Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR DIWYLLIANT, POBL A DATBLYGU SEFYDLIADOL
PEOPLE, ORGANISATIONAL DEVELOPMENT & CULTURE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	04 April 2022
TEITL YR ADRODDIAD: TITLE OF REPORT:	Workforce Plan
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Lisa Gostling, Director of Workforce & Organisational Development
SWYDDOG ADRODD: REPORTING OFFICER:	Tracy Walmsley, Head of Strategic Workforce Planning & Transformation

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Health Board is required to submit a workforce plan as part of its submission for the Integrated Medium Term Plan and also to support the PBC application process. There are many parameters which need to be considered as part of this process and it is very difficult to predict a workforce 10 years into the future however based upon the information available today an assessment of staffing requirements by job family has been produced which gives a baseline for the future and allows for refinement and detail to be further developed over coming months and years.

Cefndir / Background

Some key considerations the Health Board needs to be aware of include:-

1. In 10 years, there is a risk that over 30% of our workforce will have retired…
2. 60% of the workforce we have today will be the workforce of “tomorrow”…
3. …so we need to keep for tomorrow, the “contingent” workforce we have today…
4. …create development pathways to enable retention…
5. …average age of retirements has been 61 (2019-21)
6. …return & retire options are critical to ensure participation in workforce…
7. …aging population and workforce demographic...alternative workforce models will be critical…
8. …role/workforce design built on flexibility & lifelong learning principles
9. …UHB Turnover data indicates a higher rate than all Wales…
10. …given the commitment and high levels of training & innovative programmes for workforce development across many professional groups…
11. UHB acts as an active “workforce pipeline” for career progression & development (especially mid career) *NB this is anecdotal

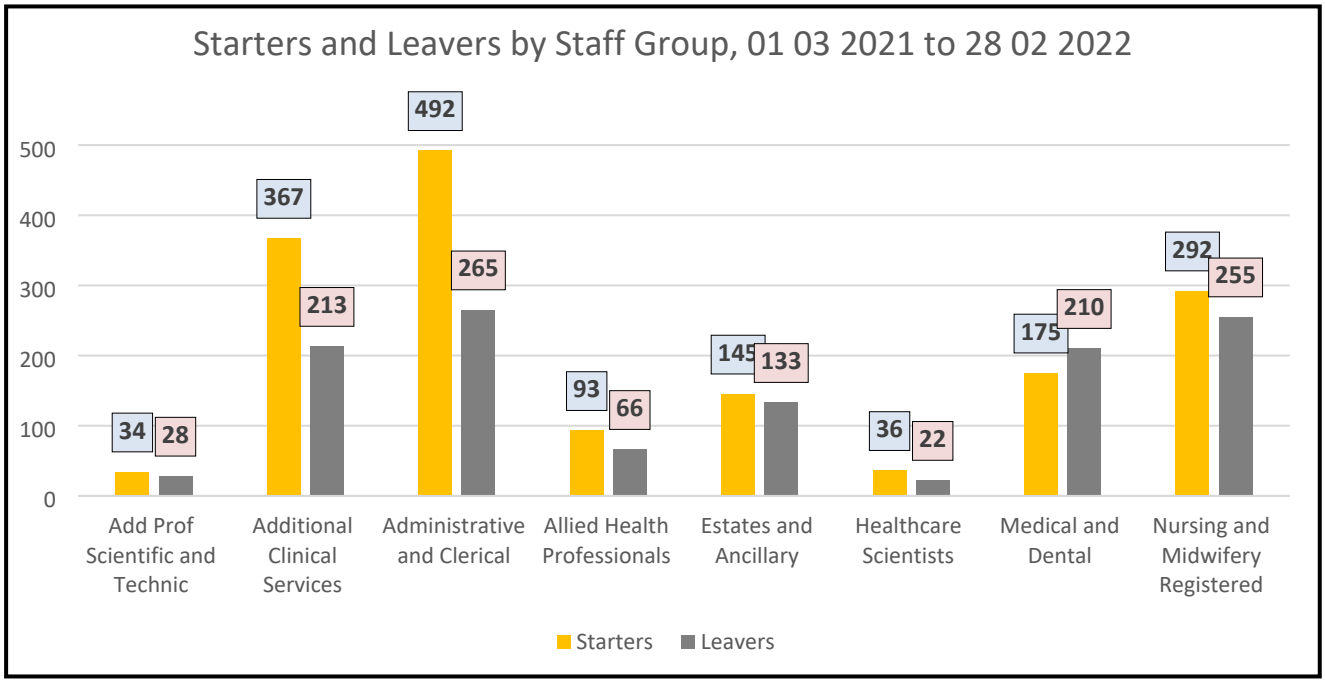
Key workforce metrics to support the workforce planning approach

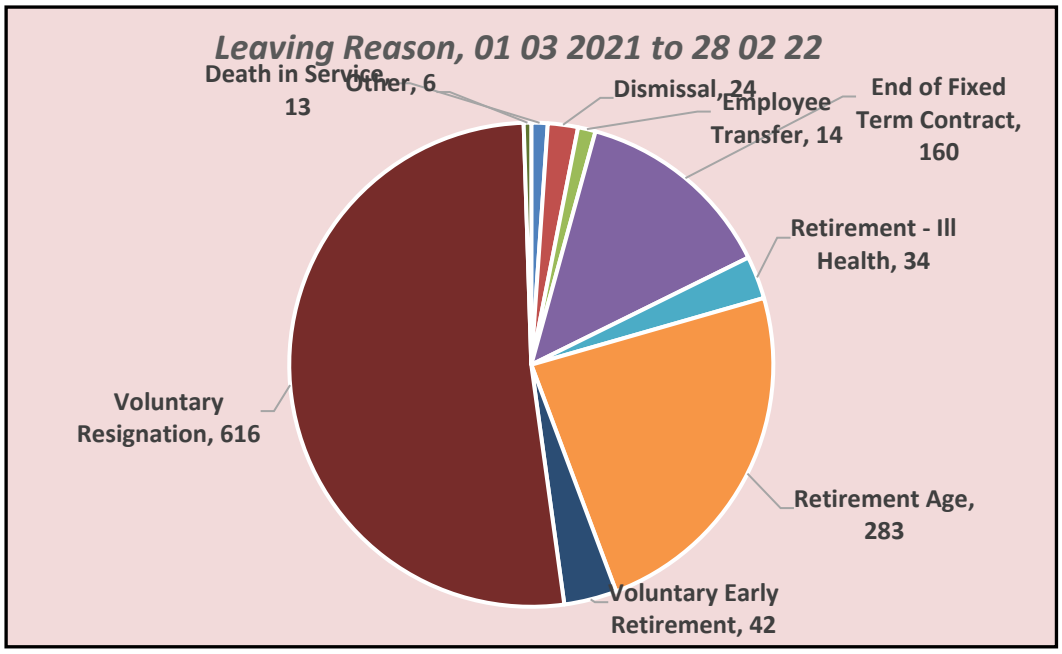
Looking back at our workforce trends the following can be noted:-

	Headcount by Month											
Staff Group	**2021 / 03**	**2021 / 04**	**2021 / 05**	**2021 / 06**	**2021 / 07**	**2021 / 08**	**2021 / 09**	**2021 / 10**	**2021 / 11**	**2021 / 12**	**2022 / 01**	**2022 / 02**
Add Prof Scientific and Technic	350	353	350	346	346	359	358	361	374	373	381	378
Additional Clinical Services	2,403	2,395	2,395	2,437	2,452	2,436	2,440	2,409	2,417	2,416	2,437	2,455
Administrative and Clerical	2,142	2,132	2,133	2,124	2,120	2,142	2,163	2,184	2,244	2,244	2,237	2,255
Allied Health Professionals	712	717	714	715	714	716	724	737	740	739	751	755
Estates and Ancillary	1,138	1,144	1,141	1,141	1,116	1,112	1,105	1,088	1,081	1,085	1,093	1,090
Healthcare Scientists	191	193	191	188	191	191	196	203	206	206	208	208
Medical and Dental	690	686	687	690	683	625	636	643	654	655	664	667
Nursing and Midwifery Registered	3,231	3,230	3,231	3,237	3,234	3,241	3,283	3,285	3,288	3,264	3,271	3,283
Students	1	1	1	1	1	1	2	1	1	1	1	1
Total	**10,858**	**10,851**	**10,843**	**10,879**	**10,857**	**10,823**	**10,907**	**10,911**	**11,005**	**10,983**	**11,043**	**11,092**

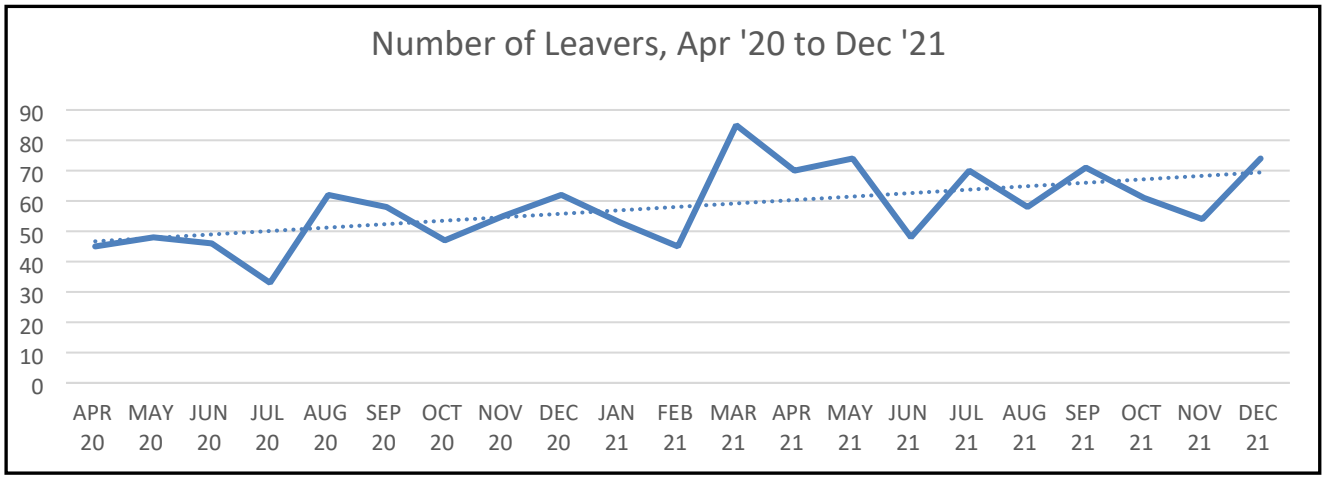
The Health Board continues to grow (albeit slowly) its workforce through its workforce strategies.

Starters and leavers by staff group are as follows.

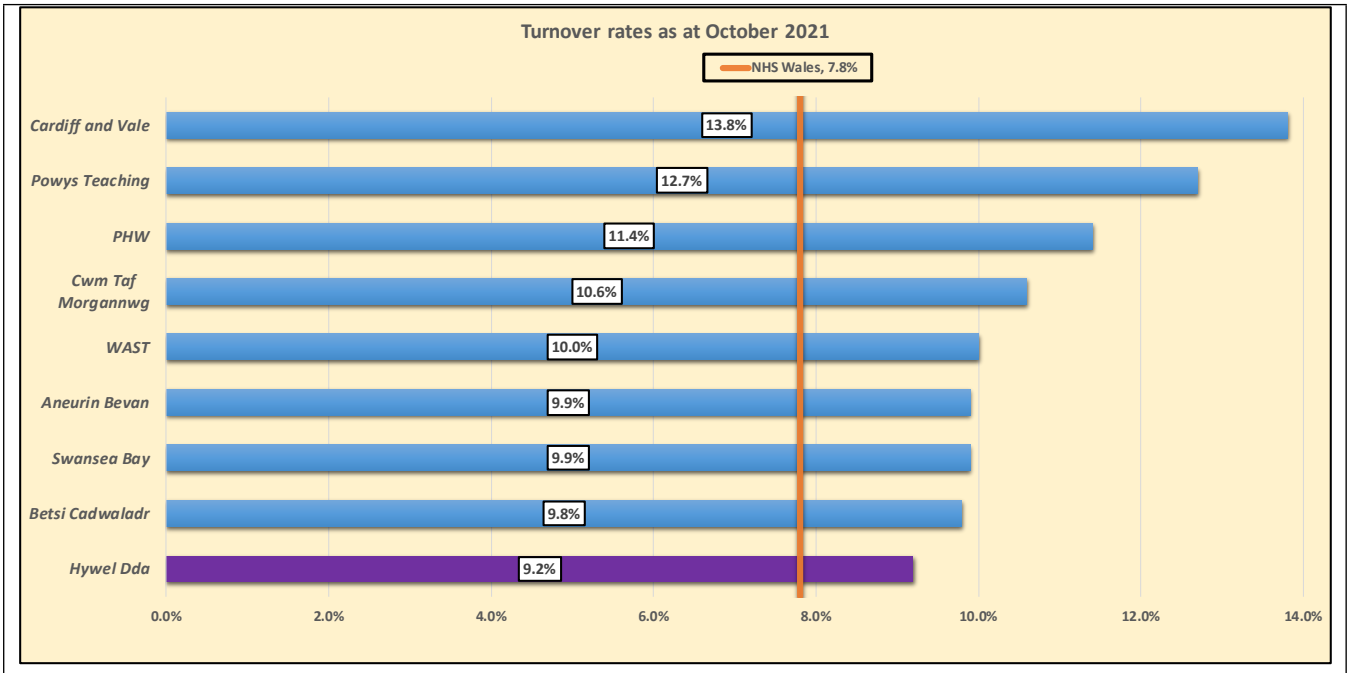




Of the 283 staff who retired 126 returned to work for the Health Board (45%) and these wouldn't be reflected in analysing pure leaver data which shows an increasing trend for leavers up to December 2021.

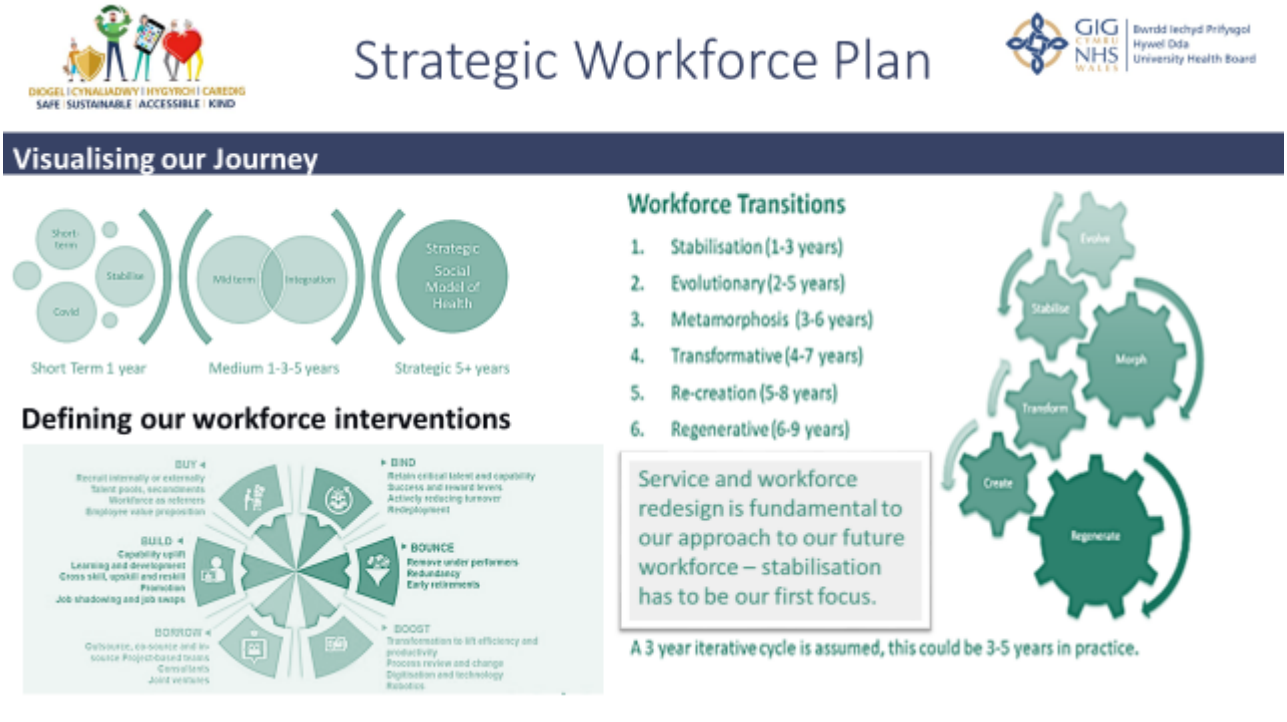


New turnover benchmarking data from across Health Boards in Wales has recently become available and there appears in the latest dataset to be a significant swing with Hywel Dda now showing the lowest turnover in NHS Wales. Also the NHS Wales information excludes staff moving between Welsh Health Boards. Further analysis excluding this number will be undertaken within the Health Board to see how close to the Wales figure the Health Board is. Also information by staff group will be re-assessed to see if any hot spot areas become apparent.

