NHS Lothian Workforce Plan

2013/14

Workforce Planning Department
HR & OD Directorate
Waverley Gate,
Edinburgh

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Introduction

This 2013-14 workforce plan sets out a detailed analysis of the national and local workforce planning context, including an assessment of workforce supply and demand. The plan is structured around the Scottish Government workforce planning guidance CEL (2011) 32, which suggested that Boards use the nationally sponsored 6 step workforce planning methodology for developing their plans.

The guidance sets out the following 6 steps, which will form the framework for this plan.

- **Step 1:** Defining the plan
- **Step 2:** Visioning the future/Mapping service change
- **Step 3:** Defining the required workforce
- **Step 4:** Understanding workforce availability
- **Step 5:** Developing an action plan
- **Step 6:** Implement, monitor and refresh.

The adoption of the 6 step approach is intended to make Board workforce planning more iterative, enabling challenges to be identified and addressed on an on-going basis rather than on an annual basis.

This updated plan provides details of the national policy context and local planning context, detailing workforce demand projections for 2013/14 and an assessment of the future workforce supply at a local level and the actions that are being undertaken to balance supply and demand.

Section 1 – Defining the plan

The purpose of this plan is to set out the progress that has been made against the planned change to the workforce and set out key workforce supply and demand challenges NHS Lothian (NHSL) is facing over the coming years. It will also detail the actions that NHS Lothian is undertaking to address these challenges through both the Board's Clinical Strategy and Human Resources and Organisational Development Strategy.

Many changes to our workforce relate to the redesign of our services and as such the planning is iterative. This plan is not intended to look at all aspects of workforce demand and supply for all job families, it will however highlight where there are emerging pressures that require to be addressed.

The plan will detail the considerable investments and efficiency savings that are being made in 2013/14 in the workforce to enhance our capacity to help meet treatment time guarantees and enhance unscheduled care services. It will also detail where medium to long term workforce risks are anticipated and what the Board is doing to respond to them.

1.1 2020 Vision for the NHS in Scotland

The Scottish Government's 2020 Vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting and, that we will have a healthcare system where:

- We have integrated health and social care
- There is a focus on prevention, anticipation and supported self-management
- Hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm
- Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions
- There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission

1.2 NHS Lothian's Clinical Strategy

In taking forward this vision within NHS Lothian a Strategic Clinical Framework 'Our Health, Our Future' has been developed as detailed in section 2.2.

Immediate strategic priorities are being taken forward under four current workstreams:

- Improving scheduled care
- Achieving waiting time standards and sustainable elective service capacity
- Reviewing primary and community care resources and capacity
- Improving the management of long-term conditions

Further details of which are included in section 2.

1.3 NHS Lothian's Values

In July 2013 the Board agreed to adopt a renewed set of values and behaviours for the organisation. This followed on from an extensive engagement which identified the most common themes identified by staff following engagement with 3,000 staff across NHS Lothian. Through the engagement process a draft set of five values and ways of behaving were identified and have in turn been fed into the development of NHS Scotland's

values and our behaviours as part of our work to improve the experience of staff and of our patients.

These values are:

- Care and compassion
- Dignity and respect
- Openness, honesty and responsibility
- Quality
- Teamwork

The next step is to support the implementation of these values across all our sites and services through a series of local engagement events and to ensure their communication and integration into all our plans and policies including the Strategic Clinical Framework. These values are therefore central to how we plan our service, our financial resources and our workforce.

1.4 Financial Plan

The financial plan for 2013-14 set out an additional £17m to bring NHS Lothian closer to parity with the level of funding identified by the National Resource Allocation Committee. This has enabled NHS Lothian to plan significant investments in services and their workforces to increase capacity and address key medical workforce challenges. Significant investments have been made within both scheduled and unscheduled care services and these are detailed in section 4.1 and 4.2.

1.5 NHS Lothian's Corporate Objectives

Corporate objectives have been developed for 2013/14 which set out 10 high level priorities around which all clinical and non-clinical services should be focused:

- To transform the management culture of the organisation.
- To plan and deliver the waiting times recovery plan to clear the backlog of patients and develop recurring demand/capacity equilibrium.
- To improve unscheduled care performance.
- To develop a cohesive strategic plan for NHS Lothian, supported by revised organisational arrangements.
- Effective internal and external communications.
- To improve patient and staff safety.
- Implementation of the Patient Centred Collaborative.
- To live within available financial resources, develop a sustainable financial plan and deliver the capital investment plan.
- To protect health, improve health status and tackle health inequalities.

- To have a robust system of performance management and reporting aligned to delivery of government targets.

1.6 Local Engagement

In developing this workforce plan there has been considerable engagement with services in terms of identifying key themes for inclusion. There has been detailed work with services to identify the changes in workforce demand as part of the financial, scheduled and unscheduled care planning processes.

There have also been detailed workforce risk assessments undertaken across all main services/specialties in conjunction with Clinical Leads. There has also been initial work with CHCPs to start to map out the workforce planning agenda associated with the integration of health and social care.

Section 2: Visioning the Future

2.1 Scotland's Changing Population

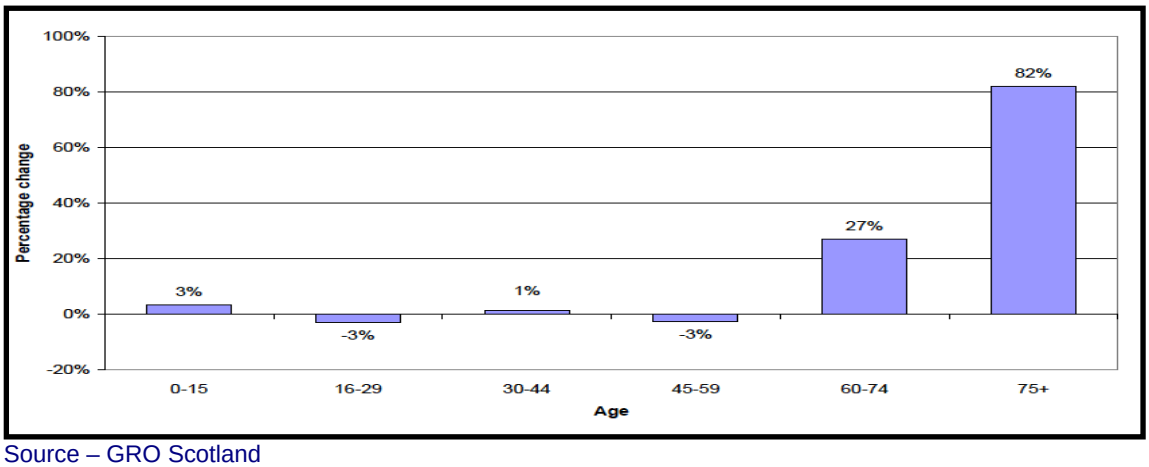
General Records Office Scotland (GROS) forecast that the growth in the population of Scotland will continue over the next 25 years. GROS project that the population will rise from 5.22 million in 2010 to 5.49 million in 2020 and to continue to rise to 5.76 million in 2035 – an increase of 10% over the 25 year period.

However, as in the period 2000 – 2010, the population will continue to 'get older' and will continue to increase proportionally faster in SEAT boards in comparison with the rest of NHSS.

The projected increase of 10% in Scotland's population will be driven by the increase in the over 60 year olds. As the graph below shows, the population aged under 60 is projected to remain fairly constant whilst the number of 60+ year olds is projected to increase significantly.

The following two figures detail the changing demographic structure nationally and within the Lothians.

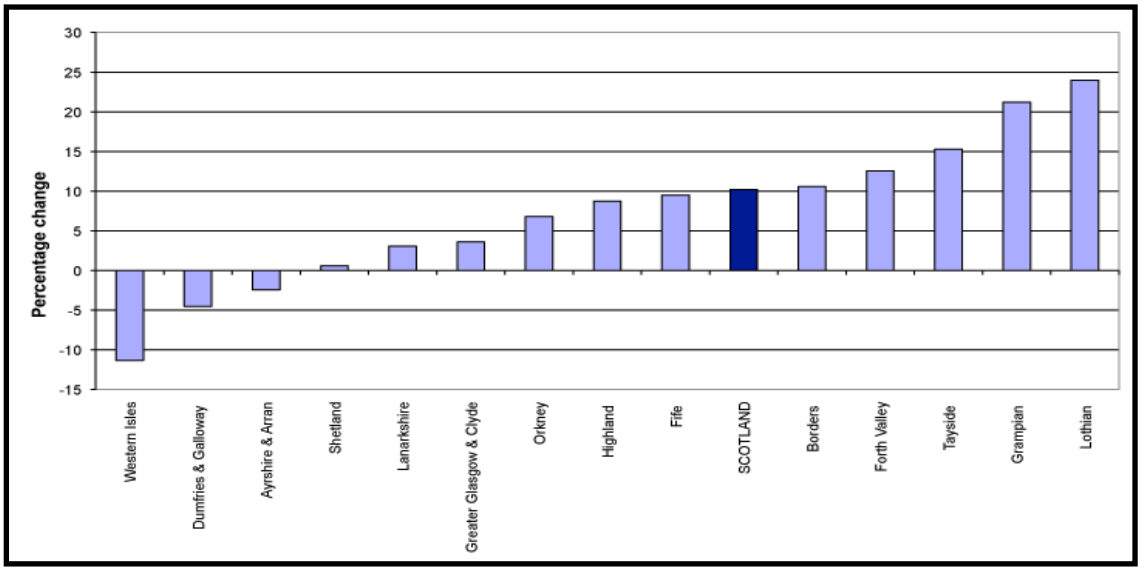
Figure 1 – Projected demographic change in Scotland by 2035



Source – GRO Scotland

NHS Lothian has the largest projected increase in the population in Scotland, across all age categories but as with the national picture the largest area of growth is with the 60-74 and 75+ categories.

Figure 3 – NHS Board level projected demographic change in Scotland by 2035



Source – GRO Scotland

This has significant implications for NHSS. It will require the ongoing shift in resources to those boards projected to have significant increases in population, particularly given this growth will be mainly in the over 60 year olds. It will also require growth in the workforce of those boards in order to deliver the increased demand in clinical services.

