NHS Lothian
Workforce Plan

2012/13

Workforce Planning Department
HR & OD Directorate
Waverley Gate,
Edinburgh

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Introduction

This 2012-13 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 for the first time is based around the revised Scottish Government workforce planning guidance CEL (2011) 32 which was published in December 2011.

This guidance has suggested that Boards use the nationally sponsored 6 step workforce planning methodology for developing their plans. This revised approach is intended to ensure that there is a level of consistency across health boards.

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.

Over the last two years there has been a requirement for all Boards to deliver significant efficiencies to allow reinvestment in services. Within Lothian there has been a detailed 'bottom up' process for the identification and achievement of efficiency and productivity savings within the both pay and non-pay costs. In planning for further efficiency and productivity savings in 2012-13 NHS Lothian has taken the view there was a need to focus on achieving a higher proportion of savings from non-pay areas and that workforce efficiencies would be undertaken through strategic work streams as detailed within this plan.

NHS Lothian has three key challenges that require to be addressed in 2012/13:

- Achieving waiting times and improving capacity planning
- Managing unscheduled care
- Achieving financial balance and producing £37.4m of efficiency savings

In discharging its duties for workforce planning, NHS Lothian is and will remain committed to working closely with staff, partnership and the population in aligning workforce capacity to meet patient needs for today and tomorrow across all sectors of our services.

Section 1 – Defining the plan

The purpose of this plan is to set out the progress that has been made against this 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 Resource and Organisational Development Strategy. For example, in developing socially responsible recruitment practices to address future skills gaps we may also prevent ill health as workless ness can impact on an individuals wellbeing.

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.

1.1 Clinical strategy 2012 to 2020 – Our Health, Our Future

The NHS Lothian Clinical Strategy 'Our Health, Our Future' is in it's final drafting stage and sets out the overall service model and principles for our clinical services, which will drive service re-design, based on safe, high quality evidence based patient pathways.

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 identifies the following initial areas of focus:

- Emergency Care high volume pathways
- Elective (planned) surgical pathways
- Older people's care pathways focusing on care and support for frail/ elderly patients with complex needs
- Enabled by improved primary care/secondary/ social care interfaces to support the pathways above

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 in this future workforce plans will incorporate the key areas of workforce redesign.

1.2 Waiting Times and Capacity Planning

Whilst the clinical strategy sets out how NHSL will enhance capacity and introduce new models of care in the medium to long term there are currently substantial challenges in achieving the current 18 week waiting guarantee. Following a review of the inappropriate use of unavailability within our Waiting Times Management systems it is clear that a significant number of patients were not been treated within 18 weeks. These are within both inpatient/day case lists and also outpatient lists. Consequently a detailed profile by specialty has been developed and capacity plans have been developed to rectify the situation.

To address these challenges in advance of implementation of the national Treatment Time Guarantee of 12 weeks from agreeing an individual's treatment on 1st October 2012 detailed capacity plans have been developed and are being implemented. These include:

- Weekly performance meetings chaired by the Chief Executive
- Recovery Delivery Team working on a daily basis to implement plans
- Establishment of a "hub" function to specifically deal with patients being seen outwith NHS Lothian with other NHS Boards or the Independent sector and ensuring the optimum utilisation of capacity secured.
- Maximising the efficiency and productivity within theatres and maximising patient attendance
- Utilising external anaesthetists during holidays to protect local capacity
- Increasing the number of day cases treated by external staff in NHS Lothian sites at the weekend

These actions have developed in partnership with Trades Unions and the Scottish Government QUEST team and are aimed at ensuring patients are treated within the 12 weeks guarantee timescale. There is also a key requirement for NHSL to improve bed capacity on an ongoing basis and work is underway with local councils to ensure that there is sufficient capacity outwith hospitals to both ensure that patients are cared for in an appropriate setting and free up capacity. The forecast expenditure on sourcing additional capacity in the short term and securing suitable capacity on an on-going basis is approximately £20m.

This investment will mean a significant increase in the clinical workforce within the Theatres Directorate and a number of surgical specialties to enhance operating capacity and provide sufficient post operative bed capacity.

Section 2: Visioning the Future

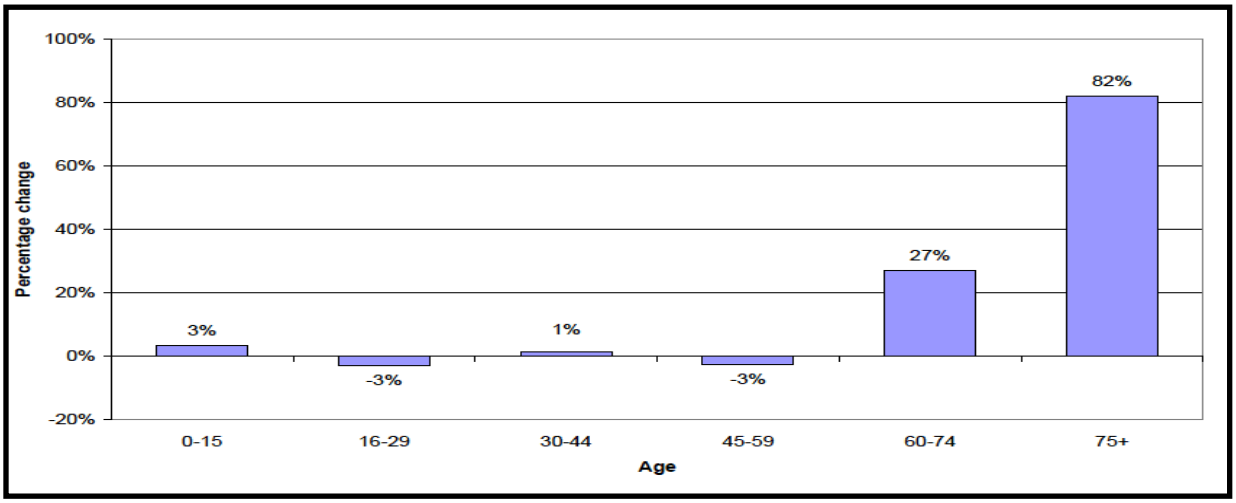
2.1 Scotland's Changing Population

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.

Figure 1 – Projected demographic change in Scotland by 2035

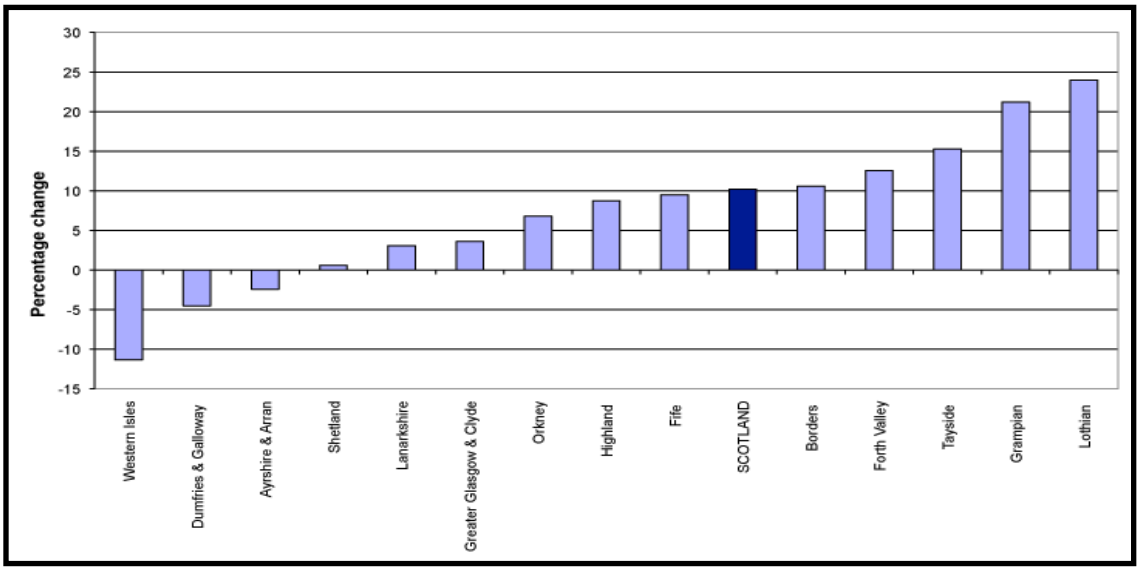


Source – GRO Scotland

This has significant implications for NHSS. The large increase in older people will increase demand for NHSS services. Also the small decrease in the 16 – 60 age groups will require the NHSS to compete in a labour market which will become increasingly competitive as the economic position improves. This aging of the population will also be reflected within our workforce and issues of heath and capability are likely to increase. Further detail on the aging of the population is detailed in section 4.2.

Secondly the projected increase of 10% in Scotland's population is not spread evenly across all the NHS Boards. As in the previous decade the population of SEAT Boards is projected to increase significantly more than other regions, as shown below:

Figure 2 – NHS Board level projected demographic change in Scotland by 2035



Source – GRO Scotland

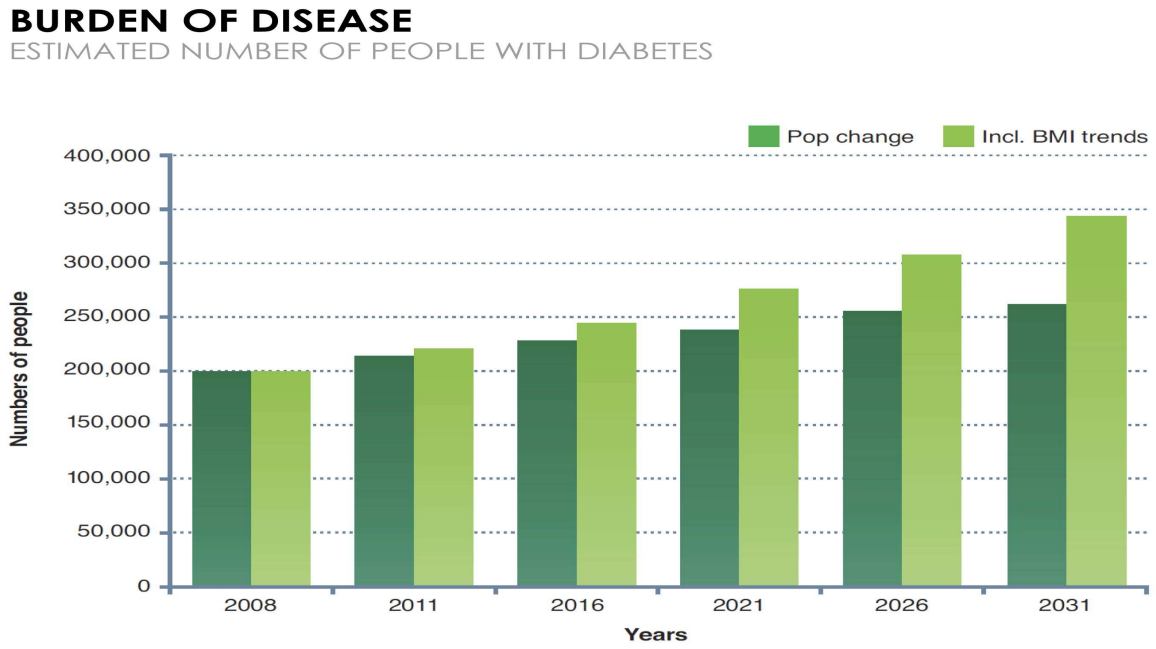
This has significant implications for NHSS. It will require the ongoing shift in resources to those boards projected to have significant increases in population, particularly given this growth will be mainly in the over 60 year olds. It will also require growth in the workforce of those boards in order 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 disease. Similar proportions of children and young adults under the age of 19 years are thought to be obese[4].