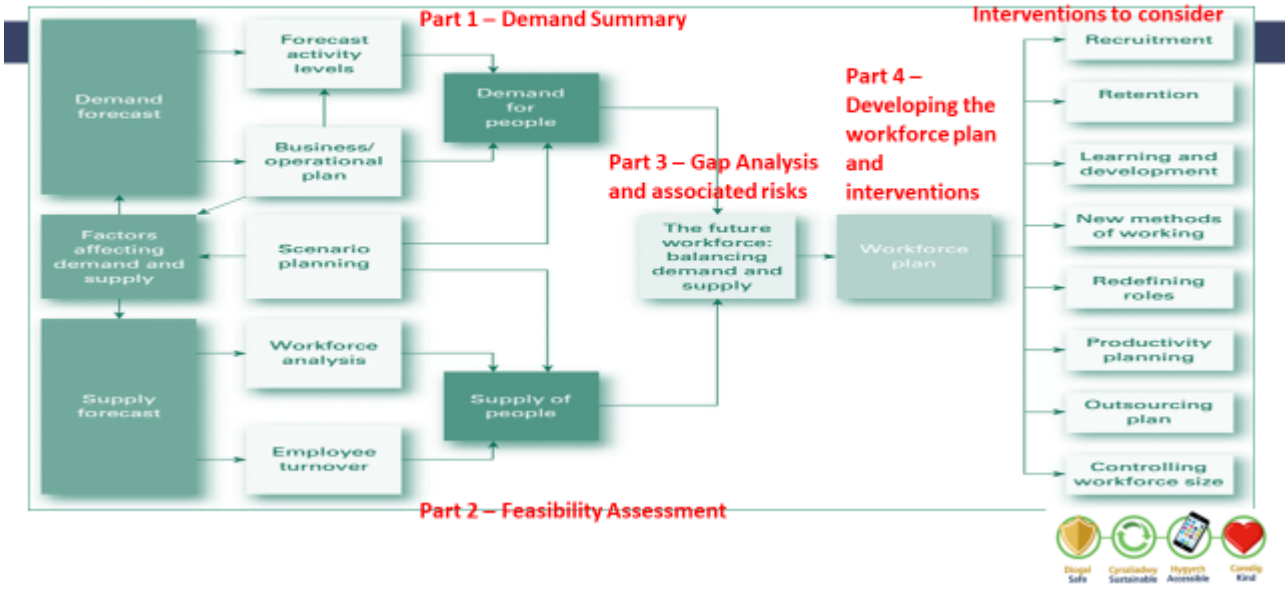


Asesiad / Assessment

The approach taken to develop a strategic workforce plan is as follows:-



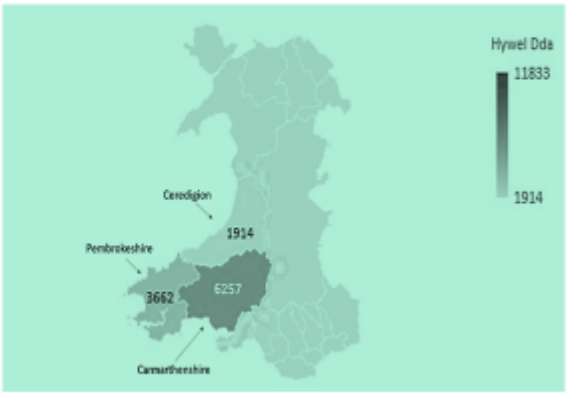
Workforce Planning Approach



Workforce Plan

Key elements

Workforce density by geography



Workforce Position

Headline – in next 10-15 years we could face a 50% workforce gap unless we radically rethink services and workforce developme

1. **10% Current Establishment Gap Now**
2. **An additional 10% increase service need potentially with general demographic growth**
3. **Then further risk of 30% gap due to retirement**

Row Labels	Budget	Actual	Vacancy	Maternity	Notional Cover
ADD PROF SCIENTIFIC AND TECHNICAL	365.8	337.2	28.6	7.6	28.6
ADDITIONAL CLINICAL SERVICES	2,182.4	2,091.5	90.9	53.7	90.9
ADMINISTRATIVE & CLERICAL	1,975.2	1,985.5	(10.3)	23.9	(10.3)
ALLIED HEALTH PROFESSIONALS	647.6	612.5	35.1	16.9	35.1
ESTATES AND ANCILLIARY	891.8	884.4	7.4	7.3	7.4
HEALTHCARE SCIENTISTS	199.5	195.6	3.8	1.0	3.8
MEDICAL AND DENTAL	924.0	610.1	313.9	3.0	313.9
NURSING AND MIDWIFERY REGISTERED	3,306.2	2,815.3	491.0	80.8	491.0
PAY BUDGET ADJUSTMENTS	10.0		10.0		10.0
STUDENTS	2.2		2.2		2.2
Grand Total	10,504.7	9,532.1	972.6	194.2	972.6

Establish Control Tool Summary December 2021

12 January 2022

3. Workforce Plan: Gap "from reality to aspiration"

Workforce Regeneration Framework

The "Workforce Regeneration Framework" is a simple tool to illustrate the options available in a complex wen of interactions – digital enhancements, service commissioning and the employee lifecycle.

These are all of the tools at our disposal as managers, leaders, service, workforce and finance professionals to "regenerate" our workforce.

The principles will stand, as we change and transition into new workforce models we have yet to explore. This is why some elements in the tables overleaf are currently "blank".

The planning tool will be demonstrated during the Committee to give a feel for how the individual worksheets are built based upon the above regeneration framework.

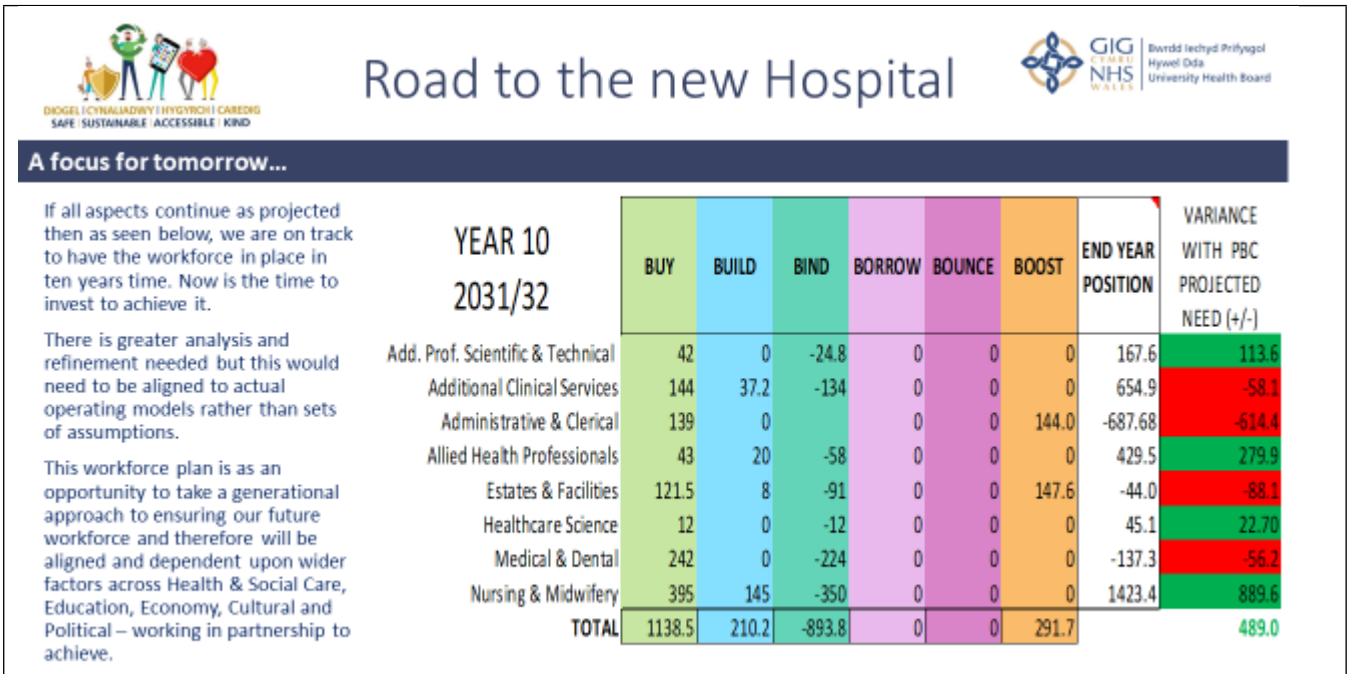
Road to the new Hospital

Where we are today:

Caveats: alignment to the PBC for the new Hospital will be dependent upon:

- HEIW commissioning activity
- HEI subsequent recruitment activity
- Internal funding to continue development pathways
- Qualifications being available to enable developments.
- Pathway design to ensure the correct skill mix for the workforce of the future
- Activity assumptions remaining consistent to those currently envisaged

YEAR 1 2022/23	BUY	BUILD	BIND	BORROW	BOUNCE	BOOST	END YEAR POSITION	VARIANCE WITH PBC PROJECTED NEED (+/-)
Add. Prof. Scientific & Technical	56	0	-24.8	1.1	0	0	12.8	-54.00
Additional Clinical Services	152	133.4	-134	20	0	0	58.5	-713.00
Administrative & Clerical	139	0	-155	18.3	0	19.78	-7.48	73.30
Allied Health Professionals	145	0	-58	2.7	0	0	-28.20	-149.60
Estates & Facilities	234.5	8	-91	111.1	0	10.25	245.55	-44.10
Healthcare Science	24	0	-12	5.5	0	0	9.6	-22.4
Medical & Dental	242	0	-224	0	0	0	-299.3	-193.50
Nursing & Midwifery	373	33.6	-320	206.1	0	0	-207.2	-533.8
TOTAL	1365.5	175	-1018.8	364.8	0	30.034		-1,637.10



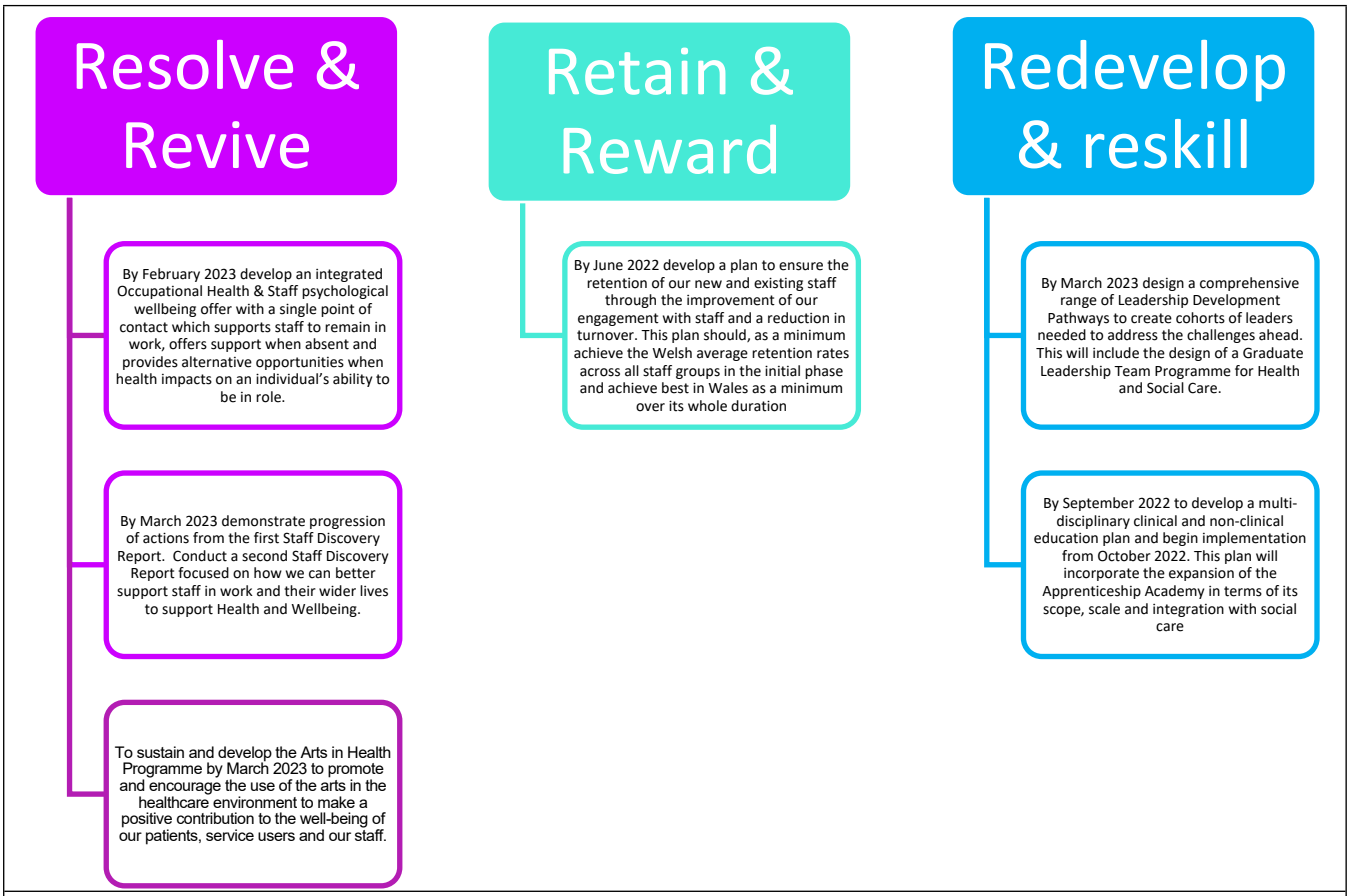
Appendix 1 is the Workforce Plan developed to support the OBC.
Appendix 2 is the Workforce Plan developed for the IMTP

Links with Planning Objectives

STRATEGIC OBJECTIVE 2 – Working together to be the best we can be

Empowering our Workforce (PO 2D; PO 2H; PO 2I; PO 2J; PO 2K; PO 2L, PO 2M)

- By February 2023 develop an integrated Occupational Health & Staff psychological wellbeing offer with a single point of contact which supports staff to remain in work, offers support when absent and provides alternative opportunities when health impacts on an individual's ability to be in role.
- By March 2023 design a comprehensive range of Leadership Development Pathways to create cohorts of leaders needed to address the challenges ahead. This will include the design of a Graduate Leadership Team Programme for Health and Social Care.
- By March 2023 demonstrate progression of actions from the first Staff Discovery Report. Conduct a second Staff Discovery Report focused on how we can better support staff in work and their wider lives to support Health and Wellbeing.
- By June 2022 develop a plan to ensure the retention of our new and existing staff through the improvement of our engagement with staff and a reduction in turnover. This plan should, as a minimum achieve the Welsh average retention rates across all staff groups in the initial phase and achieve best in Wales as a minimum over its whole duration
- By September 2022 to develop a multi-disciplinary clinical and non-clinical education plan and begin implementation from October 2022. This plan will incorporate the expansion of the Apprenticeship Academy in terms of its scope, scale and integration with social care
- To sustain and develop the Arts in Health Programme by March 2023 to promote and encourage the use of the arts in the healthcare environment to make a positive contribution to the well-being of our patients, service users and our staff.



Argymhelliad / Recommendation

- The People, Organisational Development & Assurance Committee is requested to support the further development of the model and take assurance that a workforce plan is in existence albeit needs further refinement and development.
- The plan will be supported by an educational plan which will be developed as the detail of roles for the future are know which will support the development of the financial plan required upstream of staffing requirements to enable better financial planning.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.2 Consider the implications for workforce planning arising from the development of HDdUHB's strategies and plans or those of its stakeholders and partners, including those arising from joint (sub) committees of the Board
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	1219 There is a risk there will be insufficient workforce available to deliver services required for "Recovery" and the continued response to Covid and other respiratory infections, as outlined in the UHB's annual plans 2021/22. This is caused by new variants of COVID, increase in the severity and dispersal of respiratory viruses within the population (in children and adults) which could mean an increase in infections and outbreaks within acute, community and social care facilities. Further to this, a lack of alignment of information between service, workforce and finance on workforce requirements for unfunded service pathways

	could further jeopardise workforce availability in areas of need. This could lead to an impact/affect on the Health Board's ability to staff pathways for COVID, field hospitals, surge capacity within general hospitals, community hospitals, paediatric units effectively managing the impact from of outbreaks, delivering a mass vaccination programme and the delivery of planned care, as well as increased sickness absence directly, and increased self-isolation of staff, and limiting the ability to recruit new staff quickly to provide additional support. – current score 4x4 = 16
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	7.1 Workforce
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	NSW Government
Rhestr Termau: Glossary of Terms:	Included within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Diwylliant, Pobl a Datblygu Sefydliadol: Parties / Committees consulted prior to People, Organisational Development & Culture Committee:	Executive Team Board Seminar All Wales Workforce & OD Directors Peer Group Chief Executives forum

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	
Ansawdd / Gofal Claf: Quality / Patient Care:	
Gweithlu: Workforce:	
Risg: Risk:	
Cyfreithiol: Legal:	

Enw Da: **Reputational:**	
Gyfrinachedd: **Privacy:**	
Cydraddoldeb: **Equality:**	

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Appendix
Programme Business Case within IMTP 2022-25
Workforce Technical Annexe
25 March 2022

Workforce Strategy & Change Mapping
Assessment of Impact & Implications

Version	Date	Amendments
Version 1	8 March 2022	Comments reviewed and updated
Version 2	25 March 2022	

Contents

About this Document

This technical document is an appendix to the Hywel Dda University Health Board's (HDUHB) for 'A Healthier Mid & West Wales: Our future generations living well' Programme Business Case.