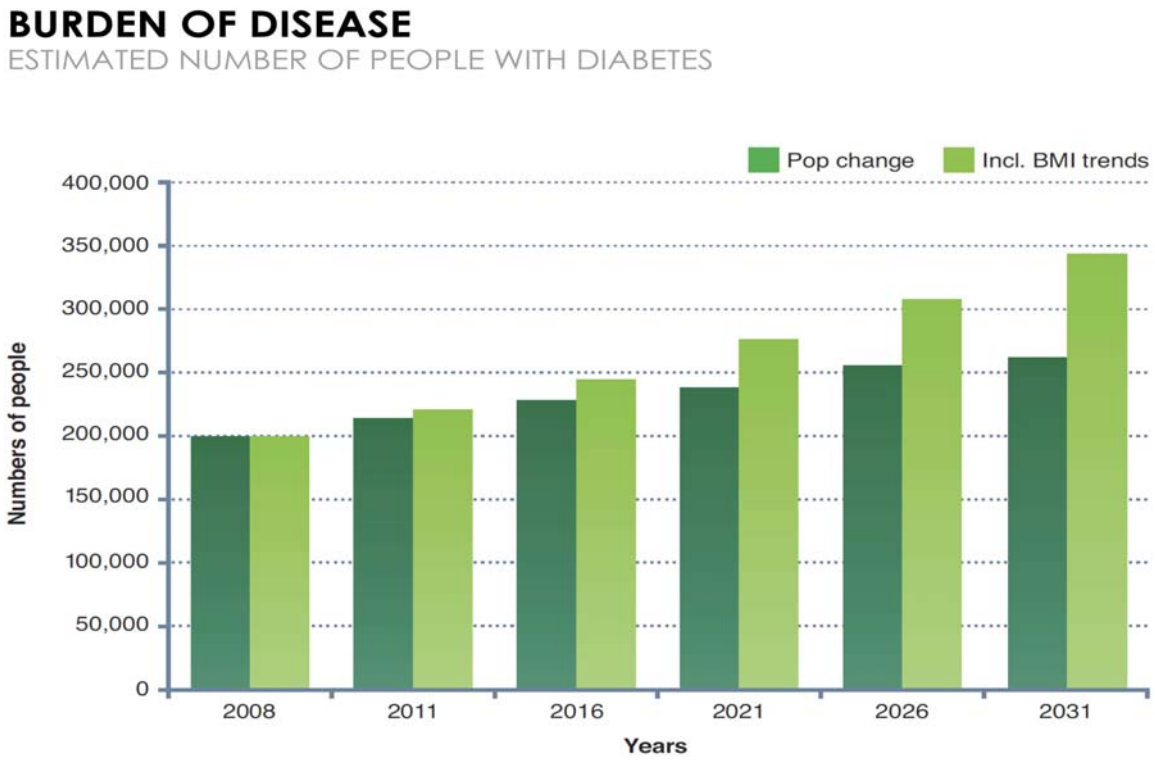
Whilst there is evidence to suggest that people are living longer, healthier lives, the patterns of disability and disease across Lothian will change as the population changes:

- The majority of over 65 year olds have 2 or more chronic conditions and the majority of over 75 year olds have 3 or more conditions
- The growth in the older population is expected to result in an increased prevalence of long term conditions equating to an additional 13,000 patients with at least one condition in the first five years of the strategy[1].
- Overall incidence of cancer is expected to increase by 1.4% per annum, equivalent to 1,000 additional new cases in a year[2].
- The prevalence of dementia in the population is expected to increase by up to 70% in the next 20 years[3].
- Approximately 25% of the adult population is obese and 64% are overweight. Obesity has a significant causal relationship with health problems such as type 2 diabetes, hypertension and coronary heart

[1] Measuring Long Term Conditions in Scotland ISD 2008
[2] Cancer in Scotland Sustaining Change, Scottish Executive 2004
[3] Scottish Public Health Observatory 2011

disease. Similar proportions of children and young adults under the age of 19 years are thought to be obese[4].

Figure 4 – Projected increase in diabetes cases by 2031



Source: NHS Lothian Public Health Annual Report 2009-11

Many of these changes will require enhanced care in the community, whilst there will also be an increased requirement for hospital based services such as Orthopaedic, General Medicine, Cancer and imaging services. Therefore a key element in dealing with these increased requirements will be through achieving further efficiency and productivity improvements as any significant expansion of the healthcare workforce will be difficult either from a financial or workforce supply perspective.

2.2 Strategic Clinical Framework 2012 to 2020

The NHS Lothian Clinical Strategy 'Our Health, Our Future' was agreed by the NHS Lothian Board in May 2012 following a comprehensive consultation process. The framework set out the overall service model and principles for our clinical services, which will drive service re-design, based on safe, high

[4] Impact of health behaviours and health interventions on demand & cost of NHS Services. Burns, H

quality evidence based patient pathways to help respond to the changing needs of our population.

The Strategy (**Our Health, Our Future**) sets out the approach to deliver the redesign of our clinical services over the next five to ten years. The key challenges and opportunities the strategy addresses are:

- Redressing the balance in capacity and demand for our emergency and elective acute care services
- Supporting longer healthier lives for the population as a whole
- Reducing health inequalities
- Improving the health of the increasing numbers of older people in Lothian
- Using our changing workforce more effectively

The strategy seeks to establish an extensive programme of clinically led redesign aimed at providing the following for patients and the public:

- Safe effective person centred care - every person, every time
- More focus on maintaining existing health
- More support to anticipate health problems and prevent or minimise these
- More and better care at home and in community settings
- Day case and out-patient treatment as the norm for most planned hospital care
- Safe, timely admission and discharge for those who do require inpatient care
- No avoidable re-admission to hospital
- More focus on use of tele-healthcare to help people to manage their own health conditions at home
- Information about patients and their care to be confidential, but also available to patients and appropriate health and care professionals when needed

This programme of redesign will inevitably have a profound effect on the workforce and future workforce plans will incorporate the key areas of workforce redesign. The implementation of the framework is being taken forward by the Strategic Planning Group which consists of service leads, Executive and Non-Executive Directors, the Employee Director and the NHSL Chairman.

Alongside taking steps to improve our services as a priority, NHSL is working with staff to create a more positive and supportive organisational culture, which is essential in supporting the achievement of the Board aims and objectives. Through affirming our vision and shared values with staff, and developing leadership capability at all levels, we will ensure that staff are able to contribute fully to delivering better health and healthcare.

At its meeting on 22 May 2013 NHS Lothian Board agreed to develop a Strategic Plan for NHS Lothian's medium and long-term ambitions in the context of the NHS Scotland 2020 Vision, the expected growth in the Lothian population including increasing numbers living with long term conditions and constrained public sector resources.

In addition to the 4 major workstreams the range of work underway to deliver agreed national strategic change service priorities, public health and health inequalities improvements, HEAT targets and efficiency and productivity workstreams are also being collated to allow the Strategic Planning Group to review the relative prioritisation and resource allocation across these programmes and projects.

Given the size and complexity of the planning agenda a project office has been established to take forward the development of a detailed project plan by the end of March 2014. This plan will map out a prioritised plan including timescale and resource requirements for each of the individual workstreams.

2.3 Unscheduled Care Action Plan

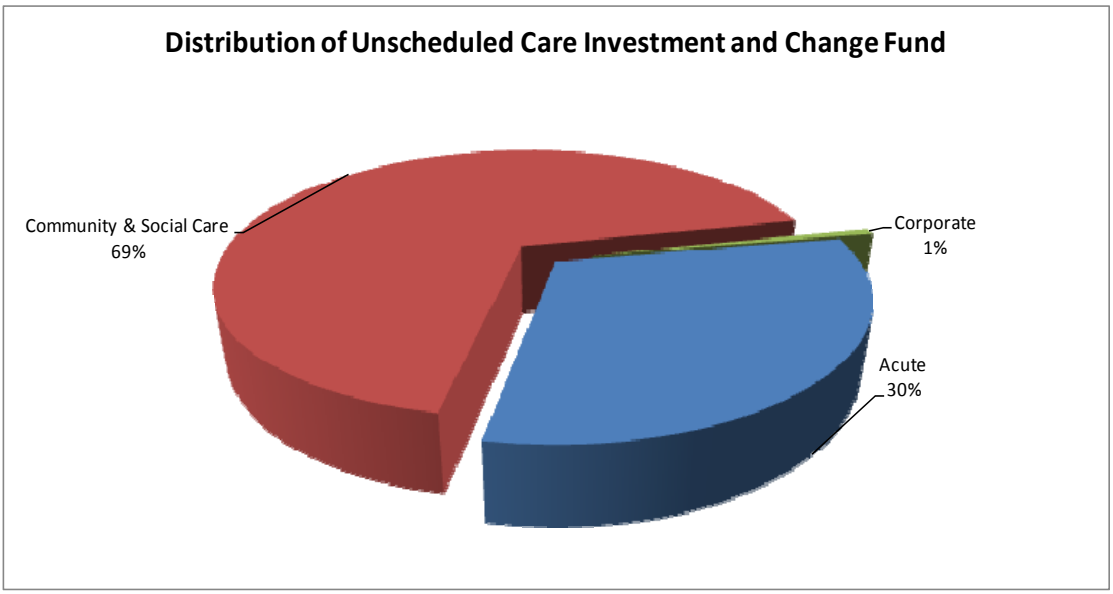
Managing the growing pressures on unscheduled care associated with a growing and aging population is a key priority both nationally and locally. As part of the nationally led planning process NHS Lothian has developed a Lothian Unscheduled Care Action Plan which sets out detailed performance measures for service provision. The plan also acts as a framework for investment in services and their workforces to achieve and sustain high quality services.

These investments are aimed at:

- Assuring effective and safe care 24/7
- Developing the primary care services
- Improving flow into, within and out of Acute Hospitals
- Making the community the right place

In considering investment within unscheduled care it is useful to look at both unscheduled care investment and also investments made as part of the Change Fund as these investments will also be key to adding capacity and resilience to services which are strongly linked with unscheduled care.

Figure 5 - Distribution of Combined Unscheduled Care Investment and Change Fund



Section 4 of this plan provides detail of the specific investments that have been made within the workforce as part of the Unscheduled Care Action plan.

2.4 Scheduled Care

Whilst the clinical strategy sets out how NHSL will enhance capacity and introduce new models of care in the medium to long term there remain challenges in achieving treatment time guarantees in a number of specialties.
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To address the challenges associated with the implementation of the national Treatment Time Guarantee of 12 weeks detailed capacity plans have been developed and implemented in most specialties. There has been significant investments in workforce in order to provide the necessary capacity to meet these guarantees. There remains a significant requirement to use the independent/private sector and that this was likely to continue in some cases where physical capacity is still in the process of being developed and commissioned.

In May 2013 95.7% of patients treated in May had been seen within the treatment time guarantee, 340 patients waited over this threshold in the month, of whom 21 had not been admitted, had no date for treatment or were not in the process of agreeing a date. Considerable efforts and investment will continue to develop the required level of in house capacity.

