NHS Lanarkshire

Workforce Plan

April 2008
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Executive Summary</td>
<td>5</td>
</tr>
<tr>
<td>2 Background</td>
<td>6</td>
</tr>
<tr>
<td>3 Introduction</td>
<td>8</td>
</tr>
<tr>
<td>4 Demographics</td>
<td>10</td>
</tr>
<tr>
<td>5 Equality and Diversity</td>
<td>13</td>
</tr>
<tr>
<td>6 Workforce Information</td>
<td>16</td>
</tr>
<tr>
<td>7 Workforce and Service Planning</td>
<td>18</td>
</tr>
<tr>
<td>8 Local Delivery Plan</td>
<td>23</td>
</tr>
<tr>
<td>9 Workforce Assumptions</td>
<td>28</td>
</tr>
<tr>
<td>Medical Workforce</td>
<td>28</td>
</tr>
<tr>
<td>General Medical Services</td>
<td>29</td>
</tr>
<tr>
<td>Dental Services and Support</td>
<td>30</td>
</tr>
<tr>
<td>Nursing and Midwifery</td>
<td>32</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>35</td>
</tr>
<tr>
<td>Other Therapeutic Staff</td>
<td>39</td>
</tr>
<tr>
<td>Personal and Social Care</td>
<td>42</td>
</tr>
<tr>
<td>Health Science Services</td>
<td>43</td>
</tr>
<tr>
<td>Administrative Services / Senior Management</td>
<td>48</td>
</tr>
<tr>
<td>Support Services / Property and Support Services Directorate</td>
<td>49</td>
</tr>
<tr>
<td>10 Workforce Projections and Affordability</td>
<td>50</td>
</tr>
<tr>
<td>11 Recruitment, Retention and Redeployment</td>
<td>52</td>
</tr>
<tr>
<td>12 Staff and Organisational Development</td>
<td>56</td>
</tr>
<tr>
<td>13 Sickness Absence</td>
<td>59</td>
</tr>
</tbody>
</table>

## Appendices

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>NHS Board Workforce Plans 2008 – Workforce Projections Template</td>
<td>60</td>
</tr>
<tr>
<td>B</td>
<td>NHSScotland Approach</td>
<td>61</td>
</tr>
<tr>
<td>C</td>
<td>NHS Lanarkshire Workforce Development Strategy</td>
<td>65</td>
</tr>
<tr>
<td>D</td>
<td>Workforce Action Plan for 2008</td>
<td>67</td>
</tr>
<tr>
<td>E</td>
<td>Nursing &amp; Midwifery Workforce Workload Steering Group Annual Report</td>
<td>72</td>
</tr>
<tr>
<td></td>
<td>2007/08</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>N&amp;M Triangulation Flow Chart</td>
<td>74</td>
</tr>
<tr>
<td>G</td>
<td>Projections Summary</td>
<td>75</td>
</tr>
</tbody>
</table>

**Acknowledgements** 76
SECTION 1: EXECUTIVE SUMMARY

This third NHS Lanarkshire Workforce Plan describes some of the challenges ahead as we move forwards with the service change agenda and outlines specific workforce issues across a range of areas. The Plan recognises the integration agenda, providing an overview of the workforce issues identified within the Local Delivery Plan and connects clearly with financial planning in the approach to developing affordable workforce projections.

NHS Lanarkshire has a radical programme of service improvement to be undertaken if it is able to achieve the following:

- 18 week referral to treatment target
- Provision of A&E services in the three main hospitals in Lanarkshire
- Delivery of a Primary Percutaneous Coronary Intervention (PCI) Service for Lanarkshire patients at Hairmyres Hospital as part of the regional planning for these services.
- Centralisation of the Haematology Inpatients services at the Lanarkshire Cancer Centre at Monklands Hospital, when it is developed.
- Development of an Emergency Response Centre which will enhance the area’s emergency services
- Implementing the priorities within the Mental Health Strategy
- Implementing the priorities within the Lothian Term Conditions Collaborative programme

To lead all the work associated with this challenging agenda, NHS Lanarkshire has established a Modernisation Board which is responsible for leading and directing whole system strategic planning, strategic redesign and service change and overseeing the service improvement agenda for NHS Lanarkshire.

Supporting the Modernisation Board, and also reporting to the Workforce Development Steering Group, is a Workforce Resource Group which provides the focus for all workforce planning and development issues arising from developing service plans. This group will also be responsible for the integration of both workforce modernisation and benefits realisation within our wider planning processes as both are intrinsically linked to achieving improved productivity, service redesign and improved benefits to patients. This group will also oversee the developing and monitoring of the Benefits Realisation Plan.

Other significant challenges face NHS Lanarkshire during the next year, not least those emerging from Modernising Medical Careers and the achievement of HEAT targets. The solutions to these challenges will require close multi-disciplinary working and established workforce planning arrangements through the Workforce Development Steering Group will ensure quality services to patients continue to improve.
SECTION 2: BACKGROUND

Strategic Context

Since the publication of the NHS Lanarkshire Workforce Plan in April 2007, we have seen publication of Better Health, Better Care: Action Plan\(^1\). This Action Plan will help us focus on the following principles:

- Wealthier and Fairer
- Smarter
- Healthier
- Safer and Stronger
- Greener

These principles set out the Scottish Government agenda, applying equally to the NHS in general as to the workforce of NHS Lanarkshire. There is a clear commitment in the Action Plan to improving the quality of care, within an environment which is striving for increasing effectiveness and efficiency. The workforce is at the heart of this, though ensuring that the right numbers of staff are in place, equipped with the right skills to deliver efficient and effective quality patient centred care.

Better Health, Better Care: Planning Tomorrow’s Workforce Today\(^2\); published in December 2007 in place of a National Workforce Plan; sets out the direction of travel for workforce planning. Planning Tomorrow’s Workforce Today describes a direction of travel to a point where workforce planning featuring as an integral element of NHS Board and Region strategic planning processes to ensure that the workforce is fully aligned. A phased approach is planned over the next 2-3 years enabling a move towards the potential development of integrated capacity and delivery plans. It suggests that given the robust workforce planning processes and systems that are now well established across NHSScotland, there is a real opportunity to aim for excellence in this role.

The workforce agenda continues to be one of the key challenges currently facing NHS Scotland as a whole and NHS Lanarkshire in particular for the purposes of this report. It is a complex and demanding agenda that requires the systematic and sustainable approach outlined by the National Workforce Planning Framework 2005\(^3\). Getting the workforce right is fundamental to achieving a step change in service delivery and improving health and health care, but this can’t be done without having an integrated approach, working closely with service and financial planners.

2008 Workforce Plan

To reinforce this, the Scottish Government has issued Guidance\(^4\) which will take forward an integrated approach, with the move towards developing workforce plans that will fully integrate with delivery and financial plans. This year’s NHS Board Workforce Plans 2008 – Workforce Projections Template\(^5\) was issued to Chief Executives on 21 November 2007. In line with the workforce planning cycle, NHS Boards are required to complete a workforce planning template which will assist the Scottish Government in determining overall demand for staff and in particular to inform decisions about training supply for relevant staff groups.

The requirement continues for Workforce Projections to be tested against the 3 feasibility factors: affordability, availability and adaptability. To begin to develop a consistent test for affordability, a suggested methodology has been provided in an annex circulated along with the template. In line

\(^3\) [http://www.scotland.gov.uk/Publications/2005/08/30112522/25230]
\(^5\) Appendix B
with the move to fully integrate workforce plans with service and financial plans, the workforce projections template will become part of the Local Delivery Plan. This is a transitional year, however, as planning cycles are not yet fully aligned, the deadline for Boards to complete the workforce projections remains at 30 April 2008 (the deadline for all other LDP templates is 18 February 2008).

This year, only workforce projections require to be submitted to the Scottish Government Health Department, though Plans still require to be published. NHS Lanarkshire will continue to move towards better integrated workforce planning, and will continue to publish its workforce plan each year, linked closely with the Local Delivery Plan.

NHS Lanarkshire’s first Workforce Plan was presented to the Board in April 2006 before submission to the (then) Scottish Executive Health Department. Comments received from the Scottish Executive Health Department Workforce and Policy Division were generally positive and the Board was congratulated on it’s first Plan and commended for the hard work in preparing the Plan, which represented an excellent attempt at describing current and future workforce needs.

Comments on our second, 2007 Workforce Plan reflected a very comprehensive plan, complying with the actions in the National Workforce Plan 2006 and the guidance within HDL (2005)52. The Board was particularly commended the robust structure of the plan, with its clear links to service planning.

The aim of this 2008 Workforce Plan in line with the National Approach outlined in Better Health, Better Care: Planning Tomorrow’s Workforce Today (Appendix B) is to:

- Set out the strategic direction for NHS Lanarkshire’s workforce
- Outline the structures and processes which will support the development of the workforce delivering our services over the next 5 years
- Describe the structures in place to develop an integrated approach to workforce, service and financial planning
- Identify the issues which will impact on the workforce
- Analyse the workforce, describing the shape and size of the current workforce
- Provide indicative workforce projections, bearing in mind service plans are not yet agreed

This Workforce Plan will provide the background for us to use the talents and experience of staff in the most efficient and effective way, ensuring they are able to continue to give of their best and meet challenges to improve health and reduce inequalities, in addition to delivering healthcare services. This integrated approach will directly support the safe delivery of services that are affordable and sustainable flexible and responsive workforce.

---

6 http://www.nhslanarkshire.co.uk/NR/rdonlyres/31C72D46-3A37-44D1-869D-A2B32267F2D5/0/1NHSLanarkshireWorkforcePlan.pdf
7 http://www.westworkforceplanning.scot.nhs.uk/files/Workforce%20Plans%202007/NHS%20Lanarkshire%20WfPlan07%20Final%20Doc.doc
SECTION 3: INTRODUCTION

Workforce planning; led in NHS Lanarkshire through the Workforce Development Steering Group; is an iterative process and since we commenced in 2006, progress has been made in the following areas:

- Producing the annual Workforce Plans in April
- Further development of an approach to test all workforce projections against affordability, working closely with finance
- Significant progress in further data collection in line with Scottish Workforce Information Standard System (SWISS) developments
- Providing a focus for Pay Modernisation in particular Agenda for Change
- Development of a Workforce Development Strategy (Appendix C)
- Development of a Nursing, Midwifery, and Allied Health Professions Workforce strategy (still in draft)
- Mapping NHS Lanarkshire activity against the National Workforce Action Plan (Appendix D)
- Commencement of the implementation of Scottish Standard Time System (SSTS)
- Continuing to update the Pay Modernisation Benefits Delivery Plan
- Workforce information systems, and production of data to support sickness absence and other management activity

Strategic change within NHS Lanarkshire

In our 2007 Plan our plans for our future health services was set out in A Picture of Health. However in June 2007, the new Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon, reversed the decision taken by the previous administration regarding the future provision of A&E services at Monklands Hospital which was a significant element in the document. In February 2008, the Cabinet Secretary confirmed her approval of the Board’s amended proposals which included:

- Provision of A&E services in the three main hospitals in Lanarkshire
- Delivery of a Primary Percutaneous Coronary Intervention (PCI) service for Lanarkshire patients at Hairmyres Hospital as part of the regional planning for these services
- Concentration of the haematology inpatient services at the Lanarkshire Cancer Centre at Monklands Hospital, when it is developed
- Development of an Emergency Response Centre which will enhance the area’s emergency services

There have been delays in developing and implementing plans because of this change of focus and for this reason, whilst this plan describes some of the ongoing work, there is a stronger focus on the strategic approach to the integration of workforce planning across the organisation, establishing a clear framework for the work ahead in the future.

NHS Lanarkshire developed its own Workforce Planning toolkit to support the organisation to link workforce planning activity with service and financial planning in preparation of the 2006 Workforce Plan. This has was refined in partnership with managers for the 2007 Plan and has been updated once more for the 2008 Plan, being used as the framework to develop local and organisation-wide workforce plans.

Publication of this, NHS Lanarkshire’s third Workforce Plan takes the integration with service and financial planning a stage further, through developing vigorous partnerships with the service planning agenda and continuing to develop ever closer links with financial planning colleagues.

A review of the overall planning process has been led by the new Director of Strategic Planning. This has involved the re-focussing of the Modernisation Board and closer integration with strategic
workforce and financial planning. To help achieve this, a Workforce Resource group has been established which will provide a forum for discussion and testing at high level of emerging service plans. Membership will include those developing service plans along with representatives from human resources, workforce development, organisational development, practice development and finance. The group will report to the Modernisation Board and to the Workforce Development Steering Group. It is expected that this will provide the vehicle to integrate workforce, service and financial planning in a positive way, pulling together key individuals to shape future service plans efficiently and effectively.
SECTION 4: Demographics

Demographics or demographic data refers to selected population characteristics or demographic profiles which can be used for specific purposes. Commonly-used demographics include race, age, income, health and deprivation. For the purpose of this document, it is important that in planning our workforce we understand our population. This is important from a number of perspectives. NHS Lanarkshire has a duty to provide health services to its population and in order to deliver appropriate services, it is necessary to consider the profile of the population it serves. It is also important for us to recognise that, as 87.7% of our workforce lives in Lanarkshire, there are aspects of the demographic profile which will also impact on our staff.

The basis of this section is provided by the Registrar General’s Annual Review 2006, which describes the shape, size and health of the people served by NHS Lanarkshire. A full copy of the report can be found in PDF and HTML format through the General Register Office for Scotland Website.

Population

For the fourth year running the overall population of Scotland has increased, this year the growth was by 22,100 to 5,116,900. This increase in Scotland’s population was caused by net in-migration. This was comprised of 8,900 from the rest of the UK and 12,700 from the rest of the world.

The current principal projection suggests that Scotland’s population will change in the following ways:

- The population of Scotland is projected to rise from 5.12 million in 2006 to a high of 5.37 million in 2031 before slowly declining, falling below 5 million in 2076. This long-term decline is mostly the result of fewer births than deaths.
- The number of children aged under 16 is projected to decrease by 7% from 0.92 million in 2006 to 0.86 million in 2031.
- The number of people of working age is projected to increase slightly from 3.21 million in 2006 to 3.23 million in 2031 (an increase of around 0.4%)
- The number of people of pensionable age is projected to rise by around 31% from 0.98 million in 2006 to 1.29 million in 2031.
- The number of people aged 75 and over is projected to increase by around 81% from 0.38 million in 2006 to 0.69 million in 2031.
- The dependency ratio – the ratio of persons aged under 16 or over pensionable age to those of working age – is projected to rise from around 59 per 100 in 2006 to 67 per 100 working age population in 2031.

While Scotland’s population is projected to fall from 2031 the populations of the other three countries in the UK are projected to continue rising, England and Wales for the entire projection period but for Northern Ireland the population is projected to peak by around mid-century and then slowly decline.

Under each of the alternative scenarios illustrated by the seven variant projections Scotland’s population is projected to rise initially; however under all but two of the variants (high migration and high fertility) the population begins to decline within the 75 year period projected.

All the variant projections show Scotland’s population ageing significantly over the next 25 years with the number of people aged 75+ projected to increase by between 71% and 91% under these assumptions.

Under the natural change only variant projection (which assumes net zero migration at every age) Scotland’s population is projected to fall by 0.06 million to 5.06 million by 2031.

Further data on the seven variant projections (High Life Expectancy, Low Life Expectancy, High Migration, Low Migration, High Fertility, Low Fertility, Natural Change, And the Principal Projection) is available on the General Register Office for Scotland website.

The population of Lanarkshire at 30 June 2006 was estimated at 558,139, an increase of 0.2% from 557,088 in 2005. The most recent projections of the future population of Lanarkshire are mid 2006-based and project a slow increase in the population size. The gradual ageing of the population is not expected to change.

The health of the population of Lanarkshire is important to consider because it begins to describe some of the service challenges, especially as 87.71% of our workforce lives in Lanarkshire. When balanced against the deprivation and poor health of the population, it could be assumed that this will have an impact on the health of the workforce.

**Births and Fertility**

The number of births and the projected trend is particularly important to us when planning maternity, neonatal and children’s services. In 2006 the average age of the mother at childbirth was 29.5 compared with 27.4 in 1991, 26.1 in 1977 and 27.4 in 1964. The average completed family size for women born in 1976 was 0.98 by time they reached 30. For women born in 1951, the same figure was 1.67.

The total fertility rate (TRF) rose to 1.67 in 2006, higher than the historic low of 1.48 in 2002, but much lower than the 1964 peak of 3.09. Within NHS Lanarkshire there were 6,584 live births in the year to 30th June 2006.

**Breastfeeding**

Encouraging and supporting breastfeeding is recognised as an important public health activity.

There is good evidence that breastfeeding in infancy has a protective effect against many childhood illnesses. Breastfed infants are likely to have a reduced risk of infection, particularly those affecting the ear, respiratory tract and gastro-intestinal tract. This protective effect is particularly marked in low birth weight infants. In recent years there have been a number of national policies and guidance recommending support to encourage mothers to start and continue breastfeeding for at least 6 weeks. For example "A Framework for Maternity Services", "Towards a Healthier Scotland" and "Our National Health - A Plan for Action, A Plan for Change".

The predicted rate of breastfeeding for 2006 in Scotland is 44.2%. The national target, set in 1994 and based on data from the UK wide Infant Feeding Survey 1990, stated that by the year 2005 more than 50 percent of women should still be breastfeeding their babies at 6 weeks of life. NHS Lanarkshire is predicted to have a breastfeeding rate of 30.4% at the first attendance of their health visitor at around 10 days.

**Death and Life Expectancy**

There were 55,093 deaths in Scotland in 2006 – 654 fewer than in 2005 and the lowest total recorded since the introduction of civil registration in 1855. There were 5.3 stillbirths per thousand births (live and still) in 2006, the same rate as 2005 and a reduction from 13.1 per thousand in 1971.

---

There were 248 infant deaths (deaths of children aged less than 1 year) in 2006; the lowest number recorded since civil registration began in 1855.

A male baby born in 2006 could expect to live for 74.8 years and a female baby for 79.7 years – increases from 69.1 and 75.4 for those born in 1981. Life expectancy is almost one year lower than the EU average for Scottish males and almost two years for Scottish females.

**Cause of Death**

In 2006, the two most common causes of death in Scotland were cancer (15,084 deaths, 27%) and ischaemic (coronary) heart disease (9,532 deaths, 17%). However, since 1981 the proportion of deaths caused by ischaemic heart disease has fallen from 29% to 17%, whereas the proportion caused by cancer has risen from 22% to 27%. And since 1995, there have been more deaths from cancer than ischaemic heart disease.

**Main causes of death by age and sex**

Cancer was the largest single cause of death amongst boys aged 1-14, closely followed by accidents. For girls aged 1-14, accidents were the most common cause, followed by cancer.

For males aged 15-34, the largest cause was suicide (intentional self harm plus events of undetermined intent) followed by accidents and mental disorders (almost entirely associated with drug and alcohol abuse). For females in this age group, cancer was the largest category. Suicides, accidents and mental disorders were the next most common causes.

Suicide was also the most frequent cause of death for males aged 35-44, mental disorders were second followed by ischaemic heart disease. For women aged 35-44, cancer was the main cause.

For both sexes and all age groups between 45 and 74, cancer was the main cause followed by ischaemic heart disease. Cancer was responsible for a higher proportion of deaths in these age groups for women than for men. Conversely, ischaemic heart disease accounted for a higher proportion of deaths in these age groups for men than for women.
SECTION 5: EQUALITY AND DIVERSITY

The NHS Lanarkshire Diversity and Equality strategy sets out a vision that places equality, fair treatment and social inclusion at the heart of our plans to modernise the service. In meeting its legal and moral duty NHS Lanarkshire’s service delivery has to ensure that it is equitable to all in meeting new and amended legislation and policy drivers at both national and local level.

For the NHS Lanarkshire to respond appropriately to local peoples’ needs, it is essential to factor in diversity and equality into mainstream policy objectives, targets and governance structures. The Scottish executive has identified six streams of inequalities:

- Age
- Disability (including Mental Health and HIV & Aids)
- Gender (including Transgender)
- Race/Ethnicity (including Gypsy/Travellers; Refugees/Asylum Seekers)
- Religion
- Sexual Orientation

Institutions that fully embrace diversity and equality can gain a number of benefits that improve efficiency, effectiveness and make economic sense. For example, staff will be able to engage more meaningfully with users and local people, and more effectively meet their needs. Organisations appear more attractive to a broader range of potential employees thereby offering more opportunities to recruit and retain key staff. As the workforce becomes more diverse, a wider variety of perspectives can add value to institutional practices by challenging the usual ways of working and identifying different ways of responding to needs or solving problems.