This workforce technical document is a live document that we will return to check our progress as to how we are meeting our workforce objectives and success factors.

It has been produced to provide the direction of travel for the workforce change required within the organisation. This document describes the potential impact of the chosen service reconfiguration (2B+ an adapted proposal from the consultation) on our workforce strategy. By discussing as a Health Board, we will assess, mitigate and manage the implications and impacts of this in relation to our workforce, and in its widest sense how we will plan with partners to develop a sustainable workforce model.

The document discusses our approach to:

1. Analysing the Workforce
   - Qualifying the approximate numbers and professional groups impacted

2. Modelling the Workforce
   - New ways of working and new delivery models including the shift of services to new geographical locations or out into the community and the potential impact on the existing and future workforce

3. Re-generating our Workforce
   - Workforce recommendations addressing our intention to "re-generate" our workforce through a methodology that illustrates our different supply routes:
     - "resource and replenish" (Buy)
     - "redevelop and reskill" (Build)
     - "retain and reward" (Bind)

4. Empowering the Workforce
   - Planned support and process for staff potentially moving work location as a result of each of the options

This document is meant as a reference guide and a set of intentions and principles to guide our workforce planning activity and interventions going forward, which will adapt to changing circumstances and needs.

It does not provide exhaustive detail but aims to answer any questions that may arise from reading the main programme business case document. If you would like further

detailed information, this can be obtained by contacting Lisa Gostling or Tracy Walmsley.

This document should not be read in isolation but within the framework of materials prepared for the consultation, programme business case and our Integrated Medium-Term Plan (of which it is intended to be annexed) to enable alignment of ideas and assumptions.

Our Workforce Reality

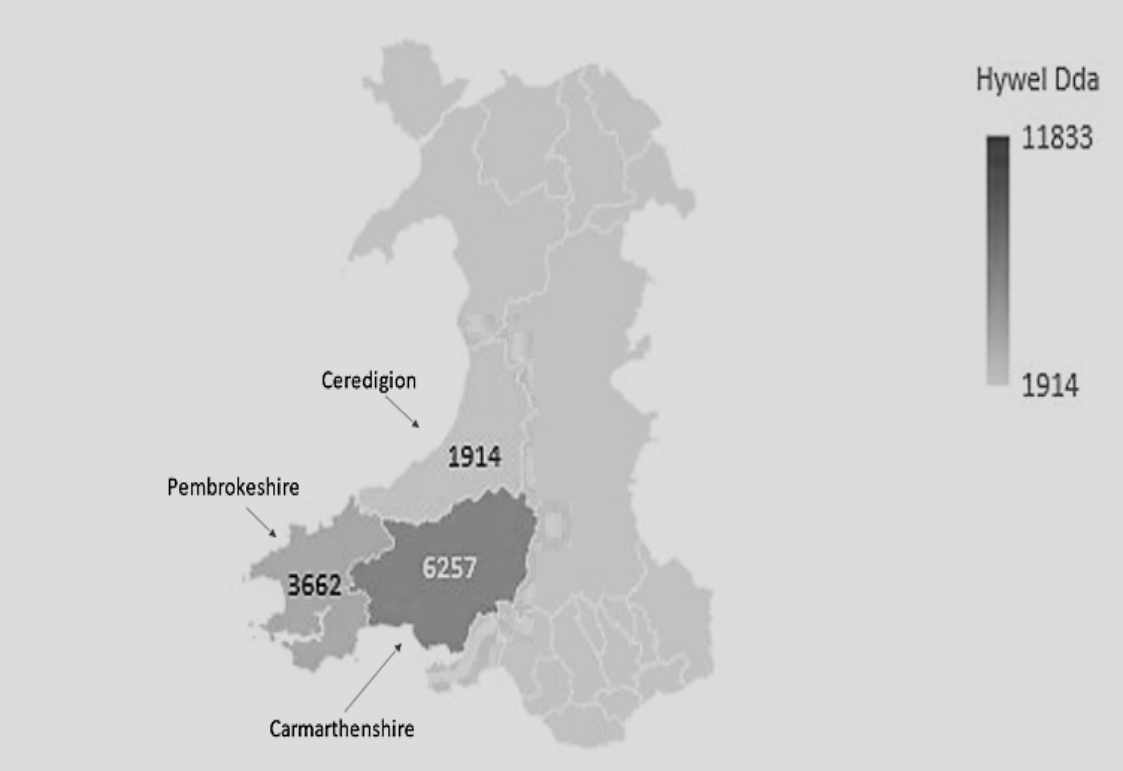
Our current workforce reality in summary, can be outlined as follows:

- We have workforce challenges
- We are working towards addressing these
- Our current position is unsustainable and
- Our approach is developing

Hywel Dda, as with all Health Boards across Wales faces a real challenge in delivering high quality, local services- delivered by its workforce. Moving out from the pandemic, we now see that it is a challenge that is exacerbated by other wider issues – financial, digital etc.

We know that the range of demographic, health and social care system design, quality, productivity and financial drivers and challenges that impact on the future workforce across the UK are more acute in Wales including the aging population (and aging workforce)[1].

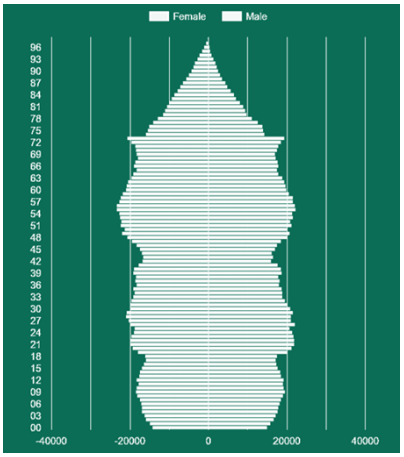
Whilst Wales struggles to recruit and retain in some areas, we also need to be mindful that 60-80% of the workforce for the next 10 years and beyond is already employed (NHS Wales – Key Themes and Trends, 2016); and issues we face nationally, with Nursing, General Practice (GP) and specific specialities, we also need to make sure that our workforce is designed to meet the ever-changing needs of our local population.



Population density and rurality play an important part in the delivery of care and access to an appropriate labour market.

The below Population Pyramid for Wales (2020) illustrates the growth that will follow in the 'aging' demographics for service delivery in the next 10 years. The average retirement of HDUHB staff since 2019 has been 61 years old, as such we will see an increase in retirements based on our workforce demography over the coming 10 years. Due to a smaller population in Wales of 10–20-year-olds it is also therefore expected that there will be a reduction in the potential workforce entrants to match those retiring from the University Health Board. That said we have been successful in attracting c15% of work workforce in the 16–20-year-old age profile which is suggested as higher than our local population of c12%.

We will continue to monitor demographic data for changes, as part of our work in 2022/23 we will undertake an analysis of the 2021 Census data. Of particular interest will be local data and the analysis being undertaken on National Health Service (NHS) which will explore the demographic and social characteristics of NHS workers; to increase understanding of the make-up of the NHS worker population and identify the social issues that are most prevalent for this population, such as housing, education, and health (ONS 2021).



Current state

As a University Health Board, we plan, organise, commission, and deliver healthcare for 393,600 people in Carmarthenshire, Ceredigion, and Pembrokeshire. Further managing and paying for the majority of care and support that people receive in hospitals, health centres, GP surgeries, dentists, pharmacists, opticians, and other settings, including within the community. The table below provides a high-level overview of the service model that the Health Board provides.

Facilities	Description
Four main hospitals	Bronglais Hospital in Aberystwyth
	Glangwili Hospital in Carmarthen
	Prince Philip Hospital in Llanelli
	Withybush Hospital in Haverfordwest
Five community hospitals	Amman Valley and Llandovery in Carmarthenshire
	Tregaron in Ceredigion
	Tenby and South Pembrokeshire Hospital Health and Social Care Resource Centre in Pembrokeshire
Two integrated care centres	Aberaeron and Cardigan in Ceredigion
Community Facilities	48 General Practices (4 of which are managed by the University Health Board)
	49 Dental Practices (including 3 orthodontic)
	98 Community Pharmacies
	44 General Ophthalmic Practices (44 providing Eye Health Examination Wales and 30 low vision services)
	Numerous locations providing Mental Health and Learning Disabilities Services
	Highly specialised services commissioned by Welsh Health Specialised Services Committee

Source: Hywel Dda University Health Board, Annual Report and Accounts 2020/21

Primary care services account for more than 90% of people's contact with the NHS in Wales, and we believe that this is representative of Hywel Dda. Primary Care encompasses General Medical Services (GMS), Community Pharmacies, General Dental Services and Community Optometry. Delivering cradle-to-grave care, these services offer holistic clinical care and deliver most of the care for the population across the whole health and care system. They are relied on within communities and are typically the first port of call. When it is unable to maintain the level of services to the population it has a profound systemic impact, with the capacity to undermine and destabilise the rest of the healthcare system. In addition to Health Board facilities, some staff, such as GPs, district nurses and therapists, pharmacists, optometrists, dentists, and support staff also provide care in people's homes.

Known Challenges

Our workforce is at the heart of our organisation; however, getting the right mix of skilled staff to provide our services is our biggest challenge. The risk of increased demand and an unsustainable workforce model is ever increasing; the pandemic and Brexit have placed new challenges on us (for example, mass testing and vaccination and diminished supply routes).

On 31st January 2022, the University Health Board employed 9,560.3 whole time equivalent (WTE) staff. Our current funded workforce is 10,549.7 WTE, resulting in a deficit of 989.3 WTE. These figures can be split across the following categories:

Category	Budget	Actual	Vacancies
Additional Professional Scientific and Technical	365.5	346.0	19.5
Additional Clinical Services	2,214.7	2,101.8	112.9
Administrative and Clerical	1,974.0	1,984.0	(10.0)

Allied Health Professionals	648.5	620.2	28.2
Estate and Ancillary	895.5	888.7	6.8
Healthcare Scientists	199.5	197.1	2.4
Medical and Dental	923.7	606.5	317.3
Nursing and Midwifery	3,316.1	2,816.2	499.9
Other	12.2		12.2
Total	**10,549.7**	**9,560.3**	**989.3**

Source: Establishment Control Tool January 2022

Contingent Workforce

We currently have an over reliance on contingent workforce due to the vast number of staff vacancies across each of the categories – particularly the clinical categories – each month. As we cannot recruit into these vacancies, despite various campaigns, this leaves a significant gap which is filled through short-term interventions – agency, bank, and overtime hours. During the 2015/16 to 2019/20 years, the University Health Board spent between £20-40m per annum on short-term agency staffing. This is calculated at between 5-10% of the total pay expenditure and has increased consistently each year since 2014/15. Between April 2020 and October 2021, the University Health Board used the bank and overtime equivalent of 500-1000 WTE, at a monthly cost of £5-17m (these figures were impacted during the pandemic).

Ageing Workforce Demographic

On 31st January 2021 60% of the total workforce number was over 40 years old, with 34% being over 51 years old, and 19.1% being over 55 years old. As there is an option for NHS staff to take early retirement from the age of 55 years onwards, this data demonstrates a significant risk to the workforce model, both now and in the near future (This is for existing staff as pension rules will change for new staff from 1/4/22 with a retirement age of 67 years of age).

Risks (associated with challenges)

Quality of care

Through the use of short-term locums and agency can come an instability and inconsistency in ways of working and communication. This can then lead to a decrease in the quality of all aspects of care – including safety, timeliness, equity, efficiency, effectiveness, patient-centred care. The lack of familiarity and understanding in local guidance, procedures, and policies as well as the fellow team members for that shift has significant impact upon the effectiveness of team working, patient flow, service development, morale, retention, staff development and recruitment.

Quality of the learning environment

With the temporary nature of locums and agency staff comes the difficulty to create a rich learning environment for trainees/students. When the locum is not a permanent employee it is less likely that they are committed to the teaching needs of the trainee/student. This potentially leads to less students/trainees choosing to train with us in the future due to previous ones giving a lower rating of the team/service/health board after a poor experience. This would have a detrimental impact on the future

workforce, as Health Education Improvement Wales (HEIW) could retract the student/trainee posts within our University Health Board, leading to a reduction in opportunities to promote the Health Board and to create a pipeline for the future workforce. Additionally, due to the developmental nature of registered and qualified clinicians, the consultants, nurses, therapists, pharmacists, and other HCPs will want to work within a Health Board that prioritises professional development and provides high quality education. Without this developmental environment there is likely to be a significant negative impact on recruitment.

Staff Well-being

In addition to the poor quality of experience, is the increased burden placed on our permanent staff to provide the education and clinical supervision of the trainee/student on placement within the Health Board. Rather than share the responsibility among a number of permanent staff providing an acceptable load, when the team is made up of a small number of permanent staff and reinforced with temporary staff, the responsibility cannot be shared, but remains solely upon the small number of permanent staff. Our experience aligns with research, which has found that locums enable healthcare organisations to maintain appropriate staffing levels and flexibility, but also gave rise to concerns about continuity of care, patient safety, team function and cost.

Difficulties to Develop Specialist Areas of Expertise

Our thinly spread specialist workforce means that it is generally more difficult for individuals to develop specialist areas of expertise as they all need to be generalist. This means that access to specialist expertise locally for the population and for consultant members of staff is reduced. This can lead to either a lower standard of care or more specialist advice being required from distant specialists in other providers. A thinly spread specialist workforce also leads to less peer support; less ability to be involved in educational and research activity; and less time to be involved in service development leadership activity, including both developing the specialist service within the University Health Board but also in developing its integration with community services. All these aspects would create an increase in competence and confidence, a sharing of skills and knowledge, gain a deeper and broader understanding, validation; all of which promote the retention of the current workforce. These points relate as much to senior/specialist therapies, diagnostic and nursing workforces as they do to the specialist medical workforce.

Impacts on Research

Activity in research is associated with higher quality of care, and innovation is required for continuous improvement. Locum, bank, and agency staff rarely contribute meaningfully to research or innovation activity, and permanent staff who are either thinly spread across sites or working alongside temporary staff often have little time to involve themselves meaningfully in research or innovation activity.

Impact on Investment and Care

Our ability to invest in additional resources, higher value activities and better technology, all of which has the potential to significantly improve our services, is reduced. More importantly, it also means that our care and treatment is more costly,

less joined-up and results in more variable outcomes for patients. This lack of continuity also has the potential to impact on the safety and quality of the health care services we provide. None of this is what we want for people living in our local communities.

Impact on Individuals

The challenges faced by the overarching workforce also significantly impact and take their toll on our individual members of staff. Trying to provide high quality, patient-centred health care services without a stable team made of the right numbers and right skill mix, but relying on a temporary and unknown workforce, is stressful and effects morale. This was seen to the extreme during the pandemic over the last two years, where workforce professions as a whole saw staffing deficits due to shielding and illness, meaning smaller teams were being stretched and having to rely on temporary staffing. This led to a number of individuals feeling 'burned out,' posing a risk through later absenteeism.

Immediate steps

Through our Health Care Apprentice programme and progressive recruitment, building on the experience gained by the 2,000 people we recruited on temporary contracts during the pandemic to give them long-term opportunities and strengthen our capacity. In the long-term we need to spend our allocation differently on workforce and reskill our staff to both support the community model and address gaps in secondary care, so that our staffing model is sustainable. We are in the process of developing our Workforce Plan for the 2022-2025 Integrated Medium-Term Plan. This will be a strategic workforce plan which will be looking at a supply and attrition model over ten years. This will illustrate our known and assumed workforce supply through various routes i.e., recruitment, education, and commissioning pathways through the HEIW, internal development programmes, alongside assumptions on how our workforce may reduce either through turnover, retirement or population decline and non-participation in the labour market, building a theoretical picture on our "likely" future workforce position over a ten-year period. It will be submitted to Welsh Government as part of the Integrated Medium Term Planning process. Given that it will be crucial for us to get our workforce right to deliver our Programme, this PBC and the Workforce Plan are closely linked.

The Health Board is also targeting deprived geographical areas/ensuring geographical inclusion. Low-band jobs are currently heavily oversubscribed, so the social value rewards to be had by redistributing these towards the residents of deprived postcodes are limited. However, as the geographical analysis of the workforce described in the main document reveals, there are opportunities to develop more targeted approaches with respect to the most deprived Lower Layer Support Output Areas (LSOAs). This type of activity could be undertaken in conjunction with other public sector anchor organisations across the three local authority areas to effectively create an internal health and care labour market.