2.5 Organisational structure change

The organisational structure within the Acute Division has been changed to provide stability to elective care whilst enhancing managerial capacity at each

hospital site to support the improvements in unscheduled care performance. It is essential that both elective and unscheduled care performance are improved simultaneously for the benefit of our patients and as Directors for Scheduled and Unscheduled care have been appointed to lead improvements.

Within the Unscheduled Care services Site Directors have been appointed for the RIE, WGH and St John's hospitals. Within Scheduled Care services there has been a Director appointed for Surgical Services, Clinical Services and Women & Children's services.

2.6 Integration of Health and Social Care

The NHS in Scotland spends almost one third of total expenditure on older peoples services on unplanned admissions, more than is spent on social care for older people. The demographic change in the population requires spending to be focussed on avoiding such admissions, focussing on anticipatory and preventative care.

In May 2012 the Scottish Government published Consultation on 'Proposals to Integrate Health and Social Care in Scotland'. Within the proposals there are clear indications that the proportionate share of funding will reduce in clinical areas and focussed on alternatives to hospital based care where at all possible and clinically appropriate. The initial focus is on Older Peoples Services as this is an area where there is considerable potential to both improve the services that individuals and carers receive and improve efficiency and productivity. The detail of how this is carried forward will be decided upon after the full consultation process.

More specifically the key reasons for proposing this new reform were:

- To ensure that adult health and social care services are firmly integrated around the needs of individuals, their carers and other family members.
- Ensure the providers of those services are held to account jointly and effectively for improved delivery.
- Services are underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve rather than the needs of the organisations through which they are delivered.
- Ensure arrangements are characterised by strong and consistent clinical and professional leadership.

NHS Lothian is well placed to respond to developing the integration agenda through the arrangements already in place at that time, namely through our joint Directors in Edinburgh and West Lothian, and with key stakeholder discussions with East Lothian and Midlothian Councils and the respective CHPs.

The main benefits of taking forward integration across health and social care are wide and varied. Not only does it offer a more effective use of the collective resource in fiscally challenging times, the integration process also allows for opportunities to strengthen the quality of outcomes and experience that people have when using health and social care services across Lothian.

For example:

- people being supported within community settings for longer, receiving a wide range of comprehensive assessment, acute, rehabilitation and social care, on an integrated basis, from a wide range of flexible staff, founded through anticipatory care plans
- an increase in numbers of people being supported to end of life at home or in homely settings
- support for those in care homes, to prevent unnecessary hospital admission
- people only coming into hospital when required, with less unscheduled care and more planned interventions, with comprehensive geriatric assessment being a key focus at the front door
- an appropriate journey within hospital, with reduced boarding
- fewer delays within the journey and appropriate and timely discharge plans in place
- pathways being designed across the whole health and social care system, ensuring people have the most appropriate journey

To date structural changes have included the integration of Mental Health, Learning Disability and Substances Misuse Services within Health and Social Partnerships. Further restructuring may take place once the Board has had sufficient opportunity to consider the implications of the Public Bodies Joint Working Bill.

2.7 Efficiency and Productivity

Whilst NHS Lothian has committed to substantial investment in services to provide additional hospital capacity and enhance unscheduled care services there remains an annual savings target for 2013-14 of £27.8m. Plans to achieve these savings comprise a ‘mixed economy’ approach, with a combination of workstream plans and local service targets.

A breakdown of these efficiency savings is listed in the table below.

Figure 6 – Efficiency Saving Targets 2013/14

Workstream	Annual Target (2013-14) (£ 000)
Facilities and Infrastructure	£1,613
Review of Laboratories	£1,327
Management and Admin	£723
WCN	£675
Pharmacy Redesign	£285
Flow and Capacity Management	£142
Edinburgh Rehab Bed Redesign	£300
Enhanced Recovery	£300
Review of Interventions	£500
Outpatients Review	£1,537
Prescribing	£4,621
Procurement	£1,248
Workstream Total - sub total	**£13,271**
Local Schemes	**Annual Target (2013-14) (£ 000)**
Edinburgh CHP	£811
East Lothian CHP	£406
Midlothian CHP	£54
West Lothain CHCP	£186
Primary Care (other)	£28
Estates and Facilities	£343
Corporate Areas	£626
University Hospital Areas	£4,476
Strategic Budgets	£7,661
Local Total - sub total	**£14,591**
TOTAL ANNUAL TARGET	**£27,862**

2.8 Regional Collaboration

Whilst NHS Lothian is primarily aimed at meeting the health needs of the populations of the Lothian's it also provides a range of regional and national specialist services. The South-east and Tayside (SEAT) planning region has a lead role in planning these services and supporting managed clinical networks.

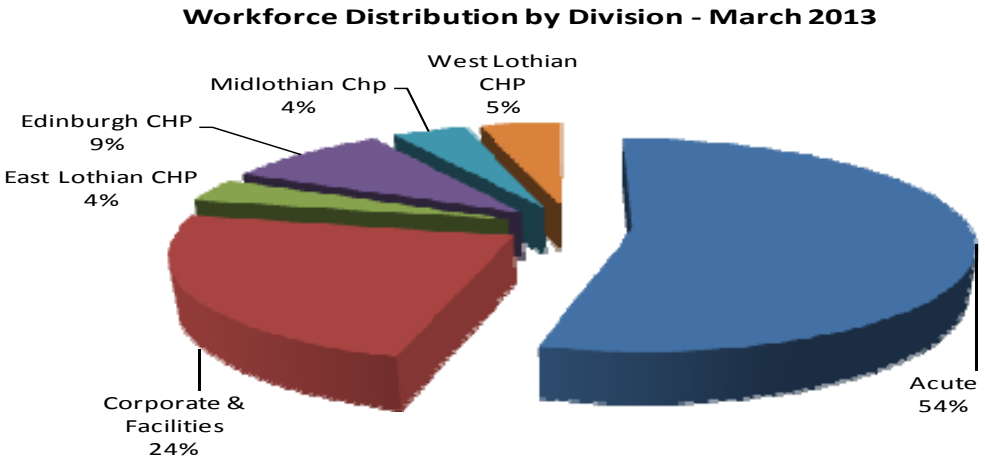
Section 3: The Current Workforce

3.1 Distribution of current workforce

The following section sets out the dimensions and characteristics of the existing workforce and analysis of key drivers affecting workforce supply.

As at March 2013 NHS Lothian utilised 19,396wte, covering all job families and (includes supplementary staffing) at an approximate cost of £783m per year in direct workforce costs. The following figure shows the distribution of the workforce by operating division.

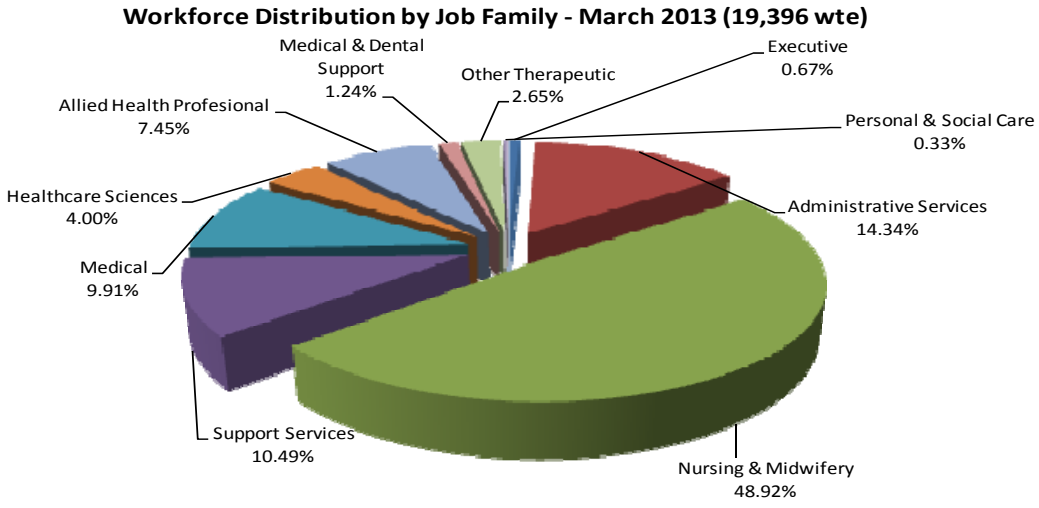
Figure 7 – Workforce by operating division



Source – NHS Lothian Payroll

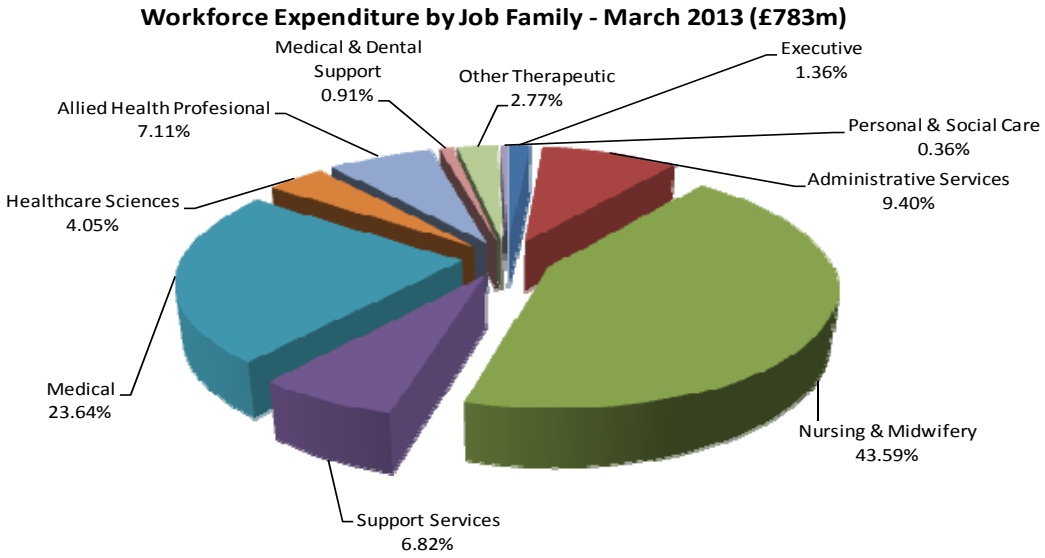
The following figures detail the workforce distribution by job family both in terms of whole time equivalents and cost.