In the context of the public sector, the challenge is to understand diversity and equality as a broad, inclusive concept. It is about understanding people, their differences and similarities. It is also about how people access services, treatment, employment and how services can have adverse impacts on people – and thus on our communities – because of a lack of appreciation of different cultures, traditions and practices. Equality is about ensuring that people are treated fairly according to their needs and making this normal practice and behaviour.

Organisational Commitment

The degree of commitment shown by organisations is vital to success. In NHS Lanarkshire we have a Board level committee which supports and oversees the implementation of its strategic action plan. NHS Lanarkshire’s Equality, Diversity and Spirituality Committee role is to provide strategic leadership and ensure the effective discharge of Corporate Governance by NHS Lanarkshire in the areas of Equality, Diversity and Spirituality. This will be achieved by mainstreaming the equality, diversity and spirituality agenda throughout all areas of health improvement, healthcare and employment practice activity

Similarly, without visible commitment and leadership by example, attitudes towards diversity and social inclusion will continue to be slow to change. Investing in training and communication for the service providers and users can also show commitment. Straightforward briefings for everyone, together with regular explanations and discussion of the issues help to show how each individual can promote diversity through their day-to-day work, whilst reinforcing positive changes in culture.

Legal Context

Existing legislation on equalities issues has engendered change in society over the last 20-30 years. The degree of progress made, and the incremental nature of this, however, has not been proportionate to that required; a fact acknowledged in recent years by the UK Government. Consequently, there has been both a strengthening of existing legislation and the creation of new legislation to attempt to accelerate the pace of change. The equality arena remains a complex and
somewhat contradictory entity. For example in relation to race a plethora of reports on health services both prior to and following the Stephen Lawrence inquiry have highlighted institutional weakness relating to service delivery, employment and relationships with communities. The understanding of the inequalities agenda has yet to become embedded into the increasingly sophisticated quality and performance management systems that have been introduced in recent years.

The Government and the Scottish Executive have made a clear commitment to reducing inequalities in health, housing, education, employment, gender, disability, ethnicity and religion. In this context the NHS Lanarkshire equality strategy has to be seen as developing as a practical document, dealing with equality issues relating to employment, service planning and delivery.

Importantly while there is a strong moral argument for changing practice the key targets, processes and outcomes are prescribed by a wide range of Statutes as well as national and local policy and guidance. Some of the primary drivers are:

- **The Race Relations (Amendment) Act 2000** (RRAA) which strengthened the Race Relations Act, 1976
- **The Disability Discrimination Act 2005**, which strengthened the DDA 1995, through the inclusion of a Disability Equality Duty (DED) to be implemented in December 2006
- **The Equality Act 2006** which amended the Sex Discrimination Act 1975 through the requirement for a Gender Equality Duty (GED), to be implemented in April 2007. The Gender Duty covers men, women and transsexual people. This Act also made it unlawful to discriminate on grounds of sexual orientation or faith, in the provision of goods, facilities and services.
- **The Employment Equality (Age) Regulations 2006**
- **The Employment Equality (Sexual Orientation) Regulations 2003**
- **The Employment Equality (Region and Belief) Regulations 2003**
  This regulation protects workers (including those on vocational training programmes) from discriminatory employment practices based on religion or similar belief (defined as religion, religious belief or similar philosophical belief).

Given our intention to address all strands of inequality, the actions we are committed to undertaking will also apply to discrimination on the grounds of faith and age.

One of the provisions of the **Equality Act 2006** is the merger of the three existing commissions i.e. the Commission for Race Equality, the Disability Rights Commission and the Equal Opportunities Commission. In 2007, they will become one body – the **Commission for Equality and Human Rights** – which will have responsibility for assessing the extent to which organisations have fulfilled their legislative duties. The Commissions expect us to provide evidence demonstrating how we have undertaken our responsibilities in relation to:

- Decisions made on the adoption of new programmes, services, functions and policies
- The ways in which we deliver these currently
- All aspects of employment practice

**Mainstreaming the Diversity/Equality Agendas**

NHS Lanarkshire is committed to ensuring that its workforce has the right skills and training to recognise and value diversity, and is appropriately organised to plan and deliver equitable and socially inclusive services.

As an Equal Opportunities employer, NHS Lanarkshire aims to ensure that employees are not subject to any discrimination on the basis of their age, race, social background, gender, sexual orientation, colour, disability, nationality, ethnic origin, marital status or religion. NHS Lanarkshire will aim to ensure that it operates a zero tolerance discrimination policy.
An understanding of diversity and improving cultural competence within the workforce will mean the profession is able to provide a better service to all its patients. It is important to recognise the direct correlation between a content workforce and efficient service delivery. It is therefore important to create a work environment for staff where they are fully aware of their rights and where they are confident they will be supported should they have any concerns. This will therefore result in an ‘open’ working environment. It is imperative that any system put in place to achieve this culture change involves frontline staff of every profession at every level.

- **Equality and Diversity Training**

To ensure that NHS Lanarkshire has commitment throughout the organisation, NHS Lanarkshire’s Non-Executive Members and Executive Directors of the Board had diversity and equality training in September 2008. This was further developed within the organisation as part of the seniors managers development programme therefore the majority of NHS Lanarkshire’s managers have received training on diversity and equality and how it applies to the organisation, within a range of contexts. This was completed in November 2007. The equality and diversity training has been followed by training on equality and diversity impact assessment, which is currently in progress and should be completed by May 2008.

- **National Equality and Diversity Questionnaire**

NHS Lanarkshire is currently carrying out a survey of all staff in an effort to improve the quality and quantity of equality and diversity data we hold on our staff. This project has been taken forward in a robust manner, with full support of managers and we are hopeful of a good response. Good quality data will allow us to monitor activity and practice to ensure we have an unbiased approach in our dealing across the workforce.

- **Diversity Champions**

NHS Lanarkshire is currently one of two lead pilots which will support staff to support to make these links and facilitate change within their own working environments. Lanarkshire Diversity and Equality Champions is a two year pilot, which on a successful completion will be mainstreamed into NHS Lanarkshire. This is a multi-representation partnership piece of work involving local and national union representation and the Scottish executive and the equalities commissions.

The role of the Diversity and Equality Champions will be to initiate and support a cultural change within their working environment. The main function of the role will be to provide a focus and channel for the discussion and implementation of equality and diversity concerns and practices in the organisation and to participate in a NHSS-wide network of equality and diversity champions. Staff will be trained and given knowledge and skills on a range of issues around; equality and diversity, discrimination, bullying and harassment within the workplace. The champions will have very clear boundaries on what their role is within their work place and will be given the resource and knowledge to refer people on. The first round of recruitment and training will be done between May and September 2007, followed by another round in early 2008.

Our NHS Lanarkshire intranet site currently has a religious and cultural website which will be expanded and developed into a diversity and equality site to support staff with current equalities issues and any future one, it will also be used as a tool to carry out staff consultation and give up to date information on equalities matters. We have published our Race Equality Scheme and Disability Equality Schemes and Gender Equality scheme, which are all available on the NHS Lanarkshire website.
ISD data has provided the basis of the data used for analysis and for the workforce projections. We recognize that there are some minor anomalies between this and locally held data. ISD have acknowledged that producing the data for September 30th 2007 has been challenging because of major developments in both of the data capture processes, and in the final data presentation formats. The Scottish Workforce Information Standard System – Workforce Information Repository is the system used to collate and analyse workforce information by the whole of the NHS Scotland, for local, regional and national reporting.

These developments have been necessary due to the assimilation of the majority of Scotland’s healthcare workforce onto Agenda for Change (AfC) and developments implemented by the Scottish Workforce Information Standard System (SWISS) Project. The developments have utilised much of the previously available data collation processes, re-aligned significant sectors of data, and also required additional data collection exercises from all Boards.

Building up from the previous core data set, the developments have re-aligned staff into the new AfC post descriptors, job families, and sub-job families. The additional data collection on behalf of SWISS involved the identification of all clinical staff professional registrations, identification of the location of service delivery by clinical staff, and alignment of workforce to local organisational financial structures in a standard format across all Boards.

The workforce of NHS Lanarkshire has been analysed in detail and benchmarked against West Region and NHS Scotland figures in the Workforce Analysis Supplement. Some of the key points are as follows:

- The workforce increased by 0.93% (wte) in the twelve month period to September 2007. It is important to note that whilst we are in a period of financial constraint, there has been investment in our workforce. Equivalent figures for West Region (1.13%) and Scotland (1.17%) were marginally higher.

- The workforce (wte) has grown over the ten year period, 1997 to 2007 by 12.31%. In the same period, the West of Scotland Region has increased by 15.97% and Scotland as a whole by 20.77%.

- 28.10% of our workforce is over 50. This has increased from 27.13% in 2007, and 25.08% in 2006. This shows that Lanarkshire’s workforce is ageing. The age profile varies considerably across different occupational groups.

- NHS Lanarkshire has a higher proportion of females in the workforce with 83.45% compared to 81.04% (Region) and 79.00% (Scotland).

Locally, the provision of workforce information within NHS Lanarkshire is provided largely by the Empower Human Resources (HR) system. This system, like the Scottish Workforce Information Standard System (SWISS), is populated primarily by data from our payroll system, but is also supplemented by data collated in SWISS. In recent months further developments within the Empower system have been instigated which will further improve the alignment with the SWISS system.

Whilst this phase of work is now largely complete we are currently reviewing workforce information provision in light of the planned implementation of a national Human Resources information system within the next few years. Progress towards a national Human Resources system is being taken forward through the SWISS Project Board. A complete OBC was submitted to the eHealth Strategy Board on 9th January 2008 and approval was given to Option 4, this being the
procurement of an HR package which interfaces with SSPS. This approval was given on the basis that further work is carried out in the following areas:

- A detailed plan is prepared for the use of the current national managed technical services contract solution sourcing provision.
- The scalability of a less than full enterprise level solution for NHS Scotland is confirmed.
- Confirmation is obtained that the business and financial implications of a new system are understood and agreed across NHS Scotland.

The SWISS Board will now progress to address each of these requirements over the coming months, consulting and updating all stakeholders throughout the process.

This will have considerable implications for all Boards as local systems will be superseded by any national system. Although it will be at least two years before the implementation of the national system, it will be important to develop an exit strategy to ensure that advantages of the current system are not lost in the transition phase.

As a result of changes in the Workforce Development team we are currently reviewing how we provide workforce information to our managers ensuring that we are able to provide information which is timely and fit for purpose. Collaboration between Finance and Workforce Development has enabled the production workforce information, via the Empower HR system, which is aligned to our current financial structure. All reports provided from Empower HR system now provide a wide spectrum analysis of data in various formats from a high level organisational approach down to separate departmental level, detailing by job family or sub family. This detailed analysis is still not available from SWISS. We plan to continue the collaboration with managers, finance and payroll to ensure that workforce information is consistent and robust.

One area of particular emphasis is sickness absence reporting as managers rely on accurate information to monitor trends in absence against national Efficient Government targets. The performance of Boards is measured against SWISS reports and we have endeavoured to mirror reports as closely as possible. The results of these reports are presented in the monthly, quarterly, or annual absence reports provided to the Sickness Absence Project Board. At the time of writing additional investment is being made in developing the Empower HR functionality to record professional registration details and improvements in the reporting of information.

The Empower HR system has also been used to identify and present workforce information on a regular basis to the Human Resources Forum. This has allowed more detailed trend analysis in the following areas, absence rates, staffing rates, bank staff costing, bank staff usage, overtime usage, recruitment activity, and staff turnover.

Equality and Diversity information has been improved in both collection and presentation of information in the last twelve months. The overall rate of data collation is improving as more effort has been directed towards capturing the data of new staff. The main stumbling block to collating this data has been the staff reluctance to provide the details.

Other data collection exercises are planned as part of the SWISS project over the next year and we will strive to ensure we continue to improve the quality and quantity of data held.
There has been a period of uncertainty over future service models since publication of the last Workforce Plan. This has resulted in a concentration on the processes and frameworks to support future plans which in the longer term should add value to planned outcomes. This section of the Plan concentrates on two main areas, the new modernisation structure and the national improvement programmes in progress and planned during the 2008/09 period.

**Modernisation Board**

NHS Lanarkshire is committed to take forward the strategic direction set out in the review A Picture of Health in relation to primary and community care services. This strategic direction has been further developed in *New Horizons, Primary Care Modernisation Plan*. The strategic direction for acute services was superseded by the outcome of the Review of Accident and Emergency Services which:

- Confirmed the retention of full emergency services in all three acute hospitals in Lanarkshire
- Supported the development of a primary percutaneous coronary intervention service for NHS Lanarkshire at Hairmyres Hospital in tandem with the planning of services with other West of Scotland Boards
- Supported concentrating haematology inpatient services at the Lanarkshire Cancer Centre at Monklands hospital when it is developed
- Supported establishing an Emergency Response Centre along with the support of other partnership agencies

In order to ensure the most effective delivery of the local strategic direction and national policy including *Better Health Better Care Action Plan* and its deliverables, NHS Lanarkshire is reviewing its arrangements for strategic planning, strategic redesign and service change.

The new structure will be driven by a re-launched Modernisation Board which will direct whole system strategic planning, strategic redesign and service change, and oversee the service improvement agenda for NHS Lanarkshire. It will determine priorities for change and lead the annual planning cycle for NHS Lanarkshire including approving the Local Delivery Plan.

The Modernisation Board will report to the Performance Management Committee and the Corporate Management Team.

Supporting the Modernisation Board will be Service Improvement Boards, which will take a strategic planning and strategic redesign lead and drive service improvements in their area of remit. Initially these will be:

- Primary, Community and Acute Care
- Older People
- Learning Disability
- Mental Health
- Children and Maternity
- Health Improvement and Health Protection
- Regional Issues

The Modernisation Board will be integral to the work of the Capital Investment Group (which provides corporate governance in relation to capital investment) as well as the Workforce Resource Group (which will manage the workforce issues associated with the development of new service models and implementation of strategic change).
The Modernisation Board will ensure appropriate engagement both for the Modernisation Board and the Service Improvement Boards and their substructures for the public and patients, clinical and other staff and staff partnership through the Modernisation Stakeholder Engagement Group, Area Clinical Forum and Area Partnership Forum respectively.

The Service Improvement Boards will have the following common functions. These are to:

- Prioritise, commission and implement specific planning, redesign and service improvement work
- Ensure the implementation of deliverables agreed with the Modernisation Board including Local Delivery Plan targets and deliverables from the Better Health Better Care Action Plan
- Ensure appropriate management of workforce and finance implications
- Establish a robust sub structure for delivery with appropriate stakeholder engagement and staff partnership
- Ensure an annual review of any strategies, including joint strategies, within their area of remit
- Ensure integration of and maximum benefit is derived from initiatives such as Improvement Programmes and MCNs
- Provide an annual work plan in line with the Annual Planning Cycle, including estimated financial and workforce implications, which will be agreed with the Modernisation Board
- Oversee the development of clinical and service models
- Oversee the implementation of best clinical practice, the provision of a robust evidence base for changes and clinical governance
- Ensure appropriate clinical and other staff and public engagement and as appropriate undertake consultation
- Ensure appropriate performance management and evaluation of changes that are a consequence of planning, strategic redesign and service improvement work

**National Improvement Programmes 2008-2011**

The Scottish Government through the Improvement and Support Team are finalising the scope for 3 national improvement programmes to run from April 2008 – March 2011. These programmes are:

- Long Term Conditions Collaborative Programme
- Mental Health Collaborative Programme
- 18 Weeks Referral to Treatment Time Improvement Programme.

These programmes will be supported in the same way as some of the previous collaborative programmes by regional managers who will assist with the integrated models and close working with Quality Improvement Scotland and the National Safety Programme. Initial work has been carried out around the first two programmes but further work is awaited around 18 Weeks Referral to Treatment Time Improvement Programme.

**Long Term Conditions Collaborative Programme**

A number of initiatives have been ongoing in the past few years in relation to a systematic approach to Long Term Conditions with a strategy being produced in 2006 and is incorporated into the Primary Care Modernisation Plan. The Community Nursing Review, Keep Well programme launched in 2006, development of services for Diabetes and COPD within the community setting, use of SPARRA data and work around self supported care and management programmes have also been progressed. Other initiatives such as telehealth / telecare are being developed that will support the long term conditions agenda.
The Long Term Conditions Self Assessment toolkit is in use within NHS Lanarkshire and forms the basis of the progress being made in a systematic monitoring basis.

Self management proposals have also been developed and signed off by the Long term Action Team and funding has been identified to take these models forward.

A multi-agency Long Term Conditions Action Group has also been in operation ensuring a whole system approach to ensuring appropriate models of care is delivered. An action plan has also been developed around the design of the national plan with clear updates and actions required.

Mental Health Collaborative Programme

A number of initiatives have already been introduced within Mental Health services which are patient centred and deal with some of the new HEAT targets in reducing;

- Annual increase in prescriptions of antidepressants
- Number of readmissions

Two localities in the North CHP have introduced a pilot project addressing the needs of patients with a mild to moderate diagnosis. Clinical associates in applied psychology offer patients a formal assessment with psychological therapy before medication is considered and those patients with milder symptoms can access information and advice. The referral route for these patients is through the GP but ‘drop in’ service models will be introduced as well as some specialised courses.

The reduction of readmissions will initially focus on the catchment area of Wishaw General with community mental health teams taking the lead role although further development work has still to be completed. The intention is that a core group will be formed comprising of clinical staff, managers and other stakeholders who will attend 4 training events. The funding of £25k will assist in facilitating these events and provide backfill to allow clinicians to attend.

18 Weeks Referral to Treatment Time Improvement Programme

This programme will be launched by the Scottish Government on 6 February 2008. The Initial Programme Planning Guidance is not available and a view will be taken over the appropriate structure to support this improvement programme once this is received.

In advance of the launch of the 18 Weeks RTT the structures in place in NHS Lanarkshire for the Unscheduled Care, Diagnostics, Planned Care as well as the Cancer infrastructure are being reviewed. There are aspects of all these programmes which will require ongoing continuous improvement and sustaining of achievements. The revised support structure will link into that being developed to support the new merged Primary, Community and Acute Service Improvement Board.

Experience to date from other Collaborative Programmes

As part of the completion of the Unscheduled Care, Diagnostics, Planned Care and Cancer Collaboratives lessons learnt were identified and each of the Collaboratives will be submitting closure reports. In advance of the production of these documents the following points can be identified:

There are currently four Collaboratives in place in Lanarkshire. They are Unscheduled Care, Diagnostics, Planned Care and Cataract.

Whilst the Collaborative process has, from a national perspective, an end point of 31 March 2008, it is intended that the relationships and structures established during the Collaborative process will continue and be incorporated into existing mainstream clinical and management arrangements.
The detail of that has yet to be agreed but has to include a reporting and decision making process that extends across Primary and Secondary Care. It also has to include appropriate support arrangements with time available for clinical and non clinical staff to sustain and further improve service delivery. A budget allocated annually by the Scottish Government to support the Collaborative process over the period of the Collaborative will cease at 31 March 2008.

The strength of the Collaborative process has been clinical leadership and engagement. This has extended across primary and secondary care although active participation has involved mainly acute clinical and management staff. There has been limited community participation, the nature and extent of which has varied across Collaboratives. In each Collaborative work streams have been agreed reporting on progress and outcomes to the Project Board. There is evidence of improvement in each Collaborative in respect of the patient journey, service quality and access to services at the appropriate time. It has encouraged innovation with the introduction of ‘straight to test’ for diagnostic tests in both endoscopy and radiology, movement to consistent and universal pre assessment, a shift towards day surgery as the norm, an improved referral process for cataract with cataract only theatre lists and a significant improvement in the management of patients when they present at Accident and Emergency. Those improvements have emerged from the Collaborative process and it is important that the potential for continued innovation and improvement is encouraged and promoted.