[1] Measuring Long Term Conditions in Scotland ISD 2008
[2] Cancer in Scotland Sustaining Change, Scottish Executive 2004
[3] Scottish Public Health Observatory 2011
[4] Impact of health behaviours and health interventions on demand & cost of NHS Services. Burns, H

Figure 3 – 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 Clinical Strategy

The development of our Clinical strategy has been undertaken with extensive involvement of key stakeholders including patient groups. Seven key themes have identified seven as a starting point for developing new models of care over the next 3-5 years. These seven key themes are:

- **Population needs-based services**

New models will be planned by looking at the needs of the local population and work with councils and other partners to meet both health and social care needs.

- **Effective, seamless and safe care**

New models of care that bring care in hospital, in primary care and in the community closer together will be developed. We will provide more joined up care pathways for patients through effective working by staff with patients and with each other.

- **Efficient services, outcomes focused**

Using evidence, funding will be focussed on where it has the biggest impact on people's health and wellbeing.

- **Innovative learning organisation**

To support our new models of care, NHS Lothian will identify best practice, locally and from further a field, and adopt it across the organisation. We will also use technology to improve care and share information appropriately.

- **Partnership working**

Engagement with all our partners, especially patients, carers and the public is essential in ensuring we adapt and design services to meet future needs.

- **Health improving**

NHS Lothian shall continue to prioritise preventative measures, and raise awareness of risk factors. Those identified as being at risk will pro-actively be offered care and assistance to maintain health.

- **Addressing health inequalities**

A continuing commitment to ensure that the right services are provided to all groups and provide additional support when needed.

To ensure the strategy for redesigning services is effective in meeting the themes and drivers identified above a set of principles for system design have been developed, which will provide the framework for service delivery in future, ensuring quality remains at the core.

These principles have been developed based on evidence from other health systems, refined through discussion with stakeholders and provide a checklist to ensure that future service models are in line with our vision.

They are:

- Maximise opportunities for prevention and early intervention
    - Shift care interventions to earlier in the patient pathway
    - Targeted interventions to further reduce health inequalities
- Care delivered in the location best suited
    - Shift what is appropriate from inpatient to outpatient/community/ primary care/self management
    - Fewer hospital sites, more fit for purpose accommodation
    - Greater co-ordination and integration of care across care settings
- Care delivered by the professional best suited
    - professionals skills fully utilised with skills and roles fully aligned to maximise effectiveness
    - Care is reliably delivered by the most appropriate member of the team
- Care standardised and specified
    - Care is designed on the basis of evidence based pathways and care bundles, and there is equitable access to best practice with no inappropriate variation in care

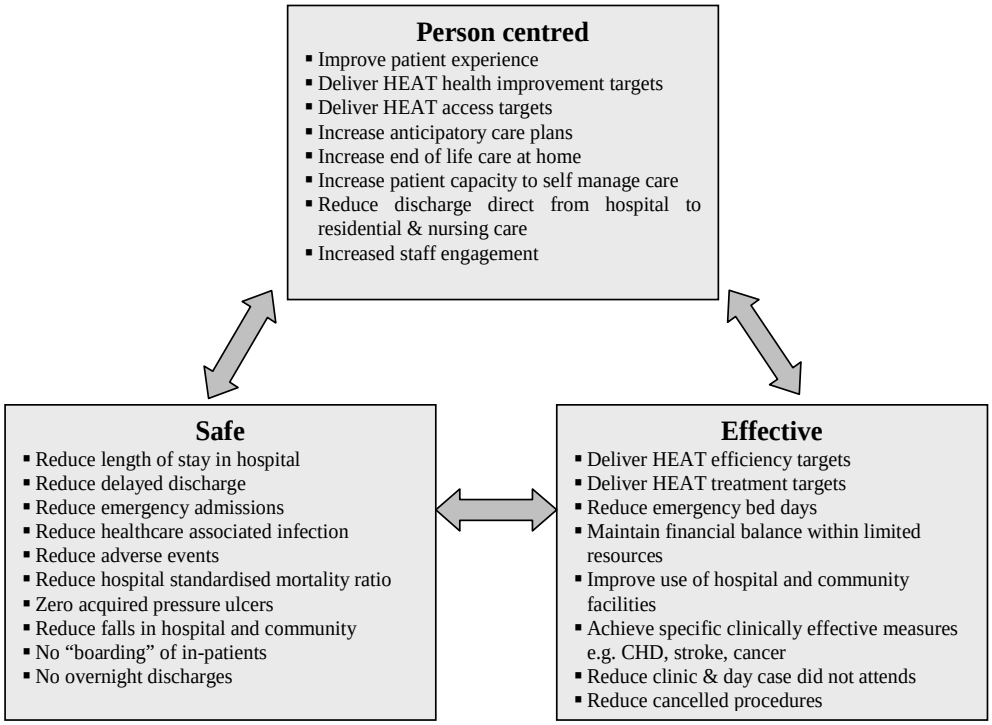
- Unit costs relentlessly reduced through waste reduction and lean processes (whilst maintaining health outcomes)
    - Care pathways designed to reduce wasteful activities for patients and staff: unnecessary duplication- of tests, appointments, recording of information etc; unnecessary waiting for patients; avoidable transfers and travel;

- Care enabled by technology
    - technology enables remote access to care and monitoring, and supports self-management
    - Information about patient history and treatment plans is shared electronically and accessible to professionals involved, and the patient/ client, to ensure best possible decisions
    - Telehealth and telecare provision is coordinated across health and social care

- Separate elective (planned) and emergency care
    - Focus on delivering both in a planned and reliable way to meet patient needs
    - Sustainable service models based on sustainable service capacity and workforce plans
    - Focus on safety and quality of care as primary drivers for clinical and operational decisions

- Service models co-designed with patients and sense-checked against patient experience.
    - Partnerships with patients and carers fully enabled
    - Pro-active care plans co-developed with patients

Figure 4 – Clinical Strategy interlinkage



2.3 Integration of Health and Social Care

The NHS in Scotland spends almost one third of total spend 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 is a clear 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 in 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.

This national agenda fits in well with the NHSL Clinical Strategy and well set out one of the vehicles through which it will be delivered.

2.4 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: Defining the Required Workforce

In seeking to define the required workforce there has been input from Directors of Operations/CHP General Managers and professional leads where possible. It also reflects integrated working with Finance and Service Planning colleagues both locally and regionally.

This section sets out the key drivers around the demand for healthcare services and associated workforce. It also sets out how NHSL seeks to address these pressures through maximising the efficiency and productivity within our services by redesigning service and workforce models.

3.1 Efficiency & Productivity

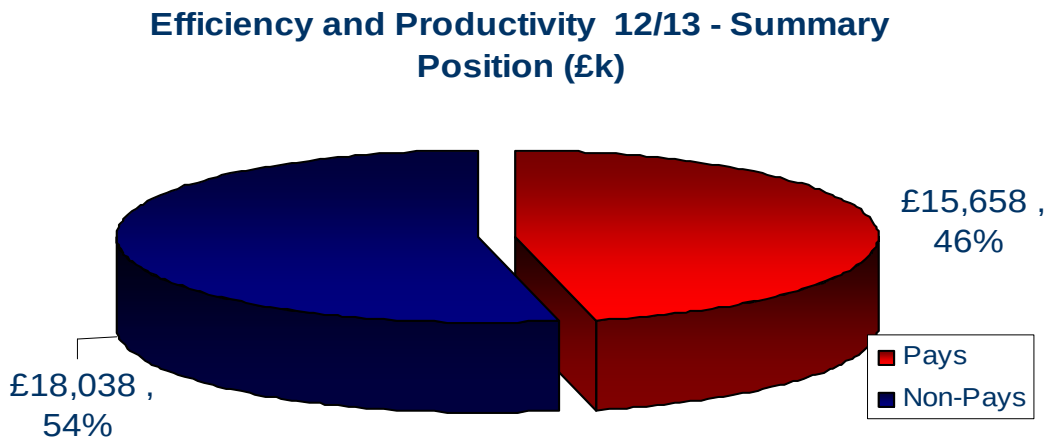
Whilst the Clinical Strategy will set out the strategic direction for clinical services in the medium to long term NHS Lothian in conjunction with local Partnership representatives identified the need to achieve efficiency and productivity savings of £37.4m in 2012-13. In 2012-13 the proportion of savings associated with workforce reduction and redesign is significantly lower than in the last 2 years (47%), with the majority of savings planned to come from non pay areas.

However the workforce reduction will remain a key element in achieving financial balance. At present detailed projections by job family are not contained within this plan however these are

under development and will be submitted to the Scottish Government prior to being published nationally at the end of August 2012.

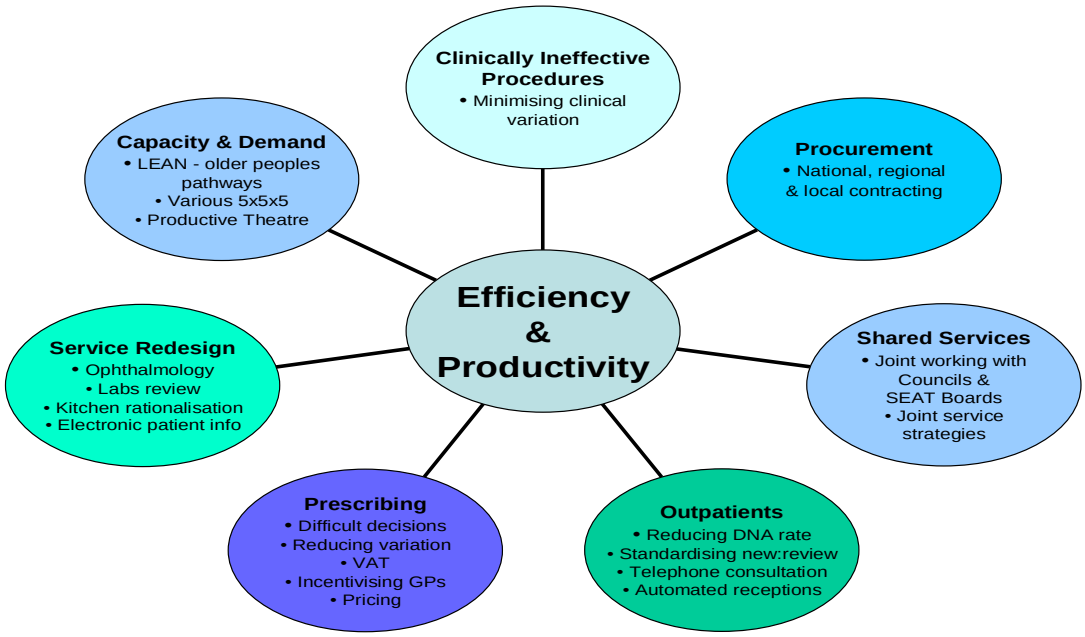
The following figure details the proportion of savings required within pay and non-pay costs in 2012/13.

