



**Greater Glasgow
and Clyde**

**Workforce Plan
2016/17**

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1 Section One

Background to the NHSGGC Workforce Plan

1.1 Introduction to the Workforce Plan

- 1.1.1 The route map to the 2020 Vision for Health and Social Care¹ outlines the Scottish Government's vision for improving quality and making measurable progress towards high quality, sustainable health and social care services in Scotland.
- 1.1.2 Everyone Matters: 2020 Workforce Vision was launched by the Cabinet Secretary for Health and Wellbeing in March 2014. This document recognises the key role the workforce will play in responding to the challenges faced in improving patient care and overall performance.
- 1.1.3 The Scottish Government has set out its vision for the NHS in Scotland in the strategic narrative for 2020.

“Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting.

We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of readmission”.²

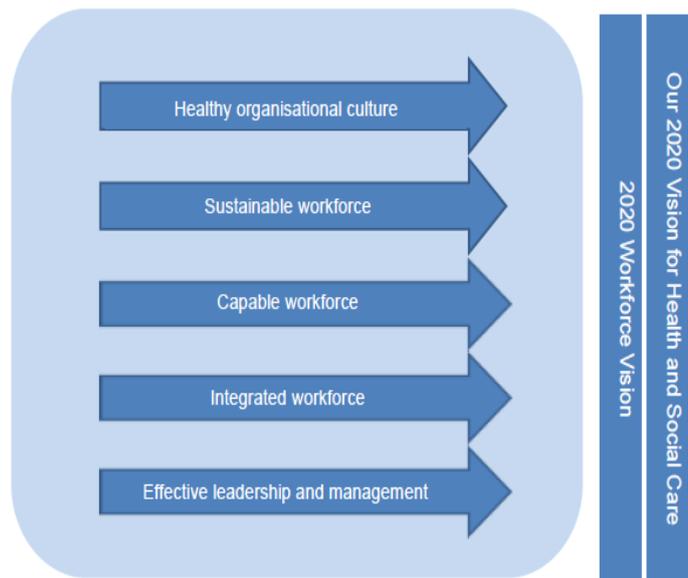
- 1.1.4 Underpinning the narrative is the Quality Strategy³, with the three central ambitions that care should be:
- Person centered;
 - Safe;
 - Effective.
- 1.1.5 The quality outcomes and 2020 vision are the major national drivers of NHS targets and strategic direction including the NHSGGC Local Delivery Plan (LDP) Standards.
- 1.1.6 Effective workforce planning ensures that services and organisations have the necessary information, capability, capacity and skills to plan for current and future workforce requirements.
- 1.1.7 This means planning a sustainable workforce of the right size, with the right skills and competences, which is responsive to health and social care demand and ensures an effective and person centred service delivery across a broad range of services and locations.
- 1.1.8 In this Workforce Plan NHSGGC will outline our actions to support the 5 priorities identified within Everyone Matters
- 1.1.9 The priorities for action in NHSGGC during 2016/17 focus on the following:

¹ <http://www.scotland.gov.uk/Topics/Health/NHS-Workforce/Policy/2020-Vision>

² Achieving Sustainable Quality in Scotland's Healthcare: A 20:20 Vision

³ <http://www.gov.scot/resource/doc/311667/0098354.pdf>

- **Creating a healthy organisational culture** developing and sustaining a healthy organisational culture to create the conditions for high quality health and social care;
- **Establishing a sustainable workforce** by changing the health workforce to match new ways of delivering services and new ways of working; ensuring that people with the right skills, in the right numbers, are in the right jobs; promoting the health and well-being of the existing workforce and preparing them to meet future service needs;
- **Maintaining a capable workforce** by ensuring that all staff are appropriately trained and have access to learning and development to support the *Quality Ambitions* and *2020 Vision for Health and Social Care*;
- **Developing an integrated workforce** ensuring that the workforce is more joined-up across primary and secondary care, across Boards and with partners across health and social care;
- **Effective leadership and management** ensuring that managers and leaders are valued supported and developed. Managers and leaders are part of the workforce and have a key role to play in driving service and culture change.



- 1.1.10 NHSGGC is required by the Scottish Government to develop and publish an annual workforce plan which sets out the strategic direction for workforce development and the resulting changes to our workforce over the next year and beyond.
- 1.1.11 The Workforce Plan has been developed using the NHSScotland six steps methodology and the NHS Careers Framework. Both of these workforce models enable us to take a coherent view of the workforce across all job families and sub-groups.
- 1.1.12 Local workforce planning activity is managed within the Acute Services Division and within the Health and Social Care Partnerships. In addition, there are workforce plans which focus on cross sector issues and plans based on service delivery models.
- 1.1.13 The workforce implications of service change and redesign are also set out in NHSGGC's financial and service plans at Board and Divisional/HSCP level. These workforce implications highlight any planned recruitment activity and are further analysed in the project implementation documents (PIDs) which are prepared to support any significant service change and which set out the financial, workforce and equality impacts of any proposed changes. All of the above workforce information is analysed and summarised by the workforce planners in order to develop the NHSGGC Workforce Plan.

- 1.1.14 It is critical therefore that all workforce plans whether stand alone documents or part of wider service planning documents are signed off by a wide range of stakeholders including local management teams, service managers and planners, financial managers and local staff side representatives and partnership forums.
- 1.1.15 It is recognised by all stakeholders that the redesign and service change plans set out in this workforce plan are at varying stages of development and implementation. In addition a number of the projects are still the subject of continuing discussion with staff side and therefore outcomes may change as consultations are completed. This flexibility is reflected in the narrative of the plan. Some of these plans will change in response to external influences and events and this may affect projected workforce change.
- 1.1.16 Regular updates on progress against the aims and targets set out in the Workforce Plan will be provided to the Senior Management Team (SMT), Area Partnership Forum (APF) and other stakeholder forums.

1.2 Actions arising from this Workforce Plan

- 1.2.1 The 2016/17 workforce actions are noted within this workforce plan under each relevant heading/topic.
- 1.2.2 These actions are summarised in an action plan which is attached to this document as appendix one.
- 1.2.3 Progress against these actions will be reported in the 2017/18 workforce plan.

1.3 An overview of NHS Greater Glasgow and Clyde

- 1.3.1 NHS Greater Glasgow and Clyde is the largest NHS Board in Scotland and covers a population of 1.2 million people. Our annual budget is £3billion and we employ 39,500 substantive staff.
- 1.3.2 The table below shows the breakdown of NHSGGC staff by Job Family as at % of the total whole time equivalent workforce:

Staff in Post as at 31st March 2016 by Job Family		
Job Family	WTE	% of WTE Workforce
Administrative Services	5,277.07	15.44%
Allied Health Profession	2,739.06	8.01%
Executives	137.42	0.40%
Healthcare Sciences	1,761.77	5.15%
Medical and Dental	3,549.32	10.38%
Medical and Dental Support	304.98	0.89%
Nursing and Midwifery	15,402.23	45.07%
Other Therapeutic	1,111.52	3.25%
Personal and Social Care	279.54	0.82%
Support Services	3,614.52	10.58%
Grand Total	34,177.42	100.00%

* Note - Given the size of the NHSGGC workforce at any given point in the recruitment cycle there can be between 400 and 700 posts being processed by NHSGGC's recruitment services team.

1.4 Local Delivery Plan (LDP)

1.4.1 NHSGGC has developed a Local Delivery Plan (LDP) for 2016/17. The LDP brings together:

- An appraisal of our strategic position and context;
- Decisions which align with our strategic direction and priorities;
- An appraisal of the detailed service, financial and workforce planning action we have underway to deliver the LDP and an outline of service and financial risks and challenges which we face for 2016/17.

