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Workforce Planning Unit, Health Workforce Directorate
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Cabinet Secretary for Health and Sport

Covid-19: Workforce Implications of First-Phase Mobilisation Planning

Purpose

1. To provide you with an assessment of the workforce implications arising from the first–phase mobilisation plans provided by territorial Health Boards, including an assessment of risk, competing pressures, available mitigation and emerging challenges.

Priority

2. Routine.

Background

3. First-phase plans for the mobilisation of services, covering the period to the end of July 2020, have now been assessed by the Health and Social Care Workforce Planning Unit to examine the extent to which they adequately scope the workforce implications for service delivery. Specifically consideration has been given to the extent to which they quantify their workforce requirements for the services they plan to mobilise, alongside the extent to which they acknowledge the emerging pressures arising from the need to provide rest and recuperation, including the management of annual leave. Furthermore, consideration has been given to whether the risks arising from Covid-19 workforce testing, both in relation to staff absence and the on-going provision of support to care homes, is appropriately factored in.

Workforce Assessment of Mobilisation Plans

4. The draft plans consistently identify workforce as a key interdependency that cuts across each of our mobilisation principles, though on the whole, they lack specific details around projected assumptions of anticipated workforce demand. Consequently, they only provide limited direct assurance about the effects of workforce pressures as mobilisation progresses, including the extent to which the workforce will need to grow and flex to deal with emerging pressures, including how workforce availability will be instrumental in future decision making.

5. Nevertheless, boards have noted the need to monitor staff redeployment patterns, to ensure that they can support both ongoing Covid-19 capacity and service delivery, alongside the resumption of key services including cancer screening services, pain clinics and limited elective services.

6. The plans anticipate that increased service delivery will be impacted by current Covid-19 related staffing absence; mainly related to staff shielding associated with underlying health conditions. As at 01 June approximately 2.78% of the workforce

was absent for a Covid-19 related reason; some 2.02% of the workforce are absent owing to an underlying health condition.

7. In the medium term, and noting that this first-phase covers the summer months, the plans anticipate an impact on workforce availability from deferred annual leave. There has been a significant reduction in overall annual leave taken during the pandemic period (March to present), normally c. 14% of leave would be taken in this period and this has reduced to around 6%. Boards are conscious that cumulatively, multiple requests for deferred leave could cause delivery issues, particularly if they coincide with a second pandemic wave, or during the normal winter flu season. This may be compounded in the medium term by the fact that staff can defer, by law, their statutory leave entitlement to next financial year. We had already authorised boards to allow staff to substitute unused annual leave from last financial year (19/20) for pay, to mitigate the impact of this; but there are welfare implications and significant financial implications to allowing any further substitution of leave for pay in-year.

8. Further, on the topic of staff welfare, the majority of mobilisation plans contained specific sections highlighting the need to promote and support staff mental health and wellbeing, not just in the short-term but also potentially on a longer-term basis as a result of the COVID pandemic. There are workforce implications here too in respect of giving effective psychological and occupational health support services to staff and to delivering effective, subject-specific training to promote resilience, amongst other things.

Workforce Demands for First-Phase Activity

9. Boards have been asked to maintain local projected Covid-19 capacity, plus 50% surge capacity to mitigate against the impact of any second-wave. They will also maintain sufficient capacity at the Covid-19 hubs and assessment centres to mitigate any future increase in Covid-19.

10. Clinical priority areas for re-establishing services vary between local plans, but all contain a projected increase in unscheduled care, elective and cancer services, in response to Scottish Government requests. Plans have assumed ongoing productivity constraints in the short term arising from:

- a need to ensure physical distancing; which is vital to managing the absence impact of testing on health and social care staff.
- reconfiguration of services
- extra staff time required, thus limiting productivity, due to PPE, infection control and cleaning requirements.

11. Noting the foregoing, it is therefore not assumed that any services in this first-phase will be operating above 50% of notional capacity, which mitigates staffing requirements for these services. This should assist in the first-phase with managing corresponding staffing pressures. It is hoped that Covid-19 clinical activity levels continue to reduce and a corresponding increase should be seen in opportunities for the return of staff to allow service capacity to build.

Managing Corresponding Staffing Pressures - Absence

12. Current Covid-19 related staffing absence across NHS Scotland has been below 4% for most of the last month **(see Appendix 1**). This is significantly less than the Reasonable Worst Case Scenario (RWCS) prediction, having been at least partly mitigated by national policies such as lockdown and opening schools for children of key workers

13. Some very limited modelling discussed at SAGE some 3-4 weeks ago suggested that evidence from test sites had reported rates of asymptomatic presentation in hospital settings of c. 8%. Positive test results of this magnitude could potentially increase the Covid-19 related absence from the current levels of c. 6,000 staff, to a figure in excess of 12,000 during any future pandemic peak periods.

14. Similarly, in outlining provision of "mutual aid" to care home settings – plans also anticipate workforce pressures arising not only from providing additional enhanced clinical support to that sector, but also from the need to mitigate staff absences in care homes created by testing.

15. Evidence for this derives from modelling undertaken by the Health and Social Care Workforce Planning Unit in conjunction with CNOD **(see Appendix 2)**, which has provided projections of workforce need associated with a 15% absence rate amongst care home staff as a result of increased testing activity. Some early staff testing figures suggest this 15% figure is a reasonable projection of positive results for now; though there is no agreed model for this.

16. It is not projected that health boards would need to provide 100% backfill for this model, given that operators should have business continuity processes in place; though modelling on that basis as a worst-case assumption, backfill support for acute short periods of isolation (14 days) for up to 7,000 staff may be needed. All Boards have been given enhanced responsibility for clinical leadership in relation to the homes in their areas and are reporting weekly around this. It is anticipated that this additional activity will continue for some time. Local systems are also heavily focussed on provision of care at home services.

Mitigation – Current Picture

17. There are a number of ways in which these additional demands on staff capacity created by mobilisation and contemporaneous pressures, are being managed:

- Boards will continue to have the ability to redeploy staff due to only 50% clinical capacity being utilised (though this figure may reduce as levels of service delivery increase with mobilisation)
- Recruitment in to health boards has been secured and HR Directors report that bank supply remains healthy in the main. Boards are relying on a mix of staff from the portal and from local recruitment.
- Recruitment to Social Care providers through the SSSC pool.