Workforce Plan
2013/14

Version 4, July 2013
Contents
1. Context .......................................................................................................................... 2
2. Drivers for change ........................................................................................................ 3
  2.1 Culture and values .................................................................................................... 3
  2.2 Staff Governance Standard ....................................................................................... 4
  2.3 Quality ........................................................................................................................ 4
  2.4 Service ...................................................................................................................... 5
    2.4.1 North Ayrshire Community Hospital ................................................................. 5
    2.4.2 Building for Better Care & Local Unscheduled Care Action Plan (LUCAP) ...... 6
    2.4.3 Transforming Outpatient Services .................................................................... 7
  2.5 Finance ..................................................................................................................... 8
  2.6 Overarching factors influencing the workforce ........................................................ 10
    2.6.1 Local population ............................................................................................... 10
    2.6.2 Integration of Health & Social Care .................................................................. 11
    2.6.3 Management restructuring of organisation ....................................................... 11
    2.6.4 Local labour market & employability ............................................................... 12
3. Overview of the current workforce .............................................................................. 13
  3.1 Workforce composition ........................................................................................... 13
  3.2 Workforce demography .......................................................................................... 14
  3.3 Shape of the workforce ........................................................................................... 15
  3.4 Age of the workforce ............................................................................................... 15
  3.5 Staff turnover ........................................................................................................... 17
  3.6 Staff health and wellbeing ....................................................................................... 18
  3.7 Supplemental staffing ............................................................................................. 19
  3.8 Learning & Development ......................................................................................... 21
4. Designing the future workforce ................................................................................... 21
  4.1 Workforce issues the NHS Board faces .................................................................. 21
  4.2 Service developments ............................................................................................. 23
  4.3 Nursing workforce ................................................................................................... 24
  4.4 Medical Workforce ................................................................................................... 25
  4.5 Workforce projections ............................................................................................. 27
5. Workforce action plan ................................................................................................. 28
6. Implementation, monitoring and review ...................................................................... 29
Annex A – Progress of Workforce Plan 2012/13 Actions ................................................... 30
1. Context

During 2012/13 the Workforce Planning Programme Board (WPPB) was established as the vehicle to drive forward a re-invigorated approach to workforce planning within NHS Ayrshire & Arran which was detailed within the previous workforce plan. The central tenet of the new approach to workforce planning has been to move from a state of workforce monitoring, with limited reactive planning to address current challenges, towards proactive workforce planning which will enable comprehensive visioning of the future workforce in terms of size and skill mix, ensuring this is congruent with the service and financial plans of the organisation and the needs of the current and future population.

There has been recognition since the formation of the WPPB that changing the approach would take time and would be achieved incrementally and as such there would be a two pronged approach which considers:

Service Developments

- Building for Better Care – the programme of improvements in front door services at both district general hospitals encompassing emergency services and development of combined assessment units;
- North Ayrshire Community Hospital – the re-provision of inpatient mental health services and care of the elderly services on the Ayrshire Central Site; and
- Transforming Outpatient Services – improving patient access to specialist advice, support, opinion and appropriate treatment by making best use of available resources;

Profession Specific

Whilst all professions, both clinical and non-clinical, will be encompassed and impacted within the service developments listed above the requirement to have uni-professional oversight of both nursing & midwifery and medical staff groups is deemed to be pertinent given their significant impact on not only the priority areas but wider business.

This workforce plan therefore sets out the work to date and planned activity for the service developments and profession specific groups.

The local approach is congruent with the national 2020 Workforce Vision – ‘Everyone Matters’ which will facilitate delivery of the NHS in Scotland vision that by 2020 everyone is able to live longer, healthier lives at home or in a homely setting:

‘We will respond to the needs of the people we care for, adapt to new, improved ways of working, and work seamlessly with colleagues and partner organisations. We will continue to modernise the way we work and embrace technology. We will do this in a way that lives up to our core values.

Together, we will create a great place to work and deliver a high quality healthcare service which is amongst the best in the world.’

Given the majority of the 2020 workforce are already employed within the service, or are in training, the workforce vision will affect all staff and local workforce planning will be responsive to the requirements of the 2020 Workforce Vision implementation framework.
2. Drivers for change

There are four overarching drivers which will influence NHS Ayrshire & Arran for the foreseeable future and these constitute the dimensions of success against which the organisation must deliver:

Diagram 1 – Dimensions of success and key drivers

The four dimensions of success are intrinsically dependent upon each other, therefore whilst the workforce plan is predominantly about people this cannot be taken in abstract from the other dimensions which will exert influence on the overall configuration of our workforce in terms of shape, size and skills required to deliver services.

2.1 Culture and values

Underpinning all four dimensions is the culture and values of the organisation. The NHS Board approved the new purpose commitments and values in May 2013:

Purpose:

Working together to achieve the healthiest life possible for everyone in Ayrshire and Arran

Commitments:

To our service users and communities
We will work together with you and your family to:
- Promote and improve your health
- Improve your safety, outcomes and quality of experience while in our care
- Live up to our customer care commitments

To our workforce
We will work together to create an open, fair and just culture where:
- We are all valued, respected and developed to be our best
- We are all informed, involved, listened to and treated fairly and consistently
- We are all safe and supported to improve our health and wellbeing
To our partners
We will work together with partners to:

- Improve health, prevent disease and reduce inequalities
- Join up our service delivery to improve outcomes
- Make best use of our resources

Values – Caring, Safe, Respectful

- I will show concern for others and care about the health, safety and wellbeing of everyone I come into contact with.
- I will do my job well, striving to learn and do things better, while taking responsibility for the quality, safety, and effectiveness of my actions.
- I will see everyone as an individual, be open, approachable, and treat everyone with dignity and respect

Work is underway to cascade the purpose, values and commitments throughout the organisation and consider how to put the associated behaviours into practice. A culture development approach, including requisite tools and training for managers, is in production to support the implementation and proposals for evaluation and monitoring are progressing.

2.2 Staff Governance Standard

The organisation has a statutory responsibility to ensure the Staff Governance Standard is embedded and adhered to as part of the governance framework – staff, financial, information and clinical governance - in which NHS Boards operate. The Staff Governance Standard requires all NHS Boards to demonstrate that staff are:

- Well informed;
- Appropriately trained and developed;
- Involved in decisions;
- Treated fairly and consistently, with dignity and respect, in an environment where diversity is valued; and
- Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

As such there is direct crossover between the Workforce Plan and the Staff Governance Improvement Plan.

2.3 Quality

The Healthcare Quality Strategy for NHS Scotland (2010) sets the foundation against which services in NHS Ayrshire & Arran are both provided and developed ensuring people (public, patients and staff) are at the heart of the NHS and there is commitment to providing the best possible care and advice compassionately and reliably by making the right thing easier to do for every person, every time from making measurable improvements.

The Quality Strategy identifies the links between staff engagement and the enhanced organisational performance and the correlation between staff experience and staff wellness with patient experience and patient outcomes. The importance of balancing the ambitions of quality, productivity and efficiency with the support and development for staff to feel engaged, valued and empowered in leading and driving quality is critical.
The Health Promoting Health Service (CEL01(2012) & CEL14(2008)) concept that ‘every healthcare contact is a health improvement opportunity’ is central to the quality ambitions for person centred and effective services.

‘As well as treating illness hospitals can create a step change in health and wellbeing, while simultaneously contributing to a reduction in health inequalities, through promoting health and enabling wellbeing in patients, their families, visitors and staff.’

Ensuring that those within the workforce who have a role to play in improving health are adequately equipped to undertake this role is imperative to achieving our organisational commitment to improve health, prevent disease and reduce inequalities

### 2.4 Service

Whilst this section provides an overview of workforce planning activity for each of the service priority areas it should be noted that each of the areas is developing individual workforce plans which will provide more in-depth detail.