1.4.2 The LDP has been developed in the context of the HSCPs' and Acute Services Division's Delivery Plans. NHSGGC now shares responsibility for strategic planning with the HSCPs but retains responsibility for the allocation of the NHS budget between the services for which we retain direct operational responsibility and those managed by HSCPs.

1.4.3 HSCPs are required to develop and approve integrated service and financial plans for the NHS and Council services which are legally delegated to them. HSCPs also have a central role in working with the NHS Board on the planning and financing of the Acute Division and our Plan cross references to Partnerships' Strategic Plans.

1.4.4 The LDP highlights a number of areas of risk reflecting the fact that we do not yet have a fully balanced financial plan across NHSGGC, a substantial programme of work continues to identify the required level of savings, and to put in place the necessary actions to achieve financial balance in 2016/17.

1.5 Strategic Position and Context

1.5.1 The NHSGGC strategic purpose is as follows:

“Deliver effective and high quality health services, to act to improve the health of our population and to do everything we can to address the wider social determinants of health which cause health inequalities.”

1.5.2 That purpose is expanded upon in the following five strategic priorities:

- Early intervention and preventing ill-health;
- Shifting the balance of care;
- Reshaping care for older people;
- Improving quality, efficiency and effectiveness;
- Tackling inequalities.

1.5.3 A key purpose of the LDP is to set out the detailed service change plans which have been developed to achieve NHSGGC's purpose and delivery of strategic priorities. These service plans will progress the delivery of:

- The Mental Health Strategy to deliver modern mental health services;
- The Clinical Service Strategy, which maps out a clear direction for acute services, updated to reflect the National Clinical Strategy⁴ and translated into detailed service change plans. Implementing service change is critical to our ability to meet unscheduled and scheduled care targets and to deliver high quality care;

⁴ A National Clinical Strategy for Scotland: <http://www.gov.scot/Resource/0049/00494144.pdf>

- Continuing the pattern of change in community services which has improved the range and efficiency of those services but not yet the more radical developments to enable us to reshape the Acute Division;
- The development of primary care in line with the national direction, local priorities identified through our recent engagement exercise and work being developed in each HSCP.

1.5.4 A delivery plan is also being developed for the Acute Services Division, which in combination with HSCP strategic plans will provide full detail of the challenges and changes NHSGGC will address in 2016/17.

2016/17 Workforce Actions – NHSGGC Change Plan 2017/20

- | |
|--|
| <ul style="list-style-type: none"> • Review the 2017/20 change plan and identify any workforce implications |
|--|

1.6 Principles for Planning

1.6.1 In order to ensure our service planning and financial and workforce decisions align with our strategic direction NHSGGC established the following principles:

- Make financial decisions for 2016/17 which are in line with our purpose, strategic direction and related strategies all of which are focussed on ensuring our services are centred on the needs of patients;
- Continue to play our part in trying to reduce the inequalities which affect our population and have a strong focus on equality impacts in making our decisions;
- Ensure that our decisions do not have unintended consequences such as unplanned transfers of pressures, responsibilities or costs to other parts of the system;
- Aim to continue to deliver the key Scottish Government targets;
- Focus on changes which make clinical and service sense and increase efficiency and productivity and reduce our unit costs;
- Ensure that where we propose to restrict access to services, or stop planned developments, we will have a clear framework for prioritisation of patient care linked to clinical benefit;
- Shift the balance of care and resources but also recognise the pressures on acute services;
- Test all new national initiatives and proposals which have financial implications against our strategy and report to the NHSGGC Board for a decision;
- Underpin our decision making with evidence about what delivers the safest, highest quality and most cost effective healthcare;
- Explicitly consider risks and benefits in making decisions;
- Remain committed to the importance of innovation and research to shape changes in the way we deliver care;
- Work across boundaries with other Health Boards and public bodies to identify ways in which we can deliver services more efficiently;
- Take a whole system approach, which is driven by:
 - cost scrutiny in every part of the organisation, led by the local teams
 - a whole system programme of change to deliver cost reduction

1.6.2 NHSGGC recognises that the scale of the challenge we face means that we are entering a period of significant change. Fundamental principles of our decision making are:

- A commitment to engagement with patients and the wider public;
- A commitment to fully engage with our staff and their representatives in shaping, planning and delivering the changes to services which will be required;

- Utilising the six steps methodology to integrated workforce planning as a means of identifying the workforce implications associated with changes to service.

1.7 Staff Governance

- 1.7.1 The NHS Reform (Scotland) Act 2004 requires NHSScotland employers to ensure the fair and effective management of staff through the application of the national Staff Governance Standard.
- 1.7.2 To support this Standard, a range of strategic workforce policies, initiatives and agreements are in place which embrace good employment practice and policy and workforce development and planning.
- 1.7.3 Implementation of these policies, initiatives and agreements supports employers in meeting the requirements of the Staff Governance Standard and supports modernisation of the workforce through partnership working and the application of good employment practices.
- 1.7.4 Facing the Future Together (FTFT), NHSGGC's Organisational Development Strategy, operates in alignment with the NHS Staff Governance Standard⁵.
- 1.7.5 The Staff Governance Standard sets out what each NHSScotland employer must achieve in order to continuously improve in relation to the fair and effective management of staff.
- 1.7.6 NHSScotland recognises the importance of Staff Governance as a critical feature of a high performing organisation. The Standard will help all staff to have a positive employment experience in which they are fully engaged with their job, their team and their organisation.
- 1.7.7 While the Standard sets out what staff can expect from Boards it also outlines corresponding responsibilities for staff (at any level within the organisation) in relation to their colleagues, managers, staff, patients, their carers, and the organisation.
- 1.7.8 The Staff Governance Standard applies to all staff employed by, or officials of, NHS Boards.
- 1.7.9 The ethos of the Staff Governance Standard should also be reflected in the arrangements with private and independent contractors and partner agencies working with NHS Boards. In order to effectively embed Staff Governance, the Standard must be owned and understood by all levels of staff from the Executive Team onwards.
- 1.7.10 The Standard requires all NHS Boards to demonstrate that staff are:
 - Well informed;
 - Appropriately trained and developed;
 - Involved in decisions;
 - Treated fairly and consistently, with dignity and respect, in an environment where diversity is valued;
 - Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

⁵ <http://www.staffgovernance.scot.nhs.uk/>

1.7.11 The Standard also requires that all staff:

- Keep themselves up to date with developments relevant to their job within the organisation;
- Commit to continuous personal and professional development;
- Adhere to the standards set by their regulatory bodies;
- Actively participate in discussions on issues that affect them either directly or via their trade union/professional organisation;
- Treat all staff and patients with dignity and respect while valuing diversity;
- Ensure that their actions maintain and promote the health, safety and wellbeing of all staff, patients and carers.

1.7.12 All of the above is accompanied by the challenge of redesigning the workforce in a way that ensures a high quality, fit for purpose and affordable service in the years ahead.

1.7.13 Facing the Future Together is the NHSGGC-wide Organisational Development (OD) strategy it focuses on how staff support each other to do their jobs, provide an even better service to patients and communities, and improve how people feel about NHSGGC, as a place to work.

1.7.14 Facing the Future Together covers five main areas:

- **Our Culture:** To meet the challenges we face we need to improve the way we work together and we all need to take responsibility for achieving that;
- **Our Leaders:** All our managers should also be effective leaders. Leadership is management plus. It is more than managing transactions, it is managing with vision and with imagination, with a drive for positive change and with a real focus on engaging staff and patients;
- **Our Patients:** We want to deliver a consistent and effective focus on listening to patients, making changes to improve their experience and responding better to vulnerable people;
- **Our People:** Our aim is to develop a workforce which feels positive about being part of the NHS; feels listened to and valued; and where all staff take responsibility to identify and address issues in their area of work in terms of quality, efficiency and effectiveness, with a real focus on improving the care we deliver to patients;
- **Our Resources:** We know that we need to reduce our costs over the next five years. We want staff to help us decide how to do that in a way which targets areas of less efficiency and effectiveness and areas where we can improve quality and reduce costs.