Figure 8 – Workforce by job family (WTE)



Source – NHS Lothian Payroll

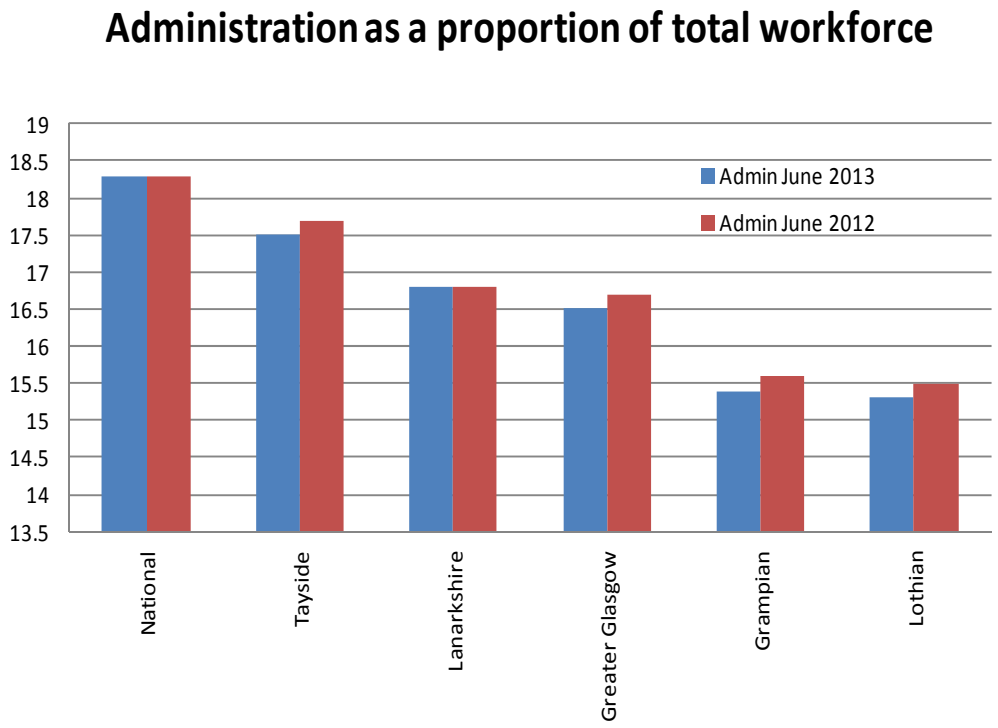
Figure 9 – Workforce by job family (£)



Source – NHS Lothian Payroll

NHS Lothian maximises the proportion of the workforce focused on providing direct patient care and has the lowest proportion of Administrative staff in NHS Scotland (15.3%). The following figure details how this compares with both the national level and the level within other large Boards.

Figure 10 – Administrative workforce as a percentage of overall workforces

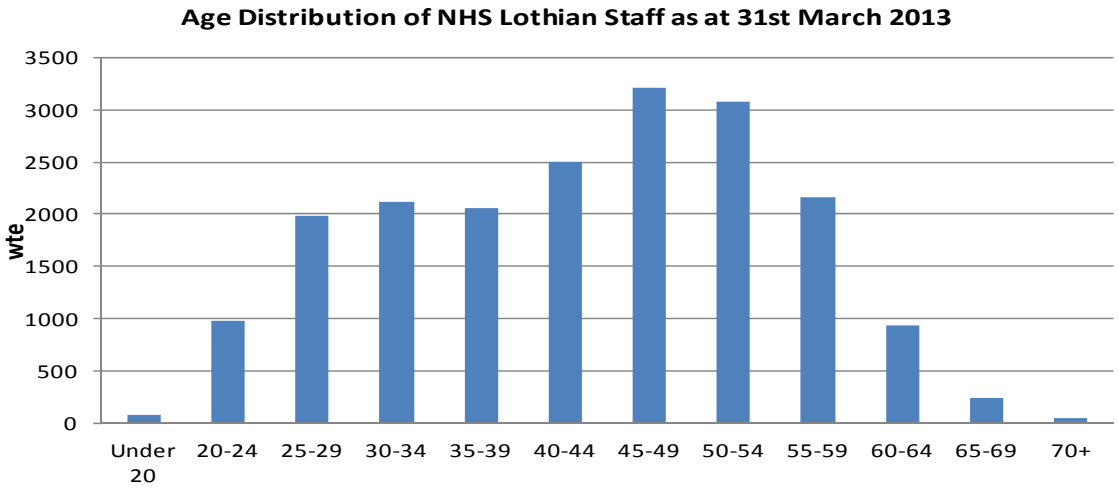


Source – ISD Scotland

3.2 Demographic Change

Demographic change within the population is one of the most significant drivers for service change and redesign. The following section details how this change is becoming evident within our workforce and will require NHS Lothian and other boards to develop recruitment and retention strategies in order to avoid the loss of a significant proportion of the workforce over the next 5 to 10 years. The development of supply channels is necessary to enable alternative routes into the workforce to enable adequate recruitment in the face of competition from other sectors.

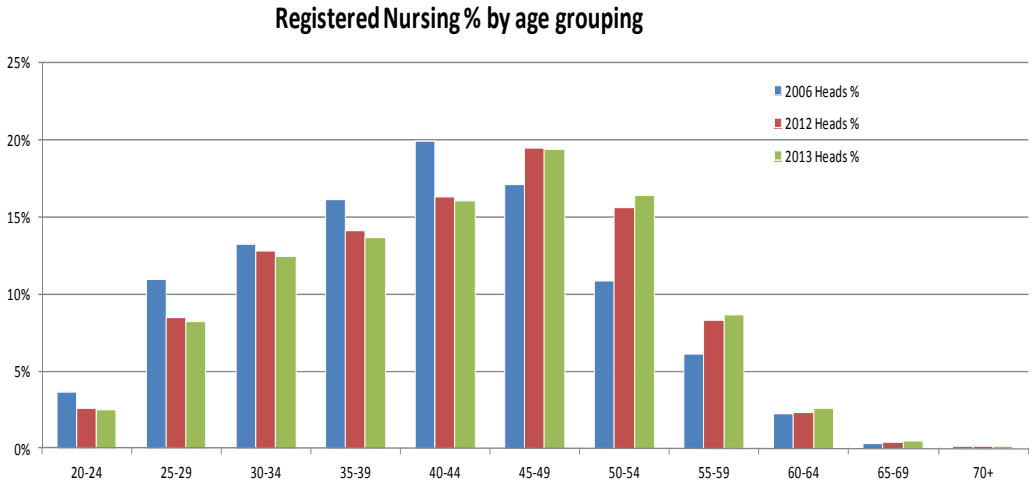
Figure 11 – Overall age distribution



Source – NHS Lothian Payroll

In March 2013 17.5% of the total of NHS Lothian workforce were aged over 55 years old, with the largest number within the 45-49 age category. This represents a 3% increase in the proportion between December 2011 and March 2013. Whilst this overall profile clearly shows the demographic imbalance within the workforce it is through looking at the individual job families that specific challenges arise.

Figure 12 - Age distribution within registered nursing

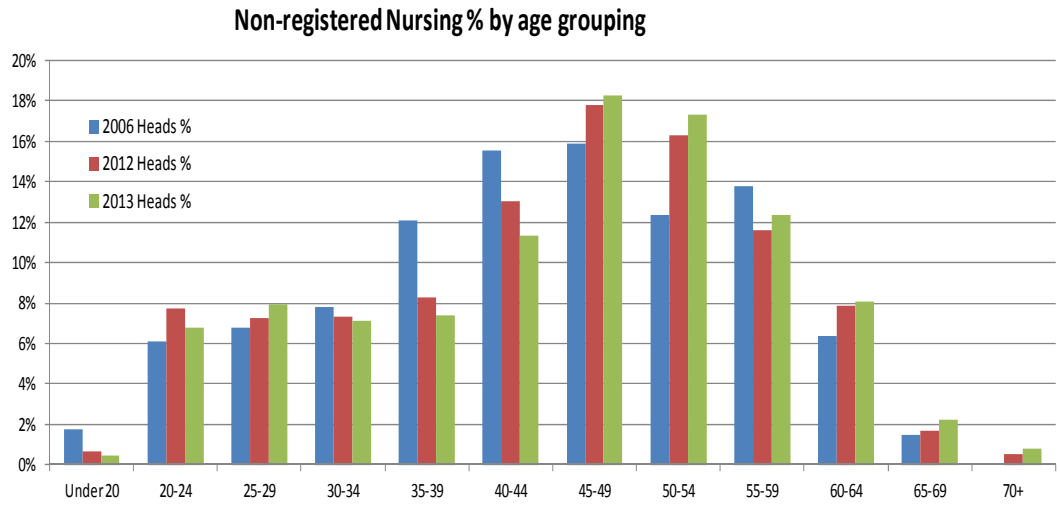


Source – NHS Lothian Payroll

Within registered nursing the ageing of the workforce is already pronounced, between August 2006 and October 2012 the proportion of staff aged over 50 has increased from 19% to 28% an increase of nearly 10% in 6 years, with a median age of 43. Whilst the changes to pensions will see the retiral age gradually increase to 68 years old, protection will be in place for those within 10 years of retirement. Within this age grouping a significant number of staff hold special class/mental health officer status and as such can retire at 55 without any actuarial reduction being applied to their pension. This means that potentially those staff within the 45-49 age category and those above may consider retiral; this equates to 46% of the registered nursing workforce.

It may be in practice there are a range of factors that influence individual decision making and not all staff will hold special class/mental health officer status however this remains a key area of uncertainty. Research carried out by NES, SEAT and NHS Lothian (2010) found that there were a very limited number of examples of how NHS organisations have sought to develop policies aimed at retaining such staff.

Figure 13 – Age distribution within non-registered nursing



Source – NHS Lothian Payroll

Within the non-registered workforce there is a similar pattern, between August 2006 and October 2012 the proportion of staff aged over 50 has increased from 34% to 41% an increase of 4% in 6 years, with a median age of 47. The increase reflects a further increase within a workforce that already had a high proportion of staff aged over 50.

The above figures detail the position within nursing as it is the largest area of our workforce and has the most noticeable ageing within the clinical workforce. However there are a significant proportion of the workforce already aged 55 years old who are either already entitled to retire or entitled to retire at 60 years old where individuals remain within the pay scheme as detailed in the following table.