Figure 5 2012/13 Efficiency and Productivity Savings



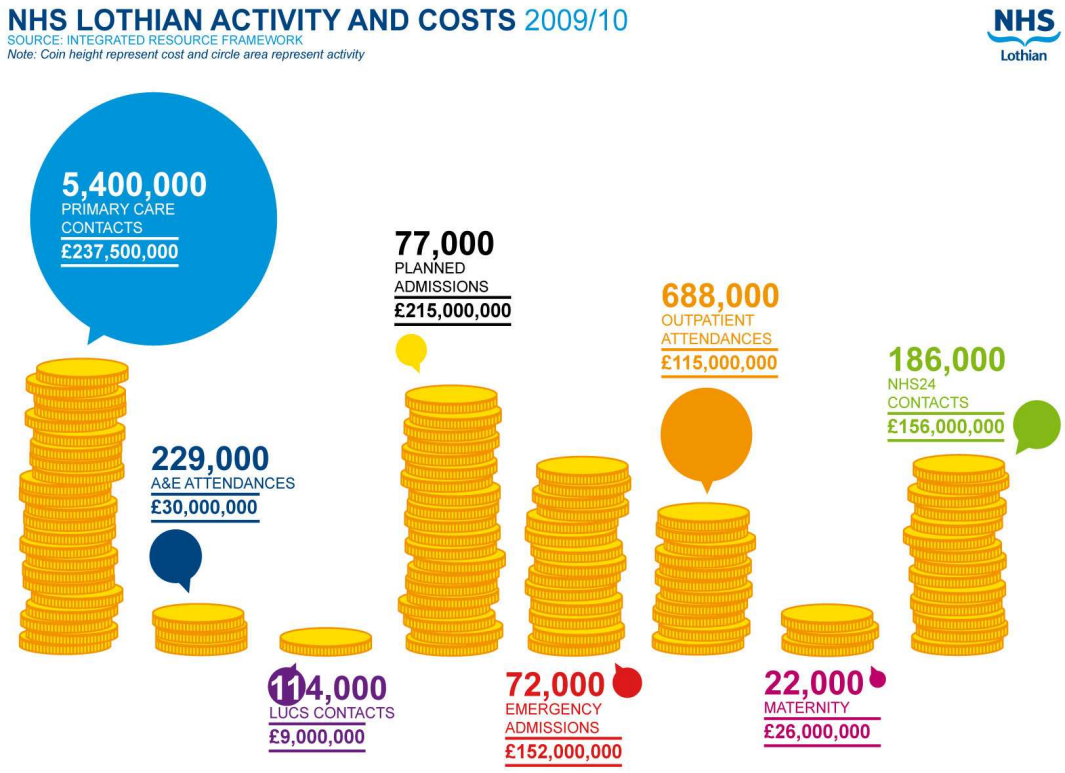
As mentioned addressing the demographic change cannot sustainably be done through using an ever greater amount of financial and workforce resources. There is a requirement to continue to generate savings for reinvestment through service and workforce redesign. The following figure details the current key internal efficiency and productivity programmes of work that are being taken forward in 2012/13 as shown in the following figure:

Figure 6 - 2012/13 Efficiency and Productivity Workstreams



Delivering financial savings through increasing efficiency provides NHS Lothian with the funding to reinvest in redeveloping our services and facilities. However the largest proportion of funding continues to be for planned and unplanned hospital admissions, with £183m being spent on un-planned and emergency admissions.

Figure 7 – Distribution of activity and expenditure



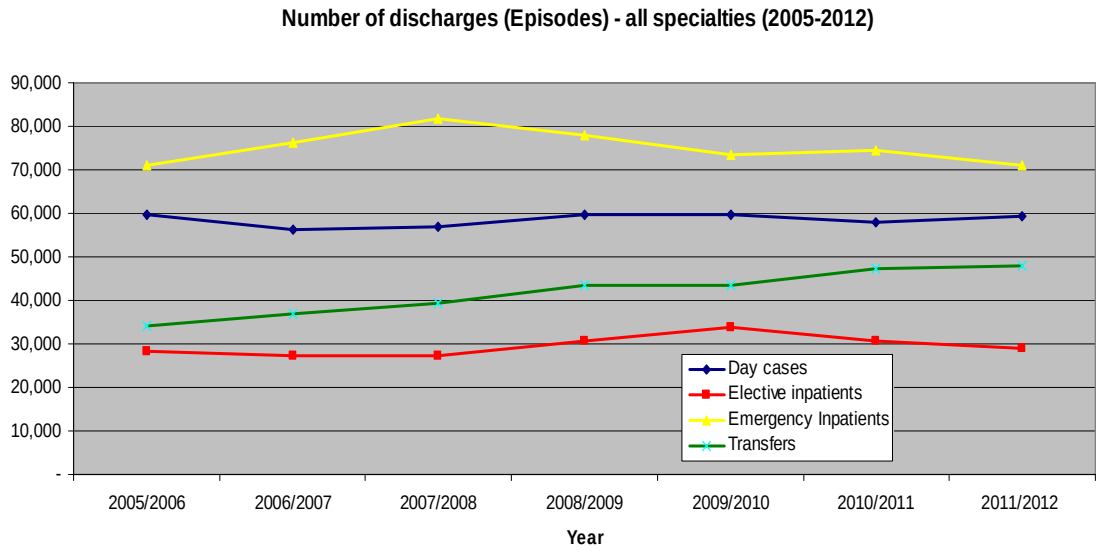
As the population grows and ages the requirement for such admissions has the potential to grow, it is therefore imperative that there is a focus on enhancing primary care services to reduce emergency admissions. This shift in the balance of care has the potential to release significant efficiencies through:

- Reducing acute bed use and length of stay
- Better understanding of activity and costs of patients pathways
- Reduced costs within acute sector of delayed discharges

3.2 Activity

Over the last two years the level of overall activity has remained broadly consistent at an overall as detailed in the following figure.

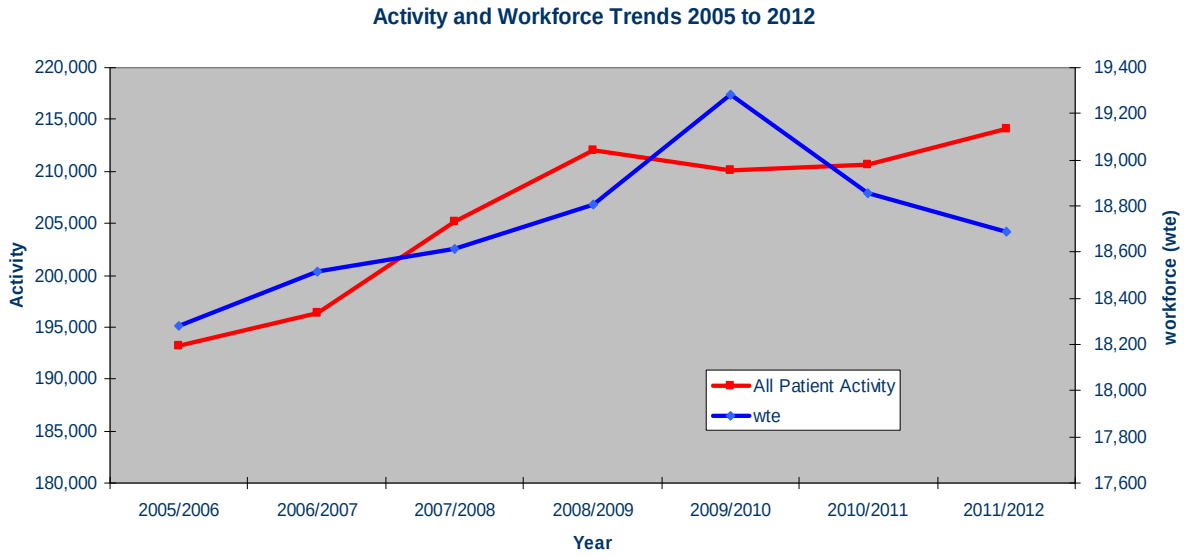
Figure 8 – Acute activity trends 2005 to 2012



Source – NHS Health Intelligence Unit

However during this period NHS Lothian has reduced its workforce significantly through implementing several hundred large and small savings schemes. This has resulted in the following improvements in productivity when comparing activity against workforce.

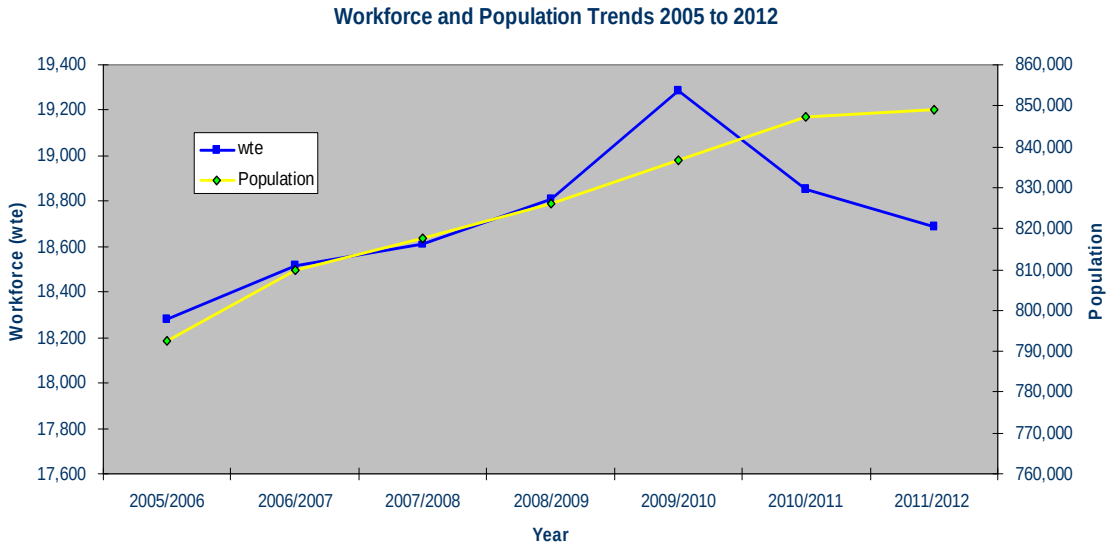
Figure 9 – Acute activity and workforce trends 2005 to 2012



Source – NHS Health Intelligence Unit

Within the Lothian Health Board area the population has continued to grow significantly over the last 7 years and as detailed in section 2 it has the highest level of projected population growth. Over the last 2 years the population has increased by 1.5% whilst the workforce has reduced by 3.1% as detailed in the following figure.

Figure 10 – Workforce and population trends 2005 to 2012



Source – NHS Health Intelligence Unit

Whilst the level of activity overall has not changed substantially there is a requirement for Boards to comply with a range of HEAT targets around access and the shortening the time between GP referral and the treatment. From December 2011 all Boards were expected to meet the national 18 week referral to treatment target. Achieving and maintaining compliance with this target necessitate both robust capacity planning and Lean administrative and clinical processes. Significant bed capacity continues to be tied up with patients who are clinically ready to leave hospital but the appropriate measures in terms of non-acute bed or home care are not in place at the required time. This will be a key priority for the integration of health and social care.

NHS Lothian has estimated that expenditure in the region of £20M will be required to tackle the ongoing issue of Waiting Times in 2012/13. Discussions with the Scottish Government have resulted in an offer of up to £10M to support this agenda which will be paid over the next 2 years. It is anticipated that this resource will be off-set against monies that would otherwise have been directed to additional NRAC funding over and above that contained in the Board's financial plan. The remaining portion will be funded by NHS Lothian.

This funding will be invested in clearing the backlog of patients and to ensure that we meet the national treatment time legal guarantee of 12 weeks from 1st October in the short term and also secure sufficient capacity on an on-going basis.

3.3 Unscheduled Care

Therefore in addition to waiting times NHS Lothian requires to more efficiently manage the pressures caused by unscheduled care. A Group has been established to focus on looking at ways in which the level of unscheduled hospital admissions can be reduced through more integrated working with General Practice and CHPs. This group is also looking at how patients that are admitted can be discharged more efficiently and effectively in clinical terms, reducing unnecessary delays and consequently increasing capacity. The current priority measures include:

- Agreeing a consistent definition of what constitutes a delayed discharge.
- Reviewing best practice around innovative GP models to improve access and in turn reduce A&E attendances
- Review best practice around Consultant led discharge planning and associated job planning.
- Development of an 'in reach' model where CHPs take the lead on the discharge of patients from secondary care on an individual basis.
- The introduction of 'real time' bed number reporting.
- Patient tracking staff to track individual patients on a daily basis.

This work-stream will become a key aspect of the integration of health and social care and as such the outputs will be key enablers.

Whilst the targets around waiting times provide key challenges around capacity, reducing unscheduled admissions has the potential to reduce the demand for hospital care through patients getting access to general practice and appropriate care before conditions result in the need for unscheduled admission. The move to a more individual patient focus within the hospital also has the potential to significantly improve bed and workforce capacity.

3.4 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 will require a constant focus on developing innovative approaches to service provision to enhance the productivity, efficiency and quality of services. This will also be a key determinant of both the size of our workforce over the short medium and long terms.