1.8 NHSGGC Workforce Planning Processes & Outputs

1.8.1 The workforce planning process reflects the NHSGGC Strategy as set out in the Corporate Plan and other key plans such as the Quality Framework. All of these plans acknowledge the challenges of meeting goals and priorities within the financial constraints faced by all NHS Boards.

1.8.2 As with NHSGGC's Corporate Plan⁶ the Workforce Plan needs to respond to these issues and provide a strategic framework for managing workforce change during this period.

⁶ [NHSGGC Corporate Plan](#)

- 1.8.3 Importantly, the Corporate Plan provides the direction for our planning and policy frameworks. These frameworks provide the detailed requirements for each of our key services and ensure that the development plans across the organisation deliver the changes we prioritise.
- 1.8.4 The Scottish Government has set out its vision for the NHS in Scotland in the 2020 strategic narrative. In our Corporate Plan we set out the changes we will make to move towards NHSGGC's vision that by 2020 everyone is able to live longer, healthier lives at home, or in a homely setting.
- 1.8.5 As previously noted the National Quality Strategy highlights six dimensions of quality – safe, effective, person centred, timely, efficient and suitable and focuses on action to ensure the first three.
- 1.8.6 In NHSGGC we have recognised that a comprehensive approach to quality needs to focus on balancing all six dimensions. The approach to improving quality in NHS Greater Glasgow and Clyde has three main strands:
- The Quality Policy Development Group;
 - Specific quality programmes and Initiatives;
 - Outcomes focused planning and performance arrangements.
- 1.8.7 The commitment to quality has been articulated and communicated across NHSGGC and this is reflected in the Workforce Plan and in supporting learning and education programmes which are focused on improving person centred care.
- 1.8.8 The Quality Strategy and our NHSGGC response is not a new or separate set of activities but a fundamental commitment which underpins all our activity and ensures that every member of our workforce is focused on improving quality and delivering person centred care in their services and in NHSGGC as a whole.
- 1.8.9 NHSGGC's Corporate Plan demonstrates how NHSGGC will make progress in improving quality and safety and the Workforce Plan demonstrates how our staff will support this. The performance of the workforce will continue to be measured by Scottish Government Health, Efficiency Access and Treatment (HEAT) targets and standards.
- 1.8.10 Workforce Planning is a statutory requirement and was established in NHSScotland in 2005 with the publication of the original guidance to all NHS Boards described in HDL (2005)52 "National Workforce Planning Framework 2005 Guidance"⁷.
- 1.8.11 This document provided NHS Boards with a base for establishing workforce planning as a key element of their planning process.
- 1.8.12 In December 2011 the Scottish Government Published CEL (2011)32⁸ which replaced the guidance in HDL (2005) 52. CEL (2011)32 provides NHS Boards with a consistent framework to support evidence-based workforce planning. The key aim of this framework is:

"to ensure the highest quality of care for patients by ensuring NHSScotland has the right workforce with the right skills and competences deployed in the right place at the right time".

⁷ http://www.sehd.scot.nhs.uk/mels/HDL2005_52.pdf

⁸ http://www.sehd.scot.nhs.uk/mels/CEL2011_32.pdf

- 1.8.13 This Workforce Plan has been developed in line with the recommendations set out in CEL(2011)32 and uses the NHS Six Steps to Integrated Workforce Planning Methodology⁹ a workforce model which enables us to take a coherent view of the workforce across all job families and staff groups. The main aim of the Six Steps Methodology is to set out in a practical framework those elements that should be in any workforce plan. Use of the Six Steps Methodology across workforce planning within NHSGGC ensures that decisions made around the design of services and the recruitment of the future workforce are sustainable, realistic and fully support the delivery of quality patient care, productivity and efficiency.
- 1.8.14 CEL32 presents two clear obligations on NHSGGC with regard to workforce planning:
- Firstly, to develop a Board Workforce Plan to be available on NHSGGC's website;
 - Secondly, to provide detailed workforce projections for each of the NHS Job Families, (using a nationally agreed template format) which will be signed off by NHSGGC's Chief Executive Officer and submitted to the Scottish Government.
- 1.8.15 NHSGGC's workforce planning process and the content of this workforce plan have informed the completion of the workforce projections which are set out in section 3 of this document.
- 1.8.16 Along with the submissions from other NHSScotland Boards the projections will allow the Scottish Government to develop a national picture of trends across all staff groups and will inform annual student intake to the nationally commissioned healthcare students groups including medical, dental and nursing and midwifery.
- 1.8.17 NHSGGC is committed to agreeing and delivering workforce plans in consultation with a wide range of stakeholders, including staff, trade unions and professional organisations. Processes and structures have been established to achieve this.
- 1.8.18 The NHSGGC Workforce Plan Development Group is the partnership group which oversees the development of the Workforce Plan. This is a corporate group with representation from all parts of the service, some professions and functions and from the staff side. The group supports the development of the NHSGGC plan and 'sense checks' the plan before it goes onto the full APF, Senior Management teams and Staff Governance Committee of the Board.
- 1.8.19 While the single system plan is in development, local service and workforce plans are also being prepared in HSCPs and the Acute Services Division.
- 1.8.20 The Draft Workforce Plan is then reviewed by:
- Senior Management Teams;
 - The Area Partnership Forum;
 - The Staff Governance Committee.
- 1.8.21 In addition to this formal consultation process the workforce planners provide progress briefings to Board committees and groups as requested e.g. Area Clinical Forum, Area AHP Committee and Area Medical Committee.

⁹ NHS Six Steps to Integrated Workforce Planning Methodology
<http://www.workforcevision.scot.nhs.uk/wp-content/uploads/2015/05/Six-Steps-Methodology-to-Integrated-Workforce-Planning.pdf>

1.9 Workforce Change 1st April 2015 to 31st March 2016

1.9.1 A summary of the workforce change in 2015/16 can be found in appendix two.

1.10 Other Agencies & Stakeholders

1.10.1 NHSGGC works with a variety of partner organisations as part of our service redesign and workforce planning processes. Local authority partners are key members of community based workforce planning activities. As key stakeholders in the workforce planning process, our structures ensure that, where appropriate, a variety of groups are sighted on the impact of our workforce plans e.g. Independent Sector, Carers' Groups, Housing Sector.

1.11 Regional Workforce Planning

1.11.1 Regional workforce planning work streams are progressed through the Regional Planning infrastructure, with workforce planning manager input as required being co-ordinated by the West Region Human Resources Directors.

1.11.2 The West Region Workforce Planning Managers provide support across a number of national and regional work streams:

- West of Scotland Cancer Network (WoSCAN);
- Regional Oral Maxillofacial Services Group (OMFS);
- Regional Child & Adolescent Mental Health Services (CAMHS);
- Regional Child Health Group;
- Regional Paediatric Clinical Network;
- Regional Neonatal Managed Clinical Network;
- Regional Medical Workforce Group;
- National Allied Health Professions Workload Planning Tool Development Group;
- National Nursing & Midwifery Steering Group.

