-2014 taken from the 2014 HSC workforce census and figure for 2000-2004 are taken from the 2005 HSC workforce census, http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf
http://www.dhsspsni.gov.uk/workforce_census_march_2005_exc_sec_11.pdf

This section includes a more in-depth look at the figures for Selected Administrative and Clerical staff this includes:

3.6.1. Administrative and Clerical Bands Grade 1-4
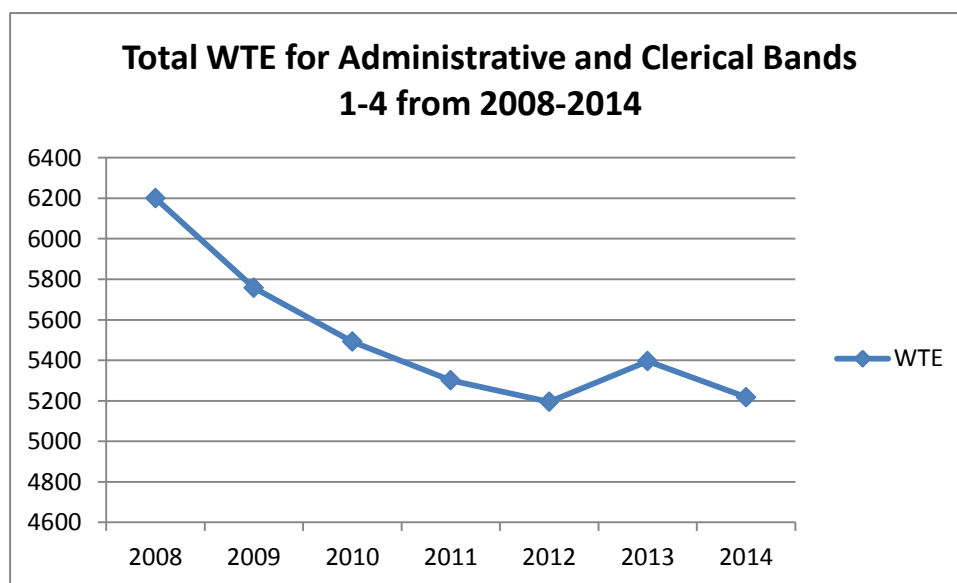
3.6.2. Medical Secretaries

3.6.3. Personal Secretaries

3.6.4. Administrative and Clerical Bands 5 and 6

3.6.5. Administrative and Clerical Band 8A to 9

3.6.1. Administrative and Clerical Grades 1-4[60]

Overall Trust Totals for Administrative and Clerical Staff Grades 1-4:

Overall 16% decrease in WTE from 2008-2014

Total WTE for Administrative and Clerical Bands 1-4 from 2008-2014

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[60] Figures for each year are extracted from the workforce census publication for that year. Available at:
 2008 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2008_web.pdf
2009 http://www.dhsspsni.gov.uk/index/statistics/workforce_census_march_2009_exc_sec_11.pdf
2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
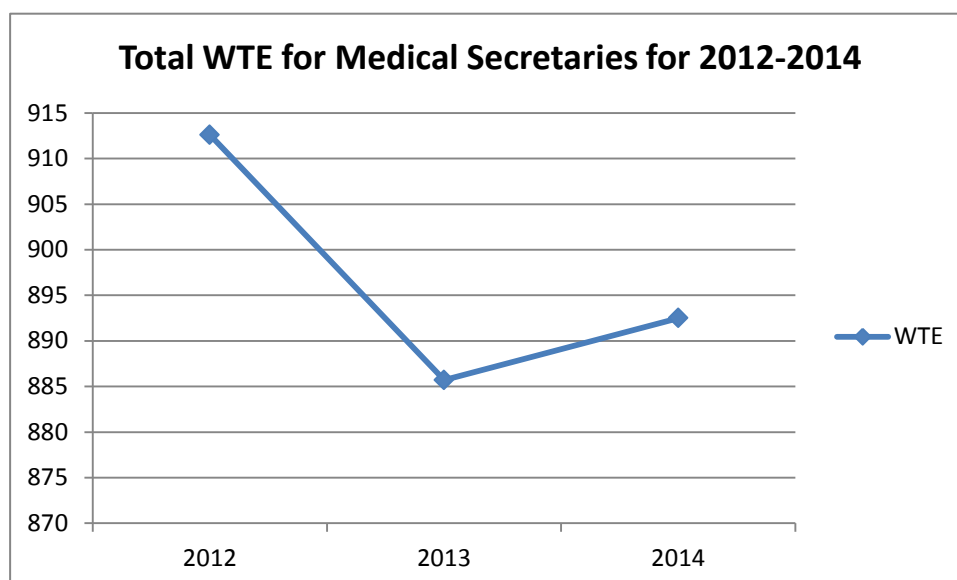2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