Additionally, the Workforce and Organisational Development Directorate is investigating the recruitment pathway for different demographic characteristics: In terms of the University Health Board's overall recruitment approach, it may also be

revealing to look not just at the profile of the existing workforce and how it changes over time, but also to analyse by geography and demographic characteristics the various stages of the recruitment process – applications, shortlisted, and successful. This could reveal if there are any process barriers relevant to different parts of the population.

Our Health Care Apprentice programme, also known as the Apprenticeship Academy (Academi Brentisaeth), has aimed to increase the number of registered nurses to fill vacancies within the Health Board by offering an affordable route into nursing. The programme employs individuals from the age of 16 upwards, without requiring any specific previous qualifications. During the first two stages of the programme, an apprentice goes through a Foundation Apprenticeship in Health Care Support Services (level 2) and an Apprenticeship in Clinical Health Care Support (level 3) through the partnership with local colleges. Then the apprentice moves on to embark university life, on a part-time basis (starting at level 4). When an apprentice finishes the programme, they gain their nursing qualification and can apply for their PIN to become a Registered Nurse (RN). While most organisations offering apprenticeships offer a 12-month level 2 apprenticeship with no guarantee of employment at the end, the Hywel Dda Health Care Apprentice programme allows apprentices to progress through levels 2, 3 and 4 through a managed programme of assessment and development. The Health Board employed 53 apprentices in the first year of the programme, and 77 in the most recent wave. We received 637 applications in 2021. In the first year 53% of those offered jobs were Welsh-speakers and 17% of those offered were male (which significantly exceeds the 7.8% ratio for male nurses in Hywel Dda). Whilst in the first year most applicants were aged 16-21, in the second year many have been in their 30s and 40s. A number seem to be coming from the hospitality sector, perhaps a reflection of the impact of Covid 19.

The success of the Apprenticeship Academy in the area of nursing has led to the development of apprenticeships in other areas, such as digital services, engineering, and corporate governance. Also currently being explored is a bespoke apprenticeship programme for people with disabilities. In addition to apprenticeships as an accessible pathway into employment with the Health Board, a number of “Grow your own” initiatives have been developed which are designed to help the existing workforce progress and become more flexible - for example by enabling nurses currently working in non-acute areas to move into acute areas. One of the many ways we are increasing access locally to the clinical profession is working with Aberystwyth University to develop part time courses in nursing and therapies (physiotherapy, speech, and language therapy etc). Previously, to access such courses, people were obliged to go to Cardiff or Bangor, which inevitably undermined our ability to develop those skills locally. In addition, hundreds of current staff are accessing a variety of courses to enable their progression to higher paid roles. These include, for example staff working as porters who are given access to courses in IT, as well as supervision and management skills to support them to progress into administrative and clerical roles. We are also keen, with HEIW support to consider the use of medical apprenticeships. For certain apprenticeship programmes, geographical exclusion might currently be a factor. While nursing apprenticeships take place at a range of locations, a lot of

corporate services are based in Carmarthenshire. There are indications that the majority of apprentices entering into these apprenticeships for example digital services, are themselves based in Carmarthenshire. There is therefore a need to ensure that there are opportunities for different kinds of apprenticeships for residents of all districts, to tackle this geographical imbalance. A quantitative analysis of the profile of applicants and successful candidates to the apprenticeship programmes will be of value in this respect, to provide a baseline and assist in future targeting. We have also identified a potential to extend the successful apprenticeship approach to mental health and to develop innovative multi-skilled apprenticeship pathways, which will contribute to our ability to provide whole-person care. Discussions are also underway with our County Council colleagues around the introduction of an integrated Health & Social Care apprenticeship. Details are being finalised, with a view to recruiting the first cohort during 2022.

During the peak of the pandemic the Health Board recruited approximately 2,000 people from the local population into newly created temporary posts, covering roles from cleaners, porters to healthcare support workers. While traditional person specifications for many of these roles might have included criteria such as “experience of being a carer” or “working in the NHS”, the decision was taken this time to focus on values and behaviours. This opened up opportunities to a large number of individuals working in sectors suffering from the pressures of lockdown, for example the hospitality industry. A strategic decision was also taken not to recruit workers from the local adult social care sector, to avoid destabilising this sector.

We are undertaking various initiatives to transfer as many of those on temporary contracts into permanent positions as possible and undertaking a wider programme of work around reviewing person specifications for jobs. This has involved redesigning specifications to make them less intimidating for local applicants by, for example emphasising the requirement for certain kinds of experience rather than a Master’s degree for band 7 jobs that officially require one. We also have initiatives in place to promote recruitment among particular under-represented groups. An example of this is prior to the pandemic we were working with All Wales People First, an umbrella group of self-advocacy groups for people with learning disabilities, to identify vacancies for individuals with learning disabilities who may be excluded by the current electronic application process. This work has been interrupted by the pandemic, but we intend to re-start it. A further set of initiatives is being carried out with various external partners, including DWP (Jobcentre Plus) and Careers Wales, and aim to support individuals who are Not in Education, Employment or Training (NEETS) and the unemployed through traineeship and engagement programmes. These provide work experience, combined with employability skills training and support to complete applications. If the individual has done well, they are invited to join a “talent pool”, which means they can be treated as an internal candidate and guaranteed an interview when applying for a post.

Understanding business needs

It has been established that the configuration of services for Mid and West Wales needs to change to meet our population’s needs over the next 20-30 years, which has been considered and developed as part of our Health and Care Strategy. However, to

make a generational shift to a wellness system there is a need to invest in primary and preventative care, whilst simultaneously investing in a community model. The current workforce model does not support this, and clinical rotas require significant resource.

To address sustainability issues across our workforce, a pre-emptive approach must be taken to facilitate joint working with primary and community care and bringing care to community settings and therefore closer to people's homes is crucial to improving the health of future generations. To achieve the organisation's vision, as described in the PBC, it is now essential we seek to understand in greater detail the impact and resource needed to deliver the following:

- A new Urgent and Planned Care Hospital, with design separation between planned and urgent care to enable us to ring-fence and reduce waiting times and respond to unscheduled care.
- Repurposing of Glangwili and Withybush Hospitals as community facing facilities to maximise the opportunity to maintain people in their own homes, including a range of diagnostic and outpatient services.
- Improving the estate for both Bronglais and Prince Philip Hospitals and our community facilities to support the right care at the right time, in the right place with the goal of increasing time spent at home and improving the experience of those patients whose needs can only be met in the acute setting.

Design Principles

The following outlines the principles that we must establish our workforce requirements around (taken from the PBC). It is now imperative that we carefully consider each of the design principles, to plan the workforce required to deliver each of these and to be in a position to articulate our future workforce needs:

- ✓ We must invest in non-medical models of service delivery where that is appropriate e.g., therapist led and delivered rehabilitation in community hospitals, stroke rehabilitation near to the patient's home, led and delivered by experienced therapists linking with the acute stroke team through videoconferencing, community support networks.
- ✓ Appropriate access to appropriate treatments; facilitated by preoperative care and outpatients delivered in the community, segregation of planned and urgent care and co-ordinate "re-ablement" and recovery.
- ✓ Minor Injuries Units (MIU's) should be nurse led with no reliance on medical staffing other than in Community Hospitals where they will have GP input.
- ✓ We will expand our numbers of Advanced Nurse Practitioners/ Advanced Therapy Practitioners/ Non-medical Consultants; increasing their competence and accountability to facilitate them being part of on-call rotas in agreed specialties [ensuring access to specialist opinion at a more local level and to ensure sustained services].
- ✓ Continued development of new roles - Advanced Nurse Practitioners, Consultant Therapists and Nurses, Physician Associates, Assistant Practitioners.

- ✓ The consultant medical workforce should not be locally singlehanded in any speciality; we must use collegiate and local and regional networks to deliver this principle.
- ✓ When patient consultations are being considered, we should deliver these close to home using telemedicine and virtual consultations; this may be provided in a local hub or community hospital to overcome technical challenges. This means that a patient will be able to speak to the clinician from their own home or a local community hub without the clinician being there. Instead, they will talk to them via a television or tablet screen.
- ✓ Use of community assets and social prescribing to 'Grow the Green' - supporting communities to support one another and develop non-health models to build resilience and take control of their own health and behaviours.

Assumptions

The organisation has talked about the fact that we cannot continue to provide services in the same way; we also know that our local population has concerns about some services and how they access them, and we know that some services cannot cope with the ever- increasing demand e.g., accident and emergency.

By looking at what has worked elsewhere and at models of community based, planned and emergency care (Northumbria, Somerset, Scotland, Christchurch, and others), and review of national and internationally published best practice from respected organisations including the Kings Fund and Community Benchmarking. We now need to focus our workforce requirements around the following key areas, to understand the implications and future needs as we seek to redesign our workforce:

- ✓ **Shift of activity from A&E to MIU – 30%** [based on current presentations in A&E that could be handled in an MIU setting]
- ✓ **10% demand reduction** [offset against demographic growth and therefore depending on time period modelled may not necessarily lead to a real term reduction in attendances]
- ✓ **MIU's will be open from 08:00-20:00 on all sites other than community hospitals** which will run a 24/7 service
- ✓ **90% of outpatient activity [new and follow ups] will be managed within the community**. There will be a number of models for this shift including consultant sessions, telemedicine, GPs with Special Interest (GPwSI) and nurse and therapy led sessions
- ✓ **Some patients will go straight from an MIU into a community bed** [anticipated to be low %]
- ✓ **50% reduction in emergency admissions for ambulatory case sensitive conditions.**
- ✓ **60% of emergency admissions** to an urgent care setting [not step-up beds] would be **discharged/ transferred within 72 hours**
- ✓ Of the **60% being discharged /transferred above, 50% would need some time in a community bed.**
- ✓ **Length of stay is based on median average for the peer group**

- ✓ **50% shift in day cases** into community for **medical specialties**

Our Workforce Ambitions

The Nuffield Trust wrote that the NHS needs to change from an illness-based, provider led system towards one that is patient led, preventative in focus and offers care closer to home. Whilst the Welsh NHS Confederation[2] acknowledged we needed to bring about a fundamental shift, from a service that treats ill health, to one that supports people to maintain health and wellbeing and live as independently as possible – "A Social Model of Health and Care."

This means we need to look at who is best placed to manage and support patients in this new model of care; we know that support workers and non-medical professional workforce provide opportunities to support patients to manage chronic disease more efficiently and effectively. Therefore, there is an urgent need to reshape the workforce and provide relevant skill sets, including a skill set that ensures the workforce are proficient in the use of digital technologies [the Kings Fund recognises that this is one of the most important things to move to a new model of care].

Furthermore, it is imperative that we focus on creating a system and workforce with greater emphasis on primary and secondary care services, moving away from our traditional way of thinking which has predominantly been focused on hospital-based care. To achieve this, new models of care, integration and alignment of primary and acute care systems will facilitate the need for a "generalist" approach, which will be achieved through co-ordination across our organisational boundaries.

It is our ambition to explore and gain clarity on what this will mean for our workforce, which will be achieved through collaboration and strategic workforce planning activity. This work is essential and will allow us to understand our true future workforce requirements, including the required investment in education, training, and development needed to deliver a highly skilled multidisciplinary workforce based on the needs of our local population and our strategic vision.

Service & Role re-design

It is clear that we must review and rethink the way we do things, to attract more highly motivated and skilled people to work within the organisation. It is also important to look at current workforce to explore the opportunities for new ways of working and to address our current workforce pressures. To achieve this, we will seek to continue actively engaging with services, exploring their current and future workforce needs through a strategic lens and using workforce planning interventions and methodologies.

Emphasis will be placed on service and role design, to ensure that changes are made in a way that promotes employee development and promoting their ability to work to their full potential. Through the work that has, and will be continuing to be undertaken, using mechanisms to ensure service and role design activity that is based on current

[2] Building a Vision for NHS Wales, 2016

and future service requirements which will be prioritised, to provide assurance for future workforce sustainability.

We are actively, and will continue to explore, concepts of “Team around the Person/Patient” in acute settings and “Team around the Family and Child” in community and wider social models of health. This will continue to build on the introduction of new workforce roles, for example Family Liaison Officers (FLOs), Psychology Assistants, Physician Associates, as well as including training some professionals to become advanced and extended practitioners in primary care and community services.

We will continue to implement a competency-based approach across workforce planning and development activity, which can help support skill mix issues, improve job satisfaction and will allow the organisation to continue developing new and existing roles. This approach will continue to benefit the whole healthcare team across all areas of the organisation, through provision of opportunities to challenge and change established roles and ways of working, to generate greater opportunities and benefits for our staff and service users.

We also aspire to build and continue the success in implementing the “Grow Your Own” workforce philosophy across all professional groups, which will be fundamental to ensure the organisation can attract and retain staff, with clearly defined development pathways and learning opportunities. This will allow for continued professional development and promotion of multi-disciplinary working. We will also build on the success of many other initiatives such as the Primary Care Pacesetter programme for Physician Associates. This will include a rotational model across secondary care provision, a joint induction programme for health and social care as well as “bespoke” training modules with social care and carers to build specific competencies such as “wound care”. Also seeing the creation of new roles such as the Surgical Practitioner and other roles aligned to the “Assistant Practitioner” role design model.

It is also imperative that we seek to understand and prioritise areas of greatest vulnerability, which includes the requirement to bolster our primary care workforce, ensuring it is sustainable moving forward. Their role is explicitly to improve the health and wellbeing of the whole local population, promoting effective self-care to prevent avoidable health problems. Also, to diagnose, treat and care for individuals with the professionals ‘wrapped around’ the patient and their family.

Education & Commissioning

It is vital for us to deliver our education strategy to develop and expand our workforce to align with strategic vision, and to build a sustainable workforce fit for the future. With the training, education and development of both our current and future staff is critical to deliver against the Health Board’s aims, strategies, goals, and visions. Therefore, it is important for us to understand our workforce and its future needs through:

- Appropriate commissioning and provision of undergraduate and postgraduate placements

- Introduction of new, and delivery of, existing training and education programmes
- Provision of greater opportunities for training, education, and skills development for current and future staff
- Exploration of new ways of working, building a multidisciplinary workforce which is able to meet the needs of our local population
- Working collaboratively to ensure our education strategy is based around the Social Model of Health, with underpinning education and training to support this vision.

Continued coactive working with HEIW and Higher Education Institutes (HEIs), will play a fundamental role in delivery of the education strategy to facilitate the learning requirements for our workforce. It is also essential for us to continue building on partnership workforce planning on a local, regional and national level. To provide greater understanding of our staff and developing them appropriately to meet future and ever-changing needs. Through robust workforce planning processes, further assurance can be provided to ensure the organisation has considered its future requirements to deliver the PBC, ensuring appropriate training and education has been commissioned to support employee development and to attract and retain new graduates.

The Health Board's commitment to expand and re-design the multi-professional workforce underpins the Education and Commissioning ask of 2023/24. With training and development plans delivered on a sustainable basis, striving for excellence with the overall ambition of improving on patient outcomes through enhanced seamless pathways. We will continue to build on this commitment as we move forward and seek to sustain our workforce to create a more dynamic skill mix and focus on integrated working across Health and Social Care.

Cultural & Compassionate Leadership

We also need to look at our organisations nationally; we know that creating 'learning organisations' is of real importance[3], whilst trusted relationships between people and professionals is also critical. The Royal College of Physicians (RCP)[4] also noted that we needed to show national leadership on the balance between service and training, and that organisations need to invest in research, innovation and data collection.

We have been on a journey to embrace the ethos of compassionate leadership and cultural change fitting the world we now work and live in. We have embraced this through the role of Organisational Development Relationship Managers – one facet of our approach to shifting our cultural paradigm alongside extensive leadership development initiatives on a system and local basis, and our aspiration is for our staff to be able to experience what a great day at work feels like. To achieve this, we are committed to listening and learning from the experiences of our staff as we develop our culture together. We want our leaders to embody compassionate behaviours,

[3] Primary Care Workforce Commission 2017
[4] Response to the Inquiry into the sustainability of the health and social care workforce – 2016; RCP

based on the Compassionate Leadership Principles for Health and Social Care in Wales (based on the work of Michael West and the Kings Fund 2014-2022).

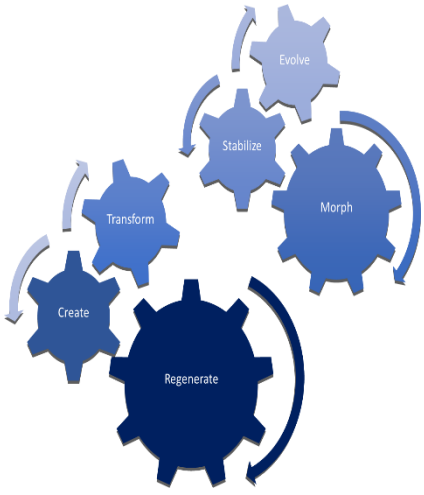
Engaging with our Community and Teams

Hywel Dda has embarked on a challenging programme to ensure sustainability of health and social care services for the population. We acknowledge that services may change location, be co-located or be redesigned and we know from our engagement sessions in 2018 that the local population supports a shift to more community-based services delivered by a more flexible, multi-skilled workforce. People are happy to be treated by nurses, therapists and other non-medical staff if sufficient training and education is undertaken as part of the development of new roles, and if the public are informed on the abilities of these staff and the new ways of working.