The expectation was that the Collaborative process would deliver improved patient access to services with a reduction in waiting times at each stage of the patient journey. This has occurred and the targets set by the Scottish Government were achieved at 31 December 2007. More challenging targets have been set for the period to 31 March 2009 in the context of an eighteen week referral to treatment target to be achieved by 31 December 2011. Delivery of targets is accompanied by additional recurring and non-recurring allocated by the Scottish Government although this is released on a phased basis linked to measurable improvements at agreed milestones. The Scottish Government has indicated that additional moneys will be released for 2008/09 and beyond although the nature and extent of that has not yet been intimated.

Continued clinical engagement will continue to be crucial with effective communication with those colleagues who are not directly involved in the work programmes. This applies to both Primary and Secondary Care. Effective management involvement and support is also crucial and again this should extend across Primary and Secondary Care. That support has to include information management support with the capture, recording and reporting of information crucial in terms of content, quality and presentation. This is currently a limited resource and represents a risk if not addressed. It is acknowledged that there is no single IT system available to track patients through each stage of their journey and it is important that work associated with service improvement informs development of systems to facilitate management of the patient.

**Scottish Primary Care Collaborative**

The goal of the Scottish Primary Care Collaborative is to assist primary care organisations in developing their capability to deliver rapid, sustainable and systematic improvements in the care they provide to patients and their communities, through a sound understanding and effective application of quality improvement methods and skills.

NHS Lanarkshire has been participating in the Scottish Primary Care Collaborative since September 2003. To date, 68 GP Practices covering 383,790 patients have been using the Collaboratives change methodology to make improvements in the delivery of care they provide for their patients.

The general aims of the Collaborative are:

- To assist primary care organisations to develop their capability to deliver rapid, sustainable and systematic improvements in the care they provide to their communities through a
sound understanding and the effective application of quality improvement methods and skills.

- To assist in improvement of clinical outcomes for patients across all five waves of the programme, initially with Diabetes and thereafter to initiate work to improve secondary prevention of Coronary Heart Disease and laterally for patients with other long term conditions such as Chronic Obstructive Airways Disease and chronic Kidney Disease (The Scottish Primary Care Collaborative 2008).

**Long Term Conditions**

The methodology used linked with ongoing work to improve the clinical outcomes for patients. The ‘measures for improvement’ for all disease processes have been recognised to exceed the challenges set by the GMS contract. Like the access component the methodology also assists in improving workload management. This component has largely focused upon practice nursing and administration staff.

The main principles include:

- Developing and validating disease registers
- Systematic approach in managing patients
- Involve patients in delivering and developing their care
- Adopt multi-skilled, multi-agency approach.

It can be said however that the % improvement for the disease categories occurred at the initiation of the new GMS contract in 2004 for the quality and outcome framework. By using the adopted methodology to approach principle one mentioned above, these outcome measures have consistently improved and disease registers are increasing.

**Lessons Learned from the Collaborative Programme:**

- Improved understanding of demand and capacity through provision of evidence to support change
- Creation of signposting for appropriate appointment type
- Introduction of creative ways of accessing a healthcare professional through formalisation of telephone appointments that are pre-book-able as a choice
- Reduction in embargos systems that cause backlog
- Improved choice for patients
- Reduced frustration experienced by patients and staff
- Improved patient satisfaction
- Creation of healthcare assistants and phlebotomists improving skill mix
- Improved the management of patients with long term conditions; active call and re-call; reduction in multiple visits:
SECTION 8: LOCAL DELIVERY PLAN

The format of the Local Delivery Plan (LDP) has been updated as one of the steps towards a more integrated planning approach. From a workforce planning perspective, this means that the LDP will be the main vehicle with which to convey the narrative about those workforce changes directly related to achievement of national targets to the Scottish Government since Workforce Plans no longer need to be submitted formally. Whilst workforce changes will in turn be reflected in the workforce projections, there are also workforce changes not directly related to achievement of targets. The workforce changes outlines in the LDP, under the target headings of Health Improvement, Efficiency, Access to Services and Treatment are as follows:

Health Improvement Targets

- In order to reduce mortality from coronary heart disease among the under 75s in deprived areas, we will be re-shaping existing provision and approaches rather than adding new additional services and this is where the workforce development required will be focused. This is already an integral part of our planned service modernisation framework (A Picture of Health) the full implementation of which is contingent upon approval of revised A&E plans due to be announced in spring 2008.

- We continually encourage GDPs to participate in the Childsmile programme, to increase child registration coverage across Lanarkshire. Incentives are promoted among practices to increase those enlisted. In addition, expansion of practices’ capacity, both in numbers and in types of patients seen, is encouraged by means of the various grants and allowances schemes agreed at national level. On-going recruitment and retention activities are pursued to ensure that there is a supply of suitably qualified dental health support workers to underpin the Childsmile programme.

- Staff to implement the child healthy weight intervention programme are not currently in post therefore implementation would be subject to funding to appoint. If funding were available in the immediate future, the first year, i.e., 2008/9, would require to be used as a development phase and therefore it is unlikely that any children would complete the programme during this year.

- During this transitional year, 2008-9 will be used to consider and determine the affordability and availability for the proposed workforce (GPs, Practice Nurses, Public Health, A & E and Antenatal staff) to achieve the agreed number of screenings using the tool for appropriate alcohol brief intervention. It is anticipated workforce adaptability may become more apparent in 2010-11. The multi-disciplinary strategy working group established will ensure that key personnel involved with NHS staff development will be involved, including: Organisational Development, Keep Well, ADAT Workforce Development Sub-group and Health Scotland.

- NHSL will have to train approximately 1160 staff across the range of staff groups in using suicide assessment tools and suicide prevention. We are confident that we will achieve the target for some groups of staff more easily than for others, for example, those working in mental health services. We anticipate that there will be challenges around gaining access to particular groups of staff such as Primary Care staff, General Practitioners and Accident & Emergency staff. We will provide training dates as far in advance as possible to allow for forward planning. We will also be engaging with appropriate heads of service to establish and agree a workable training programme.

- All smoking cessation staff are in post and there is pro-active recruitment when required. All staff have PDPs to ensure up-to-date knowledge and skills. A brief intervention training programme is in place for NHS staff and others to help engage smokers to consider quitting.
The Lanarkshire Breastfeeding Policy supports a number of objectives to improve the uptake and continuation rates. Included is mandatory training for staff, at a level appropriate to their role. A consistent approach to training that includes evaluation and review in line with annual re-appraisal of the Breastfeeding Policy exists. Target groups include midwifery and public health nursing staff, medical staff and reception staff and other key staff groups. New staff will receive the training within six months of taking up post, with update training after two years. Audit of all staff regarding practice will be ongoing.

Engaging GPs in breastfeeding training has been problematic. NHS Lanarkshire is committed to achieving UNICEF / Baby Friendly Initiative (BFI) accreditation through implementation of the BFI Staged Approach across the Board. The BFI will support the engagement of GPs at a Locality level. The potential for using an e-learning tool for GPs will be explored.

**Efficiency Targets**

- In moving towards universal utilisation of CHI, in relation to diagnostics there is risk associated with cultural change and the management / training of junior medical staff to ensure usage of patient identification labels on test requests. Clinical Divisions will monitor and enforce use of Label Policy. Some structural impediments to access to CHI in community settings will be removed by increased access to information technology and systems in these areas.

- A sickness absence Project Manager continues in post to support a range of sickness absence initiatives and funding has also been agreed for physiotherapy support. Fixed term part time posts have been established to take forward a pilot survey looking at reasons for absence and the take-up of family friendly policies.

- There is a significant workforce issue in the sheer volume of training needed for all staff (managers, reviewers and individuals) who need to know how to use the new e-KSF system for their developing post outlines and their personal development plans. Secondly there will be additional training issues for staff who are not IT literate. Additionally, staff availability and backfill funding for staff to be released for training will be an issue. A further risk to implementation is the time that it will take people to complete personal development plans in the new system – especially in the first learning year as they develop competence in the new way of doing things.

  For managers and reviewers training time will be minimised and sessions offered as locally as possible. For individual staff members the adoption of a coaching approach, delivered at the desk or on the ward, will minimise staff release time and be supported with appropriate materials. Further, through an integrated approach with the IT and general training teams, basic IT skills development will be offered. Ongoing communication with managers will be used to alert them to the need to plan ahead for personal development plan reviews more rigorously than in the past.

- In order to reduce the average length of stay in hospital for acute inpatients discharged following an urgent, emergency or other non-routine, unplanned admission, including emergency transfers there has been no increase in staffing although there has been increased emphasis on discharge planning and communication with colleagues internal and external to the organisation to facilitate discharge. The option to recruit Acute Physicians is actively being considered with the potential that provides to facilitate patient throughput.

- There has been a change in historical practice of ‘bringing patients back’ which has the potential to free up resources either to deliver improved waiting time guarantees or to be redeployed in other related areas. This should also have an impact on reducing the ratio of return to new outpatient attendances. It is possible however that necessary skill sets and
competencies will not be available in the existing workforce. This may require recruitment of new staff or retraining of staff in primary and secondary care.

- Reducing the first outpatient appointment DNA rate is facing a major challenge with Staff recruitment/retention in areas where the work pressure is considerable and the avoidance of error (due to direct patient contact) the subject of close scrutiny. This represents a considerable change agenda in service delivery that has significant staff and management time implications.

- NHS Lanarkshire is tasked with a target for increasing the percentage of new GP outpatient referrals into consultant led secondary care services that are triaged online for clinical priority and appropriate recipient service to. The workforce implications will need to be assessed in terms of the impact on Consultant Job Plans and the workload changes in primary and secondary care administration. The increased focus on IT enabled processing will also require additional IT Support roles to be established.

Access to Services

- Primary Care department staff work closely with practices to resolve any issues that arise in ensuring that access to GPs, nurses or other healthcare professionals is available within 48 hours; providing advice and guidance as required.

- A recruitment plan for additional specialist nursing staff is in place in order to ensure the maximum wait from urgent referral to treatment for all cancers is two months. It is challenging to retain scarce professional staff and to attract new ones. There has been a significant awareness and training programme emphasising the importance of complying with time lined patient pathways and working with colleagues to improve the patient journey. Additional demand for diagnostics has prompted increased attention to referral practice for all tests to ensure appropriate compliance with standards adopted for each pathway.

- There are constraints with space and access to the available skills and competencies to progress changes in the way services are in future delivered in delivering the 18 week milestone for GP referral to first outpatient appointment. There will be implications for consultant job plans and work priorities. There are also implications associated with the changes as a result of Modernising Medical Careers that will impact on available capacity.

- There will be implications for job plans and work priorities in moving towards the 18 week milestone for patients waiting for inpatient or day case treatment. There will also be implications to medical careers and the implications of that for available capacity. The option of a joint appointment with Golden Jubilee is being piloted in orthopaedics and the value of that will be evaluated during 2008/09. The anticipated changes in use of day surgery and theatres will have implications for staff and changes to work routine and practice may be required to improve throughput and overall productivity.

- The increase in capacity in 2007/08 (towards meeting the target for the waiting times for 8 key diagnostic tests) was achieved through investment in new staff linked to service improvement that included extended day working and changes to working practices with increased consistency around patient access. Recruitment of staff proved difficult in some areas and this may continue. Emphasis in analysing current requests by consultants for diagnostic tests may impact on future demand. This represents work in progress. Changes to non clinical practice and process are also being reviewed that may necessitate some retraining of staff.

- There is work in progress by agencies individually and collectively that may contribute to delivery of the suite of A&E targets. From a health perspective they include work associated with long term conditions and planned adjustments to roles and responsibilities of community nursing staff to multi agency work linked to joint improvement (previously joint futures). It will be necessary in future to link those work strands into a coherent and coordinated approach to
maximise available resources and where appropriate more effectively manage future service delivery.

- There has been significant investment in staff and equipment to deliver the 4 hour waiting time for A&E admission, discharge or treatment target during 2007/08. It will be challenging to retain those staff and to increase their number if this is considered necessary. There have been changes to working practices and those will continue to be refined and developed. This will have training and resource implications. There has been a significant change agenda to achieve the level of progress required to deliver and sustain the target. The recent winter period provided a further test of the system to deliver a quality service. A review of that experience will be reported on in April 2008.

Treatment

- The redesign of community nursing services has been completed so that they are now organised into long term conditions and public health teams and these teams have been refocused and aligned into areas of greatest need as a result of the demographic profiling of Localities. The impact that this has on reducing inappropriate emergency admission/readmission of older people is to be monitored and reported.

- An interface group between health and social care is examining the relative roles of health and homecare staff with a view to redesign that makes use of skills to improve services. The HR implications will be clarified by the outcome of this work.

- The existing clinical governance support departments within Lanarkshire (i.e., Clinical Effectiveness / Governance, Risk Management, Research & Development, Patient Affairs) do not operate as a single, cohesive department. This presents a risk to the efficient delivery of the improvement trajectory, as these departments provide the core support for a number of the criteria where progress is required. The risk will be managed through the planned restructuring of the various departments under one senior manager. The newly created post – the Head of Clinical Governance and Risk – will have responsibility for ensuring that adequate clinical governance support is provided as appropriate.

- We intend to reduce the annual rate of increase of defined daily dose per capital of anti-depressants and put in place the required support framework by recruiting a number of staff. There may be issues around recruitment of staff in sufficient numbers to roll out across Lanarkshire, assuming the pilot goes well.

- Workforce requirements will emerge from the scoping exercise looking at reducing re-admissions for those how have had a psychiatric hospital admission of over 7 days, however there are certain to be some Human Resource issues to manage in the process of introducing new clinical models, especially as we move away from more traditional models of community services based around 9-5 working patterns. These circumstances will generate risks around change management, acceptance of the new models amongst staff, training and development capacity and associated costs. Any costs will be identified as part of the planning process around the new models. Training and development requirements will be built into the capacity plans for each part of the service and there will be ongoing monitoring of staff compliance with any new ways of working.

- We are aiming to reduce staphylococcus bacteraemia and whilst current infection control staffing is in place (subject to on-going national funding); the pool of skilled professional infection control staff in Scotland is small and training is lengthy (up to 5 years); thus recruitment and retention challenges are constant. To help alleviate these, we have a competency based structure in place to complement the specific academic training and offer secondments to suitably qualified and experienced nursing staff. While Agenda for Change
had an adverse effect during 2007, this is now expected to be resolved following completion of the review process.

In addition to the specialist staff, the aim is to make infection control ‘everyone’s business’ by broadening out accountability to senior ward staff, and integrating it across the organisation using such vehicles as personal objectives, risk management and governance structures, education strategies and PDPs. In so doing, a general cultural change will be fostered, prioritising infection control at all levels and in all settings.

- In order to achieve agreed reductions in the rates of hospital admissions and bed days of patients with primary diagnosis of COPD, asthma, diabetes or CHD, the deployment of existing Community Nursing staff has been refocused and aligned into areas of greatest need as a result of the demographic profiling of Localities. The requirements for additional staffing and skills to underpin Strategy implementation will be informed by the outcome Keep Well and supported self help pilots.

In the meantime, the Self Assessment underlined the significant programme of training and development that will be needed to bring about the desired changes, including values based training to support patient and carer empowerment.

- Workforce implications of increasing the level of older people with complex care needs receiving care at home will be worked through in the light of the agreement on the baseline and trajectory, set in the context of the community nursing manpower plan and further work on clinical and service models around the interface between health and social care.
SECTION 9: WORKFORCE ASSUMPTIONS

Medical Workforce

The medical workforce projections are based on ISD September 2007 data and should be considered as work in progress. The Cabinet Secretary’s request for a review of plans for Accident and Emergency Services across Lanarkshire has had a knock-on effect on the development of service plans and therefore on the confirmation of the medical workforce numbers anticipated across the organization.

A range of changes are planned in Lanarkshire over the next few years but at present some of the detail has not yet been worked through. One of the most significant pressures impacting on the medical workforce include Modernising Medical Careers and this is being addressed as part of a raft of workforce planning activity across the medical workforce with an agreed overall investment of £3.2 million, which is in essence the figure on which these projections are based.

One of the main challenges in drawing together these projections is the high vacancy rate in Lanarkshire (over 16%). The high vacancy rate in Lanarkshire has been ongoing for a number of years and leads to a dilemma as to whether we project the figure we would like to see as staff in post for forthcoming years, allowing for a reasonable difference between funded establishment and staff in post, or do we project the number we anticipate might be in post, taking into account current, and likely, vacancy rates.

Although the second figure might be the more realistic one, this could give an unrealistically low figure on which to plan supply nationally, therefore perpetuating the problem in years to come. The risk of impact on service delivery here is a real one and provides a need to ensure that those interpreting the projections have a sense of their implications in a broader context.

An example of this is the agreed funding for 9 staff grade posts in Wishaw General A&E, where only 4 staff were recruited. This leaves a shortfall of 5 vacancies which we are unable to fill.

The high vacancy rate in Lanarkshire has resulted in a high usage of locum medical staff, and therefore it is important to recognize that despite this, services continue to be delivered and there is minimum impact on patient care. However, the supply of locum staff is becoming more limited and will lead to future difficulties.

The next phase of the European Working Time Directive comes into play from next year and this will have an impact on the service. It is not clear how significant this will be but the groups most affected will be junior and middle grade staff.

Service delivery plans to date have been based on an assumption that critical care services would be based primarily on 2 sites in the future. Now that they are to be based across all 3 sites, there will be an impact on a range of medical specialties including A&E, Acute Medicine and Anaesthetics. Workforce models still need to be worked through and the workforce projections provide only a very rough estimate of what numbers are likely to be required.

We anticipate that the number of middle grade staff, primarily staff grades, will increase to fill the potential delivery gap due to the reduction in the numbers of trainees (including FTSTAs) and it will be essential to access funding from NES to cover this.

The figures for years 5 and 10 are very speculative due to a number of reasons including uncertainty over funding, lack of clarity about service models.
General Medical Services

During the past year, the situation around the General Medical Practitioner contract has altered but this is unlikely to increase the number of GP Principals in Lanarkshire. As expected and noted in previous Workforce Plans, the trend seems to be toward taking on GPs as salaried employees but we have relatively little information about the GP workforce or indeed the practice workforce as a whole. The workforce survey completed by SGPC is not fully shared with Health Boards and was incomplete for Lanarkshire, with little improvement on last year’s response rate. Another gap in information is around the sessional commitments of individual doctors. Despite this, we know our patient list per GP remains the highest in Scotland.

There is ongoing work looking at population growth and shift particularly as this affects Cumbernauld and Ravenscraig with new planned housing developments. Planning is at an early stage here and we are unlikely to have implications on GP workforce prior to July 2008. Without this information, it is difficult to anticipate whether this will have a significant impact in terms of growth in GP numbers but should there be a major initiative by NHSL to establish new practices in areas to which the population has/will drift, this will be captured in the 2009 Workforce Plan.
Dental Services & Support

Childsmile Programme

The Childsmile demonstration programme aims to educate and encourage good oral health practices from the very beginning of the child’s life. The Childsmile programme in West of Scotland aims to provide care jointly between families at home and in general dental practices. As this programme has continued to expand in 2008 with increasing number of dental practices signed up for it, this may require an increase in the number of health support workers; in order to ensure the service can reach out to as many children as possible.

The Childsmile programme in East of Scotland is to be delivered onsite in nurseries and primary schools. As this programme is also expected to expand in 2008, there will be a requirement for an increase in trained nurses/therapists to implement the clinical programmes in nurseries and primary schools.

The Childsmile programme is expected to roll out across the whole of Scotland after its initial 3-year demonstration which ends in December 2008. The national Childsmile programme consists of four elements, namely Childsmile Core, Childsmile Practice, Childsmile Nursery and Childsmile School; developed by separate steering groups. Evaluation of the programme is governed by an Evaluation Board, which also include representatives from the Universities of Glasgow, Dundee and St Andrews.

NHS Lanarkshire has been developing and delivering the Childsmile Core and Childsmile Practice programmes. The post of Childsmile Programme Co-ordinator for NHS Lanarkshire has been agreed and is now being recruited. The post holder will be responsible to operationally manage the day to day implementation and coordination of Childsmile programmes across dental practices, nurseries and schools throughout NHS Lanarkshire.

The Childsmile School programme was launched by Shona Robison, the Minister for Public Health, at a Fife primary school on 3 December 2007. Childsmile School aims to free more children from dental decay through early intervention from dental care teams visiting primary schools to deliver oral health promotion, health education messages and initiatives like fluoride varnish. This means that specially trained dental nurses will be going into schools and providing clinical care to children. Childsmile School will also deliver a range of preventative care interventions for children in primary one and two to reduce the risk of dental decay.