Trends across the Trusts:

Belfast:	**15% decrease**	**(2050.8 to 1750.6 in WTE)**
Northern:	**24% decrease**	**(1155.9 to 882.2 in WTE)**
South Eastern:	**10% increase**	**(722.5 to 793.5 in WTE)**
Southern:	**20% decrease**	**(1159.2 to 923.5 in WTE)**
Western:	**22% decrease**	**(1112.2 to 868.1 in WTE)**

3.6.2. Medical Secretaries

Overall Trust Totals for Medical Secretaries[61]:

Overall 2% decrease in WTE from 2012-2014

Total WTE for Medical Secretaries for 2012-2014

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[61] Figures for each year are extracted from the workforce census publication for that year. Available at:
2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

3.6.3. Administrative and Clerical Bands 5 and 6[62]

Overall Trust Totals for Administrative and Clerical Bands 5 and 6:

Overall 4% increase in WTE from 2011-2014

Total WTE for Administrative and Clerical Bands 5 and 6 from 2011-2014
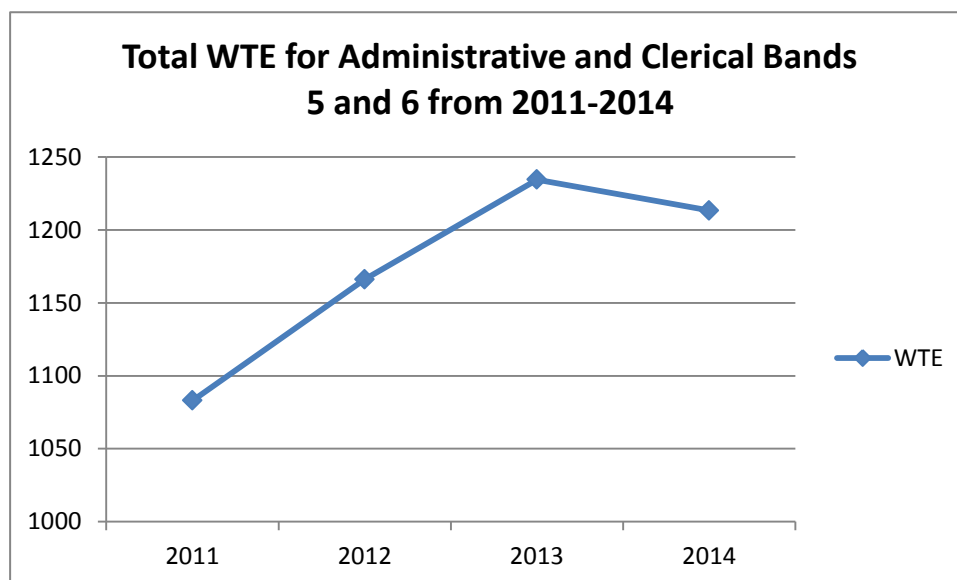
Trends across the Trusts:

Belfast:	**8% increase**	**(413.0 to 445.4 in WTE)**
Northern:	**11% increase**	**(172.8 to 192.1 in WTE)**
South Eastern:	**23% increase**	**(135.2 to 156.7 in WTE)**
Southern:	**12% increase**	**(178.2 to 199.5 in WTE)**
Western:	**19% increase**	**(183.9 to 219.5 in WTE)**