#### 2.4.1 North Ayrshire Community Hospital

**Overview of the development**
The new North Ayrshire Community Hospital facility will feature a significant new build element comprising of 11 wards and 206 single bedrooms as well as an extensive retained estate. Services that will continue to be delivered from retained estate include a Stroke Rehabilitation and Geriatric Rehabilitation ward (Pavilion 10) as well as a Rehabilitation Medicine ward (Pavilion 11) and the Douglas Grant Rehabilitation Unit. The hospital will cater for inpatient mental health services (although some inpatient and outpatient services will remain on the Ailsa site) including adult acute & rehab services, addiction services, elderly mental health services; as well as older people’s continuing care and assessment and rehab; and a range of outpatient services. The development will improve the quality of treatment and deliver the objectives as set out in ‘Mind Your Health’ the mental health strategy.

**Workforce impact – progress to date**
The Workforce Group was established in March 2013 and includes clinical and non-clinical service leads. The impacted pool of staff, across all staff groups, has indicatively been identified as 500 WTE. All changes associated with the development will be managed via the Framework for Managing Workforce Change Policy.

Initial projections have indicated an indicative increase in nurse staffing in inpatient areas however these figures will be further refined utilising the nursing and midwifery tools and taking cognisance of supplemental staffing usage and sickness absence rates. The impact upon Clinical Support Services is anticipated to be manageable via natural turnover and planning the deployment of staff (at Crosshouse and Ailsa sites) to subsume any anticipated reductions associated with predicted increases on the NACH site. The financial impact of predicted workforce changes is a prime consideration and finance colleagues are actively involved in the Workforce Group to ensure there is robust scrutiny in terms of affordability, phasing and impact/fit with the organisational financial plan.

**Workforce work plan during 2013/14**

- Establish the medical staffing model for NACH with particular focus upon the out of hours period;
• Ensure AHP staffing proposals are congruent with the clinical service models that have been proposed and optimise the three support clusters that are to be incorporated into the design of the new hospital;
• Determine the administrative staffing requirements of the new hospital by considering the combined administrative staffing, across services, that will be on-site and how this can be best aligned;
• Test and validate the draft projections that indicate an increase in nurse staffing, in both mental health and care of the elderly, by using the appropriate nursing and midwifery workforce and workload tools;
• Consider shift patterns and rostering to ensure optimal deployment of staff when the new hospital opens;
• Consider the potential wider use of volunteers – addictions services are currently piloting Peer Support Workers as part of a national initiative; and
• Ensure the workforce plan for NACH is completed to inform the completion of the full business case.

Identified workforce risks
• Ensuring nurse projections utilise an agreed and consistent approach to determining the impact of single rooms (applicable to all developments with single rooms); and
• Some staff may not wish to transfer to the new facility and will require to be redeployed.

2.4.2 Building for Better Care & Local Unscheduled Care Action Plan (LUCAP)

Overview of the development
Building for Better Care is a programme of investment for front door services at both Ayr and Crosshouse Hospitals aimed at improving the quality and effectiveness of the assessment and treatment of patients who present with emergency and urgent conditions. The phases currently in scope are:

Phase 1
• Development of new build A&E at Ayr Hospital, comprising 14 treatment rooms, 4 resuscitation bays, 1 triage room and 10 observation bays, addressing the capacity and infrastructure constraints inherent in the current service; and
• Development of a new combined assessment unit at Crosshouse Hospital comprising 42 single en suite rooms, 11 ambulatory care bays, 3 acute assessment beds and 2 outpatient rooms.

Phase 2
• Development of a new combined assessment unit at Ayr Hospital comprising 35 single en suite rooms, 8 ambulatory care bays, 2 acute assessment beds and 2 outpatient rooms.

The developments are scheduled for delivery in 2016/17.

The Local Unscheduled Care Action Plan in tandem with Building for Better Care provides the improvement schema in addressing the issues and challenges preventing consistent delivery of quality unscheduled care. The strategic themes within LUCAP being:

• Making the community the right place: developing community services and support for people with ongoing care needs;
• Getting urgent care needs met at the right time, in the right place: developing primary care response;
• Getting emergency patients to the care they need at the right time: flow and acute hospital;
• Making sure patients get the right care across unscheduled care: promoting senior decision making along the pathway; and
• The right care every time: assuring effective and safe care 24/7 at the hospital front door.

Workforce impact – progress to date
The Workforce Group was established in April 2013 and is focusing upon clinical staffing initially. A table top mapping exercise took place in June to better understand the flow of patients and the distinct roles different professions play within the patient journey and how this is likely to change with the new model of care.

In progressing work for the outline business cases initial work has taken place to identify the impact upon nurse staffing based on the bed modelling that has taken place for both Ayr and Crosshouse Hospitals in relation to the proposed combined assessment units and downstream beds. This has indicatively indicated a requirement for additional nursing staff on both sites and further work will be undertaken to refine this position utilising the nursing and midwifery tools.

The financial impact of predicted workforce changes is a prime consideration and finance colleagues are actively involved in the Workforce Group to ensure there is robust scrutiny in terms of affordability, phasing and impact/fit with the organisational financial plan.

Workforce work plan during 2013/14
• Refine the nursing workforce projections ensuring these take cognisance of available tools;
• Initiate planning with non-clinical services i.e. support services to determine workforce impact;
• Determine the workforce impact on community based services; and
• Determine the medical workforce requirements to deliver the model of care.

Identified workforce risks
• Ensuring nurse projections utilise an agreed and consistent approach to determining the impact of single rooms (applicable to all developments with single rooms);
• Supply of general and acute physicians to meet demand that the new model will present, against the backdrop that other NHS Boards will similarly be pursuing models of care utilising generalist medical staff;
• Ensure workforce plan is completed to inform completion of the full business case;
• Allocation from SGHD compared to bid as detailed within LUCAP; and
• Ability to recruit to posts as detailed within LUCAP within the prescribed timescales.

2.4.3 Transforming Outpatient Services

Overview of the development
The aim of the programme is to improve patient access to specialist advice, support, opinion and appropriate treatment by making the best use of available resources across NHS Ayrshire & Arran. The programme aligns to the National Transforming Outpatients
Programme: Improving Quality & Efficiency (CEL11(2012)) and is instrumental in delivering the Patient Rights Act 2012 and treatment Time Guarantee (CEL32/33).

Workforce impact – progress to date
Much of the work to date has been focused on transactional activity in relation demand, managing the primary/secondary care interface, patient pathway management and monitoring outpatient utilisation.

In relation to outpatient nursing workforce, the focus has been on implementing the long term nursing skill mix review including developing the band 3 role which has been underway for some time.

A short life working group was established to consider medical secretarial roles given the intrinsic role these staff play within the patient journey and transactional activity, with a baseline data collection exercise having been undertaken in late 2012 to identify any particular ‘hot spot’ areas. Areas which have been flagged include working environment, career pathway for medical secretarial staff and associated training, relief cover, culture within teams, interface with medical records and variations in workflow / allocation of work with in specialty teams.

Workforce work plan during 2013/14
- Develop recommendations arising from the short life working group on medical secretaries which address the themes that have been flagged;
- Develop the project plan for clinical staffing workforce planning;
- Engage with staff on options for extended working days;
- Engage with University of West of Scotland on training opportunities to meet changing needs;
- Update nursing workforce plan via Transforming Outpatient Services Workforce Group;
- Engage with medical, nursing and AHP staff on opportunities and impact of TOPS programme and identify associated training requirements – e.g. use of tele-medicine and use of self management techniques;
- Engage with reception staff to pilot use of self service check in facilities as part of wider programme of change and innovation impacting on reception services; and
- Support outpatient staff through transition to new Outpatient department at Ayr and closure of existing premises.