The Childsmile programme in Lanarkshire has implication in the training of dental nurses to deliver the programme within dental practices; as well as in the recruitment of health support workers by NHS Board.

Dental Premises

Premises will probably be the greatest challenge in developing dental services in the next 10 years. The situation has been made more critical by recommendations as a result of the Glennie Report on decontamination which require all dental practices to have a separate room for decontamination by 31 December 2009. This target date is currently under review.

Capital funding has been allocated to NHS Lanarkshire by the Scottish Government for the following:

The Coatbridge Dental and Integrated Resource Centre is scheduled to open in 2009. This centre will provide 10 outreach training places for dental students, 4 training places for oral health therapists, and facilities for specialist services, and an opportunity for local general dental practices to move into fit-for-purpose premises.
A new dental surgery will be established in 2008 which is linked to the development of the Biggar Health Centre.

**Primary Care Dental Services**

The need for dental care within Scotland continues to increase as the target of 1 dentist per 1750 heads of population is being strived for. The following numbers in the dental workforce are anticipated for the next few years, though funding has not yet been finalised and therefore not all these staff increases are included in the projections.

1 Year:
- Senior Salaried Dentists increased by 1 (to support outreach dental student training)
- Trainee Dental Technicians increased by 1 (in process of applying for a Vocational Training place for Dental Technicians)
- Dental Nurses increased by 2 (to support Dental Foundation Year 2 Trainee post; and to support Outreach Training)
- Trainee Dental Nurses increased by 2 (increasing number of 2-year training posts from 10 to 12)
- Oral Health Educators increased by 4 (obtained funding to recruit 1 oral health educator in Palliative Care, 2 oral health educators to target Older People, 1 oral health educator to target People in Hospital)

3 Years:
- Senior Salaried Dentists increased by 2 (to support outreach dental student training)
- Salaried Dentists increased by 1 (for Biggar Dental Development)
- Dental Nurses increased by 7 (1 to support Dentist in Biggar; and 6 to support Dental Foundation Year 2 Trainee post)
- Trainee Dental Nurses increased by 12 (additional 2-year training posts)

There has been difficulty in recruiting hygienists and senior salaried dentists, probably due to the lack of trained professionals in these areas. Also there are a number of vacancies for dental nurses and trainee dental nurses, probably due to lack of interests and job prospects.

**Hospital Dental Service**

There will be a requirement to recruit one Consultant in Orthodontics in 2008 to replace the existing consultant who will soon be retiring. In addition, early stage discussion is being held to kick start the recruitment of a part-time Consultant in Restorative Dentistry.

NHS Scotland has launched a programme called 18 Weeks: The Referral to Treatment (RTT) Standard as a goal to improve the quality of care to patients. This new programme has direct implication to the workforce development of dental services in NHS Lanarkshire. More trained orthodontists and support staff may be required.
Nursing and Midwifery

The Nursing and Midwifery Workforce Workload Steering Group (N&MWWSG) continues to oversee strategic workforce planning for all nursing and midwifery staff across the organisation. Work in the past year has continued to progress both the local and national agendas in determining and advising on the size and composition of the nursing and midwifery workforce and in relation to workload. The Group’s principal area of activity is to integrate and coordinate all the Nursing and Midwifery workforce activity in NHS Lanarkshire to ensure the Board has a nursing and midwifery workforce fit for purpose.

The annual report for the Workforce Workload Steering Group for 2007/2008 is included as Appendix E and outlines the major work streams underway though the most significant activity has been around implementing the national workforce and workload tools.

Workload and Workforce Tools

Background
The NHSScotland Nursing and Midwifery Workforce and Workload Planning Programme commenced the implementation phase in April 2007. This involved a roll-out of agreed workload tools and methods across specific clinical specialities within all NHS Boards in Scotland. The roll-out of those tools which are currently available will be complete by September 2008.

The planned process of the implementation was to have been three approaches that would provide information to underpin and inform nursing and midwifery staffing requirements. The three approaches would be:

- Acuity-Quality Tool
- Professional Judgement Tool
- Clinical Quality Indicators (CQI)

Initially it appeared that the timeline for embedding the CQI’s into all the clinical areas would run concurrently with the implementation programme. However, the implementation period for the CQI’s requires a longer lead in time than was first envisaged.

Acuity-Quality Workload Tool
The Adult Acute workload tool was applied to the Adult Acute workforce using the average bed occupancy for the period April 2006 to March 2007 inclusive. This was entered into an acuity-quality workload model, developed by Dr Keith Hurst, Leeds University, to calculate staffing requirements. This tool has been developed using a triangulated approach. It uses a combination of three methods to calculate staffing requirements. The three methods are nursing activity, patient dependency and a quality measure (CQI).

Professional Judgement Tool
The Professional Judgement tool has been developed within NHSScotland from the Telford professional judgement model and was applied over a two-week period during September 2007. The same two-week period was used for all Boards. This tool asks senior charge nurses/ward managers to give their opinion of how many nurses they needed for the workload that presented during the period of the implementation.

Findings Nationally
The initial analysis of the data captured during the first roll-out of the Acuity-Quality tool and the Professional Judgement tool within the adult acute inpatient areas across NHSScotland has identified the following:

- In the majority of areas there is a level of consistency between the tools
- Further work is required on the Acuity-Quality tool within the following areas
  - Medical receiving / admission units
  - Small wards with bed numbers less than 18

32
With the exception of Community Hospitals and the Island Boards, there is a reasonable level of consistency between the Adult Acute and Professional Judgement tools. There is a difference between the WTE numbers identified by the tools and the Budget WTE although the significance varies. The actual WTE however is significantly less than the other thee WTE.

The Adult Acute tool is a workload sensitive tool. In areas where there are small wards or low volume workloads there is some concern that the results from these areas are not sufficiently accurate. This actual WTE data requires further work to incorporate bank, agency and extra and overtime hours for all areas. To some extent the concerns that the Adult Acute tool is not suitable for small wards under 18 beds was evident. However in some of the smaller wards the tool worked well. Therefore this is an area that requires further review.

Conclusions
The overall outcome of the application of the adult acute and professional judgement tools has been very encouraging with a high degree of correlation in all specialities with the exception of the community hospitals.

Further work is required to provide a more accurate measure for actual WTE as this requires including Bank and Agency hours to allow a meaningful comparison to take place. Additionally it is not clear whether all Boards included 22.5% predicted absence in their budgeted WTE.

The results at this time require further analysis before financial implications are considered. Further work is being undertaken by the national project team to address areas of inconsistency.

Summary of progress across all specialities in NHS Lanarkshire
For each speciality – acute adult, mental health, neonatal, maternity, paediatrics and community a specific tool has been identified and developed for use. IN addition, for each specialty a standard Professional Judgement tool is applied. A national rollout programme for each speciality is being followed and the current position for NHS Lanarkshire is as follows:

- **Adult Acute** - This exercise is now complete. The acuity/dependency tool used was found to be closely correlated with the Professional Judgement model and the actual deployed staff with the exception of wards with less than 15 beds and the GP Hospitals.
- **Mental Health** - Completed locally, feedback from the centre on the results of this tool is awaited.
- **Neonatal** - The data has been submitted to the national team for analysis and the results are awaited.
- **Maternity** - A national standard version of ‘Birth Rate Plus’ has commenced in NHS Lanarkshire on 1st January 2008 and will complete on 30th April 2008.
- **Community** - The community tool commences 18th February and is based on a series of demography measures. The information is currently being collated locally.
- **Paediatrics** - The implementation of the paediatric inpatient tool will take place May /June 2008

Detailed result of each of the tools will be brought to the N&MWWSG for analysis and consideration. A flow chart has been developed to provide a structured process for analysis, reflection and implementation and this is included as Appendix F.

**Nursing, Midwifery and Allied Health Professions Workforce Strategy**
A draft NMAHP strategy is being developed and nearing completion. This outlines a set of common principles for the strategic direction of the nursing, midwifery and allied health professions in Lanarkshire, outlining a series of actions to take these forward. This document will be published in the 2009 Workforce Plan.
Nursing and Midwifery Projections

The projections for the nursing and midwifery workforce submitted to the Scottish Government Health Department reflect a conservative approach, including only those changes in post which are fully signed and approved. The major changes are a result of the following:

- Transfer of thoracic services to the Regional Heart and Lung Centre at the Golden Jubilee National Hospital
- Increase in critical care, diabetes and respiratory nurses
- Further implementation of the Community Nursing Framework
- Changes in delivery of mental health and earning disability services, with reduction in staffing as services are delivered in the community
- Increase in advanced neonatal nurse practitioners

Nursing, Midwifery and Allied Health Professions (NMAHP) Workforce Strategy

A NMAHP Workforce Strategy is currently under development. The purpose of this strategy is to outline the principles on which the Nursing, Midwifery and Allied Health Profession (NMAHP) workforce changes in size and composition will be based. This will ensure that requirements of NHS Lanarkshire in the implementation of a Picture of Health will be fulfilled.

Some of the areas covered by the strategy include:
- Attraction, retention of staff
- Promotion and use of Agenda for Change and the Knowledge and Skills Framework in this process
- Team approaches to delivering care
- Addressing skill mix
- Stability of the workforce
- Bank staff within the workforce

The strategy is nearing completion and will be included in the 2009 Workforce Plan.
Allied Health Professions

The past year has been a very busy period for the Allied Health Professions (AHP) within NHS Lanarkshire. The AHP professional leadership structure has been consolidated, although there is still some activity in relation to the team leader cluster model approach to be completed. It is expected that this will be concluded by summer 2008. An Allied Health Professions Workforce and Workload Steering Group, (which is a subgroup of the NHS Lanarkshire workforce planning steering group) has been established, with the group meeting on a quarterly basis.

Part of the work of the AHP Workforce Planning Steering Group is to advise on the composition and strategic direction of the eight professions that comprise the AHP group within NHS Lanarkshire.

There have also been a small number of significant changes during 2007 within the professional leads group with the retirement the Professional Lead for Physiotherapy, and the secondment of the Professional Lead for Radiography to NHS Fife.

National Workforce and Workload Management Project

Considerable work on AHP workforce and workload management is currently being undertaken at a national and regional level. Part of the activity of this group has been to examine the potential for an Allied Health Professionals staffing bank, and also identification of workload measurement tools. 2007 saw the establishment of a West regional workforce planning group for Allied health professionals, which is a subgroup of the West region workforce planning and steering group.

Service Reviews

Services within NHS Lanarkshire are currently in the process of concluding service reviews. These services are speech and language therapy, paediatric occupational therapy. Audiology, Orthoptics and Podiatry are in the process of undertaking reviews at the present time.

Physiotherapy in particular, proposes to undertake a comprehensive review of the physiotherapy service. Initial evaluation of the review process with production of care group action plans will be completed by May 2008.

The action plans will cover the following care groups:

- Musculoskeletal Out-Patients
- Orthopaedics
- Surgical/ITU/On-Call
- Care of the Elderly
- Cardiac Rehabilitation
- Pulmonary Rehabilitation
- Medical rehabilitation
- Neurology/Stroke
- Community Rehabilitation

With the exception of physiotherapy it is expected that the bulk of these reviews will be concluded during 2008 and will ensure that the service being provided by these clinical specialties will be more efficient and streamlined.

Service Redesign

NHS Lanarkshire has instigated an initiative called “invest to save”, and substantial investment has been secured by the Physiotherapy, and Speech and Language Therapy Services to assist in redesigning distinct elements of both services.
Physiotherapy

It is the intention of the Physiotherapy Department to introduce a self referral mechanism, and a redesign of outpatient musculoskeletal pathways for patients. In order to create capacity it will be necessary to enhance the Physiotherapy staffing for a period of time by the employment of 1 WTE band 7 project lead for a period of 18 months. In addition, 11 band 5 physiotherapists have been recruited to assist in this process for a period of one year from 2008/2009. A further 8 junior posts for 6 months in 2009 will also be recruited. It is anticipated that additional resource may be required, beyond 2009, but a clear exit strategy has been produced for the closure of this project.

Additional funding has also been released by the Scottish Government to bolster rehabilitation services under the delivery framework for adult rehabilitation in Scotland. This funding comprises employment of a band five Physiotherapist for a period of one year. In addition, funding has been released to provide a band seven Physiotherapy post for a one-year period.

This funding was released on the condition that the band five posts would be consolidated at the end of the one-year term. NHS Lanarkshire was able to agree to this request, and therefore transfer of this funding stream is awaited.

Speech and Language Therapy

The Speech and Language Therapy Service successfully bid for 3 elements under “invest to save” banner. It is estimated that 20% of Speech and Language Therapy, clinical time is spent on non clinical tasks, which could be carried out by clerical or support workers. The bid provides for 2 WTE clerical officers, one for North CHP and one for South CHP. In addition, 4 whole time equivalent speech and language therapy assistants will be employed, thereby ensuring a proper deployment of professional Speech and Language Therapy resources. An exit strategy has been included to facilitate this skill mix project by not replacing professional staff from the service to the equivalent cost of 2 WTE band 3 posts and 4 WTE band 4 posts.

A recommendation of the speech and language therapy review was to increase pre-referral work. It is anticipated that this approach will increase the accessibility to the Speech and Language Therapy Service and will address concerns raised under Hall 4 concerning child screening. This initiative will be project managed and will determine the requirements for population and prevention work to reduce the number of inappropriate referrals and reduce the number of children with impoverished language. To undertake this initiative an additional 2 band 6, Speech and Language Therapists will be employed to carry out this project. Again, an exit strategy is in place once scoping exercise is complete.

Part of the investment through “invest to save” will enable the purchase of computer assisted assessment equipment within the three acute hospitals, thereby providing an objective, measurable and repeatable assessment which assists prognosis, targets and length of episode. In the past patients have had to travel to one site to have this undertaken. This approach provides an equitable service provision across NHS Lanarkshire.

Waiting Times and Capacity Planning

A significant amount of work has been undertaken with the Allied Health Professions services groups within primary care to identify and resolve capacity issues. This work is being taken forward by the AHP Professional Leads in conjunction with the planning managers for both North and South Community Health Partnerships and the Information Services Department. The approach involves the use of a software package called checklist, which calculates the capacity for each service. One of the major issues facing the Allied Health Professions within primary care is the availability of suitable clinical accommodation. However these issues may be overcome by the introduction of flexible working to include extended hours and weekend working. Within primary care, the Allied Health Professions are currently developing action plans to detail short-term,
medium-term and long-term actions with projected results to assist in the capacity planning approach.

The Allied Health Professions are also looking at the potential of extending the working day and the provision of non-emergency work at weekends. It is the intention during 2008 to examine professions where this would have a major impact. One profession, where it would be applicable, would be in Radiography, particularly around extending the working day, for example within CT and MRI scanning. This along with providing non emergency work at weekends, would aid bed utilisation.

Physiotherapy and Occupational Therapy are also professions where extended working days and non-emergency patient contact at weekends could potentially increase discharge rates. Another consideration would be a skills transfer approach involving nursing colleagues, who could continue simple patient rehabilitation actions out-with normal working hours.

**Consultant Musculoskeletal Consultant Post**

NHS Lanarkshire is in the process of advertising its first Allied Health Professions consultant within musculoskeletal services with a view to completing the recruitment process by the beginning of April 2008. This post will also be the manager of the advanced practitioner team working within the musculoskeletal service.

**Orthotic Service Project Manager**

The Acute Division of NHS Lanarkshire is to advertise for an Orthotic Services Project Manager initially on a two-year fixed term contract. The post holder will be responsible for the strategic, budgetary, operational and clinical/technical management of all Orthotics services. This post has been banded at 8a through the Agenda for Change process. There is an expectation that the successful applicant will develop and implement a project plan to ensure equity of service provision across Lanarkshire.

**Recruitment and Retention**

Recruitment and retention does not appear to be an issue within Lanarkshire, for Allied health professions. Physiotherapy remains a profession that faces challenges in providing posts for new graduates. Orthoptic recruitment remains a challenge, but NES is looking at the potential to provide a bursary scheme thereby attracting new graduates to NHS Scotland.

NHS Lanarkshire does not have any art therapists or music therapists within its AHP professions. Music therapy, in particular may be an area where joint investment between NHS Lanarkshire and North Lanarkshire Council, would be worthy of consideration.

**Skill Mix**

Skill mix within the Allied health professions remains a challenge within some of the smaller professions. The assistant practitioner initiative within radiography is now into its second year, and NES is currently investigating the possibility of extending the assistant practitioner programme into Physiotherapy, and Speech and Language Therapy.

**Learning and Development**

The Care Aims project continues to be rolled out across six of the AHP professions and a significant number of Allied Health Professionals have been trained in this approach. To ensure sustainability of the implementation Care Aims model and philosophy, 12 AHP Care Aims trainers are being trained. The SWITCH partnership project, in conjunction with NHS Lanarkshire Occupational Therapy Services and the Occupational Therapy Services of South Lanarkshire
Council is also continuing to develop and identify areas where there is possible integration of service.

**Staffing Projections**

The Allied Health Professions projections are based purely on ISD data of staff in post, and do not take into account any vacancies within any of the professions. Apart from the short-term increase in staffing for the projects described through “Invest to Save” initiative. It is not anticipated that there will be a significant increase in Allied Health Professions staffing numbers over the coming years.

NHS Lanarkshire is sponsoring the development of 2 WTE band 6 physiotherapists to develop a staff physiotherapy service.

There are a number of Allied Health Professions posts being sponsored by the managed clinical networks (MCNs) and further discussion is required with them to ensure that proper professional leadership and advice is sought prior to the introduction of these posts in order that there is an understanding of the strategic direction for Allied Health Professions.

Some of these posts are of a substantive nature, and others such as pulmonary rehabilitation, whereby funding for 3, band 6, physiotherapists and occupational therapists have been approved for a period of two years in the first instance The Diabetic MCN has sponsored the recruitment of 5 additional dieticians, which are to be substantive posts. Also there will be 1 whole time equivalent band 7 and 1.5 whole time equivalent band 6 Dietetic posts within the eating disorder service for Lanarkshire.
Other Therapeutic Staff

Clinical Psychology

Psychology staffing levels in NHSL are amongst the lowest in NHS Scotland. Indeed NHSL is 11th out of 12 Health Board areas in terms of psychologists per head of population. NHSL has 15,312 per capita population for 1WTE applied psychologist, compared to for example Greater Glasgow & Clyde with 7769 (Workforce Planning for Psychology Services in NHS Scotland, NES/ISD, Feb 2008). A significant increase in psychology staffing is required to reach even the national average of 9792 per capita population per psychologist. Indeed given the recent increase in health deprivation indices in Lanarkshire (www.scotland.gov.uk/Publications/2006/10/13142739/6) there is an argument to be made that staffing levels should be increased above the national average.

NHSL’s recognition of this is reflected in the fact that the psychology workforce is expected to increase in 2008, with new posts being created through additional funding.

Addictions Psychology Services have a newly funded 0.5WTE Band 8a post confirmed, and another 1WTE Band 8a in the final stages of negotiation. In addition, a business case for a further 1WTE Band 7 post to work in the area of Young People’s Substance Misuse is being considered by ADAT.

Further additional funding of £120,000 has been allocated to psychology, at least a proportion of which is going towards providing an enhanced psychology service to inpatients with complex mental health needs. While the exact configuration of posts to be created with this resource has yet to be finalised, the current proposal under discussion is for 3 x 0.5WTE Band 8a posts for AMH psychology services and 1WTE Band 7 post for OAP psychology services.

While these additional posts are very welcome and should lead to significant service improvements, further investment in psychology services is clearly required when funding becomes available.

Pharmacy

The Pharmacy workforce includes pharmacy staff directly employed by the NHS within the managed services and independent pharmacy contractors providing community pharmacy services to NHS patients. Workforce planning within contracted services is commercially sensitive, however 80% of all pharmacists in Scotland are employed in the community pharmacy setting. Both services are undergoing a great deal of change driven largely by implementation of Better Health, Better Care, the e-Health strategy and the Community Pharmacy Contract. These changes require modernisation of hospital and community pharmacy services and staffing, and will inevitably require significant development of pharmacy manpower both in numbers, and in skills. There will also require to be a significant investment in technology to achieve the full benefits of both the e-Health strategy and the Community Pharmacy Contract.