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[62] Trust figures for each year are extracted from the workforce census publication for that year. Available at:
2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf
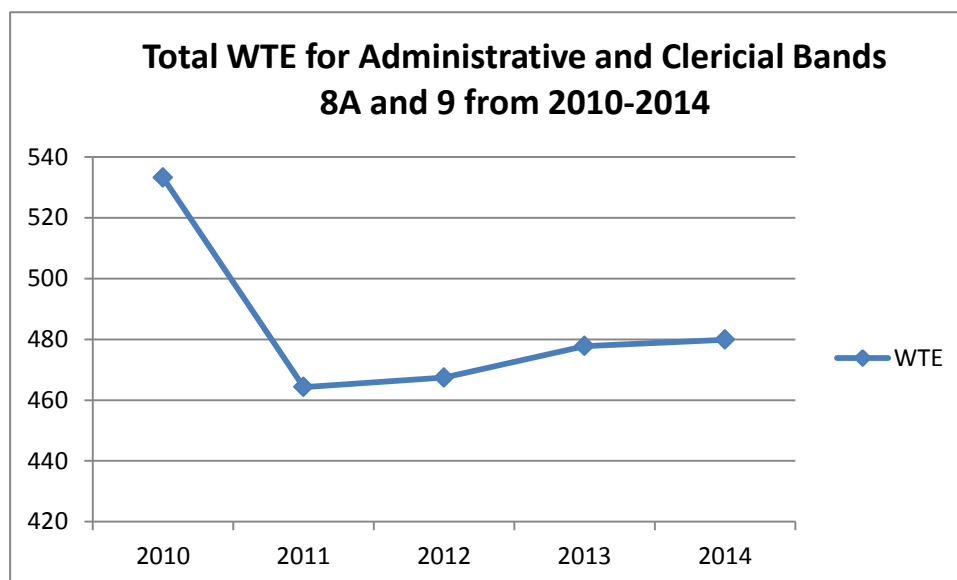2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf
2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf
2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

3.6.4. Administrative and Clerical Bands 8A to 9[63]

Overall Trust Totals for Administrative and Clerical Bands 8A to 9:

Overall 10% decrease in WTE from 2010-2014

Trends across the Trusts:

Belfast:	**2% decrease**	**(181.4 to 178.2 in WTE)**
Northern:	**10% decrease**	**(74.6 to 67 in WTE)**
South Eastern:	**1% decrease**	**(113.9 to 112.4 in WTE)**
Southern:	**46% decrease**	**(108.4 to 58.6 in WTE)**
Western:	**16% increase**	**(54.9 to 63.7 in WTE)**

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[63] Trust figures for each year are extracted from the workforce census publication for that year. Available at:

2010 http://www.dhsspsni.gov.uk/workforce_census_march_2010_web.pdf

2011 http://www.dhsspsni.gov.uk/workforce_census_march_2011.pdf

2012 http://www.dhsspsni.gov.uk/workforce_census_march_2012_-_web.pdf

2013 http://www.dhsspsni.gov.uk/workforce_census_march_2013_web.pdf

2014 http://www.dhsspsni.gov.uk/hscwc-march-2014.pdf

4 Independent Contractors and Related Staff

The HSC workforce census only includes staff employed by the HSC and excludes independent contractors also working in Health & Social Care such as General Practitioners and General Dental Practitioners. This section of the paper will look more closely this group as far as available statistics allow.

4.2. General Practitioners

According to the Business Services Organisation (established in 2009) statistics on WTE for GPs are no longer available due to changes in GMS contract (also see 4.4 below)[64].

The most recent BSO figures for GPs (November 2013) shows 1,171 GPs independently employed in NI, this represents a:

- o 10% increase from the 2000 figure, and

- o 1.8% rise from the 2008 figure.[65]

According to the Royal College of General Practitioners (RCGP), the number of GP surgeries in Northern Ireland has fallen from 366 (in 2005) to 351, the lowest number since 1991. It believes that much of the decline is explained by General Practitioners leaving the profession.

It may be that the apparent discrepancy between increasing numbers of GPs against increasing numbers leaving the profession is explained by larger numbers choosing alternative working patterns of fewer hours.

The RCGP also highlights that NI has the oldest GP workforce in the UK with 24.8% of GPs in NI aged over 55 (19.5% for Scotland, 22.3% for England, and 23.1% for Wales). [66]

The RCGP has calculated that NI has the lowest coverage of GPs per patient in the UK with just 6.4 GPs for every 10,000 people, compared with 6.6 in England and Wales and 8 in Scotland and that this translates to a shortfall of 234 family doctors for NI.[67]

This has led Dr John O'Kelly, Chair of the RCGP Northern Ireland, to say[68]

> *To gain parity with other UK nations, we urgently need a package of*
> *measures to encourage more young doctors to enter the GP workforce,*

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[64] http://www.hscbusiness.hscni.net/services/1804.htm

[65] Business Services Organisation (2014) Medical Statistical Information. Available at: http://www.hscbusiness.hscni.net/services/1802.htm (Accessed on: 20th January 2015)

[66] RCGP (2014) 'Number of GP practices reaches 24 year low as leading doctors warn services are struggling to cope'. Available at: http://www.rcgp.org.uk/news/2015/january/number-of-gp-practices-reaches-24-year-low-as-leading-doctors-warn-services-are-struggling-to-cope.aspx

[67] As above

[68] As above

retain and support current GPs, and make it easier for those who have left the workforce to come back.