Figure 14 – Proportion of staff aged over 55 years old by job family

Job Family	Total wte	wte Over 55	% Over 55
Medical	1,922.5	172.8	8.99
Medical & Dental Support	240.8	34.8	14.43
Nursing & Midwifery Band 1-4	2,611.5	542.0	20.76
Nursing & Midwifery Band 5+	6,698.7	779.3	11.63
Nursing & Midwifery Band 5+ Intern	57.0	1.1	1.91
Nursing & Midwifery Band 8+	121.2	17.9	14.79
Nursing & Midwifery Overall	**9,488.4**	**1,340.3**	**14.13**
Allied Health Profession Band 1-4	235.6	56.1	23.83
Allied Health Profession Band 5+	1,209.3	130.6	10.80
Allied Health Professionals Overall	**1444.91**	**186.8**	**12.92**
Healthcare Sciences	775.3	151.2	19.50
Other Therapeutic	513.9	50.9	9.91
Personal & Social Care	63.3	17.0	26.85
Administrative Services	2,781.7	768.5	27.63
Executive	130.5	29.8	22.84
Support Services	2,033.0	628.8	30.93
Ambulance Services	2.0	2.0	100.00
Board	19.0	12.0	63.16
Grand Total	**19,415.3**	**3,394.9**	**17.49**

Source – NHS Lothian Payroll

There are also significant hot spots within these job families and there are some small areas of disproportionate impact where the loss of even a single member of staff can have a major impact.

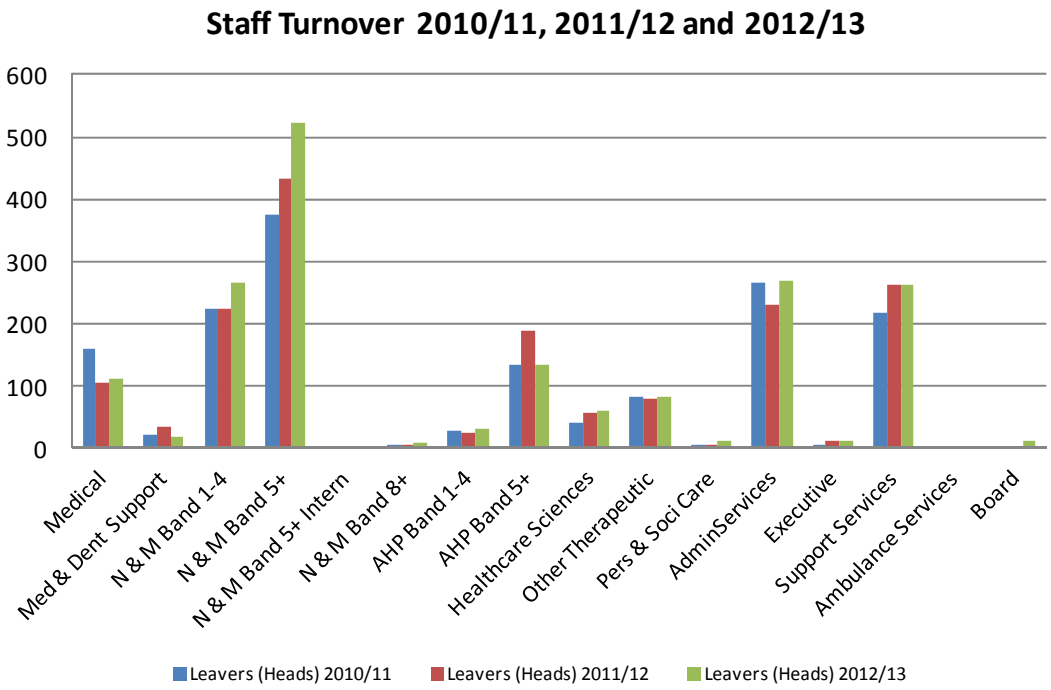
NHS Lothian is mindful of the principles set out under 'Enabling Age as Asset', including issues of flexible working, mentoring and succession planning. This has identified important lessons for NHS Boards in facilitating a genuine age aware management structure and workforce planning for a 'mixed age' staff structure. There is a need to develop employment policies that will support the ageing of the workforce especially the planned changes in retiral age.

The UK NHS Working Longer Review is looking to the possible impact of a raised pension age in NHS and is currently consulting with individuals, healthcare organisation and trades unions.

3.3 Staff Turnover

Since the onset of the global economic crisis staff turnover had reduced significantly as individuals chose to remain for financial reasons or as a result of the reduction in vacancies within healthcare and all other sectors. The following figure details the level of leavers over the last 3 years.

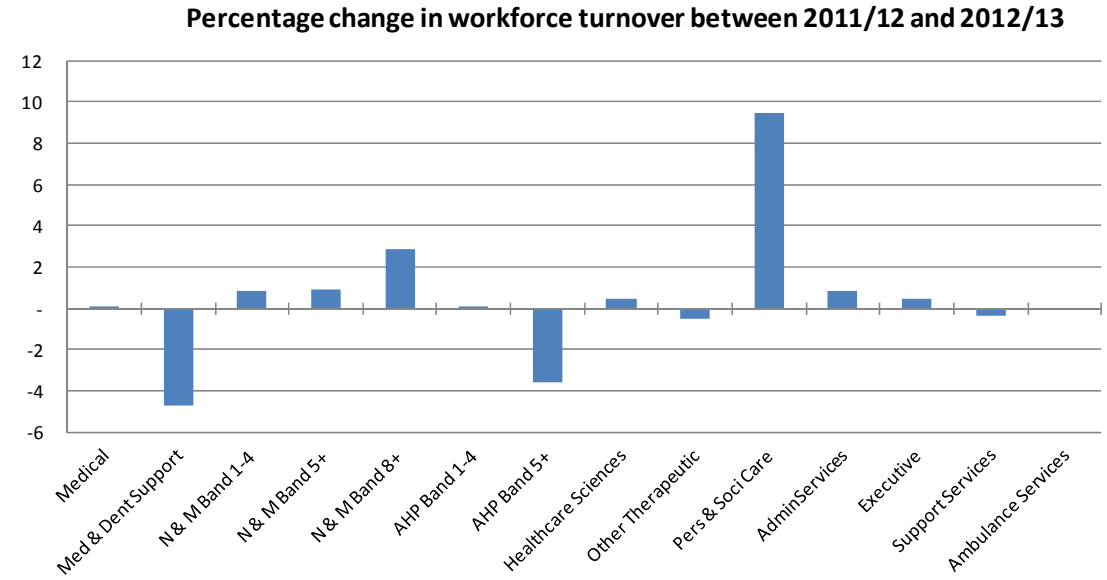
Figure 15 – Staff turnover by job family 2009 to 2013



Source – NHSL HR System

As illustrated in the figure above the overall level of leavers has remained broadly constant overall in 2012-13, there has however been some notable increases and decreases within job families as detailed in the following figure.

Figure 16 – Percentage change in leavers between 2010/11, 2011/12 and 2012/13



Source – NHSL HR System

There continues to be a sufficient level of turnover to allow redeployment of individuals where required. However the redeployment of band 7 and above remains problematic due to low levels of turnover and the lower proportion of posts at this level.

The following figure provides a comparison of the reasons for leaving in 2010/11, 2011/12 and 2013/14

Figure 17 - Reasons for leaving for all staff

Reason description	Leavers (Heads)			% of reasons why against total		
	10/11	11/12	12/13	10/11	11/12	12/13
Death in Service	16	8	14	1.0	0.5	0.8
Dismissal	46	46	54	2.9	2.7	3.0
Dismissal capability	25	18	19	1.6	1.1	1.0
End of fixed term contract	173	89	121	11.0	5.3	6.7
Ill health	49	50	52	3.1	3.0	2.9
New employment with NHS outwith Scotland	58	41	60	3.7	2.5	3.3
New employment with NHS within Scotland	116	119	199	7.4	7.1	11.0
Non Occupational illness	2	5	3	0.1	0.3	0.2
Other	357	513	240	22.7	30.7	13.2
Pregnancy	6	4	2	0.4	0.2	0.1
Redundancy voluntary	-	19	31	-	1.1	1.7
Retirement - age	206	262	397	13.1	15.7	21.9
Retirement other	34	33	53	2.2	2.0	2.9
Voluntary Early retirement - acturial reduction	17	13	39	1.1	0.8	2.1
Voluntary Early retirement - no acturial reduction	5	7	3	0.3	0.4	0.2
Voluntary resignation - lack of opportunity	7	10	10	0.4	0.6	0.6
Voluntary resignation - lateral move	35	27	36	2.2	1.6	2.0
Voluntary resignation - other	398	394	456	25.3	23.6	25.1
Voluntary resignation - promotion	26	15	25	1.6	0.9	1.4
Grand Total	**1,576**	**1,673**	**1,814**			

Source – NHSL HR System

The number of individuals leaving as a result of age retiral has increased by 135 (51%) between 2011/12 and 2012/13, there has also been an increase in staff opting to retire early voluntarily on a reduced pension. However it is difficult to draw any strong conclusions as the proportion with a reason given as 'other' has decreased by 273 and it may be that a significant proportion of early retirals were previously coded under this category. During 2013/14 NHSL will review it's approach in relation to exit interviews in order to ensure improved reporting and analysis.

3.4 Sustainability of small non-medical specialist services

There are a number of small non-medical specialist services where workforce supply issues can have a direct impact on the provision of clinical services. The workforces within these areas can have a disproportionate impact. This has been recognised nationally and a Pan Scotland review of shortage occupations has commenced. The review will:

- Identify shortage areas.
- Undertake detailed profiling of the areas including risk assessments to fully understand current position.
- Review service and workforce models across Scotland and training routes
- Identify likely future workforce demand
- Identify the workforce training and development required to ensure sustainability of services.

Locally initially priority areas have been identified; these include Oncology Medical Physics, Medical Physics and Clinical Perfusionists. There are also a number of small areas where there are insufficient/no training programmes in Scotland and low turnover which means that when gaps do arise they can be very difficult to fill.

There are also areas within nursing such as Paediatrics and Neo-natal where growth is required in advanced practice roles to provide a non-medical solution to some of the pressures resulting from the reduction in trainee doctors and other such issues. There had not been appropriate training programmes within Scotland and training trainees had to train in England. This has recently been overcome through the development of an advanced practice course has been developed nationally on a collaborative basis with Universities, Boards, NES and the Scottish Government and a programme offering 20 placed will commence in September. As services and specialties plan to deal with the significant medical workforce challenges it is likely that there will be the requirement of further advanced practice within and outwith nursing.