Service Planning

The impact that pharmacists make within NHS Scotland is being increasingly recognised and there is a growing awareness of the potential for pharmacy services to directly impact the achievement of the objectives of Better Health, Better Care, unscheduled care and planned care.

Implementation of the new Community Pharmacy Contract, is affecting the way in which community pharmacists work. Pharmacists are increasingly taking on responsibility for pharmaceutical care of patients with long-term medicines including repeat prescriptions, conducting medication reviews and undertaking supplementary and independent prescribing
Clinics. All community pharmacists now provide a Minor Ailment Service for patients exempt from prescription charges.

These new services increase the demand for community pharmacy services but will release pressures and provide benefits at other points in the NHS. Community pharmacists also have a Public Health role providing advice and support for patients, seeking to improve health and helping patients make choices about their medicines. This will also increase demand on pharmacy services but will simultaneously reduce demand elsewhere in the health system.

New ways of working within the acute service have pharmacists providing greater emphasis on patient’s pharmaceutical care and pharmacy technical staff supporting the redesigned medicines management process. This supports the patient during their hospital stay and prepares them better for discharge but also provides critical support to other clinical staff. Training of pharmacists as independent prescribers increases opportunities for pharmacists to increase patient access to treatment through changing practice.

Within the Acute Division the establishment of seven-day pharmacy services is viewed as a priority to support the National Patient Safety Initiative and both 4 hour and 18 week targets. Current acute pharmacy weekend services are provided via staff working overtime and have been fragile since initial assimilation to AFC bands at end Nov 2006. Discussions have been ongoing since and following meetings held in partnership agreement was reached that pharmacy will offer a service for 3 hours on a Saturday and Sunday morning to facilitate the safe discharge of patients. This was done without additional staffing resource and is provided via staff working overtime. The agreement is considered as medium term and as such will be in place for a period of 2 years or until there is a national agreement on Unsocial Hours / On-Call arrangements.

It is planned that during 2008 the use of patient’s own medicines during their inpatient stay will be rolled out across both Hairmyres and Monklands. This system of medicine supply has been in operation within acute wards in Wishaw for some time. The resources required for this have been identified.

A facilitated event to review pharmacy services within the acute division is planned for April, this will include consideration of seven day services, use of patients own drugs, skill mix etc.

Technology Development

Substantial increased demand has been identified for pharmacy staff both in the community and in the hospital setting. It must be recognised however that there is a developing technology associated with automatic order assembly and robotic dispensing as well as electronic prescribing and medicines administration. These developments will offset the increased workload demand placed on pharmacy services into the future allowing them to progress.

Recruitment and Retention

To date Lanarkshire has been successful in filling pharmacist vacancies but has struggled to fill all technician posts. In particular Pharmacy Technician Band 4 posts; alternatives have been considered such as appointing student technicians instead, however this is not always appropriate.

Successful appointment of Band 6 (entry level) pharmacists within the managed sector is very much dependent on the time of year the post is advertised. Pre-registration pharmacists are employed on a fixed term one-year training contract and nationally they register during July of each year after which they are eligible to be appointed to a Band 6 post. Some Health Boards offer continuing contracts to their pre-registration students offering them continued employment on successful completion of their pre-registration training. Anecdotally it appears that if Band 6 posts are advertised between May and October the chances of filling them are reduced.
A number of community pharmacies are providing a service through use of locums because of the challenges of recruiting and retaining full time managers.

**Education and Development**

As an aid to recruitment and retention it is imperative that pharmacy services provide substantial education and development opportunities for staff at all levels and ensures the service is progressive giving staff an opportunity to develop skills and work in an interesting environment.

**Other Workforce Issues**

Pharmacy has not received an uplift to its staffing establishment to cover predicted absences. Agenda for Change brought about a reduction of working hours for pharmacists and increased annual leave for most staff, however there was no compensatory increase in resource to cover this. The introduction of paid parental leave has compounded this.

Pharmacy is predominantly a female profession and at any one time has a number of staff on maternity leave. Covering maternity leave is very difficult, if not impossible, as there is no compensatory funding to cover this absence until the staff members salary becomes available. In addition it is not always possible to recruit staff with the appropriate skills on short-term contracts.

Pharmacy is a service which is relatively small and loss of one or two members of staff could have a critical impact on ongoing service provision. It is important therefore to consider fully the needs of staff in relation to family friendly employment practices. This has historically been one of our strengths and must continue into the future.

Regulations are now in place to enable both hospital and community pharmacists to practice as independent prescribers. Pharmacists are not specialists at diagnosis, however they are experts in medicines and so practicing as independent prescribers embedded within the clinical team will support better care for patients and contribute to increasing the number of clinicians available to care for patients. Areas where pharmacist’s skills will be best utilised are areas where there is poly-pharmacy and complicated medication issues.

To deliver this will require a governance framework driven by service modernisation and redesign. Within community pharmacy this is being led by the new community pharmacy contract implementation of which is moving forward to nationally set timescales. In the acute sector a pharmacy stakeholder event is planned for late January early February to initiate a series discussions on service redesign.

**Contractor Services**

There is no accurate record of pharmacists or support staff employed in the contractor services as these are independent companies who provide a service via contract to the NHS. It is recognised however that within the 115 community pharmacies in Lanarkshire there will be an increasing requirement for numbers of pharmacists. Currently at an estimate of 1.2 pharmacists per outlet will need to rise to at least 1.5 pharmacists per outlet. Additionally there will be a requirement for increased technician support leading to a substantial increase in the number of qualified pharmacy technicians in employment. There will also be a need to increase a number of qualified dispensary checking technicians to support the introduction of the new community pharmacy contract.

The standards and requirements contained within the Board’s Pharmaceutical Care Services Plan will need to be considered during any workforce planning process.
Personal and Social Care

Health Promotion

The Health Improvement agenda is continuing to flourish and it is at the heart of Scottish Government policy. This will be reinforced when the Ministerial Task Force on Health Inequalities publishes its report in May. There are major opportunities and challenges for Health Promotion and other Public Health staff. There are now a number of different disciplines engaged in the wider health improvement effort and work is underway to investigate ways of maximising multi-disciplinary and multi-agency working (This work is being led by the Staff and Organisational Development Group and also reports to the Health Improvement Board). At this stage it is not possible to predict what the implications will be in 3 or 5 years. The benefit to the public will be improved partnership delivery of the Health Improvement agenda.

In 2008/2009 the following posts will be recruited to:
Brief Intervention Training – 2x Band 5 trainers and 1x0.5 Band 3 Admin. These will be fixed term posts for one year and funding will come from Keep Well and ADAT.
Oral Health – 1x Band 5 HPO with funding from Scottish Government dental health monies. This will be a 2 year fixed term post
Sexual Health – 1x Band 7 sexual health post funded from BBV budget. This will be a permanent position.

Further work is still to be undertaken to establish a workforce plan in terms of changes to skill mix, allowances for age profile within the existing workforce. From the supply perspective, evidence would suggest that we can recruit to most posts without any great concerns with the exception of fixed term posts.

One major challenge is that funding for some posts is fixed term and this creates a number of problems for recruitment. Staff are often unwilling to move from permanent posts to fixed term positions. Other than that, there are no other recruitment or retention issues creating concern.

Learning and Development

Senior Health Promotion / Health Improvement staff who are not medically trained have been given the opportunity to seek registration with the Faculty of Public Health through the Voluntary Register (This is achieved by portfolio matched against Public Health competencies). The Masters in Public Health, or equivalent, is the course that develops many HP/Hi staff and staff are encouraged to seek to gain this qualification.

Role Redesign

With the introduction of Public Health Teams there is the need to identify the skills and competencies required to enable the Team to deliver. Work is currently underway looking to look at developing the knowledge and skills required for a Public Health Team.

Affordability, availability and adaptability

All proposed changes have funding streams attached and there are no problems anticipated with availability. In consideration of adaptability, it is expected that as we develop new ways of working it is reasonable to expect staff to change working practices. This will be considered as workforce planning develops within this area.
Healthcare Science Staff

The Healthcare Scientist Advisory Committee has reporting links to the Board via Medical Director, the committee are also included in the Area Clinical Forum and linked with the Workforce Development Steering Group for workforce planning purposes.

A very important document for Healthcare Scientists was published in Scotland in November 2008 “Safe Accurate and Effective: An Action Plan for Healthcare Science in NHS Scotland”. Whilst we are not fully compliant with all the recommendations in the report, there are a number of areas where NHS Lanarkshire are already well ahead of many other Health Boards, having already have an established active Healthcare Science committee. NHS Lanarkshire has a very robust Organisational Development Programme and staff are well supported to take development opportunities. There are also a number of opportunities identified within the report and the committee will work to ensure maximum benefit for NHS Lanarkshire and its Healthcare Science workforce.

One of the overarching issues across the professions is the slow process for accrediting new education programmes and the Scottish Government, in the national report, set aside a substantial sum of money to explore the potential for a distinct NES work stream focusing on the education and training needs of the Healthcare Science staff with early prioritisation of clinical physiology and clinical technology.

The Laboratory Workforce

Current activity in the laboratories across the 3 sites is in the region of 12 million investigations per annum this is anticipated to rise to 20 million investigations by the year 2012. To allow the laboratory service to cope with this increasing demand, it will be essential to increase automation, further develop existing staff currently and increase staffing levels. In 2007 NHS Lanarkshire participated in annual benchmarking, as recommended by the “Kerr Report”. Data was difficult to extract, but it was encouraging to note that NHS Lanarkshire had parity with similar sized Health Boards and it was highlighted that Lanarkshire had a good track record at encouraging graduates into training posts.

Planned Service Change

In the short term the laboratories plan to submit a business case based on a service model which matches the needs identified during the review of A/E services. Harmonisation of the Out of Hours laboratory service across the three acute hospitals to support the increased demand will require additional Healthcare Scientists and Healthcare support workers.

Education and Training

This year, Biomedical Scientists will be asked to submit a personal portfolio of continuing professional development (CPD). These portfolios will be assessed by the Health Professions Council and if found to be inadequate, staff could face the possibility of being removed from the register and therefore unable to be employed in the role. To ensure all staff have access to appropriate education and training in order to build up CPD portfolios, appropriate back filling of staff will be necessary. The national Action Plan is recommending that Healthcare Science staff have one half day per month for CPD and a business case to increase staff numbers to allow this development will be required.

In January this year ten 3rd year students from Glasgow Caledonian University on the integrated Biomedical Science degree came into the laboratory on an intensive fifteen week work placement hopefully to allow state registration to coincide with graduation. This development has placed a substantial burden on existing staff to deliver training as well as carry out existing duties. It has been estimated, an additional 1.0 WTE Biomedical Scientist per discipline would be helpful in dealing with both of these significant changes in education and training and a business case will be submitted this year to ensure we are better resourced to support the students in future years.
Recruitment and Retention
By 2010 - 10% of existing staff will have retired. This, in the face of growing demand for increased staff numbers at both ends of the spectrum, places a real challenge on the service. NHS Lanarkshire clinical laboratories are trying to bridge the “knowledge gap” it faces. Traditionally a post had to become vacant before it could be replaced, a plan has been agreed by Finance and Management to recruit staff to state registered posts prior to planned retirement within Pathology to allow knowledge and training to reach the level required to ensure there is less of a “knowledge gap”.

The student placements from the Biomedical Science programme should aid recruitment to Lanarkshire as the students are getting a very positive experience during their visit and feedback is very encouraging.

Extended Roles and Staff Development
Currently there is a programme of role extension for biomedical scientists who wish to train in an additional discipline of biomedical science and this is progressing well. This is consistent with recommendation 7.1 of the national Action Plan.

A proposal will be submitted to the Scottish Forum for Healthcare Science seeking funding to support a pilot study to develop associate practitioner roles through education and training, in line with recommendation 8.5 of the national Action Plan. If successful, this development would allow these individuals to take over some of the tasks previously carried out by biomedical scientists. This role extension would lead to increased flexibility around the extended day and out of hours setting, and to support anticipated increase in workload and improve turn around times. Introduction of this grade would also release some much needed Biomedical Scientist resource to scope extending their role into other specialist areas.

In addition a proposal will be submitted to pilot the development of quality assurance systems for POCT in hospital and community settings in line with recommendation 3.1 of the national Action Plan. This could also facilitate the diagnostic improvements within Primary Care in line with Better Health, Better Care.

Service Reconfiguration
Considerable work is required to develop a laboratory service model which will provide support for three acute 24/7 services. Consideration will need to be given to appropriate staffing levels to ensure a quality service for the patient. To this end a review of staff structure and skill mix will form the basis for future workforce planning and be an important part of service redesign. It is envisaged that a significant transient staff increase will be required to achieve these goals over a period of 3 years.

The Application of a Lean & Six Sigma approach will require external facilitation but be driven internally by permanent staff.

Medical Physics Workforce
As far as Medical Physics is concerned, the workforce is in balance with the current and projected demands for our services. If clinical demands change e.g. an expansion in nuclear medicine, then we would respond by requesting resources to expand our workforce. There is currently potential for expansion is in providing equipment management services to GPs. A case for this has been submitted.

As with other support services, Medical Physics responds to the demands of the service. It is important that there is involvement at an early stage of the planning process so that we can assess the impact on our resources
Clinical Respiratory Technical Workforce

Following the Cabinet Secretary’s recent approval of Board plans to maintain full A&E services on all three acute sites, it is understood that the Respiratory redesign plans have been shelved/postponed.

Current staffing levels within Hairmyres Respiratory Department are 2.8 WTE, Monklands Respiratory Department are 3.6 WTE and Wishaw Respiratory Department are 3.0 WTE. In Hairmyres Respiratory department, one Band 5 WTE member of staff was not replaced when she left in 2005. This post has never been re-advertised and this should now be reviewed in order to restore the historical staffing levels which previously existed in light of the proposal to develop the service.

Planned changes include an adjustment of skill mix by replacing deputy head of service with staff grade on Wishaw site and the development of an exiting support member of staff to provide administrative support role for the Group. Neither of these changes affects the overall WTE.

We anticipate that a new Respiratory Development Plan will emerge over the coming year which will significantly impact on planning of service provision and staffing levels and it is therefore not currently possible to produce accurate projections for future staff developments until this is agreed. However, the Managed Clinical Network for Respiratory, which has been recently formed, has already produced proposals for the development of a new outreach spirometry service. This service will go ahead in the next 5-6 months.

The proposals for the Outreach Spirometry Service are to employ 3 new Band 5 Clinical Physiologists, it is suggested that one Physiologist will be attached to each site and would divide their time between working in the community and the Respiratory Laboratory. Details of the exact hours and job descriptions remain unclear at present. It is also understood that there would be 3 Respiratory Consultant posts within Lanarkshire. This would inevitably increase workload in terms of patient testing numbers. It is likely that additional Clinical Physiologists would be required if significant increases in waiting lists are to be avoided.

Recruitment and Retention
It appears that recruitment and retention of Respiratory Clinical Physiologists within Scotland is proving to be problematic. Staffing levels in Respiratory Departments are relatively small in comparison to other clinical physiology specialities and prospects for promotion opportunities are infrequent.

Education and Training
There is currently no Clinical Physiology Degree presently available anywhere in Scotland. Glasgow Caledonian University have been approached by the Association for Respiratory Technology and Physiologists regarding this matter, but no decision has yet been made. This leads to uncertainty in meeting future demand. The national Action Plan has identified the need to look at this in more detail as a matter of urgency.

Medical Illustration

Service changes planned within the next 1-year, 3 years, 5 years
• The introduction of anti-vascular endothelial growth factor (VEGF) therapies for age-related Macular Degeneration within the Ophthalmology service will see an additional member of staff to undertake Optical Coherence Tomography.
• Roll-out of fast track skin cancer referral will see additional clinical photographer.
• Support for Telemedicine will require appointment of specialist Audio-visual technician.
• Clinical Photography support for Community based Tissue Viability Nurses will require an additional clinical photographer.

• If ophthalmology services continue at present rate an additional member of staff may be required to undertake specialist imaging such as slip lamp or glaucoma clinic diagnostic testing.

Role Extension and Staff Development
Skill mix will be amended replacing deputy head of service with staff grade on Wishaw site. There may be changes to skill mix in other parts of the service but this has not been scoped at this time.

Education and Training
If Glasgow Caledonian University continue an undergraduate programme then recruitment will not be so much of a problem. Unfortunately this appears unlikely and will mean there is only one course in the UK, based in London. We will need to make use of in-house trainees and use distance learning course at Staffordshire University. NHS Scotland needs to have a Scottish system of training our profession, through NES perhaps, as our needs are diverging from those in the English NHS.

Affordability
The skill mix plan mentioned has been funded for a band 7 post through the Lucentis BC. A business case has been submitted to support additional staff for the Skin Cancer plan. An Audio-visual technician would need to be funded centrally as they will be providing a ‘corporate’ service as telemedicine has requirements at Board level. Others developments mentioned are not subject to business cases.

Adaptability
It is the same work, just in a different setting and to a greater volume.

Cardiac Technologist Workforce
It is not possible to predict the workforce implications of service change for Cardiac Technologists though it is widely acknowledged that Picture of Health is going to have a huge impact on all Cardiology services within Lanarkshire. New SIGN Guidelines, MCN initiatives (Prevention 2010) will also drive significant service change for Cardiology within the acute sector.

Education and Training
There is no degree course for Clinical Physiology in Scotland and currently any candidates have to travel to England for extended periods for training; making the profession less attractive in terms of recruitment for the employee and also for the employer and may have a detrimental long term effect on the profession.

Specialist Dental Technology and Maxillo-Facial Prosthetics Workforce
There are no new developments in this speciality and no changes in working practice anticipated in the near future. There are opportunities to extend practice though it can be difficult to secure both funding and places on training courses as relevant training is scarce. The training lasts for 4 years and following this it can take around 5 years for staff to become fully skilled in their profession.

Pressures
Due to an ageing population and an increase in the numbers of patients in care homes, the workload is increasing; this has a knock on effect for training and development of staff. There are shortages of staff and all recent business cases have been unsuccessful and this can lead to problems with continuity. There is an urgent need to plan for service continuity, it takes three years to qualify to degree level, the only suitable course is run by Manchester University and graduates
then need to go into a training post for two years. There have been no trainees in Lanarkshire for over fifteen years and there are only two people trained to cover the maxillo-facial service in Lanarkshire.

**Audiology Services**

The Audiology department is continuing to modernise services in line with Best Practice Standards Guidance for Adult Hearing Aid users, Modernising Children’s Hearing Aid Services and we are working toward a National standard for Paediatric Hearing Services presently being developed by the Scottish Executive (SE) Audiology Services Advisory Group (ASAG). Changes in practice may require some additional staff investment and or staff re-profiling.

During 2007/08 significant numbers of Waiting list clinics were run to meet increasing demand for Digital Hearing aids and to try to address growing waiting times for assessment and hearing aid fitting, running evenings and weekends. An additional .5wte Audiologist was further required to support ENT Waiting List initiative. A Capacity Plan is presently being written to help influence future service development and direction.

**Service Plans**

There is a range of service developments planned in the foreseeable future, in particular those changes required for meeting national waiting times targets. These pressures and their implications have been considered in detail in an Audiology workforce plan. 18 week target was imposed.

**Current Workforce**

The skill mix of the service has greatly changed, not least because of the severe recruitment and retention difficulties within both the local and wider Audiology communities. Recruitment became easier in the latter half of the year and 1.2 WTE audiologists will join the Service in March 08 to complete the professional staff. There have also been a high turnover of UNHS Screeners; there are currently 4 x .5 WTE vacancies.

High proportions of the staff are Senior Audiology Assistants or students and service delivery has been redesigned to account for this and to allow us to continue to provide a competent and timeous service. Two staff although qualified to practice as audiologists are continuing in higher education to meet the requirements for their registration and will complete their studies in 2008. The BSc (Hons) Audiology began at QMUC in Sept. 05 therefore the first cohort of 15 will not be available to the Scottish workforce until 2009. The Post Graduate Diploma in Audiology has so far only provided 3 additional Audiologist to NHS in Scotland.

**Future Workforce Balancing Supply and Demand**

Balancing supply and demand is particularly difficult in the present climate. The role of the Audiology Assistant has been expanded as far as it is possible in its present form; however the introduction of a Foundation Degree in Audiology Science has been introduced to extend the role to include amongst other things, hearing assessment and hearing aid prescription. This is in line with career framework level 4, Associate Practitioner. To increase capacity into the service quickly this should be explored. Demand for Adult services has increased by approximately 50 % over the last two years. It is therefore realistic to assume that demands on Audiology services will continue to increase.