Identified workforce risks
- Releasing staff to undertake training and development in face of increasing activity; and
- Age profile of staff within outpatients.

2.5 Finance

Current Financial Year

NHS Ayrshire and Arran’s budget for 2013/14 is £603.4 million, an uplift of £16.2 million on the 2012/13 budget. As in previous years there will be additional ring-fenced in-year allocations from SGHD for specific initiatives – leading to creation of short term, fixed term posts over and above the projected workforce increase projected for the year. In particular, the impact of the Local Unscheduled Care Action Plan is difficult to predict at the time of submission.
The 2013/14 cost pressures identified amount to £28.6 million as summarised below:

<table>
<thead>
<tr>
<th>Cost pressure summary</th>
<th>£ million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay Related</td>
<td>6.6</td>
</tr>
<tr>
<td>Supplies and property costs</td>
<td>7.6</td>
</tr>
<tr>
<td>Prescribing and drugs</td>
<td>6.7</td>
</tr>
<tr>
<td>Clinical developments</td>
<td>7.7</td>
</tr>
<tr>
<td><strong>Total cost pressures</strong></td>
<td><strong>28.6</strong></td>
</tr>
</tbody>
</table>

After taking account of the allocation uplift of £16.2 million, and other income increases of approximately £0.3 million, there is a funding gap of £12.1 which requires cash releasing efficiency savings (CRES) (of which £1.9 million was workforce related) to achieve recurring revenue balance.

Whilst CRES requirements for 2013/14 have largely been met by the removal of vacant posts from budgets as at 31st March there remains a concerted effort in controlling workforce related expenditure via natural turnover; exerting greater control and scrutiny of supplemental staffing usage (bank, overtime and excess part-time hours) and seeking to reduce the number of displaced staff within redeployment.

2014/15 onwards

It is known that there will be considerable constraints on public sector funding in the coming years as demonstrated in the chart below. The uplift in 2013/14 was greater than anticipated but should not be viewed as setting a new trend.

**Chart 1 – SG Revised forecast expenditure**

*(source: Commission on Future Delivery of Public Services, Scottish Government)*

To manage these financial constraints there will be an impact locally and an influence on service in future years. As over half of NHS Ayrshire & Arran’s budget relates to workforce related expenditure there will be reductions, in line with planned service redesign, whilst needing to maintain the safety and quality of services provided.
2.6 Overarching factors influencing the workforce

2.6.1 Local population

The General Register Office for Scotland projects (based on 2010 population statistics) the overall population for Ayrshire and Arran is predicted to remain static, at approximately 367,000 until 2025. Thereafter the population is predicted to reduce – by 1% by 2030 and a further 2% by 2035.

Despite the overall static position predicted for the overall population over the next 12 years there are notable changes projected to the age profile, as illustrated below, which will exert pressure on both the healthcare services NHS Ayrshire & Arran provides as well as social care provided by local authority partners. The effect of the changing demographic is twofold, not only in relation to demand on services but also on the workforce, recognising that a significant proportion of our workforce is part of the local population.

### Chart 2 – Population Projections (source: General Register Office for Scotland)

Note

The pensionable age projections take account of legislative changes whereby by 2020 the pensionable age for women will rise to 65 (to match that for men) and between 2024 and 2046 state pension age will increase from 65 to 68 for both sexes.

Decreases in children and working age populations within Ayrshire and Arran are contradictory to the steady growth pan-Scotland position predicted in these groups. Growth in the over 65 age group is consistent with the pan-Scotland position. Within the over 65s age group sustained significant predicted growth in the 75+ age group is predicted – from an 11% increase in 2015 to 78% increase projected for 2035.

The 2020 Workforce Vision identified the big picture challenges related to demographics and population as being:

- Planning to meet the needs of an ageing population with an ageing workforce;
- Managing changing demand resulting from an increasing prevalence of complex long-term conditions and co-morbidities;
- Managing demand from an increasing population with dementia;
• Managing public expectations about care they receive; and
• Addressing the considerable variations in life expectancy between geographical and socio-economical groups.

Within the current partnership approaches there are established Older People’s Working Groups which make sure that we continue to deliver services that work for older people in line with the aspirations of Reshaping Care. We recognise that the way the older people’s population is changing means that we cannot stand still and we need to be continuously creative and innovative as we move forward and to work together with all of those services and organisations who provide caring services. To support the re-design and development of services, each partnership has been allocated funds (Change Fund) through the NHS budget. This fund is to provide “bridge funding” to re-design and further develop services in partnership with our local Authorities and to also include the third and independent sector to support the delivery of new approaches with the ultimate aim of improving quality and improved outcomes for older people.

The plans currently developed through the Change Fund process focus on services to reduce delayed discharges, to reduce emergency admissions to hospital and to enhance care at home services and support to unpaid carers. The Change Fund (£8m) is in place to fund the developments until 2015. During this time, services will require to be evaluated and assessed for future fitness of purpose as we move towards social and health care integration and the mainstreaming of these redesigned and new services. A direct impact upon the workforce arising from utilisation of the Change Fund is the risk within AHP services in relation to fixed term contracts, and associated backfill arrangements, and this detailed further at section 4.1.

2.6.2 Integration of Health & Social Care

NHS Ayrshire & Arran in partnership with local authority partners are proposing a body corporate model for the integration of health and social care in response to the Public Services (Joint Working) Scotland Bill, which is anticipated to come into force by 1st April 2015, with three Health & Social Care Partnership co-terminous with the local authorities in North, South and East Ayrshire. Chief Officers are to be appointed by October 2013 with Shadow Integration Boards to commence on 1st April 2014 to pave the way for the creation of integrated Health & Social Care Partnerships with integrated budgets by 1st April 2015.

Discussions are still ongoing to determine the range of services to be included within the partnerships and there will be variations as to the range of services directly managed by each partnership.

There is clearly a direct workforce impact on NHS and local authority staff and the mechanism for ensuring a robust and inclusive approach to workforce planning which takes cognisance of the characteristics of the respective workforces will be a key consideration.

2.6.3 Management restructuring of organisation

The organisational restructure is underway and impacts arising from this will be factored into workforce planning activity accordingly.
2.6.4 Local labour market & employability

The recession continues to have an impact on the local labour market, as illustrated in the unemployment rates for council areas below, and whilst this provides an increased supply in the local labour market this is mitigated by constrained workforce demand from NHS Ayrshire & Arran due to increased scrutiny and control of vacancies.

Table 1 – Unemployment claimant rates (based on age 16 to 64 population):
March 2012 (source: Office of National Statistics)

<table>
<thead>
<tr>
<th>Area</th>
<th>Rate</th>
<th>Number unemployed</th>
<th>Variance compared to March 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Ayrshire</td>
<td>5.9%</td>
<td>4,607</td>
<td>-0.3%</td>
</tr>
<tr>
<td>North Ayrshire</td>
<td>6.7%</td>
<td>5,725</td>
<td>-0.1%</td>
</tr>
<tr>
<td>South Ayrshire</td>
<td>4.5%</td>
<td>3,119</td>
<td>-0.2%</td>
</tr>
<tr>
<td>Scotland</td>
<td>4.1%</td>
<td>142,965</td>
<td>-0.3%</td>
</tr>
</tbody>
</table>

North Ayrshire has the highest unemployment claimant rate in Scotland as at March 2013 and East Ayrshire has the joint third highest rate compared to all local authorities in Scotland. All three local authorities showed an overall reduction in unemployment claimants when compared to March 2012.

Employment is one of the most strongly evidenced determinants of health, the World Health Organisation (WHO) notes that ‘unemployment puts health at risk’ and ‘unemployment has a direct bearing on the physical and mental health and even life expectancy for unemployed people and their families’. Unemployment therefore has a direct impact upon service provision.