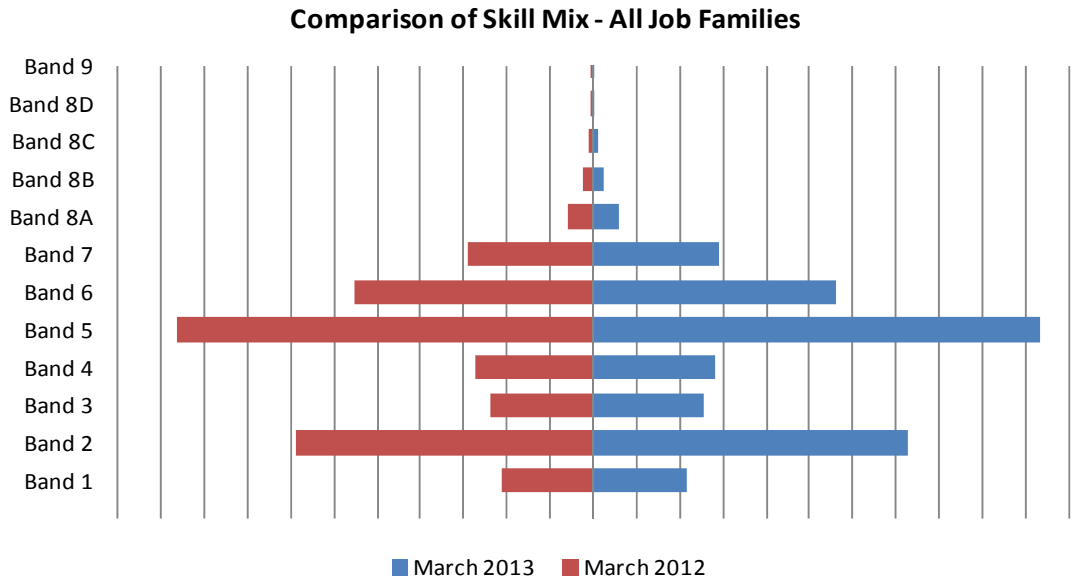
3.5 Skill Mix

Service provision within both Clinical and Non-clinical environments is constantly evolving with the adoption of new practice and the introduction of modern technologies. It is important that the balance within the workforce is also reflected on to ensure that service is provided by the most appropriate level and that senior clinical staff spend as large a proportion of time as possible carrying out direct patient care.

The Skills Maximisation Toolkit (NES, 2010) set out a robust process for reviewing patient journeys and the roles that different members of the allied healthcare professions team could and should undertake. It sets out how areas can look at the skill mix they deploy to ensure that each level within the team is maximising the contribution of there unique skill set. There are a range of similar approaches that have been undertaken within the differing areas of the workforce and the use of professionally developed tools to support the process as part of the NMAHP workload and workforce planning tools rollout.

Whilst the overall skill mix within the workforce (excluding medical staff) is relatively balanced in the B5+ workforce there would appear to be less opportunities for band 1 to 4 staff with the majority on band 2 as detailed in the following figure. This has implications in the medium to long term as competition returns to the employment market.

Figure 18 - Overall Workforce Skill mix



Source – NHSL HR System

Within this overall picture there are also marked differences between job families. The following figure details the skill mix within all job families.

Figure 19 – Workforce skill mix (March 2013)

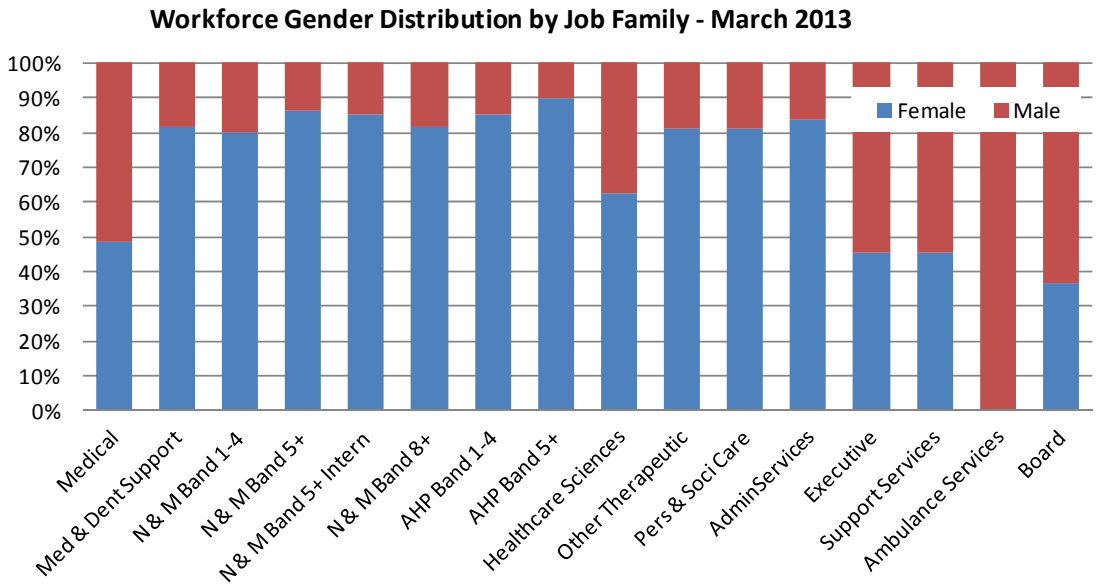
Band	Medical & Dental	Nursing & Midwifery	AHP	Healthcare Sciences	Other Therapeutic	Personal & Social Care	Administrative Services	Support Services	Ambulance Services
Band 1-4 wte	159	2,612	236	182	107	1	2,169	1,940	2
Band 1-4 %	66	28	16	23	21	1	78	95	100
Band 5+ wte	82	6,877	1,209	593	407	62	612	93	
Band 5+ %	34	72	84	77	79	99	22	5	0
Grand Total	**241**	**9,488**	**1,445**	**775**	**514**	**63**	**2,782**	**2,033**	**2**

There is currently an ongoing review of skill mix to review inconsistencies in level of skill mix across units and across specialties. To date has been across Adult in-patient units, however a review of skill mix within primary care/ community settings in 2014-15. To support the development of the non registered workforce there will be continued investment, predominantly at band 2 level. Shifts would be underpinned by evidence based analysis of existing service models and agreed phased implementation plans. It is also intended that the shift will take place across the workforce within clinical and non-clinical areas.

3.6 Work Patterns and Gender Profiles

The gender distribution within the workforce is female (76%) to male (24%), there are however significant differences within our workforce. The following figure details the gender split by job family.

Figure 20 – Gender distribution by job Family



Source – NHSL HR System

It is clear that within the non clinical areas there is a relatively similar gender ratio, however within the clinical workforce all areas of the workforce with the exception of medical are predominantly female. The picture within the clinical workforce has been relatively consistent of many years and therefore working patterns have a long standing tradition of flexible working patterns. However the feminisation within the medical workforce is a relatively recent phenomenon and has seen the proportion of female trainees increase from 35% in 1975 to 61% in recent years. This is reflected internationally within developed nations.

3.7 Medical Workforce Risk Assessment

The combination of the reduction in trainee numbers, EWTR implementation and New Deal compliance has resulted in pressure on rotas. Whilst the vast majority of rotas are compliant there is a narrow margin and the loss of even one trainee can make a rota non-compliant. As a result there is still pressure on a number of specialty rotas. Work is underway to look at actively reducing the number of rotas where possible, however specialty rotas are sometimes required as they support complex services.

These pressures have been building at a UK, Scottish, Regional and Local level and are leading to risks of losing service sustainability. This was recognised by the South East And Tayside (SEAT) Planning Group in July 2012 when it commissioned the development and implementation of a

process for assessing the level of risk within the medical workforce. This followed on from difficulties within the region in sustaining training grade rotas in all sites as a result of substantial gaps associated with unprecedented numbers of trainees being out of programme.

The tool that has been developed is based around the NHS 5X5 Risk Assessment Matrix, which maps likelihood against impact. The two scores are then multiplied to give an overall risk scoring for each risk and associated colour coding.

Likelihood	Consequences / Impact				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	V High	V High
Likely	Medium	Medium	High	High	V High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

Risks are considered for three categories of workforce; trained medical workforce, training grade medical workforce and non-medical replacement workforce. Within these three categories there are a number of individual risks, which are given a scoring from 1-5 for impact and 1-5 for likelihood.

The following are the risks that are reviewed as part of the assessment:

Training Grade Medical Workforce Risks

- Potential reduction in trainee numbers resulting from Reshaping the Medical Workforce Programme (SGHD/NES trainee numbers)
- Difficulties in sustaining trainee rotas - this may be linked to reductions identified the risk above.
- The results from the annual GMC Trainee survey and in particular the identification of any 'red flags', which may reflect issues of training quality (GMC survey results on website)
- Gaps in trained medical workforce.
- Gaps in rotas resulting from OOP due to research, maternity leave, etc.
- Gaps resulting from recruitment difficulties, including the recruitment of LAT/LAS.
- Any other factor affecting the medical trainee workforce.

Trained Medical Workforce risks

- Difficulties in recruitment of trained medical workforce
- Gaps in trained medical workforce resulting from absence sickness, maternity, study leave, etc
- OOH commitments and impact upon morale/retention, etc
- Staff shortages resulting in lack of capacity as evidenced by waiting times/lists, etc
- Productivity does not meet planned or benchmarked levels expected
- Demographic issues such as aging workforce or increased feminisation that are anticipated to lead to staffing issues over next 1-3 years
- Single handed specialist or skills shortage within the team
- Level of EPAs is too high/unsustainable - services would be unsustainable without individuals working a high number of EPAs
- Financial impact of additional payments ie to cover Waiting List payments/resident OOH working, etc
- Any other factor affecting Trained Medical workforce

Non-Medical Workforce risks

- Availability of appropriately trained staff
- Can they be trained within the required timescale
- Is there funding available to train alternative non-medical workforce
- Is the non medical workforce as productive as the medical workforce?
- Retention/turnover of non medical workforce
- Gaps in non medical workforce resulting from absence (sickness, maternity, study leave, etc)
- Any other factor affecting Non Medical workforce

Key areas of risk identified

- **Reduction in trainee numbers –** Whilst the national reshaping process is paused in most specialties still felt this represented a significant risk. A number of specialties highlighted that whilst numbers of trainees may not be reducing overall within the region the 'skill mix' was and therefore there was substantial variability in trainee numbers.

- **Training V Service –** The placement of trainees is primarily based on their training requirements rather than the needs of services. The SE region has an excellent reputation for the quality of training and as such has a significantly better ability to fill training slots when compared with other Regions across the UK. Specialties however highlighted that this could be a tension on service provision as a result of changes to trainee placement at relatively short notice. Work is underway with the Post Graduate Dean to identify possible improvements in processes.