The following section provides an assessment of the key drivers for change within each of the job families and what risks they may pose to NHS Lothian.

3.41 Medical Workforce Change

Whilst the population in Lothian is growing it is however getting disproportionately older as is the case throughout Scotland. There will inevitably be an increased requirement for the management of long-term chronic disease and long-term anticipatory care as detailed in the Clinical Strategy. The specialties where this change is expected to be most pronounced are: Medicine of the Elderly, Cardiology, Cancer, Gastro-intestinal, Dermatology, Rheumatology and Renal. This will result in providing treatment and care in community settings. This will require

increased Consultants, Specialty Doctors and non-medical specialists to work out-with the Acute hospitals in Community Treatment Centres.

Over the last 10 years the medical workforce has been expanded by 20%, (298wte) overall in Lothian as services are increasingly delivered by a trained doctor workforce. The trained workforce consisting of Consultants and Staff Grade and Associate Specialists has grown by 35% (234wte), the training grade workforce has also grown by 7.5% (64wte) over the same period. This increase within the medical workforce has been as a direct consequence of achieving compliance with the European Working Times Regulation (EWTR) and improving standards of training, however it has caused a decrease in service delivery by medical staff.

The implementation of Modernising Medical Careers (MMC) improved the quality of training through revised grading structures and curricula and increased focus on providing high quality and ensuring adequate breadth. This however has reduced flexibility for employers in using trainees to support service delivery. MMC also led to the inclusion of SHO3 doctors ('the lost tribe') into training programmes and as such introduced a bulge in a number of specialties.

Within a large Teaching Board such as NHSL providing regional and national services there are a wide range of specialities and sub specialties. Many of the subspecialties have developed over time around the developing knowledge and skills of an individual or small team. As a consequence there may not be an easily identifiable replacement where staff leave or retire there is therefore a requirement to develop succession plans to ensure there is no risk to service continuity and sustainability or the development of an alternative service model

Reshaping the Medical Workforce

There is recognition at a national and local level that trainee numbers require to reduce to avoid the risk of over supply and the national Reshaping Board has the lead role in planning the overall reductions. The South-east Region Medical Workforce Group has the lead role in planning the reduction in Lothian, Borders and Fife. The salaries associated with training posts that are removed are returned to the service to help fund workforce replacement and the regional group have a lead role in this process.

The scale of the reduction in trainees in Scotland and the UK will mean that it will be unsustainable to continue to maintain all services in their current form as the reduced number of trainees will make EWTR compliance impossible in some cases. In Lothian key areas have been asked to prepare workforce plans detailing the potential impact of reductions on services and how they intend to redesign services and/or the workforce to ensure sustainability.

The reshaping of the medical workforce is in many respects more of a workforce supply issue however these changes will create a demand for alternative workforce models either through replacing trainees with trained doctors or through non-medical replacement. However there remains significant uncertainty around the timing of the reductions as they are driven by when individuals achieve their Certificate of Completion of Training (CCT). Further details in relation to how reshaping the medical workforce impacts on workforce supply are provided in section 4.

The specialties with the largest levels of reduction at a national level are:

- A&E(14 out of a total of 137)
- Anaesthetics(38 out of a total of 314)

- Clinical Radiology(17 out of a total of 117)
- Medical specialties
  - Cardiology(7 out of a total of 57)
  - Clinical Oncology(6 out a total of of35)
  - GUM(3 out of a total of 12)
  - Rheumatology(6 out of a total of 24)
- Mental Health
  - General Adult(5 out of a total of 77)
  - LD(6 out of 20 a total of)
  - CAMHS(6 out of a total of 34)
- O&G(36 out of a total of 199)

The timing of the reductions at a regional level are driven when trainees achieve their CCT as from that point on they have a period of 6 months 'grace' in which to secure suitable employment after which the post they had held is disestablished.

The following are the key risks associated with the planned reductions:

- As the number of higher specialty trainees reduces as outlined by the Scottish Government it will not be possible to maintain the current number of compliant rotas without service and workforce redesign.
- The feminisation of the workforce will continue to cause emergent gaps in rotas in highly feminised specialties such as paediatrics and it may not be possible to recruit to gaps.
- The increasing focus on the quality and breadth of higher specialty training will further limit their flexible deployment for service contribution.
- The reduction in higher specialty trainees has the potential to reduce capacity to maintain waiting times targets.
- Medical workforce pressures in other Boards have the potential to lead to activity diverting into NHSL.
- The development of non-medical alternatives has a lead in time, requirement for double running costs and recruitment and development plans. Consequently this is unlikely to form a workforce solution in the short term.
- There is a significant financial pressure associated with maintaining services where there is no readily available workforce replacement for gaps in rotas or disestablished posts.

Within Lothian the areas of high risk concern over the period over which the reductions are planned will be:

- Emergency Medicine
- Surgical specialties
- O&G
- Paediatrics

A further detailed risk assessment is included in Appendix B

Whilst these are the areas that will see the largest reductions the loss of even one trainee has the potential to destabilise a rota. There is a requirement for all specialties to risk assess the potential loss of trainees and develop action plans that set out how the service and/or workforce will be redesigned to sustain service provision.

The planned reductions and changes such as the feminisation of the workforce (see Section 4) are already impacting on service provision. Within paediatrics in the SE region there has been unprecedented levels of maternity leave resulting in 28% of gaps in trainee posts. This resulted in the cohorting of gaps at St John's hospital to ensure sustainability of other paediatrics units in the region as failure to do so would result in activity diverting to Lothian. This has led to the paediatric unit at St John's hospital having to send patients to the RHSC out of hours for emergency care for three weeks in July. Recruitment is underway to try and recruit Consultants in paediatrics and neonatology to help support out of hours cover. Paediatrics is however a shortage specialty and as such it will be challenging to recruit the required workforce to maintain the current service model. Plans to address the impact of reduced trainee input also include the development of the non-medical workforce, however these require double running and have a lead in time.

To provide solutions to dealing with medical staffing gaps the following initiatives are being implemented.

3.42 Hospital at Night (HaN)

An important way in which Specialty rotas can be sustained is through reducing the requirement for out of hours specialty rotas, whilst maintaining quality and safety. The implementation of HaN within key acute hospital sites is now well established and has provided a range of benefits, including:

- High level of awareness
- Requests to HAN team dealt with more quickly than previously
- More even distribution of work
- Ward staff feel more supported
- Improvement in rota bandings
- Overnight breaks are being taken
- Improvement in some aspects of training
- Reduced out of hours calls to pharmacy

The HaN team consists of a skill mix of medical trainees from a range of specialties and nurse practitioners. However as the number of medical trainees reduces within contributing specialties it will become challenging to sustain HaN as it currently operates. In future the number of higher specialty trainees (ST3+) are expected to reduce from 81 to 60, with the 21 posts lost contributing to varying degrees. The losses are expected to equate to a 25% reduction on the numbers available each night. Plans are currently being developed to identify an alternative staffing model and are anticipated to involve additional advanced nurse practitioners.

3.43 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 as the Healthcare Technician (HCT) detailed in the nursing section where capacity can be released, who can:

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

There is also the potential 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.

3.44 Nursing Workforce Change

The nursing workforce consists of the registered workforce employed on agenda for change band (AfC) 5 and above and non-registered nursing employed on AfC bands 1-4. The nursing workforce is further broken down into the following groups:

- Paediatrics
- Adult General
- Mental Health
- Learning Disability
- Midwifery
- Community Nursing

Over the last 5 years the nursing and midwifery workforce has remained relatively constant overall in Lothian following a period of sustained growth in the previous 5 years (2001 to 2006), which had seen the nursing workforce grow by more than 1,000wte overall. The nursing workforce has however reduced by 260 wte between 2010 and 2012 to 8,609 wte overall

(Source - ISD) in its substantive workforce and 124 wte in supplementary staffing. These reductions have been made as part of the efficiency and productivity programme as a result of a wide range of 'bottom up' schemes including

- Reduction in the number of posts through the redesign of services.
- Reduction in nursing establishments through the restructuring of the workforce and patterns of work.
- Reduction in the level of predictable allowance for sickness absence of 1%, reflecting lower absence rates, within the Acute Division
- Reduction in the utilisation of supplementary staffing.

As indicated earlier in section 2 the focus for workforce efficiency and productivity savings has primarily been around service redesign, capacity/demand management and a review of outpatient services. At present there are indicative savings only and change in the workforce will emerge as work streams progress.

It is anticipated that there will be more detail on the extent of these savings and the areas from which they will be released and will in turn be included within the plan.

Healthcare Technician Pilot

NHSL is currently undertaking a pilot of a Healthcare Technician role which is intended to be more flexible, undertaking multi professional tasks incorporating work from Nursing, AHP Professional groups and Hotel Services. The role will provide a more flexible 'person focused' care model and will allow for a seamless transition of patients throughout their journey of care.

It is anticipated that the introduction of this new role will provide significant efficiencies within ward establishments with an increase in Clinical Support Worker Bands and a reduction in Nurses and AHP's at Band 5 and above. The introduction of the new role will also provide a career structure for Clinical Support Workers and allow registered staff to concentrate on higher level tasks in accordance with their qualifications and experience.

To determine the effectiveness of this new role it is being piloted in three wards within the Medicine of the Elderly Directorate/Services. An initial scoping exercise identified three suitable wards within St Johns Hospital, Royal Victoria Building and the Loanesk Midlothian Community Hospital.

Since the launch of the pilot in March 2011 work has been ongoing we have collected data and information to inform the development of the Healthcare Technician role and how this will integrate within the team to support more effective engagement with patients to maximise independence and enhancing the quality and safe effective care. The majority of the data has been gathered through a combination of direct observations and activity analysis. This has enabled the identification of current working practices and how these support patient-centred care delivery and informed the team of possible new models of care delivery.

The learning from 1 day pilots carried out in early 2012 has been incorporated into the training plan. Further 5 day pilots are to be undertaken with a revised skill mix incorporating healthcare technicians. The aim is to measure the shift in practice for both Registered and Healthcare Technician trainee staff and the effect this has on the delivery of care by the wider multi-disciplinary team to maximise patient independence.

Training for this role will be predominately provided in-house and tailored to meet the required need. The final determination of the agreed competences will establish the most appropriate training model. All trainees have been allocated a mentor and significant support will be provided by the Continuous Professional and Practice Team.

The pilot projects are being overseen by a steering group co-chaired by the Director of Nursing & AHPs and the Employee Director and consists of key stakeholders, partnership and patients.

3.45 Allied Health Professions Workforce Change

The Allied Health Professions workforce consists of a number of individual professional groups, each with a mix of registered and non-registered staff. This workforce is subsequently split according to AfC bands into a registered component (Bands 5+) and a non-registered component (Bands 2-4). The following professions are included:

- Occupational Therapy
- Speech and Language Therapy
- Dietetics
- Physiotherapy
- Orthoptics
- Orthotics
- Radiography
- Art Therapy
- Podiatry

The workforce is largely registered staff, with the current skill mix across the whole of the AHP workforce at 84:16 (Reg:Non reg). However NHS Lothian will continue to strive towards a revised skill mix for this workforce of 75:25 that delivers safe and effective care but in a more efficient manner. Approximately 60% of the workforce is employed on a full time basis and the vast majority (circa 90%) of the total workforce are female.

Main Themes for 2012-13

There are a number of key themes that will impact on future AHP service delivery as well as the required workforce to underpin such services during 2012-13. These are:

- To continue to review the overall capacity within the workforce with a particular focus on skills and competencies.
- Investment in new role development, e.g. Consultant Podiatrist in Podiatric Surgery.
- Invest to save models, e.g. the redesign of Musculoskeletal (MSK) Pathways
- Children's Therapy Services
- Therapy Management within Older People's service across both primary and secondary care
- Mental Health Services
- The Health and Social Care Integration agenda.