To meet these expectations, we must ensure we have a flexible and adaptable workforce that is competent, confident, and engaged. They will need different skills and competences to deliver care using new models, focusing on increased proactive care, and supported by technology, allowing them to work differently. We have been incredibly successful in moving forward in this arena examples include the Attend Anywhere, development of the “Blue Team” (Pembrokeshire) as well as development of new roles/teams as a response to Covid 19 e.g., HCSW Immunisers, Long Covid Service etc.

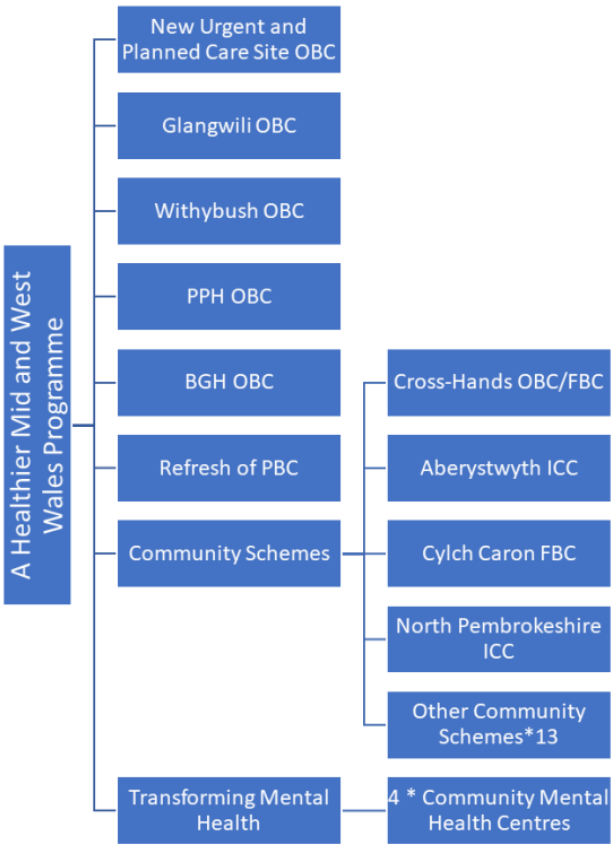
However, we are transforming services and our workforce in a challenging environment; the Health Board continues to face significant financial pressures; struggling to recruit new employees in some professional groups and has great reliance on temporary staffing, impacting on finances and quality. Therefore, we need to escalate the workforce agenda and create true workforce transformation, working with operational services to deliver innovation and support our aspiration to be an employer of choice.

Workforce planning and workforce development will be a pivotal part of our workforce programme. We are working at developing our ways of knowing how to access intelligence to identify and meet the changing needs of our local population; supporting our workforce to adapt to new ways of working as we introduce technology, scientific advancement and new skills into new models of care delivery. We know that this will not be a “straight line” from A to B; this will be an iterative and development journey working with partners, professionals and our local population to evolve this future together. We will be working towards stabilisation of fragile services, evolution of new roles and transforming how we work – this will mean a metamorphosis for some or new creations for others, ultimately working towards regenerating our health and social care workforce.



Future vision

Hywel Dda's 'A Healthier Mid and West Wales Programme' sets out the below transformational programme which will all have interlinked workforce implications.



This includes an Implementation Plan comprising of:

• A new build Urgent and Planned Care Hospital in single phase construction available by Winter 2029.

• Concurrent with the new Urgent and Planned Care Hospital, deliver new build community hospitals in Carmarthen and Haverfordwest also by Winter 2029.

• Once the Urgent and Planned Care Hospital and two new community hospitals are operational, reconfigure Prince Philip Hospital by Winter 2032.

• Bronglais General Hospital is reconfigured concurrent with the new Urgent and Planned Care Hospital by Spring 2031.

• Phased rollout of construction/repurposing of the network of community hubs to be completed by end of 2029.

Workforce Implications – Proposal B+

Overview of Workforce Impact

The options within this paper explore the immediate known service changes that may happen and the likely responses to those changes from a workforce perspective. Below we look at what these impacts will look like.

Recruitment

Through these proposals, we anticipate an increase in our permanent staff and a reduction in temporary staff. We will have a community focused workforce and will reduce the number of medical rotas we need, as we provide medical care focussed on fewer sites. We will have increased service provision [especially in preventative and well-being services], and new builds which will require compliance with safe staffing levels and service provision delivered across increased numbers of sites.

Relocation

Changes of location of services, either from new build or re-configuration of services, this will require some level of movement of staff. At present, until pathways are further developed, we are unable to measure the exact numbers of staff affected with absolute accuracy. We have assumed throughout the paper that there will be no change in staff administrative bases [ancillary staff, hotel and estates staff are remaining where they are] until we have a greater understanding of estates impact and where these vital support staff are best placed to work alongside their clinical colleagues. (Especially as we are currently undertaking an “agile working” assessment” which may have wider implications).

Education and Training

As roles changes and services reconfigure, we can see an increase in requirements for new roles and development of competences of current staff. However, until service redesign take place it is not possible to judge the full scale of requirements. We are committed to working within our established EAGLE framework to develop innovative competency-based roles that meet the needs of the local population. We will continue to work closely with social care, the voluntary sector and education partners as the agreed care models evolve.

Change

Change in any form, can be difficult to adjust to; we are alert that there will be possible changes for a large number of our staff. These changes may include location, role, increased competences and skills; all our staff will be supported with these changes by our Workforce and Organisational Development Team. Our Organisational Development Relationship Managers are in post and with other key workforce colleagues will be supporting and facilitating change and transition.

We anticipate eradicating agency, locums, and temporary staff, and foresee different types of roles than currently, and roles which may be expanded/extended or new and are delivered in a different way.

Workforce by Site

The table below shows the breakdown of staff by professional group based on headcount and by hospital site as of 31st January 2022. This gives us an indication of the number of staff likely to be impacted to some degree by the changes in the proposal [some staff may not be directly affected by the changes but may see a different career pathway or a change in competency expectations moving forward].

Staff Group	Aberaeron Integrated Care Centre	Amman Valley Hospital	Bronglais Dist Gen Hosp	Cardigan & District Hosp	Cardigan Integrated Care Centre	Glangwili General Hospital	Llandovery Hospital	Prince Philip Hospital	South Pembs Hosp	Tenby Cottage Hosp	Tregaron Hospital	Withybush General Hospital	TOTAL
Add Prof Scientific and Technic	9		31	1	1	97		77	2		2	84	304
Additional Clinical Services	18	26	284	4	19	630	17	418	67	8	23	454	1968
Administrative and Clerical	11	4	241	6	6	611	1	340	26	6	4	411	1667
Allied Health Professionals	9	2	90	5	25	215	2	106	12	10		148	624
Estates and Ancillary		14	178	8		345	10	218	35	4	5	257	1074
Healthcare Scientists			34			75		52				47	208
Medical and Dental		2	98	2		254	5	114			4	142	621
Nursing and Midwifery Registered	36	19	323	17	33	919	15	532	46	19	22	526	2507
Grand Total	**83**	**67**	**1279**	**43**	**84**	**3146**	**50**	**1857**	**188**	**47**	**60**	**2069**	**8973**

Based on 2018 assessment, we have seen approximately a 10% increase in headcount across all sites.

The table below looks at the current function of each site, any known function changes and what that might mean for the workforce specifically and generally.

Name of Facility	New Function	Existing Function	Function Change	Workforce Implication
Bronglais General Hospital	**District General Hospital**	**Local General Hospital**		Workforce implications are focused on enhanced skills and extended and expanded roles to support continued care delivery New ways of working will include nurse consultants, extended scope practitioners and MDT rotas
Prince Philip	**Local General Hospital**	**Local General Hospital**	Outpatients [up to 90%] shifted to community settings	There are c25 nursing and HCSW staff working within outpatients – consideration will need to be given to where outpatients will be delivered
Glangwili	**Community Hospital** ✓	**Local General Hospital**	No longer provide urgent care	There are c85 staff across Accident and Emergency who may be impacted as emergency services will not be provided on site. Additional staff who

				currently work on a rota basis from other service areas will also be affected. There will be opportunities for these staff as we reconfigure services, providing emergency care in a range of community and hospital-based services. There are Speech and Language Therapists who may be affected by the loss of elective surgery [although many allocated to rehabilitation] Pharmacy presently has c65 staff – of which some staff may be affected by reduction in elective surgery and change of A&E to MIU There are c80 staff across ITU who will be affected, with opportunities to work across other areas and sites
			90% shift of outpatients to community setting	There are presently c45 staff supporting the outpatient department- this number may be affected by the shift in outpatient activity to alternative environments, or through the use of technology to support virtual consultation
			No in-patient surgical activity on site	There are approximately 360 staff currently working within surgical departments.

				Additional staff who currently work within other service areas may also be affected e.g. plaster technicians. These may be impacted through adaptation to day case surgery only: however, this will be worked up in more detail as our thinking develops. There will be opportunities for current staff as services are reconfigured to provide surgical activity in other locations including the new build.
				Relevant workforce plans will need creation and implementation to meet the reconfiguration of services provided on site i.e., dependent on size of Accident and Emergency and MIUs and number of wards [and how many beds] Staff from Glangwili and Withybush may see this as a suitable site for re-location and they will be supported to achieve this through our organisational change processes
New Build	**Major Urgent and Planned Care Hospital** ✓ Full A/E ✓ Beds in all specialities [including subspecialties e.g., ENT etc]	**n/a**	Reconfiguration of Accident & Emergency to a Minor Injuries Unit	C165 staff working in the current Accident & Emergency Units in WGH and GGH will be affected by the change in use. Additional staff who currently work on a

	✓ Diagnostics – CT, MRI, U/S etc ✓ Paediatrics ✓ Neo-nates ✓ Consultant led maternity ✓ Level 1,2,3 ITU ✓ High risk elective surgery ✓ Level 2 HDU with pretransfer ability to manage Level 3			rota basis from other service areas will also be affected. There will be opportunities for these staff as we reconfigure services, providing competence-based emergency care in a range of community and hospital-based services
Withybush	**Community Hospital** ✓ Day cases ✓ MIU ✓ Step up, down and rehab beds ✓ Diagnostics	**General Hospital**	No inpatient elective surgery [day case only]	There are c200 staff currently working within the surgical department, working in theatres and wards [surgery and trauma and orthopaedics]– these may be impacted through adaptation to day case surgery only; however, this will be worked up in more detail. Additional staff who currently work within other service areas may also be affected e.g. plaster technicians. There are Speech and Language Therapists who may be affected by the loss of elective surgery [although many allocated to rehabilitation] Pharmacy presently has cc60 staff – of which some staff may be affected by reduction in elective surgery and change of A&E to MIU

				There are 42 staff across ITU who will be affected, with opportunities to work across other areas and sites
			Increase in outpatient activity [90% shift from other sites]	There are presently 39 registered nurses and HCSW in outpatients – numbers may be affected by shifts in outpatient activity
			Other	Assuming similar numbers of rehabilitation beds so have not adjusted physiotherapy/ OT and rehabilitation ward staff **Bed Reconfiguration** – there are c200 staff who work in medicine and will be affected by change in bed usage and reconfiguration of A&E to MIU [reduction in emergency admissions] although dependent on re-usage of beds these staff may enhance skills There are hotel facilities staff who may be impacted to some extent dependent on staff numbers working at hospital and services provided.
			Provision of an MIU	Will require Enhanced and Advanced Nurse Practice roles to manage MIU.
Llandovery	**Community Hub [Health Beds, MIU]** ✓ Beds [step up and down and rehabilitation]	General Hospital	Increase in outpatient activity	Need to allocate nursing, therapy and HCSW staff to outpatients to meet increase in activity

	✓ MIU ✓ X-Ray ✓ PoC testing ✓ ? MLU		Bed reconfiguration	Unsure of impact at present – staffing for present beds support rehabilitation
			Provision of X-Ray	An allocation of staff from Radiology will be required to support MIU on a daily basis.
			Will be a therapy led unit with GP input to provide medical cover as needed.	Workforce plans will be needed in resourcing and skills development as opportunity to develop new models including the use of Assistant Practitioners could be considered as we look to develop a multi skilled workforce.
Aberystwyth [new site]	**Community Hub [No Health Beds, no MIU]** ✓ Integrated Community Resource Teams ✓ X Ray [not OOH] ✓ PoC testing	n/a	All beds consolidated BGH site and focus on community resource teams Possible increase in our patient activity – to be assessed	Unlikely for there to be any staff impacted but requires further exploration and assessment of any "new roles" Estates and facilities staff impact to be reviewed
Amman Valley	**Community Hub [Health Beds, No MIU]** ✓ Rehabilitation beds ✓ Step down beds ✓ X Ray [not OOH] ✓ PoC testing	Community Hospital	Shift of beds from acute to community settings	Recruitment plan needed [see existing business plan and recruitment plan]
Cylch Caron	**Community Hub [Health Beds, No MIU]** ✓ Rehabilitation beds ✓ Step down beds ✓ X Ray [not OOH] ✓ PoC testing		X Ray provision No health inpatient beds	60 registered nurses and HCSW work on wards currently. There are a number of therapists [OT, SALT and Physio] who may be impacted by the proposed changes
South Pembs/ Hospital	**Community Hub [No Health Beds, No MIU]** ✓ Assisted living beds ✓ Community Resource Teams		Increase in outpatient activity [90% shift from other sites]	An increase in registered nurses to meet needs.

	✓ Some outpatient and specialist services [renal dialysis, chemotherapy]		New build - will need to understand model of care for delivering outpatients e.g., will they be nurse/therapy led, will they be provided on a sessional basis	Will need workforce plan for model of care and potentially recruitment plan for carers for assisted living beds and agreement on GP visitation
Pentre Awel	**Community Hub [No Health Beds, No MIU]** ✓ Assisted living beds ✓ Community Resource Teams ✓ Some outpatient and specialist services [renal dialysis, chemotherapy]		Geographical placement of staffing bases from which to deliver care in people's homes. May be used for outpatient session but no permanent outpatient staff needed	No anticipated staffing implications as considered as geographical placement of staffing bases from which to deliver care in
Cross Hands	**Community Hub [No Health Beds, No MIU]** ✓ Integrated Community Resource Teams		Increased outpatient activity	An increase in registered nurses to meet needs if established model to be used
Cardigan	**Community Hub [No Health Beds, MIU]** ✓ Integrated Community Resource Teams ✓ X-Ray ✓ MIU ✓ PoC Testing		X Ray	To be provided in a consistent standardised manner to meet MIU needs
			MIU	Will require registered nurses including Enhanced and Advanced Nurse Practice roles to manage MIU.
			Geographical placement of staffing bases from which to deliver care in people's homes. May be used for	No anticipated staffing implications as considered as geographical placement of staffing bases from which to deliver care in people's homes.

			outpatient session but no permanent outpatient staff needed	No anticipated shift in administrative staff presently using building
Minaeron	**Community Hub** **[No Health Beds, No MIU]** ✓ Integrated Community Resource Teams			

Risks and Opportunities

We recognise that the transformation across our population will come with a series of opportunities and risks for us and our workforce that we will need to manage throughout the process of transformation. Early identification of these risks and maximising the opportunities the proposals offer will support us to deliver the re-designed sustainable services and maintain quality.