Along with the National Association for Patient Participation, we are calling on the government to ensure that general practice receives 11% of the NHS budget - and to increase the number of GPs to allow us to deliver the high standards of care that our patients deserve.

Prior to the establishment of the BSO, the Family Practitioner Services (FPS) Directorate provided a range of support functions on behalf of the Health and Social Care, including the maintenance of statutory lists of practitioners. Its last statistical report was published in 2007/08.[69] These reports included substantial detail on GP Practices, such as GP & Patient Registration Data by Board; GP Age/Gender Analysis by Board; Number of GPs in a Practice by Board; and Number of Practices by List Size & Board.

By way of illustration, the following summary points are directly extracted from the last FPS statistical report regarding General Practice for 2007/08[70]:

- Between 1998 and 2008 the total number of GPs increased by 10% from 1,042 to 1,148 respectively;

- In 2008, there were 62 GPs per 100,000 registered population;

- In 2008, 39% of GPs were female, compared with just under a third (30%) in 1998;

- Over half (55%) of GPs in 2008 were aged between 40 and 54; and

- In October 2008, NI had 358 General Practices, 4 less than in Oct 2007; and

- In 2008, almost half (48%) of practices had either 2 or 3 GPs, 35% had 4 or more GPs and 15% were single-handed GP Practices.

The FPS Reports also contained detailed information regarding General Dental Services, General Ophthalmic Services and Pharmaceutical Services.

4.3. General Dental Practitioners

- According to the Business Services Organisation as of April 2014 there are 960 Dental Practitioners in Northern Ireland[71].

  - In 2014 this also includes an additional 30 assistants, 34 trainees and 40 Oasis[72] with an additional 6 salaried posts, giving a total of 1056[73].

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[69] http://www.hscbusiness.hscni.net/pdf/NI_FAMILY_PRACTITIONER_SERVICES_STATISTICAL_REPORT_2007-08.pdf

[70] http://www.hscbusiness.hscni.net/pdf/NI_FAMILY_PRACTITIONER_SERVICES_STATISTICAL_REPORT_2007-08.pdf

[71] Business Services Organisation (2014) Dental Statistical Information. Available at: http://www.hscbusiness.hscni.net/services/1802.htm (Accessed on: 20th January 2015)

[72] Oasis Dentists – in 2010, the DHSSPS awarded a contract to Oasis Dental Care (www.**oasisdentalcare**.co.uk) to increase access to dental care across Northern Ireland http://www.niassembly.gov.uk/assembly-business/official-report/committee-minutes-of-evidence/session-2011-2012/may-2012/funding-for-dental-services-departmental-briefing/

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o In 2000 there were 661 Dentists, which grew to 795 by 2008 and again to 960 in April 2014.

• The overall percentage increase from April 2000-2014 is 45%, whereas 2008-2014 equals a rise of 20.7%.

4.4. Treatment Room Nurses and District Nurses

As no specific figures were located by RaISe, it emailed the Royal College of Nursing in an attempt to get more information. The reply confirmed that there was very little available information on independently employed nurses and stated that:

> *The simple answer appears to be that the information is not collated, or if it is, I have been unable to locate it…the annual HSC workforce census only covers practice nurses and treatment room nurses employed by the HSC and not those who are directly employed by GP practices. Very few, if any, district nurses or health visitors would be directly employed by GP practices, so we are really just talking about practice nurses (mainly) and treatment room nurses (to a lesser extent)[74].*

RaISe subsequently contacted the Department of Health, Social Services and Public Safety to determine what information it held regarding such practice and treatment room nurses. The reply is included in full below[75]:

> *Under the new GMS Contract introduced in April 2004, GP practices receive core funding via a global sum block payment for the day to day running of their practice. The global sum is one of a number of funding streams and is intended to provide for the delivery of essential and additional services, staff costs, locum reimbursements and the cost of GPs' employer's superannuation. Funding for all staff was succumbed within the global sum under the new GMS Contract arrangements.*

> *Although practices hold a contract with the HSCB, they are independent contractors and as such can utilise their core funding/global sum to manage their practice however they see fit including the employment of staff. Practices are therefore under no obligation to report to any organisation, how they staff their practice nor the number or whole time equivalent (WTE) staff they directly employ.*

> *Since introduction of the new GMS Contract, there is no central data source for practice staff; the data would have to be requested from each individual GP practice.*

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[73] Please note it is possible for someone to be a dentist at one location and an assistant/Oasis, etc. at another location so the final total will not add to the sum of the individual dental types as the total represents individual people.