As a result of early discharge following delivery, Universal Newborn Hearing Screening is becoming increasingly challenging to perform whilst the infant is in hospital, necessitating an appointment for hearing screen being offered in the community. This, in addition to an increased birth rate, adds to pressure for additional staffing resource within this department to extend weekday working hours and to provide that same level of service at the week ends.
Administrative Services and Senior Management

Administrative services staff are a diverse group within the workforce, delivering the bulk of the finance and human resource functions in addition to secretarial and administrative support to clinical staff across the whole of our organisation. The range of skills and expertise these staff possess varies widely depending on the area in which they work.

The view of this group has changed little from the 2007 Plan, with increased automation of routine tasks. Numbers in the Administrative Services family have decreased in the past year, and we expect this to decrease to continue over the next few years, albeit at a slower rate. It is acknowledged that there needs to be a review of this group of staff, to begin to establish a rationale for appropriate levels of staff in the wide variety of settings involved. This will be considered through the Workforce Development Steering Group.

The number of staff on Senior Management pay is unlikely to change significantly over coming years.
Support Services / Property and Support Services Directorate

The Property and Support Service Division (PSSD) provide support services across NHSL; these include cleaning, catering, portering, laundry, property/equipment maintenance, capital investment and property management along with the contract management of the three PFI contracts at Hairmyres, Wishaw and Stonehouse Hospitals. Almost all the staff in the Support Services job family work within PSSD and therefore they are considered jointly in this Workforce Plan.

Changes to Picture of Health as a result of the Scottish Government’s review of A&E services means that we are still unable to quantify what workforce will be required in the future. What is already clear, however, is the significant number of new health facilities planned for the community with the 5-year capital investment plan identifying a figure of £100m. To offset this, there are also clinical service plans which include some contraction / closure of the Care of the Elderly Hospitals. With current knowledge, a Picture of Health is unlikely to have an effect on Support Services/Property and Support Services Division overall staff/skills/numbers.

Supply

The most significant workforce challenge for PSSD is recruiting the workforce to deliver the challenging agenda of significant capital investment in property. A number of senior management posts have been difficult to fill, some lying vacant for up to 12 months. 3 of these posts are on Senior Manager’s pay rather than Agenda for Change; however there are also a range of other senior posts across the Division which have had to be advertised on a number of occasions, with some still being vacant at the time of writing.

A significant workforce challenge is succession planning, particularly in the step from technician to estates management grades. This is due to the stepped qualification difference and partly due to protection of pay of some staff. Recruitment problems also exist with maintenance assistant and technician posts, with 6 posts being advertised recently and only 2 filled. Technicians are paid retention money (though not joiners or painters).

The requirements of maintenance is also changing as there is a necessity to buy specialist maintenance staff to maintain and repair increasingly complex equipment. For example, all lifts are now maintained through contractual arrangements where previously these had been maintained in house.

Within Hotel Services, there is little turnover in management staff but a high turnover in the largely part time workforce particularly for back shift and weekend shifts. There is also a high level of sickness absence and it would be interesting to consider whether it would be possible to explore the possibility of establishing a BankAide service to cover hotel services staff. Redeployment has added a further layer of complexity in that support services staff on sites due to close are matched to vacancies as they emerge but in some cases the staff themselves may not be released for over a year. This means that there are some areas where the vacancy can not be filled with fixed term contracts and has to be carried until the person is released. This can have an impact on the ability to provide the required service.

Developing roles

There is scope for further development of a hybrid role, blurring the boundary between catering / hotel services. The purpose of the role is to combine taking meals to patients and the cleaning of certain types of equipment. This role is being used on the Monklands and Hairmyres sites in Lanarkshire, known as “hostesses” at band 2. However there is national pilot being undertaken by Health Facilities Scotland to develop the role more widely and the role is to be called “housekeeper”.

49
SECTION 10: WORKFORCE PROJECTIONS AND AFFORDABILITY

From the Director of Finance

Implementation of NHS Lanarkshire’s updated strategy a Picture of Health, following the revised decision on Monklands A&E service, remains the key driver for aligning service, workforce and financial planning over the 10 year period covered in the workforce plan. Because of the review process NHS Lanarkshire has been through during 2007/08, much of this is in the development stage and therefore our projections require to be further refined as the service and clinical models are more fully developed and re-developed. In addition, the outcome of the spending review has resulted in a significant reassessment of the previous financial framework which supported our previous workforce projections. The revised 5 year financial plan has been submitted to the SGHD as part of the Local Delivery Plan. It should be noted there is a clear assumption within the financial plan that NHS Lanarkshire will receive its additional NRAC allocation within the 5 year period covered by the financial plan.

In producing these projections (summarised in Appendix G), Workforce Development and Finance have worked closely with occupational group leads to try to link local and ISD staff in post figures, local and ISD vacancy figures and funded establishments to try to develop a broad understanding of the current position. Only by doing this are we able to predict what the numbers will be in the future with any accuracy. At the core of the process for developing the projections are the occupational group leads who have worked with the submissions from the Project Boards and their own professional knowledge to plan numbers for the next 3, 5 and 10 years.

However, it is clear that we need to understand the ‘currency’ in which we are providing our projections. By projecting based on the level of staffing actually in post, this reflects the staffing requirements, taking into account existing vacancies and future planned developments. This will, however, result in a higher ‘gap projection’ than if the projections are done against the funded establishment. This will generate a reduced requirement than that measured against the in post total. The cost associated with the forecast against the in post level will be higher than that against the funded establishment. In general terms, the financial plan; and the assumptions contained within it; assume developments compared to the funded establishment.

We have recognised that further work needs to be done to bring these strands into closer alignment although progress with workforce planning has shown us that we are moving forward in this respect. Funded establishments have been reviewed in light of Agenda for Change and this has provided an opportunity to establish a closer relationship between financial and workforce data. This will be important as we progress towards developing the revised clinical, service and workforce models to support implementation of the new Picture of Health.

We have tried to align our projections with planned investments in Primary Care, Mental Health, Waiting Times and the local, regional and national priorities included in the financial plan. While there is some financial certainty about this for year 1, further years are based on a high level assessment of the investment that is likely to be affordable.

Medical models of care will also need to change as a direct result of MMC. Early indications are that the level of seniority, and the level of experience of junior doctors is below that previously seen, which has had a negative impact on patient care. We are now looking to establish different roles across a number of departments including Advanced Neo-Natal Practitioners, Critical Care practitioners and Physician Assistants in both Anaesthetics and A&E. In addition, we are looking at skill mix changes across nursing and AHP areas. This is key in determining where we will require to develop different models of care but nor can it be separated from those models required to support Picture of Health.

Our projections therefore assume that there will be an increase in medical staff, but our figures for 2011 and 2016 are purely speculative. At present it is not clear what will happen to doctors post-
CCT and the Consultant figures for these years include a proportion who we think will be in this group and not necessarily all Consultants in the way we classify them now. These figures would be clearly unaffordable if they were paid as Consultants.

Workforce plans under each of the Service Improvement Boards should give us a clearer picture in due course and affordability will need to be taken into account as these develop.

Another area where further clarity is required is in the timing of the implementation of the Mental Health Strategy, which already has a detailed workforce plan for implementation. This plan lays out the model we aspire to but the projections submitted this year are aligned with the current planned investments outlined in the financial plan. This, once again, will need to be tested as it relates to years 2 and 3 of the financial plan.

The projections across all of the staff groups take into account that there will continue to be vacancies, though we do hope that we will improve on our vacancy figure for medical staff. This means that the figures for each of the projected years include a variable percentage for vacancies.

We have taken a pragmatic approach to these projections, and they should be seen as the workforce that we think is affordable and realistic rather than an aspirational wish list. They have been tested against our current financial projections and are therefore affordable within the context of this over the initial 3 year period. However, as stated above the uncertainty around the next spending review means that these projections will require to be continually reviewed as the future financial framework becomes clearer and the proposal for Picture of Health implementation are developed.

Andy Goor
Deputy Director of Finance
April 2008
Recruiting and retaining staff in many occupations and professions has become increasingly difficult and therefore reflects the availability of staff. This will continue to present a serious and growing challenge. There are a number of drivers which have resulted in this situation. The demographics of the British workforce show that there are fewer school leavers coming through the system and the birth rate continues to fall. The Scottish Executive predict over the next 10 – 20 years there will be a 20% reduction in the pool of school leavers due to the declining birth rate and, as a result, the NHS will need to work hard to secure an adequate share of this diminishing resource.

An additional challenge may be that the young people we do attract may be less physically fit due to changing lifestyle patterns (SEHD 04). The current throughput from the school, college and university route is insufficient to directly replace the loss from our workforce through retiral and natural wastage. Many school leavers, graduates and the population in general have a poor perception of the NHS as an employer or as an option for a career (Coombs et al 2003). This means we must examine the whole labour market and not just our traditional sources; there are many people who could make a considerable contribution to our services, but who have never felt that the NHS was open to them.

The geographical demographics also present a number of challenges, delivering services across rural areas can be affected by recruitment difficulties. The centralisation of training and education to large cities affects the level of exposure all trainees have to peripheral units, this taken collectively with the steady reduction in staff accommodation within these units restricts the offers of experience available to our workforce. The cost of housing in many areas of Lanarkshire also makes first time house purchases out of reach for large sectors of our workforce. The cost of travel to work and childcare can also have an impact on decision-making within the available workforce.

Changes within society also affect how we deliver services, for example we live in an increasingly 24 hour society, where people work shifts around the clock, and traditional 9am – 5pm services do not match their needs. There are higher expectations about the availability of services and the growth in knowledge in our patients and users challenges many traditional and hierarchical roles within society. We also need to consider building greater flexibility into our working patterns, including opportunities to work from home.

Recruitment is a key challenge facing the NHS UK-wide. Strategies to attract suitable people to enter or return to NHS employment are on the agenda at local, regional, and national levels, with a sustained focus on ensuring that the Service can continue to meet patient needs. The purpose of this plan is to ensure NHS Lanarkshire is best placed to compete within the recruitment market place and ensure a continuing pool of quality candidates for employment at all levels by developing recruitment capability while reducing overall recruitment costs.

Changing demographic and employment environments mean that companies no longer find enough talent available in the pool of active job seekers. In the UK economy as a whole there are around 0.6 million unfilled vacancies at any one time.

Assuming continuing economic stability, this is likely to be an increasing trend, as new entrants to the employment market fall. The reduction in the pool of school leavers due to declining birth rates will have significant implications for NHS Lanarkshire, with a quarter of our existing staff already aged 50 or above.

There is significant acknowledgement that we must have a workforce which reflects the diversity of those living in the Lanarkshire area. In an increasingly complex society, we will need to take positive action to ensure we are seen as an employer that embraces those from a wide range of backgrounds and therefore improve inclusivity.

52
In this ‘sellers’ market, recruiters are engaging in more diverse means to attract potential applicants, moving away from the job ads in national printed press, to more varied, targeted use of multi-media advertising. This is particularly true of companies seeking to engage the ‘passive’ job seekers – those who are not actively looking for a career change but who may consider attractive opportunities. In order to meet this challenge, NHS Lanarkshire has developed the facility for online recruitment. Candidates are now able to either apply online, via the SHOW Website, or by downloading an application form and returning this via email. Further work is ongoing with regards to implementing this wider throughout our recruitment practises. An online recruitment module, Ecruit, has been implemented and developed within the Employment Services Section to accommodate the recruitment processes.

In recent years, NHS employers have sought to address the impact of this shrinking resource base through initiatives like job role redesign. However, there has tended to be a historically disjointed approach to NHS national workforce planning. This has contributed to national shortages across a number of specialties and created long local lead times in the recruitment of replacements as staff leave. Gaps in staffing as a result of vacancies impact on the quality of patient care and efficiency of the business. In order to maintain the short-term expected level of patient service, solutions to these staffing gaps often result in inefficiencies through incurring costs of locum, overtime, bank staff, agency usage, and excess hours.

In NHS Lanarkshire, the areas most difficult to fill are consultant and senior medical staff vacancies, where we have the highest vacancy rate in Scotland. There continues to be a higher number of nursing leavers within the Medical & A&E Division which in turn has resulted in a higher volume of vacancies, although there have been no particular difficulties in filling these posts.

There have also been a significant number of Public Health/District Nursing vacancies across various localities. A specific recruitment drive is ongoing to address this hotspot area. In addition, we also have a significant number of Physiotherapy Posts including those funded through the Invest to Save initiative. Although Clinical Support Workers continue to be recruited through the BankAide programme a successful recruitment drive was undertaken to recruit to hotspot areas.

The One Year Guarantee for Nurses and Midwives is a procedure that has been put in place to implement an arrangement to ensure that every newly qualified nurse & midwife who wishes to work in the NHS receives an offer of employment. The intention is that every existing student nurse or midwife who fulfils the eligibility criteria receives the offer of a job either through their own means or with assistance. We currently have 1 midwife employed through this initiative which is funded by the Scottish Executive.

The University of the West of Scotland, Bell Campus, train student nurses within Lanarkshire. The Employment Services team within the Human Resources Directorate continue to have a close working relationship with the University of the West of Scotland, Bell Campus, and, twice a year, organise a PR event for the semester 6 students, to explain the recruitment procedure, the support and training which is available, and what life is like working as a nurse / midwife in Lanarkshire. Recently, 44 students were appointed to Registered Nurse vacancies across the organisation. This continues to be in excess of our obligations under the one year guarantee. Information about recruitment trends for all staff groups (excl. medical & dental staff) across NHS Lanarkshire is collected and is actively being monitored.

NHS Lanarkshire has been awarded, for the 2nd year, the Jobcentre Plus Disability Symbol. The symbol is awarded in recognition of the organisations action to meet five commitments regarding the employment, retention, training and career development of disabled employees.

The award of the symbol demonstrates the positive recruitment and retention policies and practices that the organisation has in attracting unemployed job seekers, disadvantaged by health or disability, ensuring that once recruited they are given full support throughout their career development.
Medical and Dental Staff

Consultant Recruitment and Turnover
Maintaining the Medical and Dental establishment continued to be challenging within NHS Lanarkshire during the year 2007/08 as there remained a total of 37 consultant vacancies (headcount) at the end of March 2008. The work that was undertaken throughout the year showed that we successfully recruited to 53 consultant posts (12 of whom have still to start before the year end).

During the same period 22 consultants left/retired (and 1 death in service) and at the time of this report a few Advisory Appointments Committees had still to take place.

Throughout the year we have increased our consultant establishment by creating new consultant posts as follows:

- 1 Consultant in Microbiology
- 1 Consultant in Rheumatology
- 1 Consultant in Care of the Elderly
- 0.75 Consultant in Accident and Emergency
- 1 Consultant in Obstetrics & Gynaecology
- 2 Consultants in Paediatrics
- 2 Consultants in Histopathology

Proleptic Appointments
Within Lanarkshire we have worked in conjunction with the Scottish Executive to secure appointments through their Advanced Appointments Scheme. This allows SpR’s to be appointed in advance of the substantive consultant vacating their post. Additional funding was received from the department to support this initiative and NHS Lanarkshire to date have been successful in obtaining funding to assist in the undernoted proleptic appointments.

- 1 Consultant in ENT
- 1 Consultant in General Medicine

The ENT Consultant has been successfully recruited to and General Medicine is about to be advertised. When this post is filled this will bring the total to 6 proleptic appointments part financed through this scheme. We are also in the process of applying for funding for a proleptic appointment with General Medicine and in addition have financed one proleptic appointment ourselves for a Consultant Physician in General Medicine and Gastroenterology.

Shortage Areas
We have also been successful in recruiting to shortage areas by employing 3 histopathologists out of our 4 vacancies, one of these appointments was a European appointment that was initially brought to the Board through the link with the Medical Agencies. We have recruited 7 Consultants within the shortage area of Radiology although these consultants are not due to start within NHS Lanarkshire until the next financial year.

Physicians Assistants
NHS Scotland is running a 2 year pilot project to evaluate the use of experienced United States of America trained Physician Assistants (PA’s) within a range of settings. The project began in October 2006 and a formal review of the 1st year is currently being undertaken.

NHS Lanarkshire currently employ 3 PA’s, 2 are working in Emergency Medicine in Hairmyres Hospital and 1 in a GP Practice within the Coatbridge locality. NHS Lanarkshire are currently in the process of recruiting a further 3 PA’s, 2 to work in Orthopaedics between Hairmyres Hospital and the Golden Jubilee at Clydebank and 1 to work between 2 GP Practices within the Airdrie and Wishaw localities.
At the time of this report clarification was awaited from the department as to whether this scheme would be extended into the next financial year.

**Consultant Retiralrs**
Of the sixteen Consultants over 50 who left NHS Lanarkshire over the past year, twelve retired. Six were of retirement age, five took early retirement and one retired due to ill health. Of those taking early retirement, four were 59, and one was 57 years old.

A further four Consultants over 50 left NHS Lanarkshire over the past year for other reasons. All Consultants who left or retired were on the New Consultant Contract.

NHS Lanarkshire will continue to monitor those who are taking early retirement over the next year.

**Redeployment**
In a time of significant change, NHS Lanarkshire requires to offer additional support and re-training opportunities to any staff redeployed to help them function satisfactorily in their new post.

NHS Lanarkshire’s policy on Organisational Change, which was developed in partnership, recognises that organisational change may lead to the need to redeploy staff. Redeployment is a means of retaining skills and experience of valuable NHS staff. It is also about maximising the skills of the workforce, mitigating the effect of organisational change and minimising additional cost to NHS Lanarkshire as a whole.

NHS Lanarkshire is committed to a consistent and committed approach to the process of securing alternative employment for displaced staff. The organisation is also committed to the training and development of staff throughout their employment, thereby offering a number of advantages to both the organisation and staff. During organisational change there is a requirement to continue to invest in training and development activity to meet the identified needs of staff, thereby providing staff with the opportunity to enhance their employability by broadening or updating their skills. Where organisational change impacts on an employee, opportunities to retrain or gain additional skills, are made available.

NHS Lanarkshire has endeavoured to identify redeployment opportunities for all staff displaced as a result of organisational change. In order to support and progress the redeployment process, a dedicated team from within Employment Services has been identified. This team deals solely with the redeployment of staff.

The redeployment procedure involves matching displaced staff against the criteria of each vacancy, which is authorised to be filled, and identifying whether or not a cohort of suitably displaced individuals exists. Where a cohort is identified, interviews are arranged. If there are no suitably identified individuals, the normal recruitment process is followed.

For the period April 2006 to March 2007, 107 displaced staff were successfully redeployed. For the period April 2007 to January 2008, 30 displaced staff have been successfully redeployed.

The creation of the National Waiting Times Centre Board based at the Golden Jubilee National Hospital (West of Scotland Regional Heart and Lung Centre) will bring onto one site interventional cardiology and cardiothoracic services from Glasgow's Royal and Western Infirmarys and thoracic surgery from Hairmyres Hospital. Suitable alternative employment has been identified for a significant number of staff from Hairmyres Hospital who were unable to transfer with the new service.
NHS Lanarkshire continues to fully recognise the significance of proper investment in the education, training and development of staff in support of effective workforce planning and development. A clear and ongoing linkage between clinical service planning, workforce planning and the focus of education, training and development investment will help to ensure that the right staff with the right skills, attitude and competencies are available at the right time to meet clinical and service needs into the future.

To support the modernisation of clinical services NHS Lanarkshire has established a structure of Service Improvement Boards with individual programmes of work. The SI Boards will develop contemporary strategic plans for services, taking account of service redesign, new models of care and optimal use of modern technology. It is recognised that this will impact on traditional ways of working within the NHS in Lanarkshire and will create opportunity to introduce new and enhanced roles for many staff.

The implications for staff in strategy development and implementation and the potential for clinical and service change are acknowledged in the Workforce Strategy and Plan in order that necessary investment in education, training and development is recognised, prioritised and integrated into the planning and implementation phases.

NHS Lanarkshire Board adopts a multi-professional approach to the education and training of staff, where possible, recognising the major benefits to be gained from interaction, challenge, innovation and learning across all clinical and support service fraternities.