Risk	Impact	Mitigation
Increase in MIU facilities	Increased need for staff with emergency department skills Increased need for X Ray facilities to match MIU provision	Detailed workforce plan to be developed to include: Expansion of skills of MIU nurses to meet needs in majority of cases Increase number of non-medical prescribers Ensure sufficient numbers of radiographers [increased use of remote reporting to free up capacity] Development of telemedicine and reporting to support static staff
Increase in need for extended and expanded roles	Insufficient numbers of upskilled staff in relevant areas e.g., outpatients, MIU/AE, ITU will prevent consistent care pathways at all time	Detailed workforce plan to be developed to include: Early identification of numbers needed Early development of internal training programme [using EAGLE] as required

		Early liaison with educational institutes re: commissioning of relevant courses Development of alternative education packages e.g., remote learning etc.
High numbers of staff affected by reconfiguration of Glangwili and Withybush	Increased risk of higher numbers of staff leaving	Detailed workforce plan to be developed to include Early engagement Opportunities for staff implemented Optimised role reconfiguration including training opportunities Increased communication led by clinical leads Organisation change plan to be developed
Inability to recruit to new urgent and planned care build to meet bed number requirements	Inability to staff new build and/or risk of being unable to staff remaining services in other facilities	Detailed workforce plan to be developed. Organisation change plan to be developed Detailed recruitment plan to be developed Routes for recruitment developed

Opportunities		
Opportunity	**Potential**	**Maximise**
New builds – attractive for recruitment	Staff may be encouraged to join Hywel Dda based on being able to work in a state of art new facility or a repurposed community facility closer to home	Use new builds and re-purposed facilities in recruitment campaigns Regular local focus on developments – possible blogs in local papers, etc.
New roles- opportunities for career advancement and development	Staff encouraged to expand competences and skills quicker than if working in a large urban hospital as small size means greater requirement for people to be highly skilled e.g., opportunities for critical care extended skills on wards etc.	Develop a comprehensive training and development catalogue/ opportunities Ensure PADR are completed as per policy to ensure we are sighted on people's career direction and training needs

		Complete regular Training Needs Analysis with service leads
Modernised Services – supporting infrastructure - new ways of working	Use of technology in self- care management, virtual consultation and staff logistics ensures that patients are supported to maintain well-being and manage their long-term illness, releasing staff to manage more complex, less able patients. Use of technology offers staff the opportunity to increase face to face clinical time, increasing job satisfaction	Work closely with Lead for IT and technology Ensure there is a well-developed digital and workforce roadmap Explore opportunities for greater use of technology with service users
Use of EAGLE framework – already in place to support enhancement of skills/competences and extended roles	EAGLE offers a fantastic opportunity for innovative role development and expansion. The continued use of this offers assurance that competences are maintained [as aligned to requirements]	Continued use of EAGLE to expand and extend roles as needed by service and as deemed safe by clinicians, educational bodies and assessors
Risks		
Risk	**Impact**	**Mitigation**
Staff leave [too far to travel or role has changed too significantly]	Staffing numbers may reduce at a critical stage of change Unable to deliver services due to insufficient safe numbers [no consistency across delivery] Continued reliance on temporary staffing	Early engagement with staff on changes Opportunity for career progression, increased competences etc. to encourage staff to stay Early identification of competences needed to deliver proposed services Continued targeted recruitment campaigns Continue to encourage retirees to return to work Support packages for staff linked with changes to work base.
Unable to recruit sufficient staff to manage standardised services	Unable to deliver services due to insufficient safe numbers [no consistency across delivery]	Continued targeted recruitment campaigns

	Continued reliance on temporary staffing	Maintain high level of workforce development planning aligned to recruitment, development and education activity as set out in this paper Opportunity for staff to develop into new and enhanced roles
Unable to manage unscheduled services across multiple sites – rotas	Unable to deliver services due to insufficient safe numbers [no consistency across delivery] Continued reliance on temporary staffing	Continued development of expanded and extended roles Increased competence of nursing and therapy staff to manage greater acuity / need Development of MDT On-call rotas
Attraction for and compliance with FY1/2 Deanery placements	Removal of FY1 and 2 posts Unable to attract future senior staff from FY1/2 groups	Work closely with Deanery to ensure compliance Develop rotational post across sites to ensure level of experience needed
Poor development of supporting infrastructure e.g., telemedicine – impacts on ability for workforce to deliver role	Unable to deliver new care models as workforce unsupported with necessary technology e.g., virtual consultation	Ensure there is a well-developed digital roadmap Work closely with Lead for IT and technology
Staff objection to changes in workforce patterns, locations, roles etc.	Poor change management Nonacceptance of new roles/ new locations	Continued engagement and involvement of trade unions and all staff.
Poor change management Increased level of leavers	Staff dis-engaged from process and not willing to consider options etc.	Early continuous engagement with all staff Continued communication through roadshows, blogs, newsletters etc.

Visualising the Future

Workforce gap

The workforce implications within the future functional design of the Health Board estate (p.22-28) were used as the basis of the projection of the future workforce. The table below is a theoretical representation of the workforce that may be needed in 10 years. Work will continue at Operational Business Case (OBC) stage to refine the workforce need as more detail on pathways and the shift to the "Community model" is defined.

Based on the set of assumptions on the workforce shift that will be required we have calculated the potential workforce need as below.

Staff Group	Budget	Actual	Cover Utilisied WTE (ECT)	Cover utilised Temp Workforce Utilisation tool	Actual with Temp Workforce	Vacancy	Workforce Requirement
ADD PROF SCIENTIFIC AND TECHNICAL	358.4	328.2	**1.0**	**3.2**	**332.4**	30.2	400.0
ADDITIONAL CLINICAL SERVICES	2,164.9	2,110.4	**38.1**	**360.3**	**2,508.9**	54.5	2814.8
ADMINISTRATIVE & CLERICAL	1,917.5	1,903.9	**14.9**	**12.2**	**1,930.9**	13.6	1910.7
ALLIED HEALTH PROFESSIONALS	641.5	592.1	**17.1**	**8.8**	**617.9**	49.5	769.8
ESTATES AND ANCILLIARY	881.0	900.1	**138.2**	**0.4**	**1,038.7**	(19.1)	932.8
HEALTHCARE SCIENTISTS	199.5	187.8	**10.3**		**198.1**	11.6	219.5
MEDICAL AND DENTAL	924.4	591.2	**0.1**		**591.2**	333.2	800.0
NURSING AND MIDWIFERY REGISTERED	3,282.0	2,807.9	**40.2**	**567.9**	**3,416.0**	474.2	3350.0
TOTAL	**10,369.2**	**9,421.6**	**259.8**	**952.7**	**10,634.1**	**947.6**	**11,197.4**

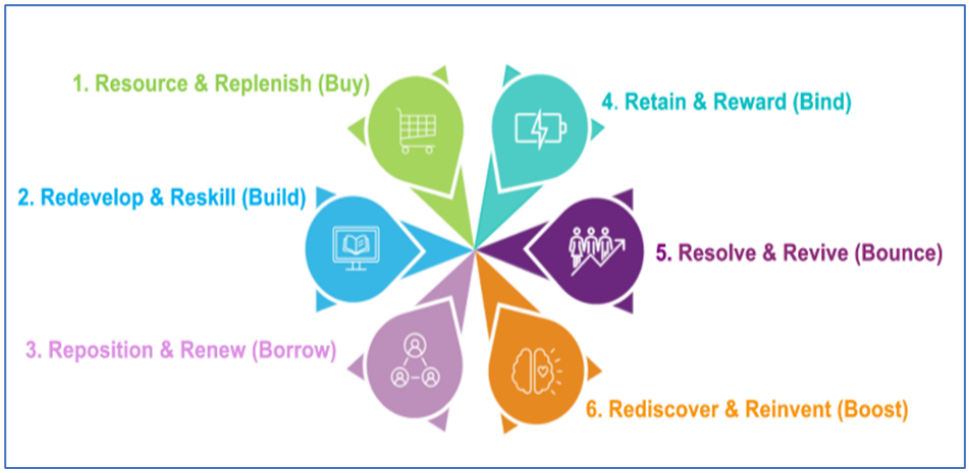
Key points to note from the above is that with the best of intentions we are likely to see a 10% increased need in workforce. When factoring in the demography of our future workforce

- Risk of 30% of our workforce retiring in the next 10 years
- 60% of the workforce we have today will be our workforce of 'tomorrow'
- Reduction in potential workforce entrants over the next 10 years (Population Pyramid for Wales 2020).

Therefore, this requires us to remodel and realign our current workforce, alongside a robust pipeline of aspirant H&SC professionals.

The Workforce Regeneration Framework

Through utilising the Workforce Re-generation Framework below we have illustrated the interventions that we are currently utilising along with our aspirational development pipeline to grow our workforce across the next 10 years.



The Workforce Re-generation Framework has been developed to demonstrate the interventions the Health Board have made available to assist services across the three counties access the stable workforce they need. The framework works alongside the Education and Commissioning Plans submitted to Welsh Government annually and have been developed through an integrated approach regionally across Health & Social Care (with Local Authority partners).

The intervention to increase workforce supply routes that can further contribute to the overall workforce plan. This will be an iterative process to align the workforce gap and supply sources, however, the detail that follow makes strides in identifying how the gap can be reduced as per interventions in the diagram above in 3 critical areas:

1. Retain & Reward (Bind)
2. Resource & Replenish (Buy)
3. Redevelop and reskills (Build)

Hywel Dda currently has one of the highest reported turnovers across NHS Wales, at 9.8% (as of May 2021). Current Welsh average for 12 month rolling turnover (headcount) is 8% (as of May 2021). Out of the other University Health Board's in Wales, we are currently 0.9% below the current best rate of 8.9%. In terms of "reason for leaving" - "Retirement Age" is highest, the majority of the other top reasons for leaving include various types of voluntary resignation. The top 5 reasons equate to over 550 people. We really need to understand this better as an organisation to ensure any interventions we make are really focused on the challenges for Hywel Dda.

If we look at staff groups against the Wales % we can see some immediately significant "outliers" that we may wish to explore in relation to reason i.e., estates and ancillary and healthcare scientists.

We will aim to reduce our current turnover rate ***by 1%. This translates to approximately 100 people over 12 months;*** 50 people not leaving us within the next 6 months, that otherwise would have. Within an 18-month period we aim to reduce our turnover by 3%. Thus, helping to minimise our growing workforce deficits.

Resource & Replenish (Buy)

As of October 2021, we have a vacancy factor of c.950WTE across all staff groups - The Medical and Dental staff group accounts for c.330WTE and the Nursing & Midwifery staff group accounts for c.499WTE. There are 447 vacancies (744WTE) currently active in the TRAC system. Of the 744WTE vacancies, 319WTE are in the Nursing & Midwifery staff group, 55WTE in the Medical and Dental Staff group and 162WTE in Additional Clinical Services (mainly HCSWs).

General recruitment activity on TRAC has increased in the Health Board. The pre-pandemic activity was c.550WTE in Oct2019 compared to post-pandemic activity of c.750WTE in Oct2021.The average number of new starters per month over the last 12 months (Nov20-Oct21) is 196HC (107WTE). This number will include COVID 19 mass recruitment exercises, and we would not expect this number to be sustained over the next 12 months as we settle back into recruitment to vacancies in the budgeted establishment only. This compares 135HC (79WTE) in the 18/19 pre-pandemic period. COVID 19 mass recruitment activity has resulted in **5330** applicants, **3137** offers and **2429** being appointed. This was in addition to all other recruitment activity associated with turnover or new workforce requirements for service developments continuing in the usual way.

The increase in activity needs to be correlated to outcomes and priority areas so secured supply can be directed to focused areas of need. Modelled supply based on interventions summarised below: which suggests that if demand and supply can be aligned, we can significantly reduce our deficits, however we know skills set and specialisms are a critical factor.

The education and commissioning process presents as an opportunity and mandatory requirement for us as an organisation to carefully consider and articulate our workforce needs to HEIW. The following information summarises the potential outturn of new graduates, according to professional group.

Whilst numbers remain steady, they do not fully address the workforce gap we are faced with, and do not meet future workforce needs to deliver the future strategic vision. Therefore, ongoing strategic workforce planning activity will take place, alongside the yearly education and commissioning cycle, to ensure the Health Board

"ask" is based on reality and long-term planning for 'A Healthier Mid and West Wales' and delivery of the Programme Business Case (PBC).

A summary of the profile for output into the workforce is given below: (please note this does not take account of attrition, purely the "ask" to HEIW)

Nursing & Midwifery (inc PT numbers)					
Year of Output	**2022**	**2023**	**2024**	**2025**	**2026**
Bachelor of Nursing (B.N.) Adult FT	155	212	194	163	160
Bachelor of Nursing (B.N.) Adult PT	11	11	37	33	41
Bachelor of Nursing (B.N.) Child	6	21	8	23	12
Bachelor of Nursing (B.N.) Mental Health	32	25	25	46	20
Bachelor of Nursing (B.N.) LD	9	15	15	9	11
Midwifery (including Conversion Programme)	16	20	20	0	15

Allied Health Professionals					
Year of Output	**2022**	**2023**	**2024**	**2025**	**2026**
B.Sc. Diagnostic Radiography	20	20	20	20	15
B.Sc. Human Nutrition and Dietetics	7	7	9	10	7
B.Sc. Occupational Therapy	12	16	20	22	11
B. Sc. Operating Department Practice	10	16	0	4	5
BSc Physiotherapy	30	30	20	27	20
B.Sc. Podiatry	4	4	0	1	4
Speech and Language Therapy (inc Welsh Language)	9	9	9	9	5

Healthcare Scientists					
Year of Output	**2022**	**2023**	**2024**	**2025**	**2026**
Healthcare Scientists - Cardiac Physiology	4	5	5	5	3
Healthcare Scientists - Audiology	4	5	2	3	1
Healthcare Scientists - Respiratory and Sleep	5	5	3	3	3
Healthcare Scientists - Medical Engineering	0	0	1	0	2
Healthcare Science - Biomedical Science - Blood	12	6	2	2	2

Pharmacy					
Year of Output	**2022**	**2023**	**2024**	**2025**	**2026**
Pre-registration Pharmacy Technician, Clinical Facing	5	5	6	12	
Pre-registration Pharmacy Technician, Technical Services	4	5	8	1	
Pharmacy Clinical Services Professional BTEC Level 4			5	7	
Post-registration Foundation pharmacists	4	5	7		
GP Pharmacist Transition Programme		3	7		
Trainee Pharmacist (Foundation Training Programme)				18	
M.Sc. Pharmaceutical Technology and Quality Assurance					1
Chartered Institute of Procurement and Supply Level 4 – Foundation Diploma				1	

Other					
Year of Output	**2022**	**2023**	**2024**	**2025**	**2026**
MSc Physician Associate	15	7	7	11	
B.Sc. Paramedicine (WAST - for future APP pipeline)					14

N.B - Figures pre-2021 cannot be confirmed as accurate and have been based on information sources available to us.

Overseas Resourcing Programme

The Overseas RN Resourcing programme offers a significant opportunity to scale up nurse resourcing and meet the strategic aims of the workforce plan and address the concerns aligned to Nurse Staffing Levels. Our intent is to arrive at 100 RN WTE in the first year and extend from there to 150 to 200WTE as modelled below.

As a resourcing programme the first 12 months of any cohort would be working as a HCSW/AP (potentially Band 4) and will then progress to Registrant status after successful achievement of Objective Structured Clinical Examinations (OSCE's). Theoretically within a 3–5-year timespan, nurse vacancies based on today's establishment will have been eradicated (i.e., vacancy profile less than 500 for RN's) and a pipeline of Band 4 HCSW/AP in train to support attrition. (Appendix 1 Table of Supporting Information includes the Resourcing: Analysis and Proposed action & Overseas RN Resourcing).

Within our ten-year projection we can see the impact the additional Overseas RN Resourcing programme will have on our workforce of the future. Our current establishment deficit sits at c.499. With the addition of these individuals over the next 3 years by 2024/25 we hope to see no vacancies within the Nursing and Midwifery staff group

Nursing & Midwifery	Year 1 22/23	Year 2 23/24	Year 3 24/25	Year 4 25/26	Year 5 26/27	Year 6 27/28	Year 7 28/29	Year 8 29/30	Year 9 30/31	Year 10 31/32
Funded establishment /SIP / Projected Gap	-499.9	-207.2	-54.6	194.8	394.6	636.4	733.4	853.4	1043.4	1233.4
Resourcing Based Activity (BUY)										
TRAC (BAU) Resourcing	100	100	100	100	100	100	100	150	150	150
Overseas RN Resourcing	100	150	200	-	-	-	-	-	-	-
Commissioning ask to HEIW	229	304	288	247	259	250	250	250	250	250
Streamlining Registrants (Actual Received)	100	100	100	200	200	200	200	200	200	200
Bank to substantive	10	10	10	10	10	10	10	10	10	10
Registrant Agency to substantive	5	5	5	5	5	5	5	5	5	5
Registrant Direct Hire	10	10	10	10	10	10	10	10	10	10
Return to Practice	5	5	5	5	5	5	5	5	5	5
Returned from Retirement	28									
Centralised RN Recruitment	10	10	10	10	10	10	10	10	10	10
Conversion to substantive from FTC	5	5	5	5	5	5	5	5	5	5
Workforce Development Based (BUILD)										
AP Development Pipeline (Potential)	33.6	57.6	104.4	142.8	174.8					
Impact on RN Residual Deficit of AP Pipeline	-413.3	-54.6	194.8	382.6	564.4	631.4	728.4	898.4	1088.4	1278.4
RN Outturn				12	72	102	125	145	145	145
Impact on RN Residual Deficit of RN Outturn	-446.9	-112.2	90.4	251.8	461.6	733.4	853.4	1043.4	1233.4	1423.4
Total Impact on RN Residual Deficit	**-413.3**	**-54.6**	**194.8**	**394.6**	**636.4**	**733.4**	**853.4**	**1043.4**	**1233.4**	**1423.4**

Full breakdown of all staff group projections can be found in Appendix A.

Recognising the increasing need to 'Grow Our Own' workforce, we must design opportunities to provide additionality to the external supply of a skilled workforce. The focus will be to:

a. Provide an ambitious expansion of our apprenticeship scheme
b. Increase the pipeline of the Band 4 Assistant Practitioner roles
c. Increase the pipeline of nurses through the internal part-time programmes
d. Create a support system that recognises the pastoral needs of the future workforce pipeline.

This is a complex piece of work to model through and deliver for two reasons

a) to balance supply and attrition against a changing service profile and
b) to manage the education & commissioning pipeline as they are interdependent educational pathways, subject to personal choice, service need, local labour market supply and funding/places from HEIW/HEI respectively (which we will be dependent on for this programme of work).