- **Increased Maternity Leave, Less Than Full-time Training and Out of Programme Research** – The majority of specialties highlighted this as a key area of risk. Within specialties such as Paediatrics and

Obstetrics this extent of gaps have resulted in substantial challenges in sustaining services. Collaborative regional workforce planning has and will continue to be necessary in order that services are sustained in the face of on-going gaps in trainee rotas.

- **Training grade recruitment** – Whilst the reshaping of the medical workforce has been seen as a key risk several specialties indicated that the inability to fill training grade posts both as part of the annual recruitment and where gaps arise during the year were higher risks to service sustainability.

- **Trained Doctor Recruitment -** Across Scotland the solution to many of the challenges associated with losing trainee service contribution has been to expand the trained medical workforce. A number of specialties highlighted that there were significant difficulties in recruiting additional Consultant posts to improve capacity and patients flow. This was considered to be a high risk in Anaesthetics and Geriatrics where attempts to recruit to new posts had been largely unsuccessful. There is a clear need to improve intelligence in workforce supply information. A number of specialties where posts were still able to be filled indicated that number of applicants per vacancy had reduced significantly.

Whilst these areas represent the key areas of risk there are a range of other risks that apply within particular specialties such as single handed specialties.

Ratings are developed following discussion with the relevant Clinical Director and help build up a comprehensive risk profile within specialties across both sites and Boards. There are now assessments for 42 clinical services within Lothian.

The assessments are fedback to local Clinical Directors and their Clinical Management Teams. They use these to inform their own service/workforce plans to minimise risk. The feedback on the process has been very positive and is now being piloted in a numbers of Boards and specialties across Scotland.

For the risks that require a Board or Regional response the findings are fedback to the SEAT Regional Medical Workforce Group. This group will coordinate actions across Boards within SEAT and feed into the national medical workforce planning processes coordinated by NES/SG.

There is a monthly report taken to the NHS Lothian Board updating on actions taken to minimise medical workforce risks in order to support service sustainability and address capacity issues within priority areas.

For those specialties at high risk local workforce plans and solutions which minimise risk have been developed and are monitored closely through existing management structures.

A medical workforce group is being established to coordinate medical workforce planning across specialties.

3.8 Promoting Attendance at Work

At a national level in 2012-13 there was an average sickness absence of 4.84%, this is equivalent to 6,507 wte and £248m across the NHS in Scotland. In addition to these costs a significant number of clinical roles require to be back filled where absence occurs and as such supplementary staffing is required

With the substantial financial pressures that all Boards are operating under Lothian has worked closely with Partnership representatives on reducing the levels of sickness absence. At the end of March 2013 sickness absence had increased slightly from 4.06% (2011-12) to 4.32% (2012-13). Despite this slight increase in sickness absence it remains significantly below national average and the average within other large boards.

Significant efforts continue to be made in maximising attendance at work through

- Comprehensive, detailed and accurate sickness absence reporting
- Local line management capability
- HR and partnership support for line managers
- Robust consistent process for managing poor attendance
- Extensive occupational health service, including counselling and staff physiotherapy service.

3.9 Socially Responsible Recruitment

NHS Lothian is involved in supporting a range of different socially excluded groups, recognising that employability is one way that NHS Lothian can help individuals move out of this situation. This is done in a range of different ways and also involves cross-organisation working as well as links to groups within local authorities who are focussed on the same purpose. NHSL is closely involved in the following areas:

- Supporting School Visits - the employability team talk about different careers and also to support employability initiatives through helping mock interviews, careers events and raising awareness of what is involved in thinking about careers and applying for jobs.

- Working with Further Education (FE) Colleges and Higher Education (HE) Institutes – this includes supporting courses aimed at supporting those with specific needs (e.g. Pathways – Get Fit Get Healthy Move On programme – for those with Learning Disabilities).

- Developing supporting networks through new services – The WORKS is an NHS Lothian vocational rehabilitation service for people living in Edinburgh who are currently supported by a Community Mental Health Team.

- Involvement in cross-organisation partnerships – specifically these are with the different local authorities within the NHS Lothian area (including City of Edinburgh' Council's Joined Up for Jobs Strategy Group and Midlothian Council's Employment Action Network (MEAN).

NHSL is also committed to providing youth employment opportunities (16 to 24) and is involved in the following areas:

- **The JET Programme** - is a partnership agreement between NHS Lothian and South Edinburgh Partnership to deliver work based learning. The purpose of the programme is to provide S4 school leavers with skills to aid their move into employment and to promote NHS Lothian as an employer of choice.

- **Programme for Alternative Vocational Education (PAVE)** - is for students in S4/5 of secondary school education, who would like to develop the personal, social, vocational and employability skills, which are required when moving from school to the world of work.

- **Youth Employability (formerly Get Ready for Work) -** Get Ready for Work is a vocational training course specially designed for the 16-18 age group offering the chance to gain experience in the workplace/job market while developing skills.

- **One Week Work Experience** - placements for secondary year 4, 5 and 6 pupils seeking experience for their chosen career path. Out of over 900 requests NHSL placed 633 individuals last year.

- **Medic Insight** - provides S5 students in Edinburgh and Lothian considering a career in Medicine with a structured and varied week of work experience providing a well-rounded, dynamic and unbiased glimpse into their potential future career.

NHSL also has it's own Healthcare Academy which helps unemployed people be one step closer to employment. The Academy is open to those who are unemployed, residing in the Lothian area who have expressed an interest in working within a healthcare setting. The course is designed to give the participants transferable core skills, and is for people who would like to work as part of the non-registered workforce (e.g. Clinical Support Worker).

Initially provided by NHS Lothian and now by Edinburgh College, this is a course that provides theoretical and practical experience to enable the students to apply for clinical support worker or other entry level posts. From August 2013 there will be 60 places covering clinical and non-clinical training. There will also be 2 further courses focussing on preparation for work relating to Clinical support workers and Maternity/Health Visiting/Public Health/Paediatrics which will be provided by Edinburgh College.

3.10 Laboratory Training School

The development of the Laboratory training school has been one of the many ongoing projects within the Department of Laboratory Medicine ReNew programme: a four year plan to create a more efficient and effective laboratory service for the patient.

Part of the ReNew programme is to amalgamate the different disciplines within the different laboratory departments at each of the four sites. At St Johns Hospital at Howden, West Lothian, this space has included a laboratory and a seminar room. The seminar room has been converted into a teaching room and the laboratory will, in the next year, be converted into a practical area in which laboratory practical training will be delivered.

The Modern Apprenticeship is now being delivered on a day release basis at the training school by both NHS Lothian Laboratory and Adam Smith College staff thereby reducing the fees for each of the students. To raise more funds, the course has been advertised to external companies and the school has been successful in recruiting two students (West Lothian Council and Edinburgh University) for the pilot.

It is anticipated that more courses will be offered to schools; Higher Education Institutes and further education colleges in order to raise more funds and subsequently subsidise the laboratory in house training and education for support workers.

4 Workforce Demand

The changing size and composition of the population is the overarching driver for change in both the services and the workforce which provides them. As detailed in Section 2, NHS Lothian faces the challenge of both a growing and ageing population. This growth in conjunction with Treatment Time Guarantees increases the requirement for capacity within services and their workforces. This will require a constant focus on developing innovative approaches to service provision to enhance the productivity, efficiency and quality of services.

These challenges have been acknowledged by the Scottish Government and in 2013/14 NHS Lothian received an additional £12.3 for investment in services affected by population pressures. This has brought NHS Lothian closer to parity with the allocation that the National Resource Allocation Committee (NRAC) has determined as the NHS Lothian share. It is anticipated that the remaining gap of £50m will be closed progressively over future years.

The following section sets out the key drivers for workforce demand and the extent of anticipated workforce change in 2013/14.

4.1 Scheduled Care

As part of the process to determine the required level of capacity NHSL has worked closely with the Scottish Government QUEST Team in using the DCAQ capacity planning tool to determine workforce requirements. These have then been considered by the Waiting Times Group for funding.

The following figure details the investments that have been supported and are being filled in 2013/14.

Figure 23 – Investment in Scheduled Care workforce by job family and Band

Job Family	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Spec Doc	Consultant	Con Locum	Other	Grand Total
Administrative Services		12.49	19.70	7.31	3.00	2.00	1.00							45.50
Allied Health Profession Band 1-4		0.00	0.26											0.26
Allied Health Profession Bands 5+					0.60	3.72	5.00							9.32
Healthcare Sciences			5.00	0.80	1.30	2.00		0.00						9.10
Medical & Dental Support					2.85									2.85
Nursing & Midwifery Band 1-4		61.96		3.00										64.96
Nursing & Midwifery Band 5+					99.26	13.22	4.00							116.48
Nursing & Midwifery Band 8+								1.60	1.00					2.60
Other Therapeutic				1.00		0.00	1.00							2.00
Support Services	3.00		6.00											9.00
Medical										6.40	35.54	0.80	0.20	42.94
Grand Total	3.00	74.45	30.96	12.11	107.01	20.94	11.00	1.60	1.00	6.40	35.54	0.80	0.20	305.01

4.2 Unscheduled Care

As set out in section 1.4 managing the growing pressures on unscheduled care associated with a growing and aging population is a key priority both nationally and locally. As part of the nationally led planning process NHS Lothian has developed a Lothian Unscheduled Care Action Plan which sets out detailed performance measures for service provision and the investments in the workforce that will be made in 2013/14 to sustain and enhance services.

These investments are aimed at:

- Assuring effective and safe care 24/7
- Developing the primary care services
- Improving flow into, within and out of Acute Hospitals
- Making the community the right place

The investments that have been made are a mixture of funding for existing posts that had been funded on a short term basis and new posts. The following figure details these investments in the workforce by job family and band/grade within the individual work streams.

Figure 24 - Unscheduled Care Workforce Investment by theme

Theme	New	Existing	Grand Total
Assuring Effective and Safe Care 24/7	58.67		58.67
Developing the Primary Care Response	0.5	0.21	0.71
Flow and the Acute Hospital	50.31	185.04	235.35
Making the Community the Right Place	32.68		32.68
Grand Total	142.16	185.25	327.41

Within these themes there are investments in 21 specific projects that have been supported, the following figure details these by job family and grade.