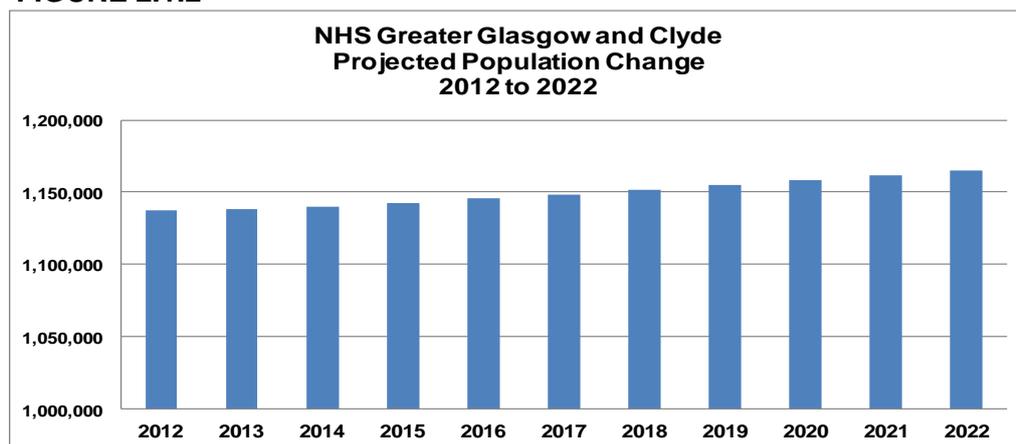
2 Section Two

Demand Drivers & Service Change

2.1 The NHSGGC Population Profile

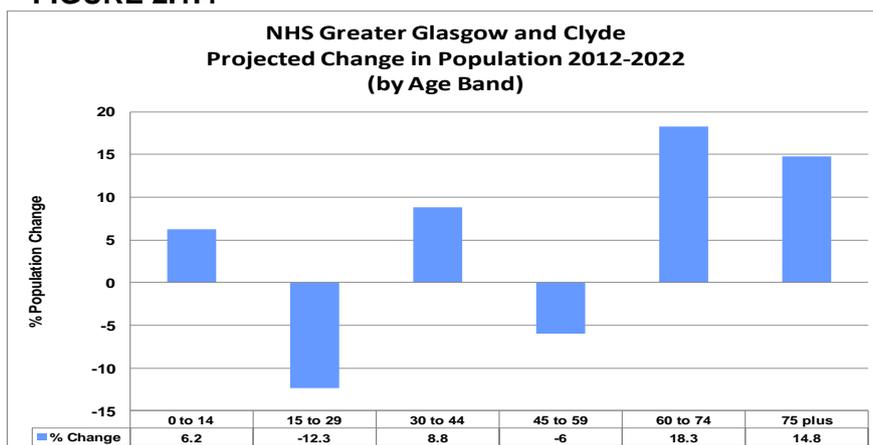
- 2.1.1 The NHSGGC population has been rising steadily over the last decade and was 2.6% higher in 2013 than it was in 2006. The total Scottish population rose by 3.8% over the same period.
- 2.1.2 The rise in the NHSGGC population has been driven mainly by rises in Glasgow City (4.9% rise), especially within the North West sector (8% rise). During this period, the populations of Inverclyde and West Dunbartonshire declined by 2.4% and 1.8% respectively.

FIGURE 2.1.2



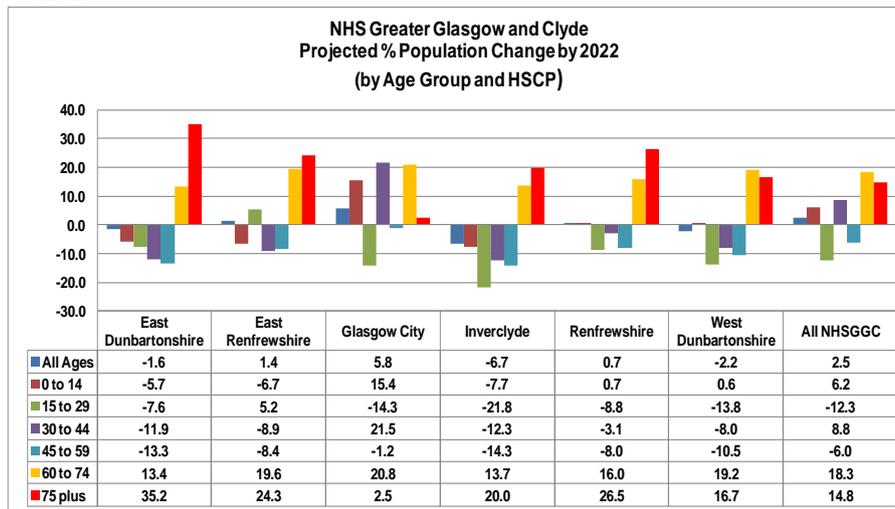
- 2.1.3 2012 based population projections predict that the total population of NHSGGC will increase by 2.5% by 2022. The total Scottish population is predicted to rise by 3.9%. Figure 2.1.2 shows the change in NHSGGC population between 2012 and 2022.
- 2.1.4 There are wide variations by age group with NHSGGC. The 15 to 29 year age group is predicted to fall by 12% by the end of this period and the over 60 population predicted to rise by 17% (see Figure 2.1.4)

FIGURE 2.1.4



- 2.1.5 As the population ages it is likely chronic disease will increase. This will increase the burden on clinical services given the increases in the over 60s and over 75s where there are higher levels of clinical healthcare need.
- 2.1.6 Figure 2.1.6 shows the percentage change in population between 2012 and 2022 by NHSGGC and HSCPs.

FIGURE 2.1.6



2.1.7 Twenty two percent of the NHSGGC population in 2013 was under 20 years of age and 16% over 65 years. This is broadly in line with the Scottish population, although a higher proportion of people across Scotland are over 65 years (18%).¹⁰

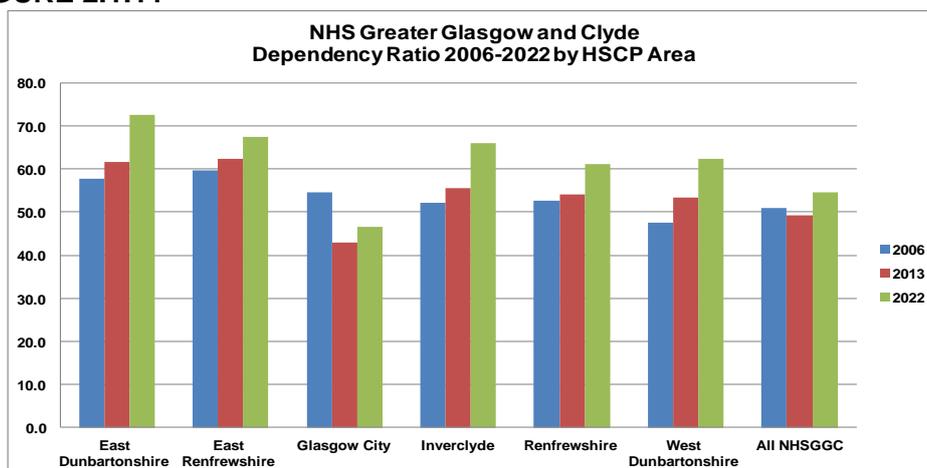
2.1.8 There is considerable variation in the older population by HSCP, with 13% of the North West Glasgow population aged over 65 years, compared to just over one fifth of the East Dunbartonshire population. There is far less variation in the under 20 year olds.

2.1.9 Dependency Ratios

2.1.10 Dependency ratios are a useful indicator of the potential social support required as a result of changing population age structures. The larger the dependency ratio, the greater the burden on the average adult as the needs of the dependents must be met by the rest of the adult population.

2.1.11 As shown in Figure 2.1.11 the NHSGGC population is getting older which will have an effect on dependency ratios.

FIGURE 2.1.11



¹⁰ <http://www.nhsggc.org.uk/your-health/public-health/the-director-of-public-health-report/>

- 2.1.12 The NHSGGC dependency ratio has remained relatively flat since 2006 but is predicted to rise to 55 by 2022. There are, however, marked variations in the dependency ratios for each of the HSCPs within NHSGGC.
- 2.1.13 Figure 2.1.11 shows Glasgow City has the lowest ratio in 2013 and has fallen since 2006 (43 and 55 respectively) however it is projected to rise to 47 by 2022. The ratios for all other HSCPs have increased since 2006 and are predicted to be over 60 by 2022. The East Dunbartonshire ratio is predicted to rise to 73.
- 2.1.14 This means that on average, there will be six dependent people for every 10 working-age people by 2022, rising to over seven dependents in East Dunbartonshire.
- 2.1.15 As the population ages it is likely chronic disease will increase. This in-turn will increase the demand on clinical services. The increase in older single person households will also drive additional demand on health and social care services as access to lay carers may be more problematic.