NHS Ayrshire & Arran is committed to supporting youth employment and runs a number of initiatives in conjunction with partners:

- Get Ready for Work – national skills and training work placement scheme for people aged 16 to 18 who are finding it difficult to access training, learning and employment. A training allowance is provided, along with support for participants to prepare for the world of work (38 participants in 2012/13);
- Transitional employment – Providing vocational training and work experience for long term unemployed aged 16+ allowing trainees to work towards a National Progression Award in Office Skills equivalent to SVQ Level 2 in Business Administration (8 participants in 2012/13);
- Modern Apprenticeships – offer people aged 16+ paid employment combined with workplace training and off-the-job learning, in order to gain new and enhanced skills and recognised qualifications. NHS Ayrshire & Arran currently have modern apprentices in administration, plumbing, electrics and medical fitting (5 currently in post);
- Schools work experience placements / college work experience placements – secondary school pupils (4th to 6th year) and/or college students undertaking placements within various departments across organisation (170 participants in 2012/13);
- Skills for work – pre-employment training programme in conjunction with James Watt College with placement opportunities in catering, domestic and portering departments with practical support from employability workshops for participants (11 participants in 2012/13); and
• Project SEARCH – during 2013/14 the Board will participate in Project SEARCH in conjunction with East Ayrshire Council. This is a one year education transition programme which provides training and education for students with disabilities to find and maintain employment. Over the course of the year 8-10 students with learning disabilities will rotate through a series of job placements, offering on the job work experience of work skills combined with tuition.

3. Overview of the current workforce

3.1 Workforce composition

As at 31 March 2013 NHS Ayrshire & Arran employed 8454 whole time equivalent staff, (10,457 headcount) across 10 nationally defined job families as detailed below – note this does not include bank staff.

Chart 2 – Workforce composition
(source: NHS Ayrshire & Arran HR System)

Make-up of the workforce (WTEs) and % of proportion

Job families are nationally defined and commonly applied by all NHS Boards.
<table>
<thead>
<tr>
<th>Job Family</th>
<th>Roles/ professions</th>
<th>Job Family</th>
<th>Roles/ professions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative services*</td>
<td>Health records, medical secretaries, clinical team support, IT services, service management</td>
<td>Medical &amp; dental</td>
<td>Includes all grades of doctors (including those in training) and dentists employed by community dental service</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>arts therapists, dieticians, occupational therapy, orthoptists, physiotherapy, podiatry, radiography and speech and language therapy</td>
<td>Nursing &amp; Midwifery</td>
<td>all branches of nursing adult, children, mental health, learning disabilities and maternity</td>
</tr>
<tr>
<td>Healthcare science</td>
<td>laboratories staff, audiology, cardiac physiology</td>
<td>Other therapeutic</td>
<td>psychology, optometry, pharmacy and play specialists</td>
</tr>
<tr>
<td>Management</td>
<td>non Agenda for Change managers (typically senior management)</td>
<td>Personal &amp; social care</td>
<td>health promotion staff</td>
</tr>
<tr>
<td>Medical &amp; dental support</td>
<td>includes dental nurses, dental technicians and theatre services such as operating department practitioners</td>
<td>Support services</td>
<td>includes chaplaincy, cleaners, portering, catering, maintenance and estates and sterile services</td>
</tr>
</tbody>
</table>

*Note the administrative job family includes posts that are part of the clinical team and are patient facing and cover a very wide range of roles from junior admin roles, within for example health records, through to senior general management roles for clinical services (who are Agenda for Change banded). Management roles are effectively a sub-set of the administrative job family however they are categorised differently as the staff within this group are on executive and senior manager grades and not Agenda for Change.

3.2 Workforce demography

The data presented in this section goes to job family level. The WPPB receive drilldown demography reports on sub job families, which provide a greater level of detail, as a standing agenda item and these reports encompass the data which is presented in this section.

The chart below shows illustrates the gender split within job families as well as the contract type (full time or part time).

![Chart 3 – Gender and contract type](source: ISD Workforce Information)
As is evident the workforce is largely female, with the exception of medical and dental staff where there are a higher proportion of males although this is in relative terms – within medicine more women are entering training however a larger proportion are choosing to work part time and utilise family friendly entitlements thus extending the time taken to train which will ultimately impact on future trained doctors. The overall organisational split is 83.7% female versus 16.3% male compared to the NHS Scotland rates of 78.6% females and 21.4% males.

In terms of contract type the organisational rate is 50.4% full time staff versus 49.6% part time. The NHS Scotland rates are 57% full time staff versus 43% part time staff. 44% of females in NHS Ayrshire & Arran work full time, compared to 49.8% across NHS Scotland, and 83.7% of males work full time, compared to 84.2% across NHS Scotland.

91.6% of our staff are aligned to Agenda for Change terms and conditions – the bulk of non Agenda for Change staff being medical and dental.

3.3 Shape of the workforce

Workforce tree charts are used as a visual tool to depict the shape of the workforce, prompting discussion and consideration of whether the skill mix of differing grades and roles within professions, departments or teams requires to be adjusted. The Agenda for Change (AfC) band is represented on the y (vertical) axis.

Chart 4 – Distribution of Agenda for Change Bands as at 31st March 2013
(source: NHS Ayrshire & Arran HR system)

Typically trees taper towards the top which is representative of there being a smaller cohort of posts which require higher or advanced skills and competences. There has been little variation in the overall shape of the AfC workforce over the last year.

3.4 Age of the workforce

The chart below shows the age distribution, as a proportion, for job families.
There is clear variability between job families and ensuring robust succession planning for the 45+ age group will be a key organisational consideration albeit this will require to be countered against national legislation. The new Public Services Pension Act 2013 means that from 2015 NHS staff will have a normal pension age equal to their state pension age. Whilst some staff are protected from the change, up to 70% of the workforce will now have a pension age of between 65 and 68 depending on their date of birth. This could increase again in the future if the Government raises the state pension age further.

The NHS Working Longer Review is a joint review between NHS Employers, NHS Trade Unions and the Health Departments of England, Wales and Scotland to consider the possible impact of a raised pension age: how will the NHS be able to provide a high quality service with an ageing workforce? The review is currently collecting evidence to identify examples of good practice that enable staff to keep working as well as countering this with issues and/or barriers that may make working to a higher pension age more difficult. The outcomes from this review will be instrumental in determining our local approach to our ageing workforce presenting a key issue for the workforce planning and staff health and wellbeing agendas to collaboratively take forward.

‘Older workers are increasingly looking to extend their working lives, with more than 50% of workers aged over 55 planning to work beyond the state retirement age. Financial reasons are most commonly cited as the motivation behind delaying retirement, but older workers also cite wanting to continue to use their skills and experience and enjoy the social interaction of the workplace as key factors’. (Managing a Healthy Ageing Workforce a national business imperative – A guide for employers: Healthy Working Lives & CIPD: March 2012).

Ensuring the health needs of our ageing workforce is critical, not least in recognising that some roles, e.g. nursing, have a substantial physical element and may become more onerous. As identified by the Health & Safety Executive (HSE: Diversity in the workforce –
There are differences in the sickness absence patterns between younger and older workers. Typically, younger workers tend to be absent more often, but for shorter periods of time, whereas older workers are likely to be absent less frequently but are more likely to have a longer period of absence.

Younger age profiles also need to be considered carefully, for Allied Health Professions and Other Therapeutic (which includes pharmacy and psychology staff) job families there is a direct correlation between the gender (predominantly female) and age (a younger age profile compared to the organisation average) and associated maternity leave rates. Both of these job families had maternity leave rates which are significantly higher (almost double) the organisational average of 1.7% in 2012/13, and have had elevated rates, compared to the organisational rate, of maternity leave for several years.