In tackling these issues, NHS Lothian will fully embrace the three Quality ambitions outlined in the Healthcare Quality Strategy as well as to build on existing knowledge and skills obtained through a plethora of learning and LEAN events undertaken in recent years.

3.46 Healthcare Science Workforce Change

Healthcare Scientists (HCS) cover 49 disciplines within 3 major groupings: Life Sciences, Physical Sciences and Physiological Sciences. Within these there are a range of subspecialties with their own distinct characteristics. This was recognised as part of the UK wide initiative Modernising Scientific Careers, which set out proposals on career pathways, regulation and standards of education and training, education and training programs and on supporting delivery.

The HCS workforce is concentrated within the Acute Division, and is focussed at the Royal Infirmary, Western General and St John's Hospital sites.

Main themes for 2012-13

The following highlights some of the main themes identified in current plans:

- Reduction in HCS establishments through the restructuring of the workforce and patterns of work
- Reduction in staffing costs through changes in working patterns and practices.
- Changes in skill mix via clinical developments and better use of technology in the coming years.

One of the main pieces of service redesign is within Laboratory Services. Laboratories are currently working on a four year plan to establish a sustainable, efficient and productive workforce model. This will involve the development of a Laboratory Training Scheme that will underpin and support changes in skill mix and ultimately staff deployment. It will also allow for a career pathway for support workers within laboratory services.

A number of the specialties within the major HCS science groups consist of small teams providing a highly complex and special services such as Medical Physics. A national review carried out by the Short Life Working Group on Staffing for Medical Physics in Scotland has recently published setting out actions to improve recruitment.

3.47 Support Services Workforce Change

The support service job family consists of nine different services:

- Catering
- Domestic
- Hotel Services
- General Services
- Security
- Laundry & Linen
- Stores
- Transport
- Sterile Services

This workforce is mainly employed on a part time basis with only 35% working full time. The gender profile of the overall workforce is that 52% of the workforce is female. Currently 96% of the workforce is employed on Agenda for Change Bands 1-4.

As with other areas there will be a number of approaches adopted to realise workforce savings and reductions. There has been detailed work undertaken across support services in identifying savings from a 'bottom up' approach. This has resulted in efficiencies being identified namely through restructuring of services and new ways of working.

NHSL recently participated in a pilot study co-ordinated by NHS Education for Scotland (NES) to map the current skill sets across the whole of the Support Services workforce. Having a better understanding of current skills sets will allow for NSHL to ensure that the relevant training and development arrangements can be put in place to support current service delivery but to also promote career development and advancement within support services.

3.48 Executive and Senior Managers Workforce Change

The current Government have a manifesto commitment to reduce the number of senior managers within the NHS in Scotland by 25 % over the current parliamentary term. This covers staff employed on executive and senior managers' terms and conditions.

Historical Workforce numbers

The following figure details the downward trend in the Executive and Senior Managers workforce.

Figure 11 – Executive and Senior Managers workforce reduction (2007-12)

2007	2008	2009	2010	2011	2012	Reduction wte	Reduction %
250	198.2	184.9	168.9	164.1	151.5	98.5	39%

Source – ISD Scotland

The table above details the downward trajectory within Lothian, although part of the reduction of numbers in 2009 to 2010 has been associated with the transfer of staff onto AfC terms and conditions. Our total target reduction is 43.6 wte to be achieved by 2014 and at the end of March 2012 a reduction of 31.7 wte i.e. 73% of the target has been achieved.

2012-13 Managerial reduction

The anticipated savings is incorporated into the Administrative targets figure. Given that many of these staff are from specialist professional areas there is limited capacity to redeploy staff and as a consequence turnover is likely to be achieved through a combination of retirals and natural turnover.

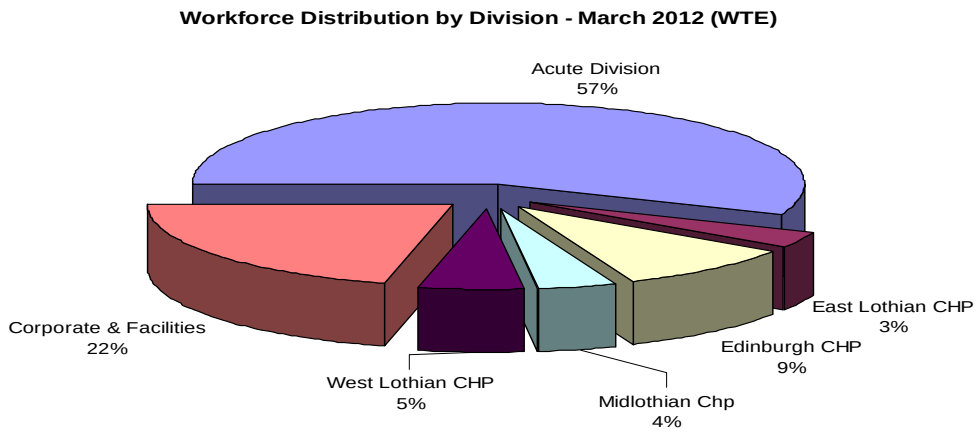
Section 4: The Current Workforce

4.1 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 2012 NHS Lothian utilised 18,686wte, covering all job families and (includes supplementary staffing) at an approximate cost of £770m per year in direct workforce costs. The following figure shows the distribution of the workforce by operating division.

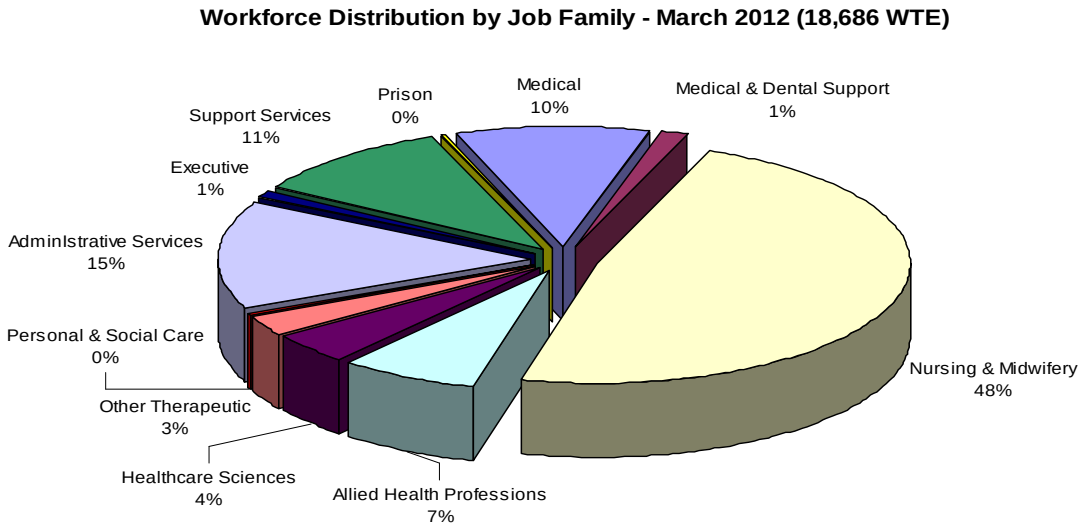
Figure 12 – Workforce by operating division



Source – NHS Lothian Payroll

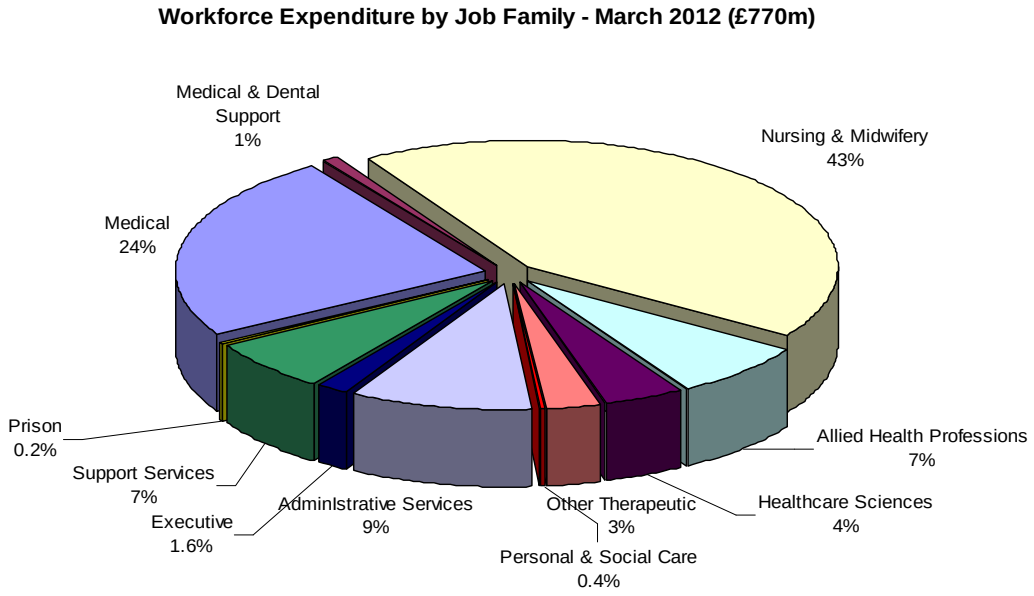
The following figures detail the workforce distribution by job family both in terms of whole time equivalents and cost.

Figure 13 – Workforce by job family (WTE)



Source – NHS Lothian Payroll

Figure 14 – Workforce by job family (£)

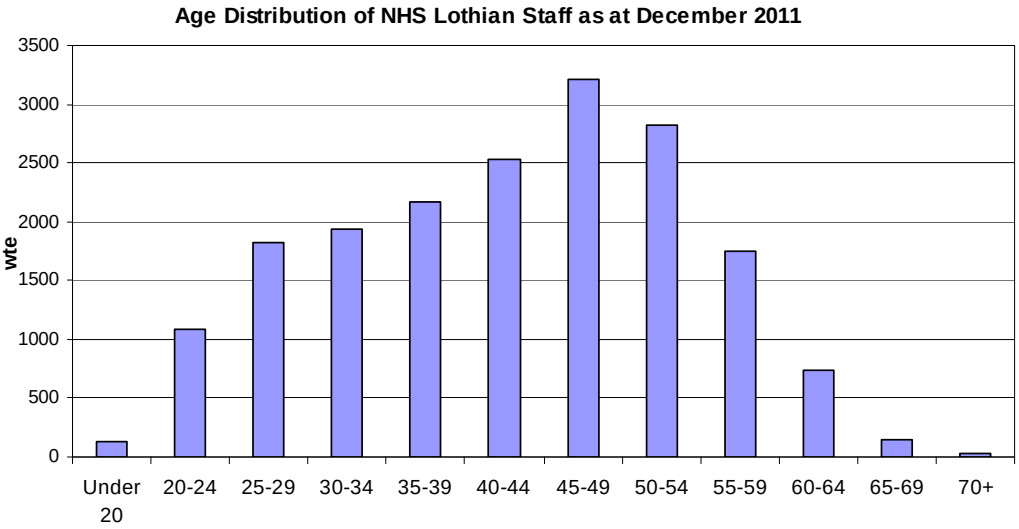


Source – NHS Lothian Payroll

4.2 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.