2.2 Service Redesign

- 2.2.1 The Clinical Services Strategy¹¹ provides the basis for future service planning and the development of detailed service change proposals, sets out the high level service models to shape the service provision and identifies the key approaches to underpin the future service planning for the populations served by NHSGGC:
- Improving health and prevention of ill health; empowering patients and carers through the development of supported self care;
 - Developing primary care and community service models; simplification of community models; focus on anticipatory care and risk stratification to prevent crisis;
 - Improving the interface between the community and hospital to ensure care is provided at the right time in the right place; Community and primary care services inward facing and hospital services outward facing; focused on patient and carers needs;
 - Developing the ambulatory approach to hospital care, with inpatient hospital care focused on those with greatest need ensuring equitable access to specialist care;
 - Redesign of specialist pathways to establish a consistent service model delivering the agreed clinical standards and good practice guidelines;
 - Developing the rehabilitation model based on need not age; working across the service within primary and secondary care and with partner organisations to provide rehabilitation in the home setting where clinically appropriate;
 - Changing how care is delivered - patient centred care; shifting the paradigm to deliver care differently for patients particularly for patients who have multiple conditions; helping patients and the public to develop and understand the new approaches to care;
 - Care which is patient focused with clinical expertise focused on providing care in the most effective way at the earliest opportunity within the care pathway;
 - Services and facilities have the capacity and capability to deliver modern healthcare with the flexibility to adapt to future requirements;
 - Sustainable and affordable clinical services can be delivered across NHSGGC.

¹¹ <http://www.nhsggc.org.uk/media/233580/clinical-services-strategy-summary.pdf>

2.3 Acute Services Division

- 2.3.1 The Acute Services Division is responsible for the provision of secondary and tertiary care services for the 1.2 million people of NHSGGC's population area. The Division also provides secondary and tertiary care for other West of Scotland Boards and some national tertiary services.
- 2.3.2 In 2015 the Division successfully opened the new Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC), which were both delivered on-time and under budget. The adult hospital is one of the largest acute hospitals in the UK and home to major specialist services such as renal medicine, transplantation and vascular surgery, with state-of-the-art Critical Care, Theatre and Diagnostic Services.
- 2.3.3 The QEUH campus also hosts a new Teaching and Learning Centre, a Clinical Research Area and a dedicated Administration Building all of which were opened in 2015. The Queen Elizabeth Teaching and Learning Centre – Stratified Medicine Scotland, developed jointly by NHS Greater Glasgow and Clyde and The University of Glasgow, is an investment of £27 million to provide a training environment for the clinical years of the undergraduate medical degree (MBChB), postgraduate training facilities for medical staff and a large variety of NHS professionals and ensures that we can train the next generation of doctors, scientists, clinical academics and support staff.
- 2.3.4 The Stratified Medicine Scotland Innovation Centre (SMS-IC) is part of the vision for Scotland to be a world class centre of research, innovation and commercialisation in stratified medicine – bringing together excellence in the academic, industrial and NHS communities to create an infrastructure that acts as a springboard to allow Glasgow to be at the forefront of the field.
- 2.3.5 Construction work is underway to develop a £16m Imaging Centre of Excellence (ICE), building on the grounds of the Queen Elizabeth University Hospital.
- 2.3.6 This ground-breaking new centre, supported by NHSGGC and funded by the UK Government and the Medical Research Council (MRC) as part of the Glasgow City Region City Deal, will provide world-leading clinical research facilities and provide a hub for academic, scientific and NHS clinical expertise into brain imaging in diseases such as stroke, dementia and brain tumours.
- 2.3.7 Most notably, the building will contain a £10 million 7 Tesla MRI scanner, an ultra-high resolution scanner which will be the first of its kind in Scotland and one of the only 7T scanners on a clinical site in the world. ICE is expected to generate up to 400 new jobs and add nearly £85 million for the local economy over the next ten years.
- 2.3.8 There are a number of areas where we envisage some relatively significant workforce change over 2016/17 and beyond, including:
- Supporting the delivery and development of the Scottish Trauma Network with a major trauma centre in Glasgow;
 - Continuing work on unscheduled care – building upon progress made to deliver improvements in unscheduled care;
 - Manage financial challenges in 2016/17, achieving required savings whilst maintaining consistent and high quality patient centred care;
 - Supporting delivery of the NHSGGC Local Delivery Plan and its key commitments.

2.3.9 There were a number of changes to the Acute Services Division in 2015 including:

- Realignment of Facilities to become Board-Wide, this moved circa 5,000 headcount from the Acute Services Division to be reported at Board-level;
- Change in the organisational structure away from specialty-based to geographically organised services;

2.3.10 The Acute Sectors and Directorates are now*

- **South Sector** – QEUH, Gartnavel Hospital, West Glasgow ACH, New Victoria ACH;
- **North Sector** – Glasgow Royal Infirmary, New Stobhill ACH;
- **Clyde Sector** – Royal Alexandra, Inverclyde Royal and Vale of Leven Hospitals
- **Diagnostic Services** – Division-wide diagnostic and laboratory services;
- **Regional Services** – WoS Beatson Oncology Centre, Centre for Integrative Care, Spinal Injuries Unit and Institute and Neurosciences, Renal Services on the QEUH campus and plastics and burns at Glasgow Royal Infirmary;
- **Women and Children Services:** Royal Hospital for Children, Maternity services at QEUH, Princess Royal Maternity Hospital, Royal Alexandra Hospital for paediatric and obstetrics.

(the associated list of services and sites is not exhaustive):

2.3.11 The following list briefly summarises proposed service changes which may, subject to public engagement, occur across 2016/17:

- Review of Gynaecology service;
- Review of trauma and unscheduled care at Inverclyde Royal Hospital
- Review of Stroke Services;
- Transition from a focus on adulthood to childhood across a range of services;
- Review of diagnostic imaging capacity across hospitals;
- Review of adult inpatient nursing workforce;
- **Review of RAH paediatric services:** proposal to retain the current full range of general and specialist outpatient children's services at the RAH, with inpatient care to be provided at the new children's hospital;
- **Review of Clyde Birthing Services:** proposal to retain all ambulatory services at the CMUs with deliveries offered in our midwife led units in RAH, PRMH and the QEUH or at home; finalising proposals on these services will include work with the CMO to look at midwifery delivery services across NHSGGC and decisions will be made in the light of the outcome of the national review of maternity services;
- **Review of Centre for Integrative Care (CIC) Inpatient Services:** proposing to deliver the full current range of CIC services on an ambulatory care basis, this reflects the fact that the vast majority of patients are now local to Greater Glasgow and Clyde;
- **Review of inpatient rehabilitation services:** proposing to transfer inpatient rehabilitation from Lightburn to the new centre of excellence at Gartnavel General Hospital with ambulatory care continuing to be delivered in the East End as part of developing plans with the new Health and Social Care Partnership for new community facilities. The current Parkinson's service will continue to be delivered in the East End.

2.3.12 Beds are a critical component of the Division's service delivery. The Acute Services Division currently has 4,805 beds:

- Glasgow Hospitals; 2,812;
- Clyde Hospitals; 934;

- Paediatric beds; 243;
- Maternity beds 154;
- Neonatal cots 94;
- Continuing care 313;
- Disability 60;
- Other regional services 196.