3.5 Staff turnover

The nationally defined calculations for staff turnover are:

\[
\text{Turnover} = \frac{\text{Number of leavers (measured as headcount)}}{\text{*average staff in post (measured as headcount for year concerned)}}
\]

\*Avg. staff in post = \(\frac{\text{Staff in post as at 1 Apr yr(n) + staff in post at 31 Mar yr (n+1)}}{2}\)

(Note all turnover detail excludes training grade doctors and dentists)

It is important to note that both local and national turnover reporting is based on leavers i.e. individuals that have exited the payroll and as such internal staff movements to another role are not reflected within turnover detail.

As illustrated in the chart the turnover rate for NHS Ayrshire & Arran has consistently been lower than the Scottish average for the past six years. In addition the organisation has also had the lowest turnover rate when compared to all territorial mainland NHS Boards. The organisational turnover rate for 2012/13 is 6.6% and is broadly consistent with the rate over the previous two financial years; the NHS Scotland rate has not as yet been published.

![Chart 6 - Staff turnover](Source: ISD Workforce Information)

The low turnover rate for the organisation is a significant factor as natural turnover often provides the leverage to enable services to redesign roles and alter skill mix albeit the
volume of internal staff movement also provides scope however this is not classed as turnover. For the last two years the turnover rate has remained static at 6.6% with approximately 673 (headcount) leavers. Turnover of the largest staff group, nursing and midwifery, has consistently remained below the organisational rate at 5.3%, 5.4% and 5.5% over the last three financial years.

3.6 Staff health and wellbeing

As identified in the quality strategy there is a correlation between staff experience and staff wellness with patient experience and patient outcomes and therefore an improvement in the health and wellbeing of staff is of paramount importance to the organisation.

A key outcome of improving staff health and wellbeing will be a reduction in the sickness absence rate. The chart below shows the sickness absence rates within the organisation over the past five years and illustrates how challenging sustaining a reduction can be.

![Chart 7 – Yearly sickness absence rates](source: NHS Ayrshire & Arran HR System)

The charts below shows the monthly sickness absence rate during 2012/13 comparing this to the level of absence for the same period the previous year and the NHS Scotland rate, by month, during 2012/13.
There is a concerted effort within the organisation to address sickness absence rates and as the chart illustrates there has been progress within the first quarter of 2013/14. The Staff Health and Wellbeing Strategy was endorsed by the NHS Board in May 2013. The re-invigorated approach to Promoting Attendance as detailed within the Draft Action Plan, endorsed by the Area Partnership Forum in May 2013, in conjunction with the new Promoting Attendance Policy will be instrumental in addressing sickness absence.

3.7 Supplemental staffing

In order to minimise service disruption and to ensure service standards are maintained NHS Ayrshire & Arran utilises bank or agency / locum as supplementary staff. Normally this is in response to staff absence, or alternatively to provide cover for hard to fill vacancies in the case of medical staff in the short to medium term, the duration of cover being variable dependant on circumstances.

This expenditure is incurred across all job families however the highest proportion is incurred within medical and nursing job families. The following charts illustrate this expenditure over the last 5 years:
Significant work is ongoing in addressing nurse bank costs with mechanisms and processes put in place to facilitate the use of the most cost effective supplementary staffing solution be it bank, overtime or excess part time hours using a ‘ready reckoner’.

Whilst overtime, excess part time hours, or the nurse bank is preferable there is occasion, particularly in periods of high demand for supplemental staff, whereby agency staff require to be utilised to ensure cover and service sustainability. There are established operational escalation procedures for proceeding to agency usage. As Chart 11 illustrates there has been a marked increase in nursing agency usage during 2012/13. Demand for nursing agency usage, and indeed wider supplemental staffing solutions such as overtime and excess part time hours, has been exacerbated by a number of factors including:

- On overall rise in the volume of unscheduled care, by 10% as opposed to the projected level of between 3-5%, necessitating opening further beds at short notice, particularly in the evening, to meet surges in activity;
- Significant increases in the very frail at risk patient group within general wards leading to an increase in one to one nursing care requirements;
- Increased demand within Intensive Care Units at both sites requiring additional capacity staffed to the appropriate level with the skilled ICU nurses;
- Increased demand within A&E requiring skilled A&E nurses;
- Increase in one to one observation requirements within mental health services; and
- Complex packages of care within the community e.g. mechanical ventilation.

The chart below illustrates the volumes (the hours utilised have been converted into whole time equivalents) of overtime and excess part time hours that have been utilised during 2012/13 compared to 2011/12. There is a direct correlation between the reduction in nurse bank usage and use of overtime and excess part time hours driven by use of the ‘ready reckoner’ tool which is utilised to determine the most cost effective supplemental staffing solution to utilise dependent upon day or time i.e. weekday, weekend, public holiday, day/night shift. Agency is utilised when other supplemental mechanisms have been exhausted however for specialist nursing roles agency may be the only immediate solution.
There appears to be a clear link between casual labour and poorer outcomes for patients and families, as was demonstrated in the Report into Mid-Staffordshire NHS Trust, therefore it is the organisation’s ambition to reduce to the lowest possible level the use of bank, locum and agency staff and further work on this area will be reflected in future iterations of the workforce plan.

3.8 Learning & Development

Learning and development is an intrinsic element of workforce planning and the organisational Learning Plan to be developed during 2013/14 will complement both this and future workforce plans.

Work is underway within the organisation to embed mandatory and statutory training requirements and implement a new induction process for new staff. Ensuring all staff have an annual performance development review (PDR), which includes personal development planning (PDP), remains an organisational priority.

The Educational Partnership, with the University of West of Scotland, Glasgow Caledonian University and Ayrshire Colleges, will seek to identify and progress opportunities to strengthen learning and development opportunities in collaboration with partners.

4. Designing the future workforce

4.1 Workforce issues the NHS Board faces

Work has been undertaken to identify ‘hotspot’ workforce areas within the organisation across clinical and non-clinical staff groups. The intelligence gained on clinical staff groups was utilised to inform the NHS Ayrshire & Arran response to the Migration Advisory Committee (MAC) review of shortage occupation lists for the UK and Scotland, which is related to workforce supply issues.
The workforce issues faced by the Board can be grouped into the following distinct categories:

**Remuneration**
Professional information technology (IT) roles – analytical, technical and project management at Bands 6+ – remain challenging to fill, the key factor impacting upon this position being the significant variation between NHS pay and the IT industry. This presents an immediate issue with posts being hard to fill but also a future pressure in terms of staff turnover. A solution to this problem is the use of contracted agency IT staff however there is a cost implication associated with this.

The removal of Recruitment Retention Premia (RRP) for hospital chaplains (Band 6) will impact upon future recruitment as remuneration will be lower than stipends and associated benefits externally.

**Fixed Term Contracts**
Whilst the use of fixed term contracts is a useful mechanism, especially in conjunction with ring fenced time limited funding, these can prove to be problematic in terms of attractiveness of taking up a fixed term role compared to Boards offering permanent position. A direct impact which has arisen from Change Fund developments has been the challenge of recruitment to Band 5 and 6 fixed term AHP roles across the professions as other Board areas have advertised permanent positions.

A number of programmes within Public Health have ringfenced funding and this can create difficulty with both recruitment and retention of staff. Staff may leave a fixed term role early to secure a post with greater permanency which leads to greater challenges in recruiting as the post is then of an even shorter term nature making filling the vacancy more challenging.

**Geographic**
Services on both Cumbrae and Arran pose some challenges directly related to staff turnover. On Arran the recruitment to existing posts and future pressures anticipated for Elderly Mental Health RMNs is problematic due to the availability of RMNs living on the island.