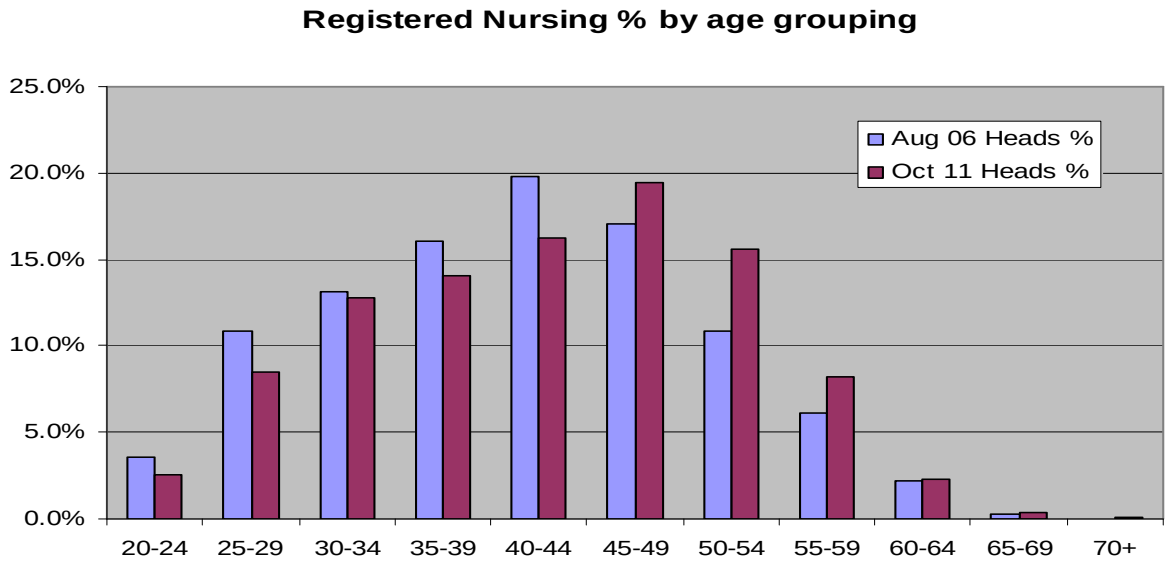
Figure 15 – Overall age distribution



Source – NHS Lothian Payroll

In December 2011 14.5% of the total of NHS Lothian workforce were aged over 55 years old, with the largest number within the 45-49 age category. 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 16 - Age distribution within registered nursing

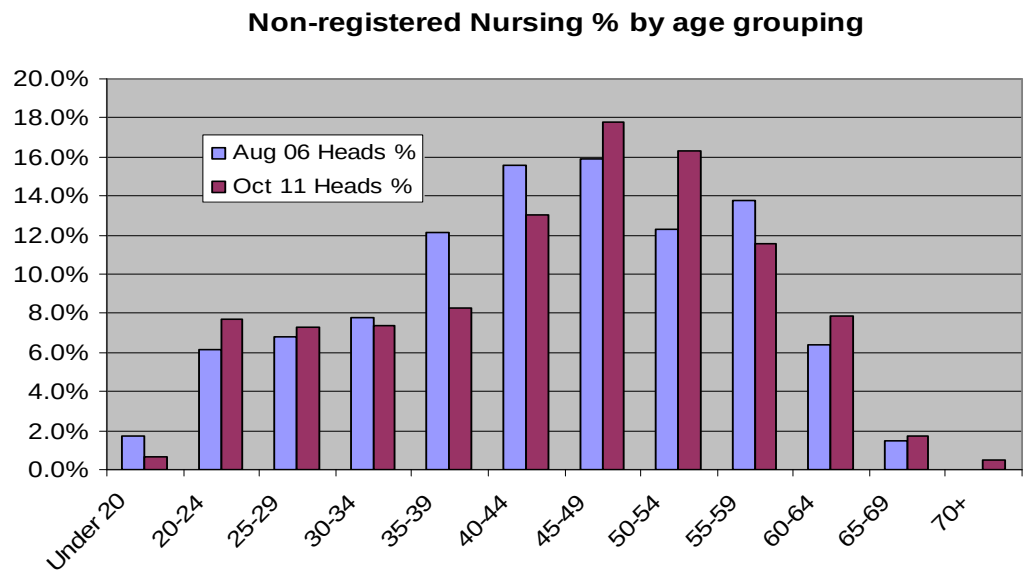


Source – NHS Lothian Payroll

Within registered nursing the ageing of the workforce is already pronounced, between August 2006 and October 2011 the proportion of staff aged over 50 has increased from 19% to 27% an increase of nearly 10% in 5 years, with a median age of 41. 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.

Whilst in practice it may well be that there are a range of factors that influence individual decision making and not all staff will hold special class/mental health officer status this remains a key area of challenge. Research carried out by NES the 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 17 – 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 2011 the proportion of staff aged over 50 has increased from 34% to 38% an increase of 4% in 5 years, with a median age of 46. 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 and over as detailed in the following table.

Figure 18 – Proportion of staff aged over 55 years old by job family

Job Family	total wte	wte over 55	% Over 55
Medical	1,833.9	144.0	7.85
Medical & Dental Support	223.9	22.0	9.82
Nursing & Midwifery Band 1-4	2,365.2	427.3	18.07
Nursing & Midwifery Band 5+	6,322.8	560.7	8.87
Nursing & Midwifery Band 8+	117.0	6.6	5.64
Nursing & Midwifery Overall	8,805.0	994.6	11.30
Allied Health Profession Band 1-4	212.5	36.6	17.22
Allied Health Profession Band 5+	1,126.8	96.6	8.57
Allied Health Professionals Overall	1,339.3	133.2	9.94
Healthcare Sciences	767.6	120.5	15.69
Other Therapeutic	495.0	29.4	5.94
Personal & Social Care	77.3	13.3	17.22
AdminIstrative Services	2,682.1	630.5	23.51
Executive	147.5	27.0	18.30
Support Services	1,961.8	528.4	26.93
Emergency Services	1.0	1.0	100.00
Board	18.0	12.0	66.67
Grand Total	18,352.5	2,655.7	14.47

Source – NHS Lothian Payroll

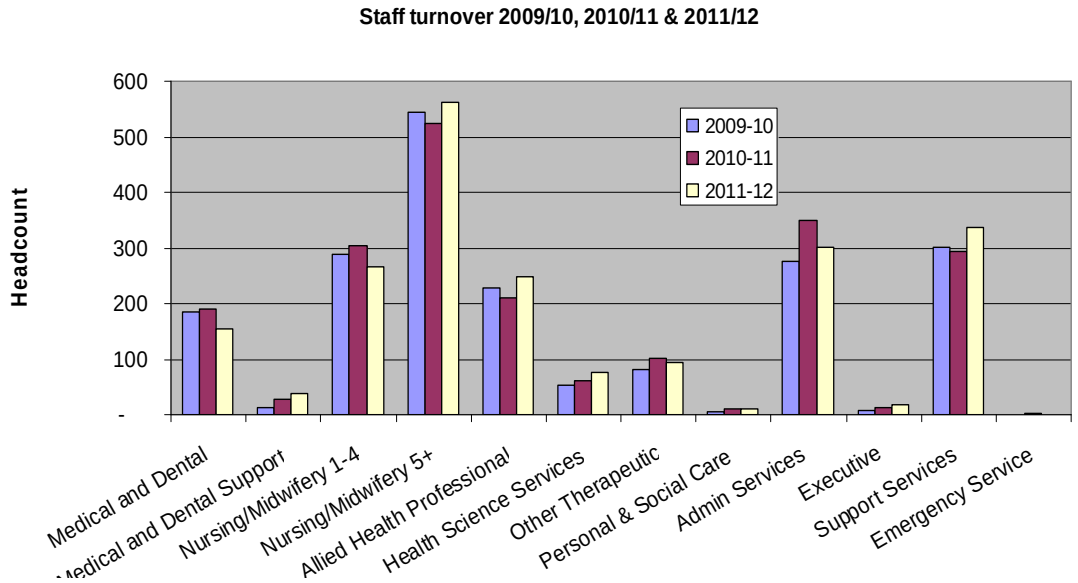
There are also significant hot spots within these job families and there are some small areas of disproportionate impact where the loss of even a single member of staff can have a major impact.

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

4.3 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 19 – Staff turnover by job family 2009 to 2012

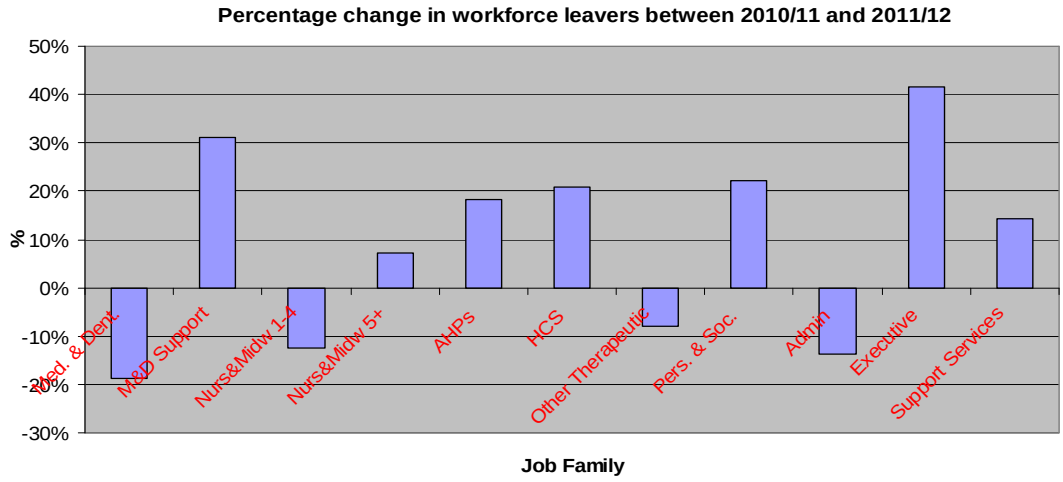


Source – NHSL HR System

Note reduction in medical turnover is due to the introduction of the medical bank.

As illustrated in the figure above the overall level of leavers has remained broadly constant overall in 2011-12, there has however been some notable increases and decreases within job families as detailed in the following figure.

Figure 20 – Percentage change in leavers between 2010/11 and 2011/12



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 and 2011/12.

Figure 21 - Reasons for leaving for all staff

Reason description	Leavers (Heads)		% of reason why against total	
Year	10/11	11/12	10/11	11/12
Death in Service	16	8	1.02	0.48
Dismissal	46	46	2.92	2.75
Dismissal capability	25	18	1.59	1.08
End of fixed term contract	173	89	10.98	5.32
Ill health	49	50	3.11	2.99
New employment with NHS outwith Scotland	58	41	3.68	2.45
New employment with NHS within Scotland	116	119	7.36	7.11
Non Occupational illness	2	5	0.13	0.30
Other	357	513	22.65	30.66
Pregnancy	6	4	0.38	0.24
Redundancy voluntary	-	19	-	1.14
Retirement - age	206	262	13.07	15.66
Retirement other	34	33	2.16	1.97
Voluntary Early retirement - acturial reduction	17	13	1.08	0.78
Voluntary Early retirement - no acturial reduction	5	7	0.32	0.42
Voluntary resignation - lack of opportunity	7	10	0.44	0.60
Voluntary resignation - lateral move	35	27	2.22	1.61
Voluntary resignation - other	398	394	25.25	23.55
Voluntary resignation - promotion	26	15	1.65	0.90
Total	1,576	1,673		

Source – NHSL HR System

The number of individuals leaving as a result of age retiral has increased by 27%, whilst the proportion of staff leaving voluntarily has reduced. However it is difficult to draw any strong conclusions as the proportion with a reason given as 'other' has increased by 44%. During 2012/13 NHSL will review it's approach in relation to exit interviews in order to ensure improved reporting and analysis.