[74] Email Reply from RCN, Head of Communications, Policy and Marketing, 8th January 2015

[75] Email Reply from DALO, DHSSPS, 22nd January 2015

> *In terms of treatment room nurses who are generally employed and paid for by HSS Trusts and based in Health Centres owned by HSS Trusts, these can be identified on the HRPTS System (Human Resources Payroll, Travel & Subsistence System) but their role also involves community nursing and their workload is not solely related to general practice. Even where a treatment room nurse can be identified on HRPTS against a specific GP practice, this does not equate to being employed by that practice; it will more likely be a base location to carry out community nursing. Even if such a nurse does carry out practice related work, it would not be feasible to disaggregate the community nursing element from the general practice element.*

4.5. Pharmacists

The Pharmaceutical Society of Northern Ireland is the regulatory body for pharmacists in NI. It currently registers 2155 pharmacists, 549 pharmacy premises and oversees the preregistration programme for over 200 trainee pharmacists[76].

The current number of registered pharmacists is an increase on the May 2013 figure of 2110 pharmacists and the 2012 figure of 2101[77].

5   Workforce Plans for Northern Ireland

The following questions were put to the DHSSPS in order to ascertain the most up-to-date position regarding workforce planning in connection with TYC.[78]

- Please provide an update on the work of the **Regional Workforce Planning Group** established to take forward the specific proposals in 'Transforming Your Care' around workforce planning – please provide as much information as possible on the progress of the work, timescales and how far advanced is the development of the framework for workforce planning;

- In addition, please provide an update regarding the status of the workforce plans published in each of the Local Commissioning Group Local Population Plans; and

- A number of other workforce reviews are in progress in relation to nursing, medical specialists and medicine – please provide more information on these and how they link to the overall regional workforce planning group.

The responses received are included below in their entirety[79]:

Q1.   An update on the work of the **regional workforce planning group** established to take forward the specific proposals in 'Transforming Your Care' around workforce

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[76] Pharmaceutical Society NI, *Annual reports*. Available at: http://www.psni.org.uk/publications/annual-reports-2/
[77] As above
[78] RaISe email sent to the DALO on 13th January 2015
[79] Email Response received from DHSSPs DALO on 3rd February 2015

planning – please provide as much information as possible on the progress of the work, timescales and how far advanced is the development of the framework for workforce planning;

Response:

- The Regional Workforce planning Group (RWPG) has now completed this interim phase of its work and the Regional Workforce Planning Framework has been developed.

- The Framework articulates the regional roles and responsibilities envisaged for HSC workforce planning; however it is recognised that this is an evolving process. In view of this, the Framework is a living document which will be subject to ongoing review and refinement as appropriate.

- Implementation of the framework will be led by the DHSSPS, and primarily taken forward through the RWPG. The primary implementation steps shall be:

    a. Development of revised Terms of Reference for the RWPG for approval by DHSSPS;

    b. Reconstitution of the membership of RWPG to fulfill the Terms of Reference and consideration of how a broader range of stakeholders can be involved;

    c. To pilot a service area review within a Programme of Care (POC) approach, with an initial focus on the Elderly Care POC; and

    d. Further development of workforce planning capability and capacity across the region.

Q2. Please provide an update regarding the status of the workforce plans published in each of the Local Commissioning Group Local Population Plans.

Response: The individual Health and Social Care Trust high level workforce statements contained within the population plans should be regarded as extremely indicative statements only, subject to more detailed refinement as reform plans are developed in full. It is not expected that Trust workforce planning should be monitored against these high-level indicative estimates. HSC Trusts are responsible for developing more detailed workforce plans to accompany service changes.

As part of the reform programme, four System Wide Initiatives (SWIs) have been identified. They relate to reform of Outpatients, Pathways, Reablement and

Acute. Currently the Health and Social Care Board is prioritising progression on the first two (Reablement is already well advanced as regional/system wide reform initiative). Central to the reform of Outpatients and Pathways will be workforce planning. The mobilisation of the SWIs will provide a significant opportunity to reshape the workforce in line with new service models. Workforce planning will be mobilised and monitored as part of the delivery of the SWIs.