The provision of out of hours, at evenings and weekends, urgent clinical care on Cumbrae following the retirement of the island GPs in March 2013 lead to an option appraisal whereby the result was an on-island Advanced Nurse Practitioner (ANP) cover 12 hours a day Monday to Friday and 24 hours at weekends will be established. The NHS Board agreed the proposals for the out of hours care and the interim arrangements for provision of in and out hours GP cover in the interim (to September 2013) until the both the new model of out of hours care and the recruitment process for new GP concludes. The development of safe, high quality, sustainable, affordable and cost effective service models for both islands is a priority for the NHS Board.

**Demographic**
As detailed earlier, the age profile of within the various job families does present challenges – from both older and younger profiles – in terms of service sustainability.

Older workforce profiles present challenges with regard to succession planning particularly for professional staff groups. Healthcare Science for example has a high proportion of
staff aged over 60 (7.8%) which is 2% higher than the overall organisational workforce profile and the profile for all healthcare science staff pan on a pan-Scotland basis.

As previously detailed the gender and age profile for some job families, such as other therapeutic and AHPs, has a direct correlation to maternity rates in excess of the organisational average which places pressures upon service provision.

Workforce Supply

Small occupational groups
For some specific roles there is an imbalance between demand and supply with the levels demand far in excess of supply on a pan-Scotland basis.

Sonographers and orthoptists are small occupational groups, both with less than 10 WTE, locally and any vacancies present a challenge in trying to recruit as this is a small cohort on a pan Scotland basis and is exacerbated by known national supply issues for these groups.

Medical physics, as a specialism within healthcare science, has also been flagged both locally and nationally as an anticipated area of future pressure due to the size of the staff group, age profile, and known supply issues.

The Scottish Government Health & Social Care Directorates have initiated work in considering these staff cohorts on a national basis.

Medical Staff
Whilst there was some success in recruiting to long standing medical vacancies during 2012/13 – 3.4 WTE emergency medicine and 3.8 WTE radiology – there still remain pressures in the system at both consultant and specialty doctor level (A&E and medical specialties). Consultant appointments need to taken in the context of lead in times as for some appointments the post holder does not commence until the preferred candidate has achieved their CCT therefore whilst a vacancy may have arose in 2011/12 it may not have been until into 2012/13 that the appointee commenced.

In addition to consultant vacancies there remain challenges in filling some trainee medical posts with particular pressure in successfully filling both general medicine and emergency medicine posts which presents problems such as rota gaps within services.

Filling GP specialist training roles is also proving difficult which will impact on future GP recruitment and is compounded by a lack of training practices.

Vacancies necessitate the requirement to utilise locums, where available, which incurs a significant financial expenditure (as illustrated in Chart 9 - Medical Agency Usage).

4.2 Service developments
The workforce planning activity underway in relation to the service developments as detailed at section 2.3 will have a direct impact upon the design of the future workforce as role development and the education and training to enable this are definitively defined.
4.3 Nursing workforce

Nursing workforce tools

The pressure on the nursing workforce to deliver high-quality, safe, effective person-centred care is greater than ever and essential to get workforce planning right. Using the workforce tools together with other workforce/local intelligence provides a sound platform to determine staffing levels, rather than making workforce decisions on historical allocation or the basis of affordability.

All Boards across NHS Scotland are being mandated to use workload and workforce planning tools which have been designed to ensure that our hospitals and communities have the right numbers and mix of nursing staff. The tools are developed in partnership with key stakeholders, researched, tested and refined with final ratification and validation nationally. To date the Nursing and Midwifery Workforce Workload Planning Program has facilitated local implementation within boards thereby assuring tools are applied systematically across the whole of the healthcare system in Scotland.

There are 12 tools, covering 95% of clinical nursing areas, from adult inpatient, community, mental health, theatres, emergency departments, neonatal, maternity, specialist nurses and children's services. Each tool has three elements addressing the acuity and patient dependency within the speciality-specific workload, local quality measures and professional judgement. The latter includes skill mix considerations. The workforce tools are valuable in their own right but additional measures are required which include local standards, environment and workforce intelligence i.e. supplementary staffing, absence, age profile and turnover etc

Diagram 2 – Nursing Workforce Triangulation Methodology

NHS Ayrshire & Arran fully support and utilise the triangulated workforce methodology for assessing the current workforce but also for improved planning for the future. The professional judgement tools have been used extensively across all inpatient areas, during June 2013, along with the adult inpatient tool. The results from application of the tools are being processed during July and the outputs will be used to inform the Nursing Workforce Summit in September 2013.

The A&E workforce tool is nationally scheduled for use at the end of August 2013.

The outputs of adopting this approach has led to an increase in staffing numbers and enriched skill mix within older peoples services with a net result of improved flexibility and responsiveness to increased demand or absence and in turn reducing supplementary staffing costs.
Predicted Absence Allowance
Nursing and midwifery establishments in the majority of areas have an additional funded allowance to allow round the clock services and provide adequate backfill for absence. This is the predicted absence allowance and is currently set at 22.5%. This allows 14.5% annual and public holiday leave, 4% sickness, 1% maternity, 2% Study and 1% all other leave. In essence this should provide safe and sustained care provision during staff absence however acknowledged factors such as high sickness, maternity leave and the need for additional training significantly impede the ability to provide adequate backfill.

Rostering
Ensuring consistent and equitable rostering practice across the organisation is a significant factor in ensuring the predicted absence allowance is effective. Historically there was limited training for Senior Charge Nurses and frontline clinical staff to assist them to develop safe and effective rosters keeping within the predicted absence allowance. A key priority during 2013/14 will be implementing the endorsed principles for effective rostering within Directorates which will include rostering guidance and a rostering toolkit for Senior Charge Nurses and midwives.

Supplemental staffing
Despite a continued reduction in nurse bank use there has been a significant increase in agency nurse use. This and other workforce data highlights key areas for development of flexible workforce solutions with substantive staffing opportunities i.e. complex packages of care in the community, additional winter beds and for acute mental health

Nurse Intern Scheme
The Nursing & Midwifery Internship program has been a great success within NHS Ayrshire & Arran with 75 placements offered throughout the year. Over 95% of newly qualified nurses entering the program secure substantive employment before exiting the scheme. The support of the program and partnership working between practice education, clinical managers and new staff has led to the one of the highest completion rates of the flying start program in Scotland

4.4 Medical Workforce

Context
Medical workforce planning is set against a unique environment, unlike the other job families, whereby NHS Boards have responsibility for the recruitment and retention of consultant and specialty grade doctors whereas the appointment to formally accredited medical training posts is undertaken on a national pan-Scotland basis. Established regional and national planning mechanisms are in place to determine both the required size and subsequent distribution of training cohorts, by specialty, across the regions and ultimately NHS Boards.

Policy and statute
The following areas have a direct impact upon local medical workforce planning:

- Reshaping the medical workforce

The objective of Reshaping the Medical Workforce has been to increase the proportion of trained doctors providing front line medical care to maximise patient safety and service quality. Ultimately this is to be achieved via better alignment between trainee numbers and likely future trained doctor appointments and as a result of this there has been a reduction in trainee numbers. Whilst Reshaping is considered complete within some
specialties there is currently a ‘pause’ (i.e. no change in the number of trainees unless there is compelling evidence for either reduction or growth) for a number of ‘front door’ specialties which is directly linked to the national work underway via the Unscheduled Care Expert Group which will make recommendations in respect of these specialties. Specialty areas we are already experiencing pressures in filling posts within, e.g. emergency medicine and general/acute medicine, are included within this group.

- Revalidation and appraisal

Medical revalidation is the process by which doctors will demonstrate to the General Medical Council (GMC) that they continue to be fit to practise, through participating in a robust and transparent annual appraisal process, over a 5 yearly cycle. The roll-out of revalidation is being phased in Scotland over a three year period. Balancing the requirement to meet continuing professional development (CPD) needs against service commitments will be a key consideration in compliance with the requirements.