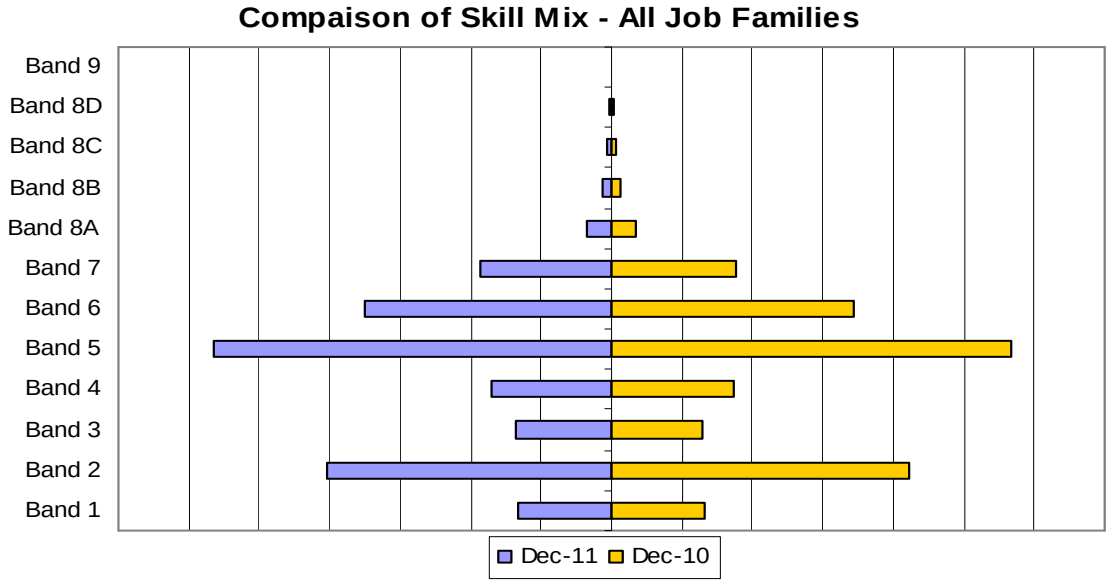
4.4 Skill Mix

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 22 - 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 23 – Workforce skill mix (March 2012)

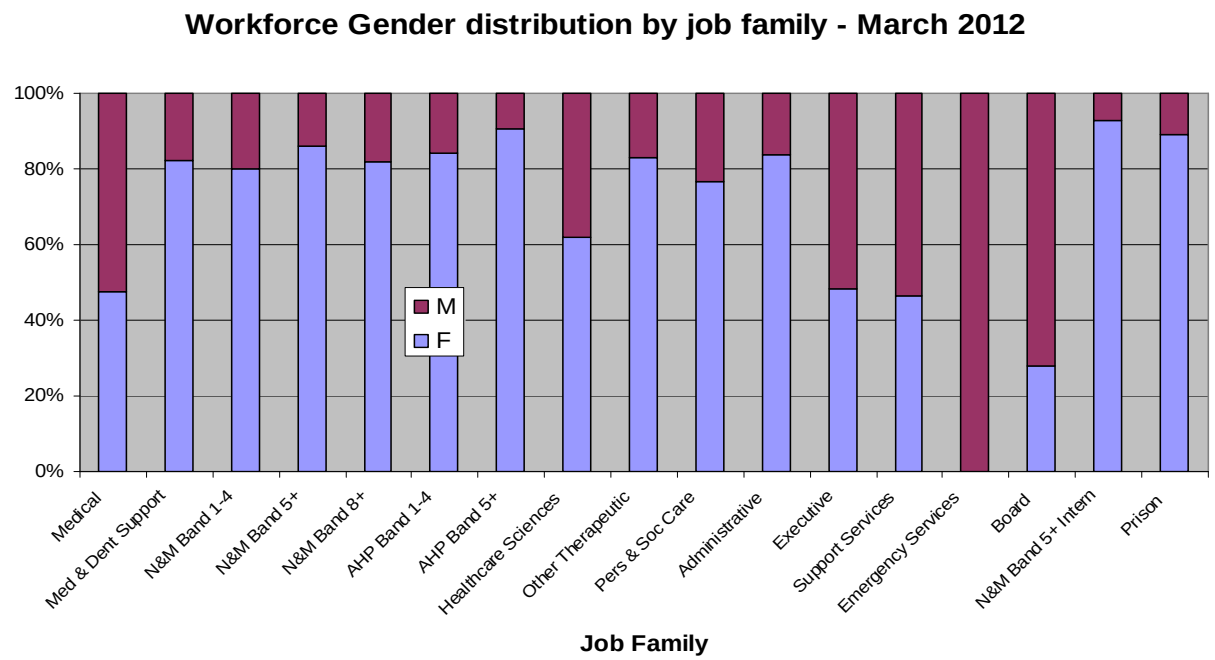
Band	Overall	Nursing	Allied Health Professions	Other Therapeutic	Healthcare Science	Medical & Dental Support	Administrative & Executive/Senior Managers	Support Services
Total B 1-4 wte	7,046	2,453	220	96	171	146	2,087	1,873
Total B 1-4 %	43%	27%	16%	19%	22%	64%	73%	96%
Total B 5+ wte	9,552	6,492	1,149	400	591	83	753	84
Total B 5+ %	58%	73%	84%	81%	78%	36%	27%	4%

Following consideration of the existing skill mix there has been agreement that NHS Lothian should seek to introduce a 5% skill mix shift between the Band 5+ workforces and the B1 to 4 workforces. 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.

4.5 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 24 – 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.

4.6 Feminisation within the medical workforce

The feminisation within the medical workforce is a relatively recent trend given the extended length of training and as such there is a limited evidence base internationally on what impact it will have on overall career contribution levels. Within the various medical training programmes there is a mix of core training with competitive entry into specialty training at ST3 level and run through specialty training.

Paediatrics is a run through specialty and within the SE Region and Lothian there are already significant problems in sustaining training grade rotas due to unprecedented levels of maternity leave amongst medical trainees. This meant that there were approximately 25% vacancies in early 2012 making it very challenging to sustain services. These changes have impacted most in paediatrics as it is the most feminised thus far however this is likely to become increasingly common as overall trainee numbers reduce.

Within General Practice the majority of trainees are also female and indications are that the majority do not intend to work full time. This is again reflected in other countries such as Canada where 60% of all medical students are female and in specialties such as General Practice 60% of family physicians under 35 years of age are female (Maxted, 2008).

At a national level these are important factors that are built into the planning process to set numbers for medical training places. There are however important implications for other specialties within the SE Region where feminisation is occurring. Given that medical training programmes are operated regionally it is important that a regional cooperation continues in planning for the reducing number of trainees and for emerging gaps.

4.7 European Working Time Regulations, New Deal and Rota Sustainability

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.

There is significant reliance on bank/agency utilisation to fill emerging gaps. Whilst NHSL has introduced a medical bank to reduce the expenditure on the combined expenditure on bank and agency staffing supplementary staffing stands at £1.67m for the first two months of the financial year if this were to be replicated over the year this would represent spend in the region of circa £20m.

The potential for a Hospital at Day/Weekend (HaD) model is currently being investigated to provide weekend cover to specialties that don't routinely admit patients at the weekend.

There is important requirement to ensure that rotas are not only 'paper compliant' following the death of a FY1 after a nightshift and subsequent Police investigation into working patterns and monitoring compliance in Inverclyde Royal Hospital in October 2011.

4.8 Promoting Attendance at Work

At a national level in 2011-12 there was an average sickness absence of 4.63%, this is equivalent to 6,112 wte and £237m 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 2012 Lothian had achieved a 0.49% reduction in sickness absence from 4.47% (2010-11) to 3.99% (2011-12). This represented a saving of 89.9 wte, £3.5M and also enabled significant reductions to be made in supplementary staffing.

As outlined in the HR & OD Strategy NHSL aims to go further and reduce sickness absence to 3.5%, releasing a further 90.5wte, £3.5M. Central to the progress that has been made so far has been

- 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.

4.9 Human Resources and Organisational Development Strategy (2011 – 2014)

The strategy adopted in November 2011 set out the intention to further develop socially responsible recruitment both to help address future skills shortage and provide employment opportunities for unemployed 16 to 24 year olds. This also helps NHS Lothian discharge its responsibility to help prevent ill health in population which has been proven to be a side effect of unemployment. The strategy detailed a commitment to:

- Create employment and training opportunities for a minimum of 190 people per year in the 16 to 24 age group

- Further develop the eleven projects currently in place to support individuals socially excluded into employment including a review of the contribution of the NHS Lothian Healthcare Academy, a review of the possible development of the relationship with the LEAP initiative, modern apprenticeships, volunteering and work experience.

- Review internal arrangements in training and development to enhance literacy and numeracy levels of staff.

- Create a sustainable job infrastructure across Agenda for Change bands 1 to 4 so that entry level staff have realistic promotion opportunities to advance their careers based on ability and ambition. This will be designed to provide staff on bands 1 and 2 with opportunities to progress to bands 3 and 4.

- Work with higher education and regulatory organisations to create an environment whereby a combination of the accreditation of experiential learning and study will give staff in bands 1 to 4 a route into the registered workforce thereby opening up opportunities to work at band 5 and above, and opening up an additional source of recruitment that will enrich the diversity of the workforce. This will require new models for employment and employability.

Whilst these commitments are about providing opportunities for young unemployed individuals they are also an important element developing the band 1 to 4 workforce of the future, helping the significant portion of the workforce that are likely to retire over the next 5 to 10 years.

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 workforce. Plans will be used to inform the 2013-14 Board workforce plan and link into the education and training strategy.	Associate Workforce Director/ Workforce Planning and Development Team	2012-13
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	Associate Workforce Director/ Workforce Planning Team	From July 2012 onwards

	include Medicine for the Elderly and Children's Services.		
Design and recruit to new roles such as healthcare technician	Continue to invest in the development of our workforce through the development and implementation of new roles that support future service delivery and aid with career progression across all levels.	Associate Workforce Director/ Workforce Modernisation Manager	Ongoing
Promoting Attendance at Work initiative.	As part of HR /OD Strategy, support line managers with accurate workforce data in the management of sickness absence and the achievement of NHS Lothian's sickness absence target of 3.5%	Workforce Planning Team	Monthly Reporting
Clinical Strategy	Support the emerging Clinical Strategy through an integrated approach aligning workforce planning needs within current and future budgetary requirements.	HR Director	2012-2022

Section 6: Implementation and Review

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

- Clinical Strategy - the strategy will be monitored ultimately at Board level however there are a range of associated groups that will be responsible for the implementation of constituent elements within the strategy.
- 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. The workforce planning team will monitor change on a monthly or quarterly basis.
- The Healthcare technician pilot is being overseen by steering group incorporating Partnership.
- 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 by the Workforce Review Board.
- Specific issues that relate to a given job family will be taken forward at both an operating division level and a Board wide professional lead group. In instances such as the reshaping of the medical workforce there will be a key regional role and national oversight.

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

Appendix A

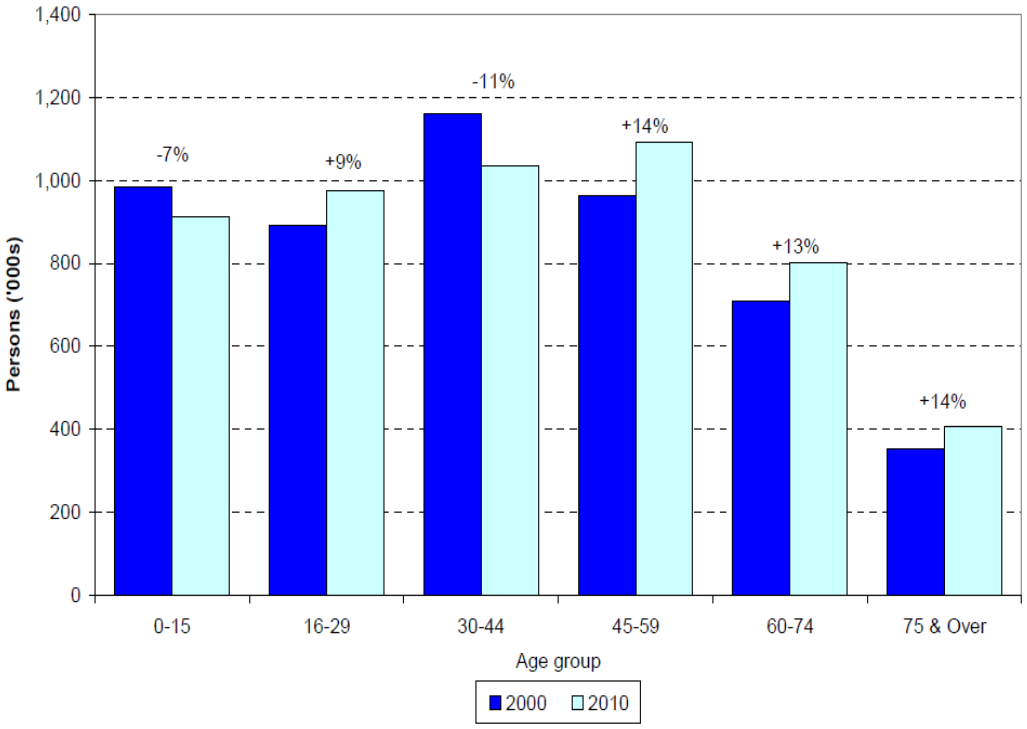
Scotland's Population Changes 2000 - 2010

The General Registrar of Scotland (GROS) mid 2010 populations estimates for Scotland [1] identify that Scotland's population grew over the 10 year period from 2000 by 3.1% (c160,000) from 5.06 million to 5.22 million. The majority of this growth has resulted from an increase in net immigration into Scotland.

