System Planning – Phases 2-4 – 10 High Impact Workforce Requirements/Availability and Education Capacity Questions

Note: Where modelling at national/ regional/ system/ local level has been/ is being undertaken check any workforce/ education capacity assumptions in that modelling v the questions below to refine discussions/ outputs/ solutions (e.g. critical care modelling in London).

Theme	**Lines of enquiry**
1. Are the impacts of **service/ health scenarios** on **workforce requirements and subsequent availability** understood?	What assumptions have been made by the system about potential (non workforce related) **reductions** in demand? - Reduced/ consolidated activity - Reduced/ consolidated bed capacity - Reduced theatre throughput - Reduced cases per list - Length of stay improvement - PPE availability - PPE productivity reduction (donning/ doffing space) - Estate restrictions and distancing requirements - Patient behaviour – not accessing services - Use of independent/ other sectors as alternatives (see below) What assumptions have been made by the system about potential **changes** in demand? - Virtual/ phone consultations (e.g. outpatients, primary care) - Use of independent/ other sectors as alternatives (workforce demand elsewhere in system) - Change in care setting (and potentially, change in location/ service/ employer to which workforce is connected) What assumptions have been made by the system about potential **increases** in demand?

	- Additional activity - Additional beds - Additional theatre throughput - Seacole, Nightingale Centres - Diagnostic hubs - Second Covid surge - Use of independent/ other sectors as additional services - Covid and non Covid sites (workforce availability, time (productivity), flexibility)
2. Are the **workforce requirements and subsequent availability** impacts on **service/ health scenarios** understood?	What assumptions have been made by the system about the potential **reductions** in workforce requirements and subsequent availability? - Absence levels and potential increase due to Covid including self isolation - Annual leave levels and other planned leave - Additional R&R time for staff - Maintaining essential training time - Additional training time - Quarantine time - BAME risk assessment and impact on staffing availability - PPE availability and time (donning/ doffing) - Educator and l&d support staff time - Learners returning to education from paid placements - Turnover – increases/ delayed - Staff shielding and caring for shielded family members (query latest Gvmt announcement on shielding scheme) - Caring responsibilities including summer holiday and autumn term school arrangements, limited childcare options and e.g. private carers/ care home availability for frail/ elderly relatives - Time for staff to take Covid tests, immunity tests - Staff (re)deployed in Phase 1 and into Phase 2 returning to original roles - Issues across competing employers (in/ across systems) What assumptions have been made by the system about potential **changes** in workforce requirements and subsequent availability?

	- Staff working between/ across care settings/ employers What assumptions have been made by the system about potential **increases** in workforce requirements and subsequent availability? - Recruitment strategies - New staff joining (including from BBS), reservist models, local industry furlough/ redundancies/ long term secondments - Effective utilisation of temporary/ agency staff - Returners from absence - Staff (re)deployed in Phase 1 and into Phase 2 who can remain in post - Additional staff who can be (re)deployed to support Phases 2 and 3 including deployment of specialists into alternative/ generalist roles - Learners who could be deployed in Phases 2 and 3 - Volunteers - Retention strategies - Part-time to full time roles (increases in hours) with associated support - Health and wellbeing support/ strategies including avoiding unreasonable or unsustainable workload/ working arrangements - Speeding up lead in training times – e.g. ACP acceleration
3. Are the impacts of **service/ health scenarios** and **workforce requirements and subsequent availability on education capacity/ provision** understood?	What assumptions have been made by the system about potential **reductions** in service/ health scenarios/ workforce requirements and subsequent availability on education capacity, and therefore future workforce supply? What assumptions have been made by the system about the potential **changes** in service/ health scenarios/ workforce requirements and subsequent availability on education capacity, such that the nature or mode of delivery of practice based education may need to alter/ changes in education capacity may be possible? - E.g. move to virtual/ phone consultations – how digital service systems incorporate practice learners and educators where previously care was face to face. In theory more/ different practice learners could engage in virtual/ phone consultations due to potential multiple access to technology and lack of restriction of physical space etc.