**Current and anticipated challenges**

Vacancies across medical grades, as detailed in section 4.1 – workforce issues the NHS Board faces – present a real challenge to the organisation both in sustaining current services but also considering plans for future service provision. Imbalance between demand and supply for some specific specialties and distinct new roles (e.g. acute physicians) on a national basis coupled with Boards on a regional basis seeking to appoint from the same, limited, available pool makes recruitment and retention particularly challenging. This situation is compounded with the decreasing trainee workforce, as a result of Reshaping, and the low fill rate within some specialties. There has been an improvement overall in filling training grade post for the August 2013 changeover and specifically within general medicine, which has been challenging for a number of years, there has been success in filling posts albeit some work is ongoing with regard to seniority.

The changing demography of the medical workforce coupled with individuals wanting to improve work life balance and/or work part time also presents challenges in the longer term. For trainees this presents as taking longer to complete training and directly increases the fragility of rotas.

Discussions nationally, both within Scotland and at a UK level, in relation to 24/7 working patterns for medical staff are at an early stage and will necessitate negotiation in relation to terms and conditions.

**Way forward**

A Medical Workforce Group will be formed during 2013 which will improve internal planning and engagement over medical workforce issues and facilitate enhanced input to regional and national medical workforce planning forums via greater local intelligence. The expectation is that the Medical Workforce Group would provide the oversight and scrutiny on a uni-professional basis to support and inform overarching organisational workforce planning:

- Ensuring service planning comprehensively considers medical model of care;
- Monitoring medical recruitment and retention across all grades in order to proactively contingency plan for vacancies mitigating service disruption; and
- Scrutiny of locum and agency utilisation.
4.5 Workforce projections

CEL 32 (2011) - Revised Workforce Planning Guidance 2011 - sets out the requirement for all NHS Boards to submit workforce projections on an annual basis. NHS Boards are asked to predict in June of each year the changes that are anticipated will take place in the workforce by the end of March the following year, by job family. The workforce projections detail the anticipated changes to our workforce, by job family, that we predict to take place by 31st March 2014. These predictions are submitted to SGHD separately from this Workforce Plan but it is important for this plan to refer to what is predicted and offer an explanation. Improvements are required both in terms of how the Board predicts workforce change moving forward and then analyses and reports on what did happen and the process and information sought by SGHD.

Projections definitions
SGHD asks Boards to submit, for each job family, the number of staff that the Board expects will be employed by the end of the following March and then at a national level compares these figures to the actual number of staff that were in post at March the previous year. The figures reflected below were submitted to SGHD in June 2013 for the staffing levels we anticipate employing as at March 2014 as compared to the staff we employed at the end of March 2013.

There are a number of limitations to this process:
- Point in time – the projections are based upon known intelligence early in the financial year and a number of factors could impact which have not yet emerged;
- Staff in post – the projections are based on actual staff in post and do not reflect staff that may be within the recruitment ‘pipeline’ or supplemental staff usage; and
- Numerical focus – Boards are simply asked to identify the numbers of staff anticipated to be on the payroll at a future point in time. This therefore masks the richness of detail relating to planned reductions/increases due to local service development or national allocations which in the main are fixed term non-recurring revenue. This predominant numbers focus may mask reasons behind changes and indeed lead to conclusions that may be wrong albeit there is limited narrative within the return to SGHD.

The data utilised for projections is defined by SGHD and commonly applied by all NHS Boards. The basis of projections is actual staff in post on the payroll, reflecting contracted WTEs, with the exception of nurse interns, medical locums, and bank staff, which are all excluded from the figures. SGHD excludes all supplemental staff usage – bank, agency, overtime or excess part time hours – and these are not reflected in the figures.
NHS Ayrshire & Arran workforce related efficiency savings requirements for 2013/14 have predominantly been achieved via the removal of vacant posts from the financial establishment unlike previous years whereby there was a necessity for workforce change, in that staff would exit the organisation in the course of the year, to achieve required savings. As projections are based on actual staff in post and not establishment this detail is not reflected within the table above.

Whilst there are indicative increases in some job families this must be countered with some being the result of finite revenue streams whereby appointments will be made on a fixed term basis e.g. Change Fund application (16 WTE of the overall projected change). In addition some of the projected workforce change relates to planned recruitment to existing vacancies (10 WTE of the overall projected change). A significant proportion of the predicted workforce change relates to national initiatives 13.2 WTE relates to the plan for Detecting Cancer Early and 15.9 WTE relates to the Local Unscheduled Care Action Plan (LUCAP).

As previously mentioned the robustness of workforce predictions are limited by point in time detail and merely reflect known intelligence at this point in the financial year and as such there could be variation in projections based on drivers that have not yet emerged or become apparent e.g. additional financial allocations from SGHD and/or unexpected changes in turnover rates within job families. An example of this will be the allocation which the Board will receive from SGHD in relation to LUCAP which will have a direct impact. The projections have been developed in conjunction with the detail included within the financial plan for the organisation as reflected within the LDP and projected increases directly correspond to agreed funding.

### 5. Workforce action plan

Annex A sets out the progress of the actions arising from the 2012/13 Workforce Plan. Many of these actions will be ongoing and have natural crossover with the Staff Governance Action Plan, Promoting Attendance Action Plan and Health & wellbeing Strategy. Those actions with less progress than had been anticipated have been incorporated within the 2013/14 actions which are detailed below. These actions are more concise than those within the previous plan however they are fundamental to the incremental improvement in workforce planning within the organisation.
Workforce planning across services
- Deliver the workforce work plans for the priority service areas as detailed in section 4.1
- Develop and launch workforce planning awareness raising eLearning module
- Proactively engage with services to ensure that managers are aware of their responsibilities to consider workforce requirements on an ongoing basis

Profession specific workforce planning
- Establish the Medical Workforce Planning Group
- Continue to monitor locum and agency utilisation for medical staff
- Continue to systematically utilise the national suite of nursing and midwifery workforce and workload tools to inform the deployment and future design of the nursing and midwifery workforce and inform the nursing workforce summit meeting
- Finalise and launch the organisational rostering policy and associated guidance

Collaborative Working
- Consider and develop an approach to workforce planning tailored to the needs and requirements of the Health & Social Care Partnerships
- In conjunction with partners develop new approaches to employability for young unemployed which build upon existing programmes
- Develop the Educational Partnership – in collaboration with University of West of Scotland, Glasgow Caledonian University and Ayrshire Colleges

Workforce information and intelligence
- Develop a mechanism to robustly predict and track workforce change on an ongoing basis incorporating financial establishments, vacancies/turnover and supplemental staffing utilisation
- Continue drilldown analysis of demographics – age, gender, skill mix - of staff groups and strengthen the process by requiring professional / service leads to detail actions planned to address findings

Learning and development
- Develop a Learning Plan reflecting PDPs, statutory and mandatory training etc.
- Embed mandatory and statutory training requirements with monitoring processes mechanisms established
- Implement and embed the new induction process for new staff
- Provide workforce development approaches to ensure the workforce have the requisite skills to contribute to reducing inequalities

6. Implementation, monitoring and review

The Workforce Planning Programme Board will be responsible for ensuring the implementation of the actions within the plan and formal scrutiny will be provided by the Staff Governance Committee.
Annex A – Progress of Workforce Plan 2012/13 Actions

Progress in achieving the action plan is detailed below:

Workforce Planning Programme Board (WPPB)
The WPPB will provide the strategic overview for workforce planning and effectively be the central hub in developing the workforce strategy for the organisation therefore ensuring this is embedded is a key priority during the year.