During this period Scotland's population has seen significant changes in both its age profile and distribution.

The change in age distribution is shown below. The greatest increase, 13-14%, in population occurred in the 45+ year old age categories. The population aged below 45 fell by around 9%.

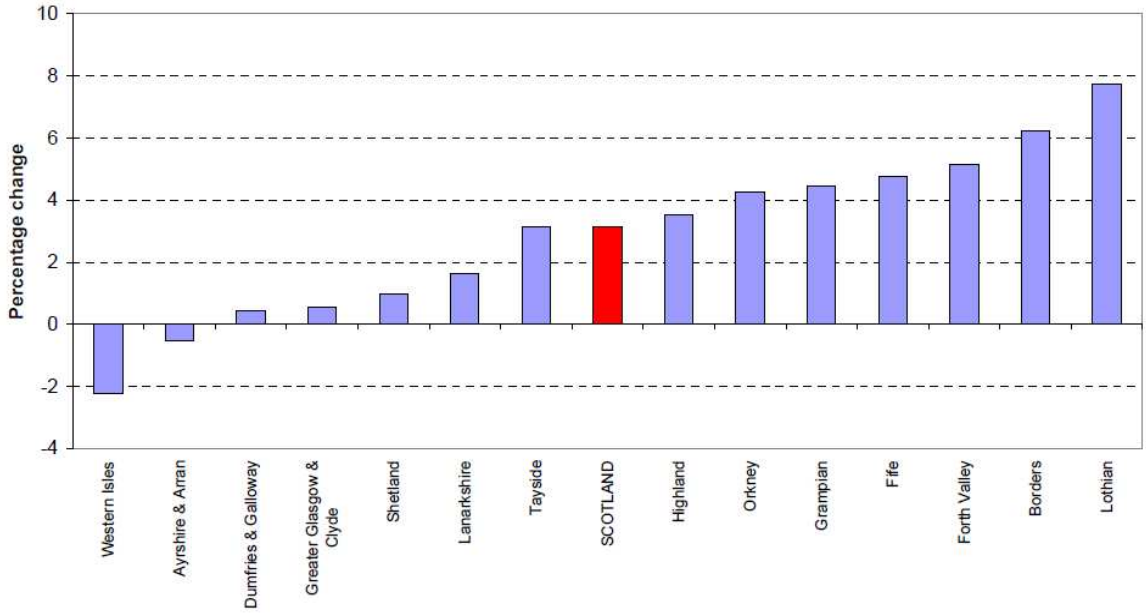
Figure 1 – Demographic change within the Scottish Population between 2000 and 2010



Source: General Registrar of Scotland

Scotland's population also grew at different rates across NHS Health board areas, with the South East and Tayside (SEAT) boards showing the highest rates of growth over this period, as shown below:

Figure 2 – Percentage population change by Health Board area between 2000 and 2010



Source: General Registrar of Scotland

The SEAT region has seen the highest population growth of any region in Scotland during the period 2000 – 2010. Changes in the population profile are accounted for in the NRAC methodology for funding the NHS in Scotland (NHSS). However there is a time lag in making funding adjustments and the above population changes has put additional pressure upon services within SEAT.

Appendix B

Speciality Specific Risks

As part of a high level assessment of key medical specialty areas and their associated risk within NHS Lothian, the following list has been developed.

Anaesthetics – (Low Risk)

- Anaesthetics has a 2-3 year core programme followed by a 5 year ST Programme.
- Trainee reductions – there has been no reduction in trainee numbers over the past 2 years and no reductions planned for August 2013. There will likely be a small reduction in future years.
- Rota sustainability – given above there are no major issues identified
- Capacity - Protecting local capacity through the provision of external anaesthetists to enable core sessions to be delivered during the holiday period and in advance of new appointments starting in August.
- Recruitment – CCT numbers should mean there is an adequate supply of newly qualified staff
- Non medical workforce – Assistant Practitioner – Anaesthetics was piloted but was met with resistance within medical and nursing staff and not pursued. NHS Education Scotland withdrew funding for training programme.
- Financial risks - minimal
- Service risks - minimal
- Timescales – 2013 onwards

Emergency Medicine – (High Risk)

EM has a 2 year core programme followed by a 4 year ST Programme.

- Trainee reductions – National plan is to reduce EM trainee posts from 137 to 24. This is under review. ACCS posts would remain unaltered. For NHSL this meant a reduction from 22 to 6-8 EM posts. NHSL disestablished 2 EM posts in August 2011. Plan is to disestablish a further 10 posts, 2 ACCS posts and 8 ST posts (of which 2 are NHSL funded) in August 2012. A business case for workforce redesign within A&E has been agreed by SMT.
- Rota sustainability – high risk given training post reductions and difficulties in recruitment of locums.
- Capacity – Delays and or inability to recruit increases pressure on meeting 4 hour target.
- Recruitment – it is increasingly difficult to recruit to ST4 LAT posts, recruitment for August 2012 has been unsuccessful. Recruitment of Specialty Doctors and consultants should be easier given number of new CCT holders.
- Non medical workforce – A&E business case describes expanded role/increase in use of nurse practitioners.
- Financial risks – High, A&E business case assumes funding return from NES for disestablished posts. Assumes recruitment of specialty doctors. If service has to recruit to Consultant posts then financial gap. High risk.

- Service risks – High, risks around recruitment of replacement staff. Reductions in EM trainees will have impact upon workforce model in place currently at St Johns and Sick Kids.
- Timescales – August 2012

Medical Specialties – (Medium Risk)

- Medicine has a 2 year common core programme followed a range of ST Programmes in medical specialties ranging from 4 to 5 years duration.
- Trainee reductions – There has been a reduction of 3 trainees across the medical specialties in last 2 years. There are a further 2 posts being disestablished in August 2012 (2 GUM posts). A further HST post in cardiology is being converted to Core.
- Rota sustainability - given above there are no major issues identified. (Need to check impact on GUM rota). However the 'pool' of trainees that is used to staff HaN services is gradually diminishing. Pressure will be from number of gaps due to difficulties in recruiting to ST and LAT posts – see below.
- Recruitment – increasingly difficult to recruit to LAT posts for August 2012 – gaps in number of specialties i.e. Acute medicine (1), Cardiovascular (2), Clinical Oncology (1), Endocrinology (1), Geriatrics (2-3), Medical Oncology (1) and Respiratory (2). Also ST posts not recruited to in Acute Medicine, Geriatrics, Haematology and Medical Oncology.
- Non medical workforce – there is increasing use of nursing staff to support service model ie Advanced practitioners on HaN
- Financial risks – medium, associated with the number of gaps and failure to recruit LATs
- Service risks – medium, there will be pressure to sustain some specialty rotas as even small changes in trainees puts pressure on rotas
- Timescales – incremental change from August 2012

Diagnostics – (Low risk)

- Diagnostics is composed of a series of run through ST programmes of 7-8 years duration in Radiology, Microbiology, Histopathology and Pathology.
- Trainee reductions – No change in numbers in last 2 years. 2 Clinical Radiology post being disestablished but 1 Interventional radiology post being introduced in August 2012.
- Rota sustainability – No change
- Capacity – Currently a number of patients are out-with the 6 week target for upper and lower colonoscopy due to a lack of capacity. Over the last 12 months the service has relied on visiting consultants undertaking work at the weekend and staff working out of hours.
- Non medical workforce – increased use of non medical staff in laboratories. Ongoing work in increasing use of radiographer reporting on plain film x-rays which should release trainee time and consultant time to meet growing demand for more complex work
- Financial risks - minimal
- Service risks - minimal
- Timescales – n/a

Surgical – (High Risk)

- Surgery has until now been composed of a number of run through ST Programmes of 7-8 years duration in specific surgical specialties.
- Trainee reductions – there has been no change in overall number of trainees. The main change has been the creation of Core Training Programme in 2011/12. (Note: there was a reduction in Cardiothoracic trainees prior to 2010 but NES funding was 'swapped' to fund board funded posts). This has had minimal service impact to date. There is a planned reduction in HST numbers in the future, but funding likely to be diverted to expanding core
- Rota sustainability – no change in immediate future
- Capacity – Waiting times issues have identified lack of capacity in the medical workforce particularly within outpatient services, in the following areas:
    - General Surgery
    - Urology
- Non medical workforce – no significant development of new roles or expansion of existing workforce to 'fill the gap'.
- Financial risks – high, resulting from lack of capacity issues
- Service risks – high, difficulty in meeting waiting times targets
- Timescales - immediate

Mental Health – (Low Risk)

- Mental Health has a 2 year common core programme followed a range of ST Programmes in mental health specialties of 4 years duration.
- Trainee reductions – there has been a reduction of 1 post in Learning Disability last year. There will be a further 4 posts disestablished in August 2012 but these will be converted to Core Training.
- Rota sustainability – the conversion to core helps sustain OOH rotas. The LD post has been replaced with a Specialty Doctor. There has also been significant rota redesign across NHSL.
- Recruitment – there are national recruitment difficulties in specific specialties ie CAMHS but there is growing evidence that recruitment to Specialty Doctor posts is becoming easier.
- Non medical workforce – increasing use of MH nurses in redesigned workforce models
- Financial risks - low
- Service risks - low
- Timescales – n/a

Obstetrics and & Gynaecology – (High Risk)

- This is a run through ST Programme of 7 years duration.
- Trainee reductions – 1 post was disestablished in 2010 and a further post will disestablished in August 2012. Further reduction is anticipated – up to another 6 ST posts (48 reducing to 42) – although timescales to be determined. The reduction, coupled with anticipated maternity leave, OOP, LTFT working, etc will mean there will be insufficient trainees to staff current rotas.

- Rota sustainability – Current rotas across the SE will be unsustainable from Feb 2013 onwards if anticipated maternity leave, OOP, etc impacts.
- Recruitment – the SE was unsuccessful in recruiting to 2 LAT posts. NHSL currently in the process of recruiting additional Consultants.
- Non medical workforce – minimal impact, there is a requirement to have senior trainees/trained doctors available 24/7 due to clinical risk issues.
- Financial risks – high, suitable qualified Locums or trained doctors will be required to fill rota gaps
- Service risks - high
- Timescales – February 2013

Paediatrics – (High Risk)

- This is a run through ST Programme of 8 years duration.
- Trainee reductions – no trainee reduction in last 2 years but significant gaps due to maternity leave, OOP, LTFT working, etc.
- Rota sustainability – all SE rotas currently have significant gaps –
- Recruitment – Very difficult to recruit Locums. V difficult to recruit Consultants to DGH roles with significant OOH component. V difficult to recruit to Community posts.
- Non medical workforce – developing ANNP/APNP roles but difficult to recruit to, fund, retain, access training, etc.
- Financial risks – high, already incurring high locum and additional staffing costs
- Service risks – high – St Johns
- Timescales – immediate

Public Health – (Low Risk)

No immediate issues –

General Practice – (Low Risk)

No immediate issues