	What assumptions have been made by the system about the potential **increases** in service/ health scenarios / workforce requirements and subsequent availability on education capacity? - E.g. if additional services were being provided for catch up/ increased demand where might this offer increased placement capacity?
4. Are the **education capacity/ provision** impacts on **workforce requirements and subsequent availability,** and **service/ health scenarios** understood?	*Nb – this question relates to how maintenance, increase, changes in education capacity requirements have themselves been considered in relation both to what workforce would be needed to support them and the availability of that workforce, and where relevant the service/ health scenarios that would need to be in place to enable that education (capacity) to be delivered. Whilst this question focusses mainly on education **capacity** in the Restoration and Recovery phases, it may also relate to changes in the nature/ regulation of education and how that flows through into the necessary workforce support and service/ health scenarios. It is different to question 3, which focusses more on how different service/ health scenarios and workforce requirements and subsequent availability affects education (capacity).* What assumptions have been made by the system about potential **reductions** in service/ health scenarios/ workforce requirements and subsequent availability due to education provision? - So if, for example, there needs to be a greater number of practice learners on placement, due to the need for learners to catch up with practice learning that has not been completed in the usual time period due to Covid, if this was provided then how would that affect the availability of the workforce (for other duties); and in turn the service/ health (activity) scenarios What assumptions have been made by the system about potential **changes** in service/ health scenarios/ workforce requirements and subsequent availability due to education provision? - E.g. do practice educators need to train/ alter their ways of working/ increase the time they spend on education due to students being on placement in phone/ virtual clinics; and otherwise not/ less physically present?

	- E.g. if more practice based education can be provided across the professions, what impact would this have down the line on workforce availability for 'service'? What assumptions have been made by the system about potential **increases** in service/ health scenarios / workforce availability and subsequent availability due to education provision? - E.g. do simulated environments give an opportunity for alternative safe, quality learning which then frees up time from previous traditional placements which gives more time for service provision (or other types of education)?
5. Is there a **system wide clinical model** in existing system plans, and how do the workforce requirements/ availability and education capacity considerations affect this?	Is there a system wide clinical model (planned/ in place)? Does the model include a workforce model/ team design/ roles/ ratios? Is the model reflective of safer staffing models? What assumptions have been made by the system about the impact of workforce requirements and subsequent availability and education capacity issues on the (development of the) model? Does the model allow for phased escalation in cases of extreme workload associated with Covid-19 or other surge events/ impacts? How far is the system equipped to deliver the workforce required by the (amended, planned) clinical model? Are there specific key roles without which the clinical model cannot be delivered? If so are there alternative roles? What mitigation strategies are in place to cover any shortfall in workforce requirements and subsequent availability and education capacity?

6. Has the system considered **how** its contribution to **growth in key national priority areas such as nursing, mental health and primary care can be achieved,** specifically in relation to respective targets?	Has the system factored in these workforce targets and lead in training times/ education capacity? How has it done so? How do these developments represent opportunities for the system to build resilience/ transform?
7. How has the system considered the contribution of **workforce innovation** and **education reform** in its plans?	How have/ will innovations adopted in response to Covid which have been effective be embedded across the system? For example, new roles including but not limited to: • Nursing Associate roles • Physician Associates • Community Health Workers • Apprentices • Bed Buddies How has the system reviewed areas of innovation that have been less successful to consider lessons learnt and impact on future adoption and spread? How is the system planning on developing and adopting practices including but not limited to? • Digitally enabled workforce • Agile and flexible workforce
8. How has the system considered impact on **BAME learners and staff** and wider families, communities?	Have strategic approaches been adapted to recognise Covid-19 implications for the BAME workforce? If so, how? How far do the plans provide diverse opportunities for staff to develop, and move into different roles?
9. How have **staff, partners and stakeholders** been involved in the	How far does the planning represent an integrated approach across health and social care?

ongoing (re)development of workforce and education elements of system plans, and is there wider ownership/ support/ buy-in?	How far has the system considered the issues and solutions across health and social care? How far have solutions been considered across health and social care? How far have systems engaged with LEPs to consider local labour market issues and potential solutions as anchor systems? How far have systems leveraged each other's skills and expertise; those of their constituent health provider and commissioner organisations, trades unions, professional bodies, NHSE/I, HEE and PHE Regions and national ALBs/ wider support organisations to assist in planning and solutions?
10. Are the implications of the plan **costed/ affordable**?	Given workforce represents c70% of health spend, how far have the workforce and education elements of system plans been costed as part of integrated service, activity, finance, quality planning? Are plans affordable?