The Staff and Organisational Development Group, which was formed in January 2007 meets on a regular basis to lead and co-ordinate the formation and monitoring of learning, development and training plans and staff development policy.

This partnership group provides support for the effective delivery of strategic change across NHS Lanarkshire, ensuring that organisational priorities and strategies, learning initiatives and investment are linked.

This includes full consideration of strategies and plans for new and changed models of care and commissioning of responsive multi-professional, multi-agency development and training programmes.

The Staff and Organisational Development Group also monitors progress for the Board against the "Appropriately Trained" section of the Staff Governance Standard and reports regularly to the Board’s Staff Governance Committee.

Senior staff from Organisational Development and Training, Practice Development Centre for Nurses, Midwives and Allied Health Professions and Continuing Medical Education regularly attend and participate at the Staff and Organisational Development Group to ensure integration and optimum multi-professional, patient and public focussed outcomes in the work of the Group.

The group has a key responsibility to project manage implementation of the Knowledge and Skills Framework of Agenda for Change seeking to marry the focus of enhanced staff knowledge and skills with developments and changes in clinical and support service practice. This includes specific leadership and responsibilities in relation to HEAT Target E3 which requires all staff covered by Agenda for Change to have a KSF PDP in place by March 2009.

The Board’s Learning Plan and Personal Development Planning processes will remain fluid and responsive in planning for and meeting the education, training and development needs of staff in the context of the changing models of care, new roles and enhanced skills which will be required of clinicians and support service staff into the future.
A number of specific Education and Training initiatives have been identified in the current Workforce Strategy and Plan. A summary of these initiatives is as follows:

**Community Nursing Service**

- Continued development of GP aligned, appropriately skilled and competent Community Nursing Teams to target areas of high deprivation and health inequalities.
- Continued development of Community Nursing staff to implement Anticipatory Care in the prevention, detection and treatment of long-term conditions.
- Continued development of roles and clinical skills in the area of Care Management (in partnership with Local Authorities) for long-term conditions.
- Continued development of the skills, competencies and integration of School Nurses and Health Visitors to establish effective Public Health Nursing Teams.
- Continued Development of the skills and competencies of Treatment Room Nurses to provide local Health Centre based minor injury and illness services.

**Mental Health Service**

- Development of skilled specialist nurses and allied health professionals in clinical areas such as forensic, eating disorders, psycho-social and child and adolescent services to deliver a correct balance of general and specialist care.
- Development of enhanced and effective clinical leadership.

**Laboratory Services**

- Recognition of the impact of co-terminus degree training placements and the importance of supporting proper mentorship for trainees.
- Development of specialisation and enhanced staff skills in the clinical areas of genetics, molecular biology, cancer histology and biochemistry, coronary heart disease and diabetes monitoring.

**Radiology**

- Development of a rolling programme of Ultrasonographer training for existing radiographers.
- Development of reporting skills and experience within existing radiographers.

**Acute Hospital Services**

- Continued development of enhanced skills and competencies for nursing and allied health professional staff in theatre nursing, pre-admission screening, endoscopy and arthroplasty practitioner roles and extended scope physiotherapists.
- Development of new and enhanced assistant, practitioner and advanced practice roles with improved skills mix in teams in areas such as critical care and anaesthetics.
- Development of clinical staff through MINTS Training to facilitate creation of enhanced See and Treat services.
• Continue to enhance the level and capability of nursing staff within the HECT and other designated areas to reflect developments in models of care and use of clinical skills.

**Child and Maternal Health**

• Development of nursing skills and competencies to support the care of children with increasingly severe, complex and continuing needs.

• Development of advanced neonatal nurse practitioners and neonatal support workers.

• Creation of bespoke development and training programmes to support enhanced clinical roles in Discharge Co-Ordination, Physiotherapy (minor injuries), Clinical Support Work (Phlebotomy, Plaster Tech, ECG interpretation), Nurse Prescribing and nurse led Infectious Diseases and Dermatology.

**Allied Health Professionals**

• Continue with the enhancement of continuing professional development to introduce a care group/multi-professional approach, involving social care colleagues where possible.

• Continue formal programmes of vocational training for AHP assistants and technical instructors.

**Organisation Change and Development**

• Continue to provide focused organisational development support to facilitate Acute Services and Community Health Partnership (CHP) development across NHS Lanarkshire.

• Development of clear annual corporate, team and individual objectives, lead and supporting roles and performance management arrangements.

• Development of enhanced joint shared objectives across Acute and CHP services and with Local Authorities in Lanarkshire.

• Development of an NHSL Leadership Framework as a focus for investment in leadership, enhanced management and supervisory skills and competence, succession planning, performance management and clinical leadership skills and competence.

• Provision of SVQs for laundry and administrative staff.

• Extensive programme to support implementation of e-KSF.
The Sickness Absence Project Board continues to lead and direct activity to reduce absence due to sickness. The Board is responsible for communications to staff and managers and uses a range of mechanisms for this including communication through divisional management structures, staff briefing emails and articles in the Pulse publication for staff. A new development has been the use of text messages for all staff with NHSL mobile phones.

**Training for managers** continues, provided on a monthly basis for those managers not available for the main thrust of training during 2006/07. The training is based on the ratified policy, and covers the use of family friendly policies and stresses the need for return to work interviews with all staff and the importance of monitoring sickness absence. The possibility of a training pack is being explored, and there are plans to include elements of sickness absence training into the Management Development Programme and supervisor’s course.

**Occupational Health targets** of 20 days for referrals are being met and continue to be monitored. The Sickness Absence Project Manager also meets with managers to support them in a range of ways. Currently there is an audit of reasons for sickness absence taking place in a range of focus areas across the organisation to establish whether staff are accessing family friendly policies.

The **Employee Counselling Service** remains in place and regular reports are brought to the Sickness Absence Project Board providing detail of the issues with which employees present and various other indicators including return to work during engagement with counselling and which part of the organisation they work for.

**A fast-track physiotherapy service** is a further investment towards supporting staff in work and speeding return to work for those with musculo-skeletal disorders and new physiotherapy staff have been recruited. Staff can self-refer to these services directly and the expected benefits include:

- Improved patient outcomes
- Reduced treatment intervention period
- Improved choice and access to services
- Impact on prescribing costs
- Increased cost-effectiveness
- Greater patient satisfaction

Regular **monthly sickness absence reports** providing a detailed breakdown of sickness absence figures are circulated to the Sickness Absence Project Board members and thence to divisional management teams for performance monitoring purposes. The data quality has improved considerably during the past year and further work is being carried out on the Human Resources information system, Empower, to add an increasingly detailed level of reporting for managers.

**A Sickness Absence Soft Audit** has been carried out in the form of a survey across selected areas of the organisation, looking at reasons for absence, pattern of absence (self-reported), awareness of support mechanisms available and a number of key indicators. This is currently being analysed and it is hoped the outcomes of this will help shape the next steps in targeting absence management activity.

Despite these robust and wide ranging mechanisms, sickness absence figures, reported regularly across the organisation, continue to climb. Sickness absence will continue to be a significant management and workforce challenge as we try to move towards our Efficiency target of 4% by March 2009.
APPENDICES:

Appendix: A

NHSScotland approach

To ensure NHSScotland has the right staff in the right place with the right skills at the right time, the workforce needs to be fully aligned with service delivery in a way that enables the delivery of high quality services that are both affordable and sustainable over the longer term. To deliver this vision for workforce planning, we need to:

■ Ensure the workforce supports affordable and sustainable delivery which places people at the heart of services;

■ Work with partners across and outwith NHSScotland to ensure workforce planning delivers accessible services across organisational and professional group boundaries;

■ Develop new roles, redesign services and review models of delivery to enable a shift in the balance of care towards more local, community focused care;

■ Improve knowledge and intelligence of the workforce, particularly across primary and social care, in liaison with Local Authorities and the voluntary sector as appropriate;

■ Ensure education and training of the workforce enables quality standards to be met across services;

■ Implement and support pay modernisation and new frameworks to enable changing practices, improved productivity and benefits realisation;

■ Attract and retain the best talent in a shrinking labour market to ensure today’s workforce is well placed to meet tomorrow’s requirements; and

■ Work with educational partners, such as NHS Education for Scotland (NES) and Higher Education Institutes (HEIs) to ensure education and training supports a confident, competent, flexible and adaptive workforce.
Dear Colleague

NHS Board Workforce Plans 2008 – Workforce Projections Template

In line with the Framework for Workforce Planning in NHSScotland, NHS Boards are already engaged in developing and updating their workforce plans for publication in April 2008. As part of this process a workforce projections template is required to be completed by all NHS Boards to assist the Scottish Government in determining overall demand for staff and in particular to inform decisions about training supply for controlled staff groups.

The template is different from last year in that it is a mandatory element of the workforce planning process. The template has also been updated to reflect changes arising from assimilation of the majority of NHSScotland staff onto Agenda for Change and the developments implemented under the Scottish Workforce Information Standard System (SWISS). It has been developed over the past year by the ISD Workforce Steering Group in conjunction with NHS Boards and the wider user community.

The template is being issued at this point, along with the advice and technical notes for completion, to give NHS Boards early sight of the Scottish Government requirements. However it will not be populated with NHS Board baseline data until 30 January 2008 when the NHSScotland workforce data as at September 2007 is due to be published by ISD. The template, with the appropriate baseline data, will be reissued on 30 January. Meanwhile, provisional high level summary data has already been circulated to NHS Boards for verification and validation which will in turn inform the baseline data to be issued in January.

This year, in line with the move to fully integrate workforce plans with service and financial plans, the workforce projections template will become part of the requirements for the Local Delivery Plan (LDP) incorporating HEAT requirements, the guidance and template for which will be issued in mid December. The LDP/HEAT templates are due to be returned by late February and any short term workforce projection data would be welcomed as part of this. However, as this is a transitional year and timetables are not yet fully aligned, the deadline for the longer term workforce projections
The requirement for the workforce projections to be tested for the 3 feasibility factors; affordability, availability and adaptability also remains.

As with current workforce planning requirements, NHS Boards are asked to ensure projections are affordable, particularly over the immediate three-year period. A suggested methodology for testing affordability is outlined in the attached annex. NHS Board Chief Executives are required to ensure that affordable projections have been developed in line with service delivery needs, as detailed on the front of the workforce projections template.

Please complete and return the workforce projections template to myself (email address above) by 30 April 2008.

Should you have any questions about the workforce planning process this year please contact marilyn.barrett@scotland.gsi.gov.uk. Questions about the detail within the template can be directed to david.baird@isd.csa.scot.nhs.uk.

Yours sincerely

Joanne Gillies
Head of Workforce Planning Unit
TESTING THE AFFORDABILITY OF NHS BOARD WORKFORCE PLANS

1. This note sets out a suggested method for boards to cost and test the broad affordability of workforce projections. Costing and testing for affordability is an essential exercise, and will help to assist boards in joining up service, finance and workforce planning. While boards do currently carry out this kind of testing, it was felt that some straightforward central guidance may help standardise approaches.

2. There are no hard and fast rules in testing for affordability, and this note sets out a suggested minimum framework. More sophisticated approaches are available and these are discussed briefly at the end.

3. This note should be read alongside the notes in the workforce projections template.

Method

4. A simple way to test for affordability is to:
   - estimate from pay data average whole time equivalent (wte) unit costs by staff type;
   - uprate for assumed rates of pay inflation;
   - apply both to forecast workforce numbers to estimate the likely total cost going forward; and to
   - compare costs against an appropriate benchmark – e.g. expected board total budget levels.

Workforce

5. A number of staff types are excluded explicitly from the workforce projections template – bank, agency and locum staff. A true test of affordability should include an informal estimate for the costs of these staff, and we suggest below a separate, less detailed approach.

6. As a minimum, boards should base workforce and costing calculations around the job family sub-totals given on the workforce projections summary sheet:
   - hchc medical staff (broken down into Consultant, SAS and Other trained grades)
   - hchc dental staff
   - medical and dental support
   - nursing and midwifery staff
   - allied health professionals
   - other therapeutic staff
   - personal and social care
   - healthcare science staff
   - emergency services
   - administrative services
   - support services

7. The baseline staff data in the workforce projections template - and the basis for forecasting staff numbers and workforce costs - is staff in post at 30 September 2007 (to be published 30 January 2008).

Unit Costs
8. Payroll data should be used to estimate the average wte cost to the board of employing staff by the staff groups given above. This should include: total annual salary, unsocial hours and overtime payments, and social security costs and NHS superannuation costs.

9. This gives estimated unit costs across the 11 aggregate staff groupings (and the three sub-groupings of hchs medical staff) covered by the workforce projections template.

10. For staff not covered by the Workforce Projections Template – agency, Bank and locum staff - boards should also calculate likely cost implications and include these in the total cost. This will allow the full picture affordability picture to be captured. For this exercise we suggest that a simple, high-level financial cost is used, rather than deriving costs from staff wte unit costs.

**Wage Inflation**

11. To demonstrate consistent planning, boards should use the same assumptions about forecast pay inflation used in the financial figures for the board’s LDP.

**Testing for Affordability**

12. For this year, we recommend that to test formally for affordability, boards should consider for the **first three years** of the forecast:

   - total forecast staff costs as a share of the Revenue Resource Limit;

13. Staff costs and affordability are difficult to assess for forecasts 5 years ahead (and, where relevant, 10 years ahead, since funding levels are not known. However, boards may want to look at:

   - forecast annual rates of change of staff costs, compared with **historic** rates of change of both staff costs and relevant budgets;
   - forecast staff costs against a few feasible scenarios for likely budget levels at years 5 (and, where relevant) 10

14. These approaches provide a quick test of the numbers. The approach for the first three years of forecasts shows performance against a formal and known, binding constraint. The approaches for years 5 and perhaps 10 are a quick ‘sense check’ of the overall cost numbers.

**Limitations and Developments**

15. Using standard, board-level aggregated unit costs allows an easy way into estimating the affordability of proposed service and linked workplan changes. It is as a useful tool in showing how near-term changes to aggregated workforce numbers may impact upon board budgets. However, we do acknowledge that such simplified assumptions become less useful in forecasting further into the future. We also acknowledge that, in taking this minimum approach, the cost and affordability implications of shifts in skill mix and staff composition may not be fully captured.

16. The approach set out above is a suggested minimum. Boards can apply the method in a more sophisticated way by disaggregating the broad staff groupings by staff type and perhaps pay band. It would also allow use of estimates of different rates of pay inflation for different staff types. This would allow the affordability impacts of forecast changes in staff mix - across staff types and across different pay bands - to be estimated more accurately.
## Appendix C

**Better Health Better Care: Workforce Action Plan for 2008 (Board actions)**

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsibility</th>
<th>NHS Lanarkshire Approach to taking this forward.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. NHS Boards to ensure workforce plans are fully aligned in support of service delivery that meets the needs of patients.</td>
<td>NHS Boards</td>
<td>Workforce planning developed in partnership with the PoH Programme Boards using the Workforce Planning Toolkit. Patient needs are at the heart of workforce planning and service planning.</td>
</tr>
<tr>
<td>2. NHS Education for Scotland and NHS Boards to focus on service redesign, new roles, role development and new ways of working to provide more effective utilisation of the current workforce.</td>
<td>NHS Education for Scotland NHS Boards</td>
<td>Lanarkshire has a consistent approach to the development of new roles and works with NES, where appropriate, to develop new ways of working.</td>
</tr>
<tr>
<td>3. NHS Boards to work with NHS Education for Scotland and other educational partners to ensure educational support priorities reflect workforce development requirements.</td>
<td>NHS Boards NHS Education for Scotland and other educational partners</td>
<td>Lanarkshire continues to work with NHS Education for Scotland and education providers to ensure provision meets the needs of the service</td>
</tr>
<tr>
<td>4. NHS Boards to ensure future workforce planning is based upon the delivery of services focused on patient need.</td>
<td>NHS Boards</td>
<td>Clinical models are being developed to best meet patient needs. As each of these is completed, a service and workforce model will be developed to support implementation.</td>
</tr>
<tr>
<td>5. NHS Boards, Scottish Government and ISD Scotland to work together to improve intelligence held on primary care workforce.</td>
<td>NHS Boards Scottish Government ISD Scotland</td>
<td>Lanarkshire has made a slight improvement in the data collection exercise for 2007.</td>
</tr>
<tr>
<td>6. NHS Boards and NHS Education for Scotland to focus on service redesign, new roles and role development, and different ways of working that will enable shifts in the balance of care.</td>
<td>NHS Education for Scotland NHS Boards</td>
<td>NHSL will make plans to develop services taking into account the balance of care once there is approval from the Cabinet Secretary.</td>
</tr>
<tr>
<td>7. NHS Boards to build on current productivity and efficiency efforts, including pay modernisation benefits realisation.</td>
<td>NHS Boards</td>
<td>Pay modernisation continues to be used to effect service redesign.</td>
</tr>
<tr>
<td>8. NHS Boards to ensure workforce plans fully aligned with financial plans to demonstrate that staff projections are both affordable and sustainable.</td>
<td>NHS Boards</td>
<td>NHSL continue to develop collaborative approaches to planning.</td>
</tr>
<tr>
<td>9. NHS Boards and NHS Education for Scotland to work together to ensure skills and expertise of staff meet patient need.</td>
<td>NHS Boards Scottish Government</td>
<td>Taken forward through Staff &amp; OD group.</td>
</tr>
<tr>
<td>10. NHS Boards and the Scottish Government to work together to identify</td>
<td>NHS Boards</td>
<td>NHSL is involved in this development as a</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>professional groups that are appropriate for statutory professional regulation.</td>
<td>Scottish Government</td>
</tr>
<tr>
<td>11.</td>
<td>NHS Boards and Regions to continue to embed their workforce planning processes and publish their annual plans.</td>
<td>NHS Boards and Regions</td>
</tr>
<tr>
<td>12.</td>
<td>NHS Boards and ISD Scotland to work together to improve quality and consistency across workforce and financial planning data, including ensuring a robust baseline for workforce planning.</td>
<td>NHS Boards ISD Scotland</td>
</tr>
</tbody>
</table>
Appendix D

Workforce Development Strategy

December 2007
1 Introduction

The purpose of this Workforce Development Strategy is to provide a vision of the how the workforce will change in size and composition in order to fulfil the requirements of NHS Lanarkshire as the implementation of a Picture of Health moves forward. A Picture of Health describes the model of care developed to meet the needs of the Lanarkshire community. The Workforce Development Strategy has been developed to underpin an overarching Workforce Strategy for Lanarkshire and will sit alongside both a Human Resource and an Organisational Development strategy.

Our workforce is our most important resource. The quality of care and range of services that we are able to provide is dependent on our ability to recruit, develop and retain quality staff in the right numbers, with the right skills and appropriate attitudes and values.

2 Context

NHS Lanarkshire Health Board serves a population of 557,088, the third largest of the NHS Scotland Boards and employs circa 11,139 (HC) staff, the fifth largest workforce, over an area of 2,181 square kilometres and holds a total annual budget of £800 million. A single Board is responsible for the Governance of NHS Lanarkshire and the Corporate Management Team is accountable to the Board for the overall management of the business of NHS Lanarkshire.

NHS Lanarkshire has developed a clear and approved framework of Governance covering Staff Governance, Health and Clinical Governance and Financial Governance in order to operate effectively and within legal limitations set down in legislation. Staff Governance incorporates the functions of Workforce Development, Human Resource and Organisational Development.

NHS Lanarkshire’s financial position has had an impact on its workforce in that there has been a slower increase in workforce numbers over the past 10 years compared to NHS Scotland; but the shape and skills within the workforce continue to develop to meet the demands placed upon it. The pace of change in the NHS and the implications of service redesign and modernisation require further development and investment in our workforce.

3 Service Modernisation

NHS Lanarkshire is committed to achieving Scottish Government targets and will deliver on a number of key priorities and service changes over the next few years. The Workforce Development Strategy will support the achievement of these priorities. In February 2008, the Cabinet Secretary confirmed her approval of the Board’s amended proposals for modernisation of services across Lanarkshire which included:

- Provision of A&E services in the three main hospitals in Lanarkshire
- Delivery of a Primary Percutaneous Coronary Intervention (PCI) service for Lanarkshire patients at Hairmyres Hospital as part of the regional planning for these services
- Concentration of the haematology inpatient services at the Lanarkshire Cancer Centre at Monklands Hospital, when it is developed
- Development of an Emergency Response Centre which will enhance the area’s emergency services

There have been delays in developing and implementing detailed plans because of a change of focus and this has provided an opportunity to build more robust support mechanisms around the workforce implications of these changes.