<table>
<thead>
<tr>
<th>Action</th>
<th>Progress</th>
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<tbody>
<tr>
<td>Establish the group and agree Terms of Reference</td>
<td>ToR agreed at first meeting of group in July 2012</td>
</tr>
<tr>
<td>Define what the workforce dimensions of success should be as the basis of the workforce strategy for the organisation</td>
<td>Work still to be undertaken to determine the workforce dimensions of success and the metrics that will be utilised to monitor these.</td>
</tr>
<tr>
<td>Ensure workforce planning is a key consideration within the emerging clinical strategy</td>
<td>Workforce Planning Programme Board agreed that the priority areas would be: Service Priority areas: Transforming outpatients; Emergency Care; Re-provision of inpatient mental health – each of these streams has a workforce group Profession specific planning areas were agreed as nursing, via the Nursing &amp; Midwifery Workforce Development Meeting, and medical – structure to support this to be agreed by Executive Medical Director.</td>
</tr>
<tr>
<td>Develop a work programme for the year detailing the workforce planning activity that will be undertaken at service level</td>
<td></td>
</tr>
</tbody>
</table>

Tools and techniques
There are a range of nationally acknowledged tools and techniques, some of which are routinely used locally however some need reaffirmed so there is a clear understanding of their use, value and necessity.

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<tr>
<th>Action</th>
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<tbody>
<tr>
<td>Raise awareness and provide training on the 6 steps methodology as the common framework for workforce planning</td>
<td>Work is in progress to develop a workforce planning awareness raising module on LearnPro and development of the 6 steps methodology training is being progressed nationally by the National Workforce Planning Forum.</td>
</tr>
<tr>
<td>Develop a simple workforce planning template for Directorates to use in developing their workforce action plan</td>
<td>Common templates have been used within the workforce priority areas which build upon the core workforce ‘questions’ that were agreed by the WPPB.</td>
</tr>
</tbody>
</table>
**Efficiency and productivity**

Workforce related expenditure accounts for approximately 60% of the overall organisational spend therefore ensuring we make the most effective, efficient use of this resource for both existing and developing services is vital.

<table>
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<tr>
<th>Action</th>
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<tbody>
<tr>
<td>Continue to scrutinise supplemental spend at operational, tactical and strategic levels to ensure the most effective use of resource</td>
<td>Supplemental spend integral element of financial reporting arrangements. Nursing &amp; Midwifery Workforce Development Group scrutinises nursing supplemental use as a standing agenda item. Quarterly workforce report for CMT includes supplemental usage for all staff groups.</td>
</tr>
<tr>
<td>Attempt to appoint to long term medical staffing vacancies to alleviate agency usage or seek alternative safe models of service delivery</td>
<td>During 2012/13 there has been success in appointing to some of the challenging specialties with long term vacancies such as emergency medicine (3.0 WTE), general medicine (3.4 WTE) and radiology (3.8WTE).</td>
</tr>
<tr>
<td>Consider skill mix and shift patterns within nursing</td>
<td>The skill mix and shift length patterns are considered when utilising the professional judgement tool. Work is underway exploring alternative shift patterns which are flexible and responsive to peaks in workload demand and sudden unplanned peaks in absence.</td>
</tr>
<tr>
<td>Continue to use natural turnover as a lever to redesign the workforce</td>
<td>Whilst natural turnover is used a lever it should be noted that rate for NHS Ayrshire &amp; Arran has consistently been lower than the Scottish average for the past six years. In addition the organisation has also had the lowest turnover rate when compared to all territorial mainland NHS Boards. The organisational turnover rate for 2012/13 is 6.6% and is broadly consistent with the rate over the previous two financial years.</td>
</tr>
<tr>
<td>Continue rostering master classes for charge nurses</td>
<td>Rostering master classes have been available and utilised for the last 12 months. It is recognised further training will be required when facilitating the implementation rostering guidance/policy. This is essential prior to eRostering.</td>
</tr>
<tr>
<td>Develop an organisational rostering policy</td>
<td>Within the Nursing &amp; Midwifery Workforce Group seven high level rostering principles have been developed by the group and endorsed by the CMT. A short life working</td>
</tr>
</tbody>
</table>
Use of Nursing and Midwifery workforce tools to support the delivery of safe and effective care which will lead to movement of staff where necessary

Establish the medical bank

**Workforce information and intelligence**

Workforce information and intelligence forms the building blocks to designing the future workforce. Whilst there is a wealth of workforce information available it has not been fully accessible to be utilised as a management tool in terms of planning and operational management.

<table>
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<tr>
<th>Action</th>
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<tbody>
<tr>
<td>Provide routine organisational workforce dashboard for consideration at Directors Team / APF / Staff Governance Committee / NHS Board</td>
<td>CMT receive a quarterly workforce report with high level metrics and accompanying narrative.</td>
</tr>
<tr>
<td>Develop drill down reports / dashboards for Directorates</td>
<td>Drill down reports of staff in post manipulated by directorate; department; job family; job sub family; and grade are available within AthenA for use by operational managers.</td>
</tr>
<tr>
<td>In conjunction with eHealth scope technology that could be utilised to develop online dashboards</td>
<td>Ongoing work with eHealth in determining workforce dashboards which will be available via Qlikview</td>
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</table>

**Working with our partners**

In response to the changing demography of the population, and national policy in response to this, the delivery of services in collaboration with local authority partners will require a more robust workforce planning approach.

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<thead>
<tr>
<th>Action</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress workforce planning by working in partnership with local authority partners on a pan-Ayrshire basis through the Joint Strategy for Older People’s Services Programme Board</td>
<td>A pan Ayrshire workforce group for Joint Services for older people was convened to support the JSOP Programme Board, who contributed to the workforce section of the 10 year vision for joint services.</td>
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</tbody>
</table>
Learning and development
In order to provide high quality healthcare services we need staff who will actively participate in continuous learning and development to ensure they have the requisite skills and competencies to fulfil their role.

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<tr>
<td>Ensure all staff are aware of mandatory and statutory training requirements and actively ensure this is kept up to date</td>
<td>Mandatory and statutory training an integral element of PDR discussions. M&amp;S training catalogue to be launched on AthenA</td>
</tr>
<tr>
<td>Maximise the use of Learnpro as an online learning delivery method to improve access and flexibility</td>
<td>Approximately 100 modules currently available on Learnpro and 30 currently in development. Over 100,000 Learnpro records for staff within the organisation.</td>
</tr>
<tr>
<td>Continue to participate in the national nurse intern scheme</td>
<td>The internship program has been a great success within NHS A&amp;A. Despite the funding being reduced by 50% in this financial year we have continued to offer placements for up to 65 newly qualified nurses and midwife interns. The uplift in the overall allocation of board funds for 2013-14 will allow continuity for the program to be managed centrally and in keeping with the parameters set down by NES. Over 90% of newly qualified nurses secure substantive posts before the end of their allocation with one notable exception - midwives are less likely to secure posts but are joining nurse banks.</td>
</tr>
<tr>
<td>Provide appropriate learning and development programmes</td>
<td>Learning and development programmes will be developed in line with agreed organisational strategies.</td>
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</tbody>
</table>

Staff Health and Wellbeing
Staff health and wellbeing directly correlates to organisational performance and is therefore an improvement is intrinsic to success.

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<tr>
<td>Develop a Staff Health and Wellbeing Strategy</td>
<td>Staff Health &amp; Wellbeing Strategy, which identified key priority areas, endorsed by the NHS Board in May 2013.</td>
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<tr>
<td>Identify key priority areas</td>
<td></td>
</tr>
<tr>
<td>Re-invigorate the approach to attendance management to improve the sickness absence rate</td>
<td>Promoting Attendance Lead in post and Action Plan has been considered and endorsed by the APF.</td>
</tr>
</tbody>
</table>