2.4 Health Inequalities and Prevention

- 2.4.1 Early Intervention and Prevention is an established strategic priority across NHSGGC. Our priorities in addressing health inequalities and prevention across NHSGGC are outlined in our [2015-16 Equality Monitoring Report](#) alongside our [2016-20 A Fairer NHS Greater Glasgow & Clyde – Equality Outcomes Framework](#). In addition, our [Strategic Direction for Health Improvement](#) details the extensive programme of health improvement activity aimed at delivering this strategic priority.
- 2.4.2 This priority is also the focus of the Joint Strategic Commissioning Plans for each of the six Health and Social Care Partnerships (HSCPs) detailing the actions in place to tackle Health Inequalities and Prevention for the Partnership areas ([Renfrewshire HSCP:draft](#)); [Inverclyde HSCP](#); [Glasgow City HSCP](#); [East Renfrewshire HSCP](#); [East Dunbartonshire HSCP](#); and [West Dunbartonshire HSCP](#)).
- 2.4.3 In finalising our financial plan we have assessed the impact of the reduced national allocation for prevention and health improvement and reductions in national funding for services which are critical to tackling inequalities, including those for people with drug and alcohol problems.

2.5 Antenatal Care and Early Years

- 2.5.1 HSCPs are currently working together to deliver the Getting it Right for Every Child (GIRFEC)¹² work plan and the major challenges to be overcome to deliver the new pathways.
- 2.5.2 Maternity services are progressing preparations and joint arrangements with health visiting services to ensure readiness to deliver GIRFEC commitments.
- 2.5.3 Our programme of service reviews also includes considering the deliverability of the national policy to increase health visitor numbers. Details of this are outlined in Section 3 of this plan.

2.6 Primary Care

- 2.6.1 In September 2015, we launched a programme of engagement for a wide range of interests to develop a direction for GP Services across NHSGGC. The output from these engagement events clearly identified the pressures within Primary Care GP services. NHSGGC are working with HSCPs to develop an action plan to address the issues identified.
- 2.6.2 In January 2015 a major project to test new ways of structuring primary care services was launched in Inverclyde. The pilot examines how the role of the GP can be refocused, reducing the time they spend on tasks that could be more appropriately done by other health professionals and examining how these staff can support patients in the community.

¹² <http://www.gov.scot/Topics/People/Young-People/gettingitright>

- 2.6.3 We have a programme of work to implement the 2016/17 General Medical Services contract and we are integrating into that our proposals for the primary care transformation fund. Our approach is to mitigate pressures on GPs and develop strong relationships between HSCPs and GPs to reduce workload and improve morale while we develop longer term plans for primary care.
- 2.6.4 HSCPs are considering how the national review of Out of Hours services which will be reflected in their forward plans and we are working on a number of changes to GP out of hours in 2016/17 to continue to provide a safe and sustainable service.
- 2.6.5 For 2016/17 HSCPs will lead planning to deliver:
- **Better management of older people and chronic disease in the community:**
 - Improving pre hospital care including support to GPs;
 - Improving systems and services to deliver early discharge;
 - Improving care in nursing homes;
 - Extended and integrating arrangements for domiciliary support;
 - Identifying developments which delivery the CSS joined up care system;
 - Reshaping out of hours services.
 - **Enabling acute care to be focussed on patients with acute needs:**
 - Action to enable patients to die at home;
 - Identifying care pathways which can be modified to reduce reliance on hospital services;
 - Delivery of the Paisley development programme outputs in each HSCP area;
 - Shifting care from an unplanned to planned basis;
 - Further reducing delayed discharges.
 - **Changes to address service pressures and inefficiencies:**
 - Identifying and addressing variation in use of diagnostics;
 - Identifying and addressing variation in the use of outpatient and inpatient services;
 - Reviewing a number of care pathways where there is potential for efficiency;
 - Transport.
- 2.6.6 There are significant risks in relation to primary care and community services including:
- The extent to which the immediate demand pressure on GPs can be mitigated to secure services to enable a more transformational programme of change;
 - The pressures and focus on acute services continue to create real challenges to shift the balance of care;
 - The financial pressures which we have set out in this plan require us to generate savings in community services;
 - Pressures on social care services which have the potential to directly impact on NHS services;
 - While the primary care transformation fund is a welcome additional resource more major investment in primary care is required.

2.7 Health and Social Care Integration

- 2.7.1 Work is currently underway with each of the six HSCPs to ensure the delivery of key national and local standards/targets that they have lead responsibility for delivering. There is agreement that these standards will also be embedded within each of the six Strategic Commissioning Plans and reported routinely to their respective leadership teams.
- 2.7.2 NHSGGC have whole system planning arrangements with the HSCPs, including the developing the relevant financial plans.

2.8 Scheduled Care and Unscheduled Care

- 2.8.1 For both scheduled and unscheduled care our new pattern of hospital services has been established during 2015/16 and we are now taking stock of capacity and any performance issues which have emerged.
- 2.8.2 The Acute Services Division is continuing to review and assess capacity requirements in the light of the increasing pressure on scheduled care. Sustaining current levels of activity will prove challenging in the light of the pressures on unscheduled care and the financial position.
- 2.8.3 We will work closely with the Scottish Government's Access Support Team that has been established as part of the 'Getting Ahead' – sustainable whole systems management for elective services' programme.
- 2.8.4 During 2015/16 we had significant challenges in meeting the unscheduled care target. We have worked closely with Scottish Government colleagues to improve our performance and we have a process underway to review the delivery of our unscheduled care plan and assess areas for improvement, with Partnerships. The additional levels of non recurring funding in currently in use for unscheduled care are not included in this plan on a recurring basis.

2.9 Financial Planning

- 2.9.1 The Scottish Government set out its budget to the Scottish Parliament in December 2015. This set out an up lift of £511 million or 5.3 % to the Health budget.
- 2.9.2 For NHSGGC, this resulted in a funding up lift of £92.8m. £59.1m of this was Social Care Funding and was “passed straight through” to the six HSCPs; the uplift to the NHSGGC was £33.7m (1.7%).
- 2.9.3 NHSGGC faces reductions in “bundled funding” and the New Medicines Fund. When offset against 2016/17 cost pressures of £96m, the majority constituted of pay cost growth (£50m) and prescribing cost growth (£25m), NHSGGC is facing the significant challenge of requiring to save £69m of recurrent savings in order to break even.
- 2.9.4 NHSGGC also continues to face severe financial challenges and financial risks, including the cost of new medicines, including those for Hepatitis C, and orphan / ultra-orphan and end of life medicines.

- 2.9.5 NHSGGC, and, in particular, the Acute Services Division continues to experience significant cost pressures in Medical workforce costs where significant expenditure on agency and locum cover has been incurred to support activity levels. Actual non elective and elective inpatient activity continues to increase significantly, together with long-term vacancies, difficulties recruiting and the requirement for waiting list initiatives to achieve Treatment Time Guarantee targets.
- 2.9.6 Nursing pay also continues to be a significant cost pressure, with excess bank and agency spend driven by activity levels and accentuated by higher than average sickness/absence rates.
- 2.9.7 As outlined above, a comprehensive planning process involving all Directors and a wide range of managers, and in concert with the HSCPs, commenced in the autumn 2015. This involved identifying savings schemes to address the financial gap.
- 2.9.8 At the time of drafting this document, “green and amber” rated savings totalling £43.5m full year effect (£34.5m part year effect) have been identified. In addition, a range of “red rated” schemes have been identified, including some service redesign propositions outlined elsewhere in this document that require further work and consultation, totalling £11.5m full year effect (£8m part year effect).
- 2.9.9 The Acute Services Division Management implemented a £10m cost containment programme in December 2015 to take effect before the 31st March 2016 in order to start the new financial year at, or close to, balance. However, this has proved extremely challenging, not least through the continual use of winter beds which have remained open to help manage demand and capacity. As such, £7.5m of non-recurring coverage will be required through 2016/17. The Acute Division also underachieved projected 2015/16 recurrent savings by £3m and HSCPs underachieved by £7m. These were covered non-recurrently in-year by each Division. Further work and discussions are currently on-going to establish if these can be covered internally again in 2016/17.
- 2.9.10 The table below is a summary of the current 2016/17 position:

FIGURE 2.9.10

NHS Greater Glasgow and Clyde	
2016/17 Savings Requirements	
Savings Summary	2016/17 Full Year Effect (£m)
2016/17 Savings Target	69
Savings Summary Risk Status	
Green	20.35
Green/Amber	12.85
Amber	11.63
Total Green/Amber	44.83
Red	11.73
Total NHSGGC Saving Requirement	56.56
Additional Savings Required	12.44
Revision to initial assumptions/investments	3.3
Cash Requirement in Year	9.14

- 2.9.11 It is clear from the above table that as well as £11.7m of complex and challenging “red risk” rated schemes, on a full-year effect for 2016/17, NHSGGC still has a savings gap of £9.1m (rounded up to £10m). It is proposed at this stage that these savings maybe realised through the National Workstreams.
- 2.9.12 Through the joint work of the Chief Executives, Directors of Finance and Scottish Government colleagues a number of workstreams have been developed both to support Boards in their local delivery of savings plans, and to examine whether a national approach to certain propositions can be agreed and delivered. Work is on-going to determine whether these national initiatives will have a further positive impact locally.
- 2.9.13 A number of these workstreams are already incorporated in our local schemes (and 2016/17 cost containment programme) but a small number could deliver savings to NHSGGC. This includes a review of effective prescribing medicines and Shared Services for both corporate and clinical support functions.
- 2.9.14 Until the outcome of these national workstreams become clear and for the purposes of achieving financial balance, the £10m will be allocated proportionately, and the three parts of the business are therefore required to identify additional schemes to close the gap – and present these to a future NHSGGC Board meeting. Should the national workstreams subsequently deliver the projected savings in-year, these additional local savings schemes will be deferred into 2017/18.
- 2.9.15 As outlined above, Directors and Managers continue to work to address the remaining savings gap and finalise a balanced Plan. Due to the timing of the implementation and impact of these schemes in-year, NHSGGC have again recognised the need to cash manage the business towards the realisation of these savings.
- 2.9.16 This will be achieved through the further utilisation of non-recurring provisions and reserves. For 2016/17, this will include a timing benefit repayable in future years through the reversal of historic provisions totalling £32.5m for NHSGGC. This was identified as part of the national Balance Sheet Flexibility Group and involves reclassifying the funding source of pre-2010 provisions, particularly in relation to Pension and Injury Benefit provisions. This does not impact on the actual level of provision, just the funding source, and will involve a charge to the RRL as the liabilities crystallise over a number of future years.

2.10 Managing Financial Risk

- 2.10.1 It is clear from the above detail there is a real risk NHSGGC will not achieve financial break-even in 2016/17. To have a chance of break-even, all these risks must be managed. In addition, definitive management action and tangible results must be achieved around the following key risks:
- Achievement of the Acute Division cost containment programme, locum agency spend and sickness absence rates driving nurse bank and agency spend;
 - Continued support from the Scottish Government around the achievement of key waiting times targets, particularly in the winter period;
 - Managing any changes to the unscheduled care model within the current financial envelope;
 - Achievement of all savings schemes outlined above, including service redesign propositions;

- Continued work to finalise, consult, approve and deliver the “red” rated schemes;
- Achievement of £10m savings from the National Workstreams including shared services and/or identification, presentation and delivery to the October 2016 Board meeting of additional schemes equal to that sum from the three key areas of the business.

2.10.2 In terms of quantifying risk inherent in achieving break-even, and in addition to the £10m FYE gap outlined above, it is estimated the Plan carries financial risk of between £20m to £25m. Should this risk crystallise, there are insufficient reserves to provide cover. It would require receipts from projected land sales to ensure financial balance. However, the complexity and uncertainty over the timing and level of receipt of land sales must also be highlighted.

2.10.3 Whilst NHSGGC at this point continues to work toward a balanced budget for 2016/17, it is apparent that again in 2016/17 NHSGGC will be reliant on non-recurring sources of funding and reserves to achieve in-year balance. This position is clearly not sustainable. The continued use of non-recurring funds and reserves in 2016/17 to fund day-to-day business will create a significant risk to the sustainability of NHSGGC into 2017/18 and beyond. There is a real risk NHSGGC enters 2017/18 with minimal reserves.

2.11 Financial Planning - 2017/18 and Beyond

2.11.1 There is a need for a change in financial planning for 2017/18 and beyond. This will require the development and embedding of a more collegiate, continuous improvement environment that delivers savings on a more consistent basis.

2.11.2 NHSGGC has an excellent track record of achieving savings and improving efficiency. However, due to the scale of the financial challenge and underlying recurring financial imbalance, a transformation programme will be required to deliver a step change in the size and scale of recurring savings and efficiencies needed.

3 Section Three

Defining the Required Workforce

3.1 Workforce Projections 2016/17

- 3.1.1 This section sets out the workforce change rationale and known projections, by Job Family, with a high level supporting narrative.

3.2 Medical and Dental

- 3.2.1 NHSGGC will continue work to address the short, medium and long term workforce challenges facing our medical workforce, particularly in our Acute Services Division, including:

- The sustainability of services across all specialties reflecting the expectations of 7 day working and, particularly for NHSGGC, the challenges of doing so across a large number of sites with a finite availability of the medical trainee and trained workforce;
- The supply and demand challenges in relation to the Consultant workforce. Although there are different challenges in different areas, challenges exist across Radiology, Dermatology, Neurology, Psychiatry and Acute Medicine;
- The issues relating to trainee experience and working arrangements including changes to Junior Doctors hours and Junior Doctor rota compliance;
- Significantly reducing the use of medical locum staff, and, where appropriate, increasing the substantive number of Consultant medical staff to support this;
- The impact of Greenaway implementation will be significant in NHSGGC particularly in respect of training and the potential emergence of skills gaps.

- 3.2.2 **The Temple Report¹³ and introduction of maximum 7 day consecutive shift working.**

- 3.2.3 The Temple Report looked at the impact of the 48 hour week on the quality of training that is necessary to ensure continuing supply of a world class workforce, able to deliver high quality services to patients.

- 3.2.4 Following the Temple Report, the Scottish Government Health Department, introduced a requirement to ensure no junior doctor would be rostered to work more than 7 consecutive shifts. As at March 2016 98.5% of rotas comply with this requirement and an action plan is in place to address the small number remaining.

- 3.2.5 The reduced hours have resulted in changes to shift patterns in many specialties. This has resulted in a decrease in training opportunities as more time is spent out-of-hours where there is reduced supervision.

- 3.2.6 Seven day shifts also reduce trainer and trainee interaction because of the introduction of time off in core day time hours. The consequence is a requirement for more Doctors to cover out-of-hours care, an increase in the number of rota gaps and an even more challenging recruitment position. The Temple Report recommends that NHS Boards move away from using Junior Doctors to provide out of hours cover to a model which utilises the current trained workforce.

- 3.2.7 During 2015/16 NHSGGC Locum and Agency staffing costs increased. There a number of underlying factors underpinning this. These are:

¹³ https://www.hee.nhs.uk/sites/default/files/documents/Time%20for%20training%20report_0.pdf

3.2.8 **Recruitment:**

- There are continuing challenges with recruitment in some specialties notably Radiology, Urology, Older People, Ophthalmology, Psychiatry and some Oncology services;
- It has always been challenging to recruit to Inverclyde and retain consultant staff in some of the specialities. It has been particularly difficult in recruiting to roles which cover the RAH/IRH/VoL and this has resulted in significant locum/agency costs in Emergency Care, Critical Care and Older People Services;
- Within Acute Services Division North Sector there are difficulties with recruitment in Older Peoples Services, in Diagnostics with Radiology, in Regional Services, Oncology and in South Sector, Older People. This is reflected in the locum and agency spend for these sectors and can also create an internal market when other sectors and Boards who are under pressure to recruit to a critical post attract an employees from another area and adversely impact service delivery elsewhere.