68
The proposals present the opportunity for us to take a managed and systematic approach to the planning, design and delivery of the change agenda and a management system has been developed which clarifies accountabilities, avoids duplication of effort and balances corporate and local dimensions of change.

4 Strategy Development

The development of a Workforce Development Strategy for NHS Lanarkshire is based on meeting the key organisational priorities from Scottish Government targets, A Picture of Health, as well as those outlined in the Staff Governance Standard which sets down clear requirements for people governance in all NHS organisations. To be successful we must have clear and well implemented strategies and plans to attract, recruit, develop and retain the right numbers and type of staff. The strategy defines focused, coherent and prioritised objectives to develop the future workforce we require to deliver on Picture of Health and in meeting Scottish Government targets.

In order to truly support the delivery of the objectives of a modernised Health Service in Lanarkshire, the Workforce Development Strategy must involve and have the ownership of all staff. This means that the actions required to deliver the Strategy are the responsibility of every manager and indeed every member of staff.

The Workforce Development integrates the following streams:

- participation in the development and implementation of national and particularly regional workforce development activity
- development of a Workforce Plan to provide a skilled, effective and efficient workforce for NHS Lanarkshire
- workforce planning including workforce data and information
- links with service and financial planning and redesign
- integrating major strands of system workforce development activity

5 Workforce Development Steering Group

The Board’s Workforce Development Steering Group oversees Workforce Development. Chaired by the Director of Strategic HR and Workforce Development the membership comprises the Finance Director, the Executive leads for each of the Programme Boards, the Director of Nursing, the Medical Director, the Director of Organisational Development, the Employee Director, the Staff Side Chair of the Human Resources Forum and the Chair of the Area Clinical Forum.

NHS Lanarkshire developed its own toolkit to support the organisation to link workforce planning activity with service and financial planning in preparation of the 2006 Workforce Plan. This has been refined in partnership with managers and is being used as the framework to develop workforce plans. The group exists to:

- ensure that NHS Lanarkshire has a clear vision and strategy to ensure the skilled, effective and efficient workforce required to deliver the aims and objectives of the Board
- ensure the integration of service and financial planning, service redesign, training and education, career and role development within workforce development
- develop and monitor the implementation of the Pay Modernisation Benefits Delivery Action Plan
• develop a workforce development strategy and plan which meets national guidance in order to provide a capable and competent workforce

• optimise support and assistance from higher and further education providers both locally and through positive exploitation of regional activities

• engage in Regional and National workforce development activity

6 Pay Modernisation

The introduction of the new Consultants Contract, the General Medical Services contract for General Practitioners, Agenda for Change and the future Community Pharmacy and General Dental Services Contracts has radically changed the remuneration arrangements for staff. As well as modernising the pay and terms and conditions of service, the pay modernisation agenda provides real opportunities to support the modernisation of the workforce, achieve the best staff utilisation and improve staff satisfaction through the development and evolvement of roles.

7 Staff Governance Standard

Our National Health: A Plan for Action, A Plan for Change set out a number of challenges for the service and in particular NHS Boards. One of the key challenges was the introduction of a Staff Governance Standard for NHS Scotland employees. Together with financial and clinical governance, staff governance completes the governance framework within which NHS Boards are required to operate. The standard was further reinforced in the summer of 2004 when staff governance became a legal requirement for all NHS employers through an amendment to the NHS Health Act.

The Staff Governance Standard sets out the rights and responsibilities for NHS Boards and their staff to ensure that the workforce is:

• Well informed
• Appropriately trained
• Involved in decisions which affect them
• Treated fairly and consistently
• Provided with an improved and safe working environment

Progress against these requirements are measured and audited independently on an annual basis and through a bi-annual staff survey.

8 NHS Lanarkshire Values

NHS Lanarkshire has agreed to work in partnership with the people of Lanarkshire to fulfil a commitment to improving health, reducing health inequalities and building trust and confidence in our relationships with the Public, Staff and Organisations with whom we work. In support of this commitment, we have developed a set of Organisational Values through meaningful public and staff contribution. The context for the influence of Values is complex and challenging. NHS Lanarkshire will manage the balance between public and staff aspirations for the NHS with our responsibility and accountability for the proper stewardship of resources. The Values will exert significant influence over Strategy Development, Re-design and Modernisation of Clinical Services.
and over our priorities and performance as we strive for continuous improvement as an exemplar employer.

In pursuit of improvement we will Value:

- Quality, Patient-Focussed Services
- Quality, Healthcare Environment
- Continuous Improvement
- Involvement
- Communications
- Respect
- Fairness and Consistency
- Competence and Continuous Learning

9  Workforce Development Strategy Objectives

Workforce Planning enables the organisation to assess its future staffing needs against service requirements, in terms of numbers and roles, and to put in place the recruitment, retention and training and development strategies and infrastructures that are considered necessary to secure and sustain those staffing requirements.

<table>
<thead>
<tr>
<th>Key actions to achieve objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop an annual Workforce Plan in order to provide a skilled, effective and efficient workforce taking into account national, regional and local service and financial planning and priorities – link to the Local Delivery Plan</td>
</tr>
<tr>
<td>Use an integrated Workforce Development approach to plan and develop the workforce in the CHPs, the Acute Division and in Corporate Directorates in line with service and financial planning and redesign activity</td>
</tr>
<tr>
<td>Ensure that workforce redesign, training and education, career and role development are aligned through the Workforce Development Steering Group</td>
</tr>
<tr>
<td>Ensure Workforce Planning is fully integrated with service and financial planning</td>
</tr>
<tr>
<td>Implement agreed change in accordance with NHS Lanarkshire’s Organisational Change Policy</td>
</tr>
<tr>
<td>Ensure Workforce Development activity fits with Regional and National Workforce activity</td>
</tr>
<tr>
<td>Assess the future size and shape of the workforce linking to a clear vision for service reform and development</td>
</tr>
<tr>
<td>Construct a Pay Modernisation Benefits Delivery Plan demonstrating the benefits of Pay Modernisation and monitor its implementation</td>
</tr>
<tr>
<td>Continue to develop the HR information system to ensure that accurate workforce information meets service needs</td>
</tr>
</tbody>
</table>

10  Implementation

The Workforce Development Strategy will be implemented by the Workforce Development Steering Group through its annual work plan.
Appendix E

WORKFORCE WORKLOAD STEERING GROUP ANNUAL REPORT 2007/08

Purpose

This report has been developed to provide an overview of the work undertaken by the Workforce Workload Steering Group during 2007/08 NHS Lanarkshire Workforce Workload Steering Group has over the past year continued to progress both the local and national agendas in determining and advising on the size and composition of the nursing and midwifery workforce and its relationship to workload. The Group’s principal area of activity is to integrate and coordinate all the Nursing & Midwifery workforce activity in NHS Lanarkshire to ensure the Board has a nursing and midwifery workforce fit for purpose.

Membership

Paul Wilson                  Director of Nursing, Midwifery & AHP’s  (Chair)
Margaret MacCallum         Senior Nurse Advisor
Joan James                 Divisional Nurse Director
Ruth Thompson              Acting Associate Director of Nursing
Noreen Kent                Associate Director of Nursing
Frances Leckie             Acting Divisional Nurse Director
Norman Provan              Associate Director of Nursing
Anne-Marie Carr            Associate Director of Nursing
Evelyn Ryan                Partnership representative
David Boyd                 Partnership representative
Graham Johnston            Head of Management Services
Brian McWatt               Head of Finance
David Shields              Service Development Manager
Marie Kellagher            Regional Workforce Adviser
Pamela Milliken            Associate General Manager
Kate Thomas                Head of Workforce Development

The following is an outline of the work undertaken by the group during 2007/08

The work to date has included:

- The development, validation and implementation of an in-house staffing model for ward staffing model for ward environments which is regression based and dependant upon patient activity by means of occupied bed days, patient dependency average length of stay.

- The refinement of the in-house staffing model to accurately capture staffing needs of specialist areas such as Theatres, Out Patient areas, ITU, Emergency receiving Unit’s, Renal Stroke Infectious Disease, ENT and Medical Oncology.
- Benchmarking with GRASP (a commercial company specialising in staff and workload measurement) for Paediatrics, Mental Health, Neonatal, Maternity, Old Age Medicine and GP Hospitals

- Benchmarking locally and nationally in particular within the mental health staffing and treatment room review.

- The development and refinement of a dependency-monitoring tool.

- The development and implementation of a sickness/absence monitoring collection tool - SKAB’s to ensure a consistent approach in the capture of sickness/absence information across NHS Lanarkshire.

- Modelling work undertaken to identify the additional predicted absence allowance, which will be required as a result of the introduction of Agenda for Change.

- The action plan has been updated and agreed by NHS Lanarkshire Board for taking forward the recommendations from the Scottish Executives Nursing & Midwifery Workload and Workforce Planning Project. Appendix 1 describes the work and provides the results obtained to date from the national Workforce Workload Planning Project.

- Nurse Staffing studies were undertaken in Old Age Medicine, GP Hospitals Neonatal and special school nurses.

- The development of a Nursing, Midwifery and AHP Workforce Strategy to take a longer – term view of the NMAHP workforce, in particular the mix of support worker/professional/ higher specialist professional/ admin/ support services staff

**Recommendations**

The Workforce & Workload Steering Group is asked to consider and to report to NHS Lanarkshire Board through the Workforce Development Board. In addition, to disseminate and highlight the achievements of the Workforce & Workload Steering Group during 2007/08 to the Divisional Management Teams and CHP’s.
Appendix F

Description of Service

Normative Approach

Triangulation Approach

Work Measurement

Initial Conclusions

Compare and contrast with existing staffing levels
Benchmark against others
Benchmarking against others

Generate Cost Options

Test Options against Clinical Quality Indicators

Provide Advice to Directors of Operational Units
February each year

Risk Management Governance

Implementation & Monitoring

Review with timescales

Clinical Quality Indicators
## Appendix G: Projections Summary

### NHS Scotland Workforce Summary

<table>
<thead>
<tr>
<th>Year ending 30th September</th>
<th>ISD Baseline Data</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 5</th>
<th>Year 10</th>
<th>Year 17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2007</td>
<td>2008</td>
<td>2009</td>
<td>2010</td>
<td>2012</td>
<td>2017</td>
</tr>
<tr>
<td>WTE Staff in Post</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WTE Expected</td>
<td></td>
<td>9,350.5</td>
<td>9,412.3</td>
<td>9,451.3</td>
<td>9,410.3</td>
<td>5,532.3</td>
<td>456.7</td>
</tr>
<tr>
<td>NHSScotland Workforce</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCHS medical and dental</td>
<td></td>
<td>495.5</td>
<td>515.3</td>
<td>530.3</td>
<td>531.3</td>
<td>456.7</td>
<td>456.7</td>
</tr>
<tr>
<td>HCHS medical staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant</td>
<td></td>
<td>398.8</td>
<td>414.5</td>
<td>422.5</td>
<td>423.5</td>
<td>423.5</td>
<td>423.5</td>
</tr>
<tr>
<td>Staff and associate specialist grades</td>
<td>279.1</td>
<td>287.2</td>
<td>293.2</td>
<td>294.2</td>
<td>294.2</td>
<td>294.2</td>
<td>294.2</td>
</tr>
<tr>
<td>Other trained grades</td>
<td></td>
<td>15.6</td>
<td>15.6</td>
<td>15.6</td>
<td>15.6</td>
<td>15.6</td>
<td>15.6</td>
</tr>
<tr>
<td>HCHS dental staff</td>
<td></td>
<td>34.1</td>
<td>33.2</td>
<td>33.2</td>
<td>33.2</td>
<td>33.2</td>
<td>33.2</td>
</tr>
<tr>
<td>Consultant</td>
<td></td>
<td>34.1</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Staff and associate specialist grades</td>
<td>398.8</td>
<td>279.1</td>
<td>279.1</td>
<td>279.1</td>
<td>279.1</td>
<td>279.1</td>
<td>279.1</td>
</tr>
<tr>
<td>Other trained grades</td>
<td></td>
<td>15.6</td>
<td>15.6</td>
<td>15.6</td>
<td>15.6</td>
<td>15.6</td>
<td>15.6</td>
</tr>
<tr>
<td>Medical and dental support</td>
<td></td>
<td>62.6</td>
<td>67.6</td>
<td>74.6</td>
<td>74.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>4,875.7</td>
<td>4,870.0</td>
<td>4,706.6</td>
<td>4,675.6</td>
<td>4,675.6</td>
<td>4,675.6</td>
</tr>
<tr>
<td>Nursing and midwifery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td>493.3</td>
<td>48.0</td>
<td>49.0</td>
<td>49.0</td>
<td>49.0</td>
<td>49.0</td>
</tr>
<tr>
<td>Adult</td>
<td></td>
<td>3,475.5</td>
<td>3,504.6</td>
<td>3,511.9</td>
<td>3,511.9</td>
<td>3,511.9</td>
<td>3,511.9</td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td>48.0</td>
<td>49.0</td>
<td>49.0</td>
<td>49.0</td>
<td>49.0</td>
<td>49.0</td>
</tr>
<tr>
<td>Mental health</td>
<td></td>
<td>1,008.0</td>
<td>813.0</td>
<td>813.0</td>
<td>813.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning disabilities</td>
<td></td>
<td>95.4</td>
<td>88.1</td>
<td>89.1</td>
<td>54.1</td>
<td>54.1</td>
<td>54.1</td>
</tr>
<tr>
<td>Maternity</td>
<td></td>
<td>226.8</td>
<td>239.6</td>
<td>243.6</td>
<td>247.6</td>
<td>247.6</td>
<td>247.6</td>
</tr>
<tr>
<td>Not assimilated</td>
<td></td>
<td>22.7</td>
<td>9.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allied health professions</td>
<td></td>
<td>787.8</td>
<td>804.6</td>
<td>804.6</td>
<td>804.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Art therapy (art/music/drama)</td>
<td></td>
<td>45.7</td>
<td>53.2</td>
<td>54.2</td>
<td>55.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dietetics</td>
<td></td>
<td>172.5</td>
<td>175.4</td>
<td>174.5</td>
<td>174.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational therapy</td>
<td></td>
<td>7.1</td>
<td>7.1</td>
<td>9.5</td>
<td>10.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthoptics</td>
<td></td>
<td>202.7</td>
<td>221.7</td>
<td>221.7</td>
<td>208.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Podiatry</td>
<td></td>
<td>78.2</td>
<td>80.2</td>
<td>81.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiography</td>
<td></td>
<td>147.7</td>
<td>146.7</td>
<td>146.7</td>
<td>146.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech and language therapy</td>
<td></td>
<td>107.1</td>
<td>113.4</td>
<td>109.8</td>
<td>112.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not assimilated</td>
<td></td>
<td>6.8</td>
<td>7.9</td>
<td>7.9</td>
<td>8.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other therapeutic staff</td>
<td></td>
<td>215.1</td>
<td>217.6</td>
<td>219.5</td>
<td>219.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical psychology and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>counselling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genetic counselling</td>
<td></td>
<td>83.8</td>
<td>86.3</td>
<td>86.3</td>
<td>86.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optometry</td>
<td></td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
<td>128.1</td>
<td>130.0</td>
<td>130.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Play specialists (nursery nurses)</td>
<td>1.1</td>
<td>1.1</td>
<td>1.1</td>
<td>1.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not assimilated</td>
<td></td>
<td>2.0</td>
<td>2.0</td>
<td>2.0</td>
<td>2.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal and social care</td>
<td></td>
<td>59.3</td>
<td>63.8</td>
<td>61.3</td>
<td>60.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthcare science staff</td>
<td></td>
<td>399.2</td>
<td>403.2</td>
<td>403.2</td>
<td>403.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biomedical sciences</td>
<td></td>
<td>268.9</td>
<td>266.5</td>
<td>266.5</td>
<td>266.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical sciences</td>
<td></td>
<td>45.1</td>
<td>45.1</td>
<td>45.1</td>
<td>45.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical physiology</td>
<td></td>
<td>53.3</td>
<td>56.3</td>
<td>56.3</td>
<td>56.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical technology</td>
<td></td>
<td>30.3</td>
<td>30.3</td>
<td>30.3</td>
<td>30.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other healthcare science staff</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not assimilated</td>
<td></td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative services</td>
<td></td>
<td>1,668.0</td>
<td>1,668.0</td>
<td>1,650.6</td>
<td>1,646.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support to clinical staff (patient services)</td>
<td>501.7</td>
<td>504.2</td>
<td>501.2</td>
<td>506.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central functions</td>
<td></td>
<td>1,023.2</td>
<td>1,025.2</td>
<td>1,033.7</td>
<td>1,027.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management grades (non Agenda for Change)</td>
<td>106.7</td>
<td>106.7</td>
<td>106.7</td>
<td>106.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not assimilated</td>
<td></td>
<td>37.4</td>
<td>32.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support services</td>
<td></td>
<td>681.9</td>
<td>681.9</td>
<td>683.4</td>
<td>685.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General medical service</td>
<td></td>
<td>387.0</td>
<td>387.0</td>
<td>390.0</td>
<td>393.0</td>
<td>400.0</td>
<td></td>
</tr>
</tbody>
</table>

Notes:
1 HCHS refers to the Hospital, Community and Public Health Services of the NHS.
2 Excludes doctors in training.
3 Directors of Public Health are now included under the Consultant category.
4 Although the overall total includes the 'other/not applicable' and 'not assimilated' categories the split by category does not.
5 The purpose of these projections community, care of the elderly and NHS24 have been allocated to the adult category using sub families / post descriptors.
6 This category includes: clinical psychology, therapists, clinical associates, counsellors and psychotherapists.
7 Staff in Post is shown as Headcount, please project as WTE.
# Appendix: Acknowledgements

<table>
<thead>
<tr>
<th>Section</th>
<th>Contributor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>Kenneth Small / Hina Sheikh</td>
</tr>
<tr>
<td>Workforce and Service Planning</td>
<td>Pamela Milliken / Colin Blair</td>
</tr>
<tr>
<td>Workforce Projections and Affordability</td>
<td>Andy Goor</td>
</tr>
<tr>
<td>Recruitment, Retention, and Redeployment</td>
<td>Elspeth Martin / Marlene Fraser</td>
</tr>
<tr>
<td>Staff and Organisational Development</td>
<td>Kenneth Small</td>
</tr>
<tr>
<td><strong>Workforce Assumptions</strong></td>
<td></td>
</tr>
<tr>
<td>Medical Workforce</td>
<td>Alison Graham</td>
</tr>
<tr>
<td>General Medical Services</td>
<td>Philip McMenemy</td>
</tr>
<tr>
<td>Dental Services and Support</td>
<td>C. Albert Yeung</td>
</tr>
<tr>
<td>Nursing and Midwifery</td>
<td>Paul Wilson / Margaret MacCallum</td>
</tr>
<tr>
<td>Allied Health Professions</td>
<td>Peter McCrossan</td>
</tr>
<tr>
<td>Other Therapeutic Staff</td>
<td></td>
</tr>
<tr>
<td>Clinical Psychology</td>
<td>Jennifer Borthwick</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Christine Gilmour</td>
</tr>
<tr>
<td>Personal and Social Care</td>
<td>Gabe Docherty</td>
</tr>
<tr>
<td>Healthcare Science Staff</td>
<td>Betty Kyle</td>
</tr>
<tr>
<td>Administrative Services / Senior Management</td>
<td>Robin Wright</td>
</tr>
<tr>
<td>Support Services / Property &amp; Support Services</td>
<td>David Browning</td>
</tr>
<tr>
<td><strong>Other special thanks to:</strong></td>
<td>Lynne Khindria</td>
</tr>
<tr>
<td></td>
<td>Patricia Leiser</td>
</tr>
<tr>
<td></td>
<td>Finance Directorate</td>
</tr>
<tr>
<td></td>
<td>ISD Scotland</td>
</tr>
<tr>
<td></td>
<td>All those many other individuals who have</td>
</tr>
<tr>
<td></td>
<td>contributed</td>
</tr>
<tr>
<td></td>
<td>And all those who took the time to forward</td>
</tr>
<tr>
<td></td>
<td>comments</td>
</tr>
</tbody>
</table>

77