Figure 25 - Investment by Job Family and grade

Job Family	Band	New	Existing	Grand Total
Administrative Services	Band 2	2.2	2	4.2
	Band 3	2.75	1.75	4.5
Administrative Services Total		4.95	3.75	8.7
Allied Health Profession Bands 5+	Band 5		0.5	0.5
	Band 6	5.25	5.9	11.15
	Band 7	1.5		1.5
Allied Health Profession Bands 5+ Total		6.75	6.4	13.15
Nursing & Midwifery Band 1-4	Band 2	20.24	31.64	51.88
	Band 3		2	2
	Band 4		16	16
Nursing & Midwifery Band 1-4 Total		20.24	49.64	69.88
Nursing & Midwifery Band 5+	Band 5	30.13	104.67	134.8
	Band 6	43.02	5.8	48.82
	Band 7	8.35	3	11.35
Nursing & Midwifery Band 5+ Total		81.5	113.47	194.97
Other Therapeutic	Band 2	2		2
	Band 5	3		3
	Band 6		1.5	1.5
	Band 7	1.5	0.2	1.7
Other Therapeutic Total		6.5	1.7	8.2
Personal & Social	Band 6		1	1
Personal & Social Total			1	1
Support Services	Band 1		4.08	4.08
	Band 2	5	2	7
	Band 3		1	1
Support Services Total		5	7.08	12.08
Medical	Consultant	7.52	1	8.52
	Spec Doc	2.95	0.21	3.16
	GP	6.75	1	7.75
Medical Total		17.22	2.21	19.43
Grand Total		142.16	185.25	327.41

Further investments in workforce associated with the NHS Lothian Change Fund are anticipated, these will however predominantly be within social care.

As the integration of Health & Social Care progresses there will be a need to reflect a wider scope for workforce planning as historical boundaries between services and their workforces are eroded.

These investment figures represent what has been identified as necessary to provide capacity across all services, however it may be that in some instances it will not be possible to recruit sufficient numbers and as such creative solutions may be required to close any gaps.

4.3 Laboratory Medicine ReNew programme

The increasing requirement for services within both acute and primary care as a result of demographic change also have an increased requirement for clinical support services such as laboratory medicine. There has been and will continue to be substantial growth in diagnostic testing which will require either significant investment in workforce to ensure throughput or service redesign and new technology such as automation. Approaches to automating

are being considered as part of the strategy which may have the potential to substantially improve throughput and improve quality.

4.4 Public Health Nursing Services – Future Focus

The focus on public health nursing in Scotland is changing. With the circulation of CEL 13 (2013) on 28th June 2031, there is now a shift of focus away from the current Public Health nursing role (PCN) back to the roles and titles of Health Visitor and School Nurse.

Each of these roles will offer a focus to a specific sub-section of the population. For example Health Visitor roles will have a focus on 0-5 years (including preconception) while School Nurse roles will have a focus on school years (age 5-19 years).

This delineation reflects emerging healthcare policy development linked to the early years initiatives, such as Getting it Right For Every Child (GIRFEC), The National Parenting Strategy, reintroduction of the 27-30 month review, roll out of the Family Nurse Partnership and *A* Scottish Framework for Nursing in Schools.

This shift of focus will allow for the delivery of targeted interventions by a specialist workforce, better equipped to address the specific needs of the respective age groups and their families.

A new Scottish Government Children, Young People and Families Nursing Advisory Group will take forward work to support NHS Boards to effect this change during 2013/14.

4.5 Non Medical Workforce Solutions

The development and utilisation of non medical staff has the potential to alleviate some of the medical workforce pressures. Examples to date include:

- Advanced Critical Care Nurse Practitioners enabling :
  - Replacement for doctors of the medical rota
  - Retention of experienced nurses in a clinical role
  - More efficient treatment planning
  - Ability to undertake procedures

- Consultant Podiatrist able to:
  - Operate as an autonomous practitioner
  - Undertake 70% of current range of foot surgery
  - Operate at 50% of the cost of the medical workforce alternative

There are however difficulties associated with such roles in other areas, these include:

- Difficulties in changing service model ie Neonatal/Maternity services.

- Resistance from existing workforce to change workforce roles and responsibilities
- Significant lead time, double running costs and developing new career paths i.e. potential to be seen as a career ‘cul de sac’.

Whilst these are senior non-medical roles there is also the potential for technical roles such within nursing section where capacity can be released, through training non-registered staff to:

- Cannulate
- Take blood samples
- Run ECG’s
- Catheterise

There is also the opportunity to maximise the potential within the existing workforce, ensuring that where staff have the knowledge and skills to undertake activity currently undertaken by the medical workforce they are encouraged to do so. In areas such as Radiology there are radiographers suitably trained to undertake reporting of plain film x-rays, however they are only currently undertaking 15% of the potential activity that are capable of.

There is a need to share the learning more from areas such as critical care where non medical solutions have been developed and implemented. Solutions need to be replacements for medical staff not another level of staff requiring supervision.

The medical workforce risk assessment process has shown that most specialties do not have a non-medical replacement alternative. In areas such as Critical Care advanced practitioners have been developed and are now replacing registrars on senior rotas and operating at a comparable level at a comparable level of productivity.

4.6 Learning and Development Strategy

Work is currently underway across many professional groups and service areas in the organisation, engaging managers and staff to develop high level action plans of what they aspire to do / have in place in the coming years linked to national / local / professional drivers. This is being incorporated into an overall learning and development strategy which will cover 2013 to 2015. The strategy will set out the learning and development priorities and the ways in which the workforce can be developed to meet service and patient need. This will also set out innovative channels for the delivery of learning and development.

4.7 Executive and Senior Managers Workforce Reductions

Senior Manager Cohort			
Staff in post as at:			
Mar-10	**Mar-11**	**Mar-12**	**Mar-13**
174.5	166.0	142.7	126.5

The above table indicates a reduction in the Senior Manager cohort of 48 WTE since March 2010. However the following should be noted:

- → 36 WTE have left the organisation and these posts have not been replaced.
- → 4 WTE posts were removed under organisational change but they were redeployed into other managerial posts under Agenda for Change.
- → 4 WTE posts were part of a regrading exercise between Senior/Executive pay and Agenda for Change and this had been agreed by the Remuneration Committee.
- → 4 WTE were posts that have been removed but we are now in the process of filling these once again.

We will of course continue to monitor our target during the lifetime of this Parliament but we remain confident that the 25% reduction will be achieved.

Section 5: Action Plan

As detailed within this plan there are a wide range of workforce demand and supply pressures that need to be planned for and consequently there is a need to develop local workforce plans for each Clinical Management Team/CHP during 2012/13. This process will be supported by the workforce planning and modernisation team.

Issue	Action	Lead	Timescale
Workforce planning and modernisation team to support CMTs/CHPs in the development of local Workforce Plans	Provide an overview of 6 step workforce planning methodology and workforce redesign methodologies. Support areas to develop local workforce plans through the provision of information, advice and support. Support areas in the development of new roles and ways of working required to address pressures/risks within the	Associate Workforce Director/ Workforce Planning and Development Team	2012-14

	workforce. Plans will be used to inform the 2014-15 Board workforce plan and link into the education and training strategy.		
HR&OD - Socially Responsible Recruitment initiatives	In light of emerging demographic patterns and pressures, support and engage in the roll out of new models of employment such as Modern Apprenticeship programmes that meet NHS Lothian's wider social responsibilities that in turn ensures effective succession planning and service delivery.	HR Director	2012-2014
Regional approach to medical workforce planning and role development	In line with national policy/ actions, continue to engage with all parties in managing workforce supply issues across individual specialty/ service areas.	HR Director/ Medical Director/ Regional Workforce Director/ Workforce Planning Team	Ongoing
Integration of Health & Social Care	Assist at a National and local level in supporting the health and social care integration agenda through a review of current data reporting and workforce statistics. Initial areas of focus would include Medicine for the Elderly and Children's Services.	Associate Workforce Director/ Workforce Planning Team	From July 2012 onwards
Develop a revised new Learning Development Strategy for 2013 to 2015.	The development of a new strategy is underway including extensive consultation with professional groups / service areas to develop a picture of what the workforce will require to look like to meet the local and national drivers. The strategy will set out how NHSL intend to develop the workforce to balance workforce supply and demand and close skills gaps.	Associate Workforce Director/ Workforce Modernisation Manager.	2013-15
Promoting Attendance at Work initiative.	As part of HR /OD Strategy, support line managers with accurate workforce data in the	Workforce Planning Team	Monthly Reporting

	management of sickness absence and the achievement of NHS Lothian's sickness absence target of 3.5%.		
Develop a medical workforce risk assessment process for application in all specialties.	The development of a robust assessment of medical workforce risks will enable NHS Lothian and the SEAT to more effectively plan and sustain services. The outputs from the process will also be used to influence national policy in relation to the medical workforce planning. Detailed updates will be reported to the JMT and Board.	Medical Director/HR Director/Head of Workforce Planning	2013-14
Clinical Strategy	Support the emerging Clinical Strategy through an integrated approach aligning workforce planning needs within current and future budgetary requirements.	HR Director	2012-2020

Section 6: Implementation and Review

The monitoring process for each of the areas covered by this plan will vary.

Strategic Clinical Framework - The development of a detailed project plan by the end of March 2014 will provide a prioritised implementation timeframe for NHS Lothian's medium and long-term ambitions in the context of the NHS Scotland 2020 Vision. This plan will map out a prioritised plan including timescale and resource requirements for each of the individual workstreams. This will feed into the Strategic Planning Group, which will in turn feed into the NHS Lothian Board who will monitor progress.

Learning and Development – The implementation of the learning and development strategy which is currently being developed will be overseen by the Learning & Development Strategy Steering Group. The JMT, Board and Partnership will be asked to provide the necessary resources to support the strategy and will be kept informed of progress in implementation.

Efficiency & Productivity - The monitoring of progress against efficiency and productivity plans will take within the individual operating divisions, the NHS Lothian Efficiency and Productivity group and overall by the Corporate Management Team. Regular updates are also provided to the NHS Lothian Partnership Forum. The workforce planning team will monitor change on a monthly or quarterly basis.

Medical Workforce Supply – The medical workforce risk assessment process feeds into the Regional Medical Workforce Group and SEAT planning group, given many issues such as trainee rotations are regional. There is also local review at CMT, JMT and Board level. There are also strong links with the SG Health Department who decide national policy in relation to reshaping the medical workforce.

Sustainability of small non-medical specialist Services – There is a national Short Life SG Working Group on small occupations which is developing a comprehensive picture of where there are these service exist. Locally there is a medical physics and rehabilitation working group, which is scoping current and future workforce requirements and the redesign required to ensure sustainability. This group links in with the Healthcare Science Workforce Group and the individual services who will review progress.

Generic Workforce Supply – the range of workforce supply areas such as demographic change, staff turnover and skill mix will be addressed at operating division level, corporate level and board level professional lead groups.

All significant changes to the workforce are discussed with the NHS Lothian partnership forum.