This is the first iteration of this pipeline which will need to be modelled against our demography to ensure a pipeline of apprentices can be sourced at scale on a recurrent basis from our local labour market, – further work against census data will be needed to test this approach. Based on recent practice 50 is feasible and expansion by 100 also appears feasible based on internal support mechanisms).

If we focus purely on modelling of the three areas above apprenticeships, the Band 4 Assistant Practitioners, internal part-time programmes into our workforce pipeline over the next 10 years and building on the assumptions made in the retention and resourcing sections; our workforce profile could present as follows:

Nursing & Midwifery	Year 1 22/23	Year 2 23/24	Year 3 24/25	Year 4 25/26	Year 5 26/27	Year 6 27/28	Year 7 28/29	Year 8 29/30	Year 9 30/31	Year 10 31/32	PBC PBC Projected Need at year 10	PBC Projected Gap +/-
Funded establishment /SIP / Projected Gap	-499.9	-207.2	-54.6	194.8	394.6	636.4	733.4	853.4	1043.4	1233.4	3350	699.60
Workforce Development Based (BUILD)												
AP Development Pipeline (Potential)	33.6	57.6	104.4	142.8	174.8							
Impact on RN Residual Deficit of AP Pipeline	-413.3	-54.6	194.8	382.6	564.4	631.4	728.4	898.4	1088.4	1278.4		
RN Outturn				12	72	102	125	145	145	145		
Impact on RN Residual Deficit of RN Outturn	-446.9	-112.2	90.4	251.8	461.6	733.4	853.4	1043.4	1233.4	1423.4		
Total Impact on RN Residual Deficit	**-413.3**	**-54.6**	**194.8**	**394.6**	**636.4**	**733.4**	**853.4**	**1043.4**	**1233.4**	**1423.4**	**3350**	**889.6**

If we maintain all the interventions identified in the table above between years 1- 4 dependent on service models being similar today we may be able to have a "workforce oversupply" subject to external/internal labour market influence by year 4 and we may want to reflect on the ability to increase workforce development activities earlier, if feasible. This needs to be an iterative piece of workforce planning and link into IMTP,

and wider business cases to ensure alignment overall. Please note this need to be heavily caveated as noted above - demography and attrition within education and establishment may shift this position. Further work based on a range of assumptions and scenarios linked to internal and external research on demand and supply will be needed.

The below table shows the correlation between the HCSW supply route and the RN pipeline. To maintain our Grow Your Own pathways we must ensure the educational options are available in the L2-4 apprenticeships to ensure RN success for years 4-10.

Additional Clinical Services	Year 1 22/23	Year 2 23/24	Year 3 24/25	Year 4 25/26	Year 5 26/27	Year 6 27/28	Year 7 28/29	Year 8 29/30	Year 9 30/31	Year 10 31/32	PBC PBC Projected Need at year 10	PBC Projected Gap +/-
Funded establishment /SIP / Projected Gap	-112.9	58.5	185.9	336.5	403.7	418.9	466.1	513.3	560.5	607.7	2814.8	-105.30
Resourcing Based Activity (BUY)												
TRAC (BAU) Resourcing (Apprentice. B2,3 &4)	144	144	144	144	144	144	144	144	144	144		
E&C - L4 Prog.(TO BE CONVERTED TO EXPECTED STREAM	8	20	65	20								
Bank to substantive												
Agency to substantive												
HCSW initiatives												
Assumption WTE Resourcing TOTAL	**152**	**164**	**209**	**164**	**144**	**144**	**144**	**144**	**144**	**144**		
Workforce Development Based (BUILD)												
Development Pipeline - TOTAL Apprentices	167	155	180	180	180	180	180	180	180	180		
Number to be deducted for movement to RN pipeline	-33.6	-57.6	-104.4	-142.8	-174.8	-142.8	-142.8	-142.8	-142.8	-142.8		
Total WTE Increase from Development	133.4	97.4	75.6	37.2	5.2	37.2	37.2	37.2	37.2	37.2		
Total Impact on Workforce	58.5	185.9	336.5	403.7	418.9	466.1	513.3	560.5	607.7	654.9	2814.8	-58.1

Points for consideration (as inherent risks to programme of workforce development):

- Requires commitment for the Level 4 from HEIW and HEIs to ensure funding through HCSW Funding Allocation or the commissioning process.
- Depending on the agreement of HEIW/HEI for the commissioning of nursing places to supporting this proposal.
- No distance learning provision offered, requiring consultation with HEIW and HEI's in relation to how local provision will be provided.

Consultation with HEIW is ongoing and supportive of our workforce planning assumptions, we will continue to consult with and engage in discussions on the most appropriate course of actions going forward.

All the workforce supply routes need to be balanced and then aligned to the identified workforce gap by priority and risk assessment, to achieve this in a systemic way**,** there is a need to strengthen the approach to workforce planning at a national, strategic and operational level to support the development of the workforce plan to meet identified and anticipated workforce gaps through education commissioning, organisational analysis, workforce planning activity and workforce design.

This includes:

a. Significant research and data analysis to understand and align

- Population Health Data
- Labour Market Intelligence
- Census Data i.e., Education, Employment, Travel

- NB new Census data will start to emerge from March 2022.

b. Data modelling tools to enable organisational analysis, workforce planning and workforce design

- Currently no “end to end” tool exists within Wales or Health Board and unlikely to be in the “market place” so a mixture of buy and build will need to be employed to:
  - Create internal capacity for supply modelling
  - Align all data sources for demand.

c. Investment in capability in workforce planning:

- Six Steps Workforce Planning Methodology and specific training approaches with facilitation and elements of PM (Project Manager) support
  - Population Health Based
  - Scenario Based
  - Competency Based (links to role design).

Although our efforts to reduce the gap using the interventions outlined within the ‘Bind, Buy and Build’ elements of the Regeneration framework, it also important that we focus on all elements of the framework, to include activity relating to ‘Borrow, Bounce and Boost’, each of which is summarised below.

We must continue to work collaboratively, seeking to explore options to access the talent market based on short, and longer-term needs. This will be achieved through continuation of partnership working with external agencies/organisations, as well as engaging with individuals on a case-by-case basis to deliver the required temporary workforce when required.

Based on the success of previous recruitment initiatives, the organisation can, and must continue, its efforts to explore all supply options available to us. However, we must also look to strengthen our workforce, seeking to implement prudent, cost-effective options wherever possible, not only to reduce our variable spend, but to add much needed diversity, agility and sustainability to our workforce.

Examples of how this has, and will continue to be achieved, are summarised below:

- Utilising of Bank/Agency/Locum Staff
- Deployment/Redeployment of Staff
- Regional Collaboration of Recruitment Initiatives
- Reviewing of the Internal Recruitment Process
- Continued Relationships with Partner Organisations
- Continued Research into Best Practice and Learning from Lived Experiences
- Engagement with New on-contract Agencies

- Regular Meetings with on-contract Agencies; to Discuss Current Requirements of the HB
- All Wales Temporary Staffing Group to ensure Best Practice is embedded for Bank and Agency Staff
- Student Nurse Recruitment
- Working with the Service to Identify Additional Demand in Advance
- Partnership Agreements

As an organisation, we will continue to move in a positive direction, ensuring we implement and maintain appropriate standards, values and behaviours. We must use opportunities to 'resolve and revive', helping our current and future leaders to engage and to be motivated as we embark on significant change across the health board.

It is imperative that we deliver robust guidance, support and the required infrastructure to support our workforce and to navigate change appropriately, building resilience and promoting collaboration whilst doing so.

We will also continue to prioritise the well-being of our employees, seeking to provide person-centred advice and support to assure a positive working environment for our employees.

Our approach to 'resolve and revive' our workforce, will be delivered through the following examples, which further emphasis the requirement for partnership working across the organisation:

- Supporting the Return from Absence in the Workplace,
- Providing Expert Advice from Occupational Health,
- Expertise in Managing Standards of Behaviour and both Formal & Informal Processes,
- Assisting in Respect & Resolution Meetings,
- Engaging with Trade Unions through Consultative Forums,
- Assisting in the Management of Locum Gaps,
- Provision of Specialist Medical and Dental Terms & Conditions Advice,
- Advising on AFC Terms & Conditions, and Policy Application,
- Drafting & Reviewing of Workforce Policies and Procedures,
- Helping Managers to Effectively Manage Change,
- Conducting & Co-ordinating Flu,
- Vaccination Campaigns.

Rediscover & Reinvent (Boost)

Through use of creative and transformative approaches, we will continue to improve and rethink our ways of working through collaborative partnerships, experimental pathways, technology or other means.

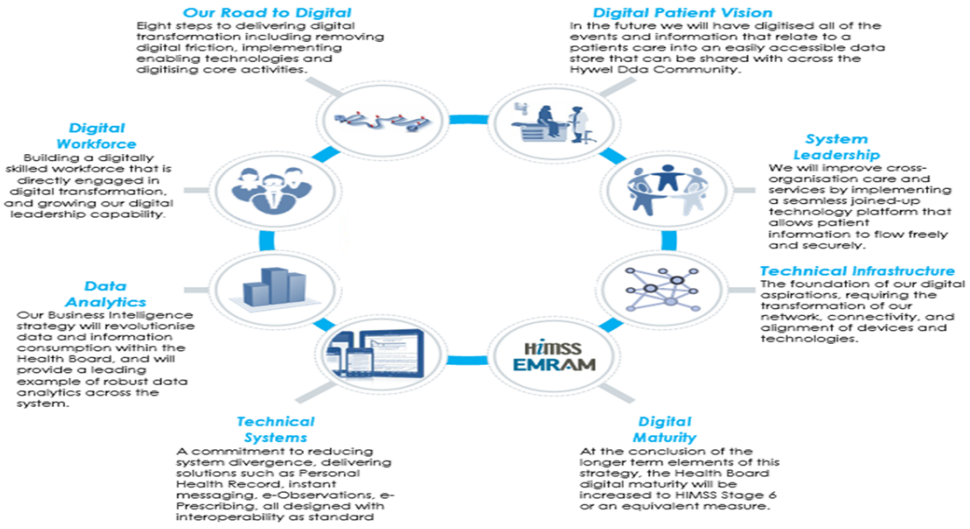
This will be enabled through anticipating future trends/needs, being innovative to meet changing demands and advances in health care and technology e.g., Artificial Intelligence, which as an example, may reduce our workforce demand or improve productivity/efficiency, reducing our vacancy position, by enhanced working techniques or improving outputs.

We will continue to connect with services to facilitate transformative and integrated working, to provide high quality care with realistic resources, alongside essential role design activity, as the skill set, and expertise of our workforce is required to change. We must be encouraged and proactive in our outlook as we seek to better understand the transformation and potential efficiencies available to use, focusing on our digital roadmap to ensure we are able to provide our workforce will the capability and expertise to shape the way our services are delivered in the future.

Examples of how this will be achieved include:

- Utilising AI/Digital Solutions
- Creative & Innovative Planning
- Role (Re)Design
- Implementing Transformation
- Development of Change Mapping
- Innovative Modelling
- Promoting Integration & Collaboration
- Regional Initiatives
- Promoting Third Sector & Local Authority Involvement
- Developing and aligning the digital and workforce road map...

We are working closely with our digital colleagues to develop a digital workforce roadmap that will align our aspirations with educational and development support to enable transition to an increasingly digitalised environment.



Partnership Working

There is continued opportunity to work with our partners, and the need for multi-agency working to develop the workforce and services, will be prioritised throughout our efforts to achieve delivery of high-quality care, facilitated through provision of workforce sustainability, planned and based around service and population needs.

A collaborative approach is, and will continue to be fostered across the organisation, as we seek to ensure a holistic understanding of how we can work together effectively. Whilst recognising the strength and value in contribution from internal and external colleagues, teams and organisations.

Introduction of the Regeneration Framework will provide opportunity for colleagues/teams across Workforce and Organisational Development (W&OD). To explore and understand the opportunities for working together, creating a culture of shared learning, to ascertain 'what' and 'how' the interventions included within the framework can be undertaken and aligned appropriately, to work towards a common goal.

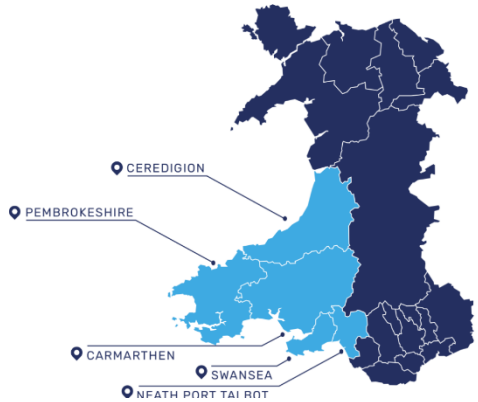
Alongside this, W&OD and the wider organisation will continue to develop strong partnerships, engaging, contributing to, and supporting strong partnership working across a variety of initiatives, which include:

A Regional Collaborative for Health (ARCH)

The aim of the ARCH Education, Workforce and Skills portfolio is to ensure the ARCH projects support the development of opportunities in education, workforce and skills improvement through collaboration with universities. The delivery of these activities will provide education programmes to meet NHS Service's needs, working towards provision of high standards of teaching to facilitate greater workforce attraction, development and retention of staff.

The Workforce and Skills Development Project Group (within ARCH, working with HDUHB, SBUHB and HEIW) are developing and delivering projects in a number of other areas including:

- Workforce Re-design - development of integrated roles across Local Authority and NHS,
- Workforce Pipeline – developing apprenticeships, physician associates and a pipeline of nursing students from our HCSW roles,
- Up-skilling – developing a range of skills development and innovative practice-based learning,
- Workforce stabilisation – Developing innovative solutions for registered practitioner training, and creation of clinical academic posts,
- Development of scientific careers (including Modernising Scientific Careers).



(ARCH, 2022)

The Mid Wales Health Collaborative (MWHC) has prioritised the development of the workforce of Mid Wales.

This includes the development of:

- Centre for Excellence in Rural Healthcare
- Development of Physician's Associates
- Future workforce models

West Wales Regional Workforce Programme Delivery Board -

Currently scoping a regional workforce development strategy and developing a regional approach to the Social Care Workforce Development Programme (SCWDP). We currently have four joint streams of work in place with our local authority social care partners from Carmarthen, Ceredigion and Pembrokeshire County Councils:

1. Training & development
2. Recruitment
3. Workforce Planning
4. Apprenticeships

This programme of work is continually evolving as shared learning and resources is explored. As part of this agenda

Preparing for the Future

We need to be aware that:

- ✓ Service redesign may need support to commence the programme of work
- ✓ Services may become "stuck" in the change process and may need support to move forward with their programme of work
- ✓ Individuals may need to work through the implication of any change for them personally and professionally

To manage and mitigate circumstances that may present, we will look to continue our work, facilitating service redesign activities across service areas and supporting individual change programmes/career counselling.

This will be supported by:

- Dedicated leadership and management structure, including clinical leadership
- Dedicated teams across communications, engagement and change management
- Resources to enable strategic workforce planning by building capacity skills development and tools to enable assessment
- Project management resources and tools to enable collaborative working
- Other infrastructure/resource needs

Conclusion

We are proud of our workforce, and we are committed to ensuring they have the skills, knowledge, and competence to make them the excellent workforce of our future. We are aware of the potential impact on our existing and our future staff in varying ways and will present unique challenges; some will be easier to overcome than others. However, we commit to deliver the competence-based workforce needed to ensure we sustain the right services moving forward.

We are also committed to ensuring every day in Hywel Dda has the capacity to be "a good day in work" for our staff which enables them to be their best selves at work. Our aspiration is to ensure our culture is one that encourages our people to thrive. How we manage this change and how it feels to work in Hywel Dda will be just as important for our staff as it will for our patients.

Appendix A

Workforce Projections

The below tables are an illustrative projection of each staff group depicting the potential options available within the Regeneration Framework to support our workforce requirement for the PBC.