Q3.   I understand that a number of other workforce reviews are in progress in relation to nursing, medical specialists and medicine – I would be grateful for more information on these and how they link to the overall regional workforce planning group.

Response: The Regional Workforce Planning Group acts as the forum through which all matters relating to regional workforce planning are co-ordinated. A range of uni-professional reviews are currently at various stages of completion. These follow the traditional approach to workforce planning taken to date and will provide significant workforce intelligence on supply and demand; age profiles; areas of positive development; areas of concern; projected needs in line with service development; and emerging trends within the workforce, albeit, from the perspective of a single profession. An update in relation to the current programme of reviews is as follows:

Review of the Nursing Workforce

1.   The Review of the Nursing workforce was taken forward by the Department's Chief Nursing Officer, project managed by the Northern Ireland Practice and Education Council (NIPEC).

2.   Work is underway to cost the Workforce Plan, prior to consultation, after which, the Plan and recommendations will be presented to the Regional Workforce Planning Group and the DHSSPS Central Nursing and Midwifery Advisory Committee (CNMAC) for professional approval.

3.   Once agreed, CNMAC's Workforce and Education Sub-Committee will be charged with overseeing and supporting the implementation of the recommendations with timely reports to CNMAC on progress and annual reviews.

Review of the Medical Workforce

4.   The Centre for Workforce Intelligence (CFWi) has been appointed through external consultancy, to review the medical workforce, including undergraduate intake levels. The review will provide contextual information and an overarching picture of how the medical workforce is evolving. Data analysis will be comparable with data produced for England as a similar exercise has been completed there using the same diagnostic tools.

5.   The Review which will include all levels of the medical workforce will provide information on emerging trends and key priorities for this profession going forward and provide a snapshot predicting how the service may need to look in the future.

6.   The approach is following the Centre for Workforce Intelligence framework which comprises 4 stages –

     i.   <u>Horizon scanning</u> - exploring the potential challenges, opportunities and likely future developments that could influence workforce planning.
     ii.   <u>Scenario Generation</u> – exploring how the future might evolve by looking at a range of plausible futures and describe how likely future developments identified in horizon scanning may combine to create plausible scenarios.
     iii.   <u>Workforce Intelligence</u> – analysing future uncertainties and the impact of policy options to produce information that supports immediate action, medium term operational decisions, or long term strategic decisions.
     iv.   <u>Workforce Modelling</u> – developing models to inform policy, strategy and planning around the workforce and provide supply and demand projections.

7.   An initial workshop took place on 22nd and 23rd May 2014. CFWi has provided the Department with a scenario generation report flowing from this workshop - this has been circulated to attendees for comment. CFWi is now focusing on the data gathering element of the exercise. A second workshop which is likely to be undertaken 'virtually' will be arranged. It is expected that a Review Report will be available before the end of this financial year.

Medical Workforce Planning Sub-group

8.   A Medical Workforce Planning Sub-group (which feeds into the Regional Workforce Planning Group (RWPG)) has also been established to develop a suite of medical workforce plans for primary and secondary care for the 5-year period 2014/15 to 2019/20. The medical workforce planning exercise by specialty is being led by the Director of Public Health at the Public Health Agency. The Terms of Reference (TOR) for this work stream have recently been revised to ensure plans are in place as early as possible for those specialties where there are currently shortages and/or are key to the successful delivery of Transforming Your Care.

9.   The specialties reviewed in this cycle are confirmed as:
   i.   Paediatrics including community services and neonatal care
   ii. Trauma and Orthopaedics
   iii. Emergency Medicine
   iv. Primary Care
   v.   Urology
   vi. Radiology

A plan for the next phase of specialties will be brought to the RWPG for the next meeting in March 2015.

Radiology

10.   A Working Planning Sub-group has been convened as part of the DHSSPS Review of Imaging Services. A baseline data collection is underway and scheduled to be complete in early 2015. The results of this exercise will be presented to the Project board at their next meeting, which is expected to be in March.

Domiciliary care

11.   A Workforce Partnership has recently been established, under the aegis of the Connected Health and Prosperity Programme Board, with the aim, in the first instance, to align the future skill-sets of the domiciliary care sector workforce with service user need. It is intended that the work of this group will complement the regional project to review the model of domiciliary care which is being led by the Health and Social Care Board.