Nursing Workforce

Nursing & Midwifery	Year 1 22/23	Year 2 23/24	Year 3 24/25	Year 4 25/26	Year 5 26/27	Year 6 27/28	Year 7 28/29	Year 8 29/30	Year 9 30/31	Year 10 31/32	PBC Projected Need at year 10	PBC Projected Gap +/-
Funded establishment /SIP / Projected Gap	-499.9	-207.2	-54.6	194.8	394.6	636.4	733.4	853.4	1043.4	1233.4	3350	699.60
Resourcing Based Activity (BUY)												
TRAC (BAU) Resourcing	100	100	100	100	100	100	100	150	150	150		
Overseas RN Resourcing	100	150	200	-	-	-	-	-	-	-		
Commissioning ask to HEIW	229	304	288	247	259	250	250	250	250	250		
Streamlining Registrants (Actual Received)	100	100	100	200	200	200	200	200	200	200		
Bank to substantive	10	10	10	10	10	10	10	10	10	10		
Registrant Agency to substantive	5	5	5	5	5	5	5	5	5	5		
Registrant Direct Hire	10	10	10	10	10	10	10	10	10	10		
Return to Practice	5	5	5	5	5	5	5	5	5	5		
Returned from Retirement	28											
Centralised RN Recruitment	10	10	10	10	10	10	10	10	10	10		
Conversion to substantive from FTC	5	5	5	5	5	5	5	5	5	5		
Assumption WTE Resourcing TOTAL	**373**	**395**	**445**	**345**	**345**	**345**	**345**	**395**	**395**	**395**		
Retention (BIND)												
Assumption WTE General Turnover (-Retention)	100	100	100	100	150	150	150	150	150	150		
Retirement	220	200	200	200	200	200	200	200	200	200		
Retention Initiatives												
TOTAL 'additional' WTE (resourcing minus turnover)	53	95	145	45	-5	-5	-5	45	45	45		
Workforce Development Based (BUILD)												
AP Development Pipeline (Potential)	33.6	57.6	104.4	142.8	174.8							
Impact on RN Residual Deficit of AP Pipeline	-413.3	-54.6	194.8	382.6	564.4	631.4	728.4	898.4	1088.4	1278.4		
RN Outturn				12	72	102	125	145	145	145		
Impact on RN Residual Deficit of RN Outturn	-446.9	-112.2	90.4	251.8	461.6	733.4	853.4	1043.4	1233.4	1423.4		
Total WTE Increase from Development	33.6	57.6	104.4	154.8	246.8	102	125	145	145	145		
BORROW												
Bank	88											
Agency	118.1											
Total WTE Increase from Temporary Workforce	206.1											
Total Impact on RN Residual Deficit	**-413.3**	**-54.6**	**194.8**	**394.6**	**636.4**	**733.4**	**853.4**	**1043.4**	**1233.4**	**1423.4**	**3350**	**889.6**

Additional Professional Scientific & Technical

Additional Professional Scientific & Technical	Year 1 22/23	Year 2 23/24	Year 3 24/25	Year 4 25/26	Year 5 26/27	Year 6 27/28	Year 7 28/29	Year 8 29/30	Year 9 30/31	Year 10 31/32	PBC PBC Projected Need at year 10	PBC Projected Gap +/-
Funded establishment /SIP / Projected Gap	-19.5	16.8	34	51.2	68.4	85.6	102.8	120	137.2	154.4	400	100.40
Resourcing Based Activity (BUY)												
TRAC (BAU) Resourcing	30	30	30	30	30	30	30	30	30	30		
ODP												
Pharmacy - Commissioning figures	14	24	46	27								
Pharmacy - Streamlining figures												
Psychology												
Physician Associates	11	7	7	7	7	7	7	7	7	7		
Initiatives	5	5	5	5	5	5	5	5	5	5		
Assumption WTE Resourcing TOTAL	**60**	**42**	**42**	**42**	**42**	**42**	**42**	**42**	**42**	**42**		
Retention (BIND)												
Assumption WTE General Turnover (-Retention)	23	23	23	23	23	23	23	23	23	23		
Retirement	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8		
Retention Initiatives												
TOTAL 'additional' WTE (resourcing minus turnover)	35.2	17.2	17.2	17.2	17.2	17.2	17.2	17.2	17.2	17.2		
Workforce Development Based (BUILD)												
ODP												
Pharmacy												
Psychology												
Physician Associates												
Total WTE Increase from Development	0	0	0	0	0	0	0	0	0	0		
BORROW												
Bank	1.1											
Agency												
Total WTE Increase from Temporary Workforce	1.1											
BOUNCE												
Regional												
BOOST												
Digital Productivity (minus ??%)												
e.g. wearable devices, robotics, AI												
Total Impact on Workforce	16.8	34	51.2	68.4	85.6	102.8	120	137.2	154.4	171.6	400	117.6

Additional Clinical Services

Additional Clinical Services	Year 1 22/23	Year 2 23/24	Year 3 24/25	Year 4 25/26	Year 5 26/27	Year 6 27/28	Year 7 28/29	Year 8 29/30	Year 9 30/31	Year 10 31/32	PBC PBC Projected Need at year 10	PBC Projected Gap +/-
Funded establishment /SIP / Projected Gap	-112.9	58.5	185.9	336.5	403.7	418.9	466.1	513.3	560.5	607.7	2814.8	-105.30
Additionality / Changes to Staff Group												
Resourcing Based Activity (BUY)												
TRAC (BAU) Resourcing (Apprentice. B2,3 &4)	144	144	144	144	144	144	144	144	144	144		
Apprentice - Band 2												
Apprentice - Band 3												
Apprentice - Band 3 - Trainee AP												
Apprentice - Band 4 - AP (Nursing)												
Apprentice - Band 4 - AP (Therapies)												
E&C - L4 Prog.(TO BE CONVERTED TO EXPECTED STREAM	8	20	65	20								
Bank to substantive												
Agency to substantive												
HCSW initiatives												
Assumption WTE Resourcing TOTAL	**152**	**164**	**209**	**164**	**144**	**144**	**144**	**144**	**144**	**144**		
Retention (BIND)												
Assumption WTE General Turnover (-Retention)	134	134	134	134	134	134	134	134	134	134		
Retirement												
Retention Initiatives												
TOTAL 'additional' WTE (resourcing minus turnover)	18	30	75	30	10	10	10	10	10	10		
Workforce Development Based (BUILD)												
Development Pipeline - TOTAL Apprentices	167	155	180	180	180	180	180	180	180	180		
Apprentice - Band 2												
Apprentice - Band 3												
Apprentice - Band 3 - Trainee AP												
Apprentice - Band 4 - AP (Nursing)												
Apprentice - Band 4 - AP (Therapies)												
Number to be deducted for movement to RN pipeline?	-33.6	-57.6	-104.4	-142.8	-174.8	-142.8	-142.8	-142.8	-142.8	-142.8		
Impact on Residual Deficit of Pipeline												
Total WTE Increase from Development	133.4	97.4	75.6	37.2	5.2	37.2	37.2	37.2	37.2	37.2		
BORROW												
Bank	20											
Agency												
Commisioning (10%?)												
Total WTE Increase from Temporary Workforce	20											
BOUNCE												
Regional												
BOOST												
Digital Productivity (minus ??%)												
e.g. wearable devices, robotics, AI												
Total Impact on Workforce	58.5	185.9	336.5	403.7	418.9	466.1	513.3	560.5	607.7	654.9	2814.8	-58.1

Administrative & Clerical

Administrative & Clerical	Year 1 22/23	Year 2 23/24	Year 3 24/25	Year 4 25/26	Year 5 26/27	Year 6 27/28	Year 7 28/29	Year 8 29/30	Year 9 30/31	Year 10 31/32	PBC Projected Need at year 10	PBC Projected Gap +/-
Funded establishment /SIP / Projected Gap	10	-7.48	-40.7382	-76.0108	-110.931	-201.213	-287.885	-371.09	-450.966	-527.647	1910.7	-454.35
Additionality / Changes to Staff Group												
Resourcing Based Activity (BUY)												
TRAC (BAU) Resourcing - ALL	139	139	139	139	139	139	139	139	139	139		
Conversion of Agency to Substantive												
Pure Administrative Roles												
Hybrid Roles (FLO/Ward Clerk)												
Clinical Managerial Roles (Band 7 & above)												
Managerial Roles (Band 7 & above)												
Initiatives												
Assumption WTE Resourcing TOTAL	**139**	**139**	**139**	**139**	**139**	**139**	**139**	**139**	**139**	**139**		
Retention (BIND)												
Assumption WTE General Turnover (-Retention)	120	120	120	120	120	120	120	120	120	120		
Retirement	35	35	35	35	35	35	35	35	35	35		
Retention Initiatives												
TOTAL 'additional' WTE (resourcing minus turnover)	-16	-16	-16	-16	-16	-16	-16	-16	-16	-16		
Workforce Development Based (BUILD)												
Development Pipeline - Apprentices?												
Pure Administrative Roles												
Hybrid Roles (FLO/Ward Clerk)												
Clinical Managerial Roles (Band 7 & above)												
Managerial Roles (Band 7 & above)												
Total WTE Increase from Development	0	0	0	0	0	0	0	0	0	0		
BORROW												
Bank	18.3											
Agency												
Total WTE Increase from Temporary Workforce	18.3											
BOUNCE												
Regional												
BOOST												
Digital Productivity (minus 1% Year 1-4, 4% years 5-9, 10% Year 10)												
e.g. wearable devices, robotics, AI	19.8	17.3	19.3	18.9	74.3	70.7	67.2	63.9	60.7	144.0		
Total Impact on Workforce	**-7.5**	**-40.74**	**-76.01**	**-110.93**	**-201.21**	**-287.88**	**-371.09**	**-450.97**	**-527.65**	**-687.68**	**1910.7**	**-614.4**

Allied Health Professionals

Allied Health Professionals	Year 1 22/23	Year 2 23/24	Year 3 24/25	Year 4 25/26	Year 5 26/27	Year 6 27/28	Year 7 28/29	Year 8 29/30	Year 9 30/31	Year 10 31/32	PBC PBC Projected Need at year 10	PBC Projected Gap +/-
Funded establishment /SIP / Projected Gap	-28.2	61.5	152.5	236.5	337.5	404.5	409.5	414.5	419.5	424.5	769.8	274.90
Additionality / Changes to Staff Group												
Resourcing Based Activity (BUY)												
TRAC (BAU) Resourcing - ALL	38	38	38	38	38	38	38	38	38	38		
Conversion of Bank to Substantive												
Conversion of Agency to Substantive												
Commissioning ask to HEIW	102	106	79	96	62							
Streamlining Registrants (Actual Received)												
Dietitians												
Occupational Therapists												
Orthoptists												
Physiotherapy												
Podiatry												
Radiography												
Speech Therapy												
AHP Other												
Initiatives	5	5	5	5	5	5	5	5	5	5		
Assumption WTE Resourcing TOTAL	**145**	**149**	**122**	**139**	**105**	**43**	**43**	**43**	**43**	**43**		
Retention (BIND)												
Assumption WTE General Turnover (-Retention)	50	50	50	50	50	50	50	50	50	50		
Retirement	8	8	8	8	8	8	8	8	8	8		
Retention Initiatives												
TOTAL 'additional' WTE (resourcing minus turnover)	87	91	64	81	47	-15	-15	-15	-15	-15		
Workforce Development Based (BUILD)												
Development Pipeline - AP Band 4			20	20	20	20	20	20	20	20		
Dietitians												
Occupational Therapists												
Orthoptists												
Physiotherapy												
Podiatry												
Radiography												
Speech Therapy												
AHP Other												
Total WTE Increase from Development	0	0	20	20	20	20	20	20	20	20		
BORROW												
Bank	2.7											
Agency												
Total WTE Increase from Temporary Workforce	2.7											
BOUNCE												
Regional												
BOOST												
Digital Productivity (minus ??%)												
e.g. wearable devices, robotics, AI												
Total Impact on Workforce	61.5	152.5	236.5	337.5	404.5	409.5	414.5	419.5	424.5	429.5	**769.8**	**279.9**

Healthcare Scientists

Healthcare Scientists	Year 1 22/23	Year 2 23/24	Year 3 24/25	Year 4 25/26	Year 5 26/27	Year 6 27/28	Year 7 28/29	Year 8 29/30	Year 9 30/31	Year 10 31/32	PBC Projected Need at year 10	PBC Projected Gap +/-
Funded establishment /SIP / Projected Gap	-2.4	15.1	25.1	32.1	39.1	45.1	45.1	45.1	45.1	45.1	219.5	22.70
Additionality / Changes to Staff Group												
Resourcing Based Activity (BUY)												
TRAC (BAU) Resourcing	7	7	7	7	7	7	7	7	7	7		
E&C (EXPECTED STREAMLINING)	12	10	7	7	6							
Bank to substantive												
Agency to substantive												
Initiatives	5	5	5	5	5	5	5	5	5	5		
Assumption WTE Resourcing TOTAL	**24**	**22**	**19**	**19**	**18**	**12**	**12**	**12**	**12**	**12**		
Retention (BIND)												
Assumption WTE General Turnover (-Retention)	10	10	10	10	10	10	10	10	10	10		
Retirement	2	2	2	2	2	2	2	2	2	2		
Retention Initiatives												
TOTAL 'additional' WTE (resourcing minus turnover)	12	10	7	7	6	0	0	0	0	0		
Workforce Development Based (BUILD)												
Apprentices/Level 4?												
Level 4												
Total WTE Increase from Development	0	0	0	0	0	0	0	0	0	0		
BORROW												
Bank	5.5											
Agency												
Total WTE Increase from Temporary Workforce	5.5											
BOUNCE												
Regional												
BOOST												
Digital Productivity (minus ??%)												
e.g. wearable devices, robotics, AI												
Total Impact on Workforce	15.1	25.1	32.1	39.1	45.1	45.1	45.1	45.1	45.1	45.1	219.5	22.7

Estates & Ancillary

Estates & Ancillary	Year 1 22/23	Year 2 23/24	Year 3 24/25	Year 4 25/26	Year 5 26/27	Year 6 27/28	Year 7 28/29	Year 8 29/30	Year 9 30/31	Year 10 31/32	PBC Projected Need at year 10	PBC Projected Gap +/-
Funded establishment /SIP / Projected Gap	-6.8	245.5	272.4	299.0	325.3	264.2	208.1	156.4	108.8	65.1	932.8	20.99
Additionality / Changes to Staff Group												
Resourcing Based Activity (BUY)												
TRAC (BAU) Resourcing	121.5	121.5	121.5	121.5	121.5	121.5	121.5	121.5	121.5	121.5		
Bank to substantive												
Agency to substantive												
Initiatives - Enhanced Cleaning	113											
Assumption WTE Resourcing TOTAL	**234.5**	**121.5**	**121.5**	**121.5**	**121.5**	**121.5**	**121.5**	**121.5**	**121.5**	**121.5**		
Retention (BIND)												
Assumption WTE General Turnover (-Retention)	81	81	81	81	81	81	81	81	81	81		
Retirement	10	10	10	10	10	10	10	10	10	10		
Retention Initiatives												
TOTAL 'additional' WTE (resourcing minus turnover)	143.5	30.5	30.5	30.5	30.5	30.5	30.5	30.5	30.5	30.5		
Workforce Development Based (BUILD)												
Apprentices	8	8	8	8	8	8	8	8	8	8		
Total WTE Increase from Development	8	8	8	8	8	8	8	8	8	8		
BORROW												
Bank	111.1											
Agency												
Total WTE Increase from Temporary Workforce	111.1											
BOUNCE												
Regional												
BOOST												
Digital Productivity (minus 1% Year 1-4, 8% years 5-9, 15% Year 10)	10.25	11.65	11.9	12.2	99.6	94.7	90.2	86.0	82.2	147.6		
e.g. wearable devices, robotics, AI												
Total Impact on Workforce	245.55	272.40	298.983	325.301	264.241	208.065	156.384	108.837	65.0945	-44.05	932.8	-88.1

Medical & Dental

Medical & Dental	Year 1 22/23	Year 2 23/24	Year 3 24/25	Year 4 25/26	Year 5 26/27	Year 6 27/28	Year 7 28/29	Year 8 29/30	Year 9 30/31	Year 10 31/32	PBC PBC Projected Need at year 10	PBC Projected Gap +/-
Funded establishment /SIP / Projected Gap	-317.3	-299.3	-281.3	-263.3	-245.3	-227.3	-209.3	-191.3	-173.3	-155.3	800	-348.80
Resourcing Based Activity (BUY)												
TRAC (BAU) Resourcing	226	226	226	226	226	226	226	226	226	226		
Conversion of Bank to Substantive	8	8	8	8	8	8	8	8	8	8		
Conversion of Agency to Substantive	8	8	8	8	8	8	8	8	8	8		
Foundation												
SAS												
Consultants												
Other Medical Grades - GP												
Dental												
Physicians Associates E&C (Streamlining) include for awareness												
MAPS roles?												
PAA Surgical Practitioner												
Medical Apprenticeships												
Initiatives												
Assumption WTE Resourcing TOTAL	**242**	**242**	**242**	**242**	**242**	**242**	**242**	**242**	**242**	**242**		
Retention (BIND)												
Assumption WTE General Turnover (-Retention)	213	213	213	213	213	213	213	213	213	213		
Retirement	11	11	11	11	11	11	11	11	11	11		
Retention Initiatives												
TOTAL 'additional' WTE (resourcing minus turnover)	18	18	18	18	18	18	18	18	18	18		
Workforce Development Based (BUILD)												
Foundation												
SAS												
Consultants												
Other Medical Grades - GP												
Dental												
PA E&C (Streamlining)												
MAPS roles?												
PAA Surgical Practitioner												
Medical Apprenticeships												
Total WTE Increase from Development	0	0	0	0	0	0	0	0	0	0		
BORROW												
Bank												
Agency												
Total WTE Increase from Temporary Workforce												
BOUNCE												
Regional												
BOOST												
Digital Productivity (minus ??%)												
e.g. wearable devices, robotics, AI												
Total Impact on RN Residual Deficit	**-299.3**	**-281.3**	**-263.3**	**-245.3**	**-227.3**	**-209.3**	**-191.3**	**-173.3**	**-155.3**	**-137.3**	**800**	**-56.2**