3.2.9 **Medical Workforce Age and Demography:**

- Pension changes have altered the landscape in terms of predicted retiral rates. Medical Staffing are currently undertaking a scoping exercise in partnership with the Medical Staff Forum to establish the risk presented by senior medical staff retirements;
- As identified within the Temple Report there is now growing evidence of a link between gender and working part time, therefore it is reasonable to assume that as women are promoted within medical structures there will be a higher proportion of senior and middle grade doctors seeking to work part-time and/or take career breaks. This will require NHSGGC to consider more flexible working patterns.

3.2.10 2016/17 actions to address this issue are identified at the end of this section

3.2.11 **Changes to the General Practice Training Scheme**

3.2.12 In response to the recognised shortage of participants in the GP training scheme nationally, the Scottish Government have confirmed the creation of 101 extra 3-year GP training schemes. These are to be implemented in February 2017. This will take the total numbers of GP trainees in Scotland being employed each year to 400.

3.2.13 It is expected that the financial impact of this on Health Boards should be cost neutral, with the costs to be met within current NES resource. As part of this plan it is also intended to phase out 4 year training schemes, converting them to 3 years. With current trainees in 4 year schemes the full effect of this will take a further 3 years to implement.

3.2.14 The majority of the 4 year training schemes at the moment (134) are within the West of Scotland and 71 of these are within NHSGGC.

3.2.15 Of the 123 GP vacancies which were left after Round 1 recruitment this year, 88 of these were on the 4 year scheme, 38 of which were in NHSGGC. It is projected therefore that by increasing the 3 year schemes it will improve the recruitment rate as the 4 year schemes are proving to be unpopular and difficult to fill.

- 3.2.16 The full impact of this change is hard to predict at the moment as it is not yet clear what the change will be to hospital specialty placements or where these new posts will be established across Scotland as a whole. We do, however, know that, 66 of these new roles will be in the West of Scotland and from that can anticipate that NHSGGC may be allocated up to 40 of these places.
- 3.2.17 The above issues present both immediate and medium/long-term challenges for NHSGGC in respect of the medical workforce.

2016/17 Workforce Actions – Medical and Dental

- Analyse and improve NHSGGC recruitment and advertising strategies, with the aim of reaching a wider pool of potential medical staff in Scotland, the UK and further afield – with a focus on hard-to-fill posts
- Develop the current NHSGGC Medical Locum Bank to improve its capacity, and expertise to supply the temporary medical workforce required
- Continue the implementation of the e-Job Planning system, completing Phase 2 in 2016 and Phase 3 by the end of 2017
- Identify and develop extended and advanced practitioner roles across professions and disciplines which have the potential to release workload and support medical practitioners within multi-disciplinary teams
- Recruit to GP student training position numbers identified as part of the wider Scottish Government exercise to increase training numbers

3.3 Nursing and Midwifery

- 3.3.1 The NHSScotland 2020 Workforce Vision¹⁴ envisages that by 2020 everyone will be able to live longer healthier lives at home, or in a homely setting supported by a healthcare system integrated with social care, and a focus on prevention, anticipatory care and supported self management. The National Quality Strategy¹⁵ defines the core principles of service quality and the importance of clinical and staff governance structures which support the delivery of safe, effective, compassionate and patient centred care.
- 3.3.2 NHSScotland published CEL 32 (2011)¹⁶ to provide NHS Boards with a consistent framework to support evidence based workforce planning, and recommended that all NHS Chief Executives ensure that professional, validated workforce measurement tools are used. The key aim of the framework was to ensure the highest quality of care for patients by ensuring NHSScotland has the right workforce with the right skills and competences deployed in the right place at the right time.
- 3.3.3 Revised guidance issued in October 2013, mandated that from April 2014 and where available, all Boards must apply Nursing & Midwifery Workforce Planning tools.
- 3.3.4 Nursing & Midwifery Workload Tools**
- 3.3.5 Following the recommendation from the Francis Report (Feb, 2013); Keogh Report (July, 2013) and the Rapid Review of the Safety and Quality of Care for Acute Adult Patients in NHS Lanarkshire (Dec 2013) all standards should include evidence-based tools for establishing the staffing needs of each service. It is also recognised that guidance needs to be flexible and give due regard to the requirements of different specialities and limitations on resources.

¹⁴ [Everyone Matters: 2020 Workforce Vision, SGHD, 2013](#)

¹⁵ [The Healthcare Quality Strategy, SGHD 2010](#)

¹⁶ [Scottish Government CEL 32\(2011\), Revised Workforce Planning Guidance for NHS Boards](#)

- 3.3.6 The national tools were developed in partnership with key stakeholders, researched, tested and refined with final ratification and validation. To date the Nursing and Midwifery Workforce Workload Planning Programme (NMWWPP) has facilitated local implementation within Boards thereby ensuring tools are applied systematically across the whole of the healthcare system in Scotland. This has been supported with by the development of a Nursing and Midwifery Workload and Workforce Planning Toolkit¹⁷.
- 3.3.7 NHSGGC is committed to using the Nursing Workforce and Workload Planning Tools. There are currently 12 tools, covering acute and community services, mental health, theatres, emergency departments, neonatal, maternity, specialist nurses and children's services.
- 3.3.8 Across NHSGGC the suite of Nursing and Midwifery workload/workforce planning tools have been applied to in-patient environments, both adult and paediatric, this includes acute hospital settings, and mental health settings. In addition specialty specific workload/workforce planning tools have been applied across Nursing and Midwifery Specialty Teams across NHSGGC including Clinical Nurse Specialists, Community Nursing and Health Visitors.
- 3.3.9 A work stream to collaborate with the Prison Healthcare Service to appropriately introduce and apply a Nursing Workload/Workforce planning tool to this service is in progress.
- 3.3.10 **Governance and Rollout Schedule for Tools application**
- 3.3.11 NHSGGC has developed a Board Action Plan for the use of the mandated Nursing and Midwifery Workload Measurement Tools.
- 3.3.12 In addition, in line with Recommendations 31 and 32 of the Vale of Leven Public Inquiry Report¹⁸, professional and operational guidance has been developed to support the escalation and monitoring of safe and effective staffing levels on a shift by shift basis which includes skill mix and the use of the NMWWP tools from service level to Board level.
- 3.3.13 A Nursing and Midwifery rostering policy has been developed to provide a framework for Managers and senior Nursing & Midwifery staff to ensure efficient and effective Nursing & Midwifery staff across NHSGGC and HSCPs.

3.4 Key issues impacting on Nursing and Midwifery

3.4.1 Nurse Revalidation

- 3.4.2 The Nursing and Midwifery Council (NMC) made the decision in October 2015 to introduce revalidation for all nurses and midwives in the UK with the first Nurses and Midwives required revalidating their registration with the NMC on the 1st April 2016.
- 3.4.3 The Nursing and Midwifery Professional Governance and Regulation Directorate and Workforce Analytics Department have worked together to develop a process in partnership with Sector/Directorates and HSCPs for revalidation reporting requirements.

¹⁷ [The Nursing and Midwifery Workload and Workforce Planning Toolkit \(2nd ed, 2013\)](#)

¹⁸ <http://www.valeoflevenhospitalinquiry.org/>

3.4.4 NHSGGC has provided Nursing and Midwifery staff with extensive support and education for the NMC revalidation process to mitigate against clerical or process issues which will result in a failure of the revalidation process, which in turn will result in a lapse of registration. A lapse in registration automatically results in a registrant being unable to legally practice as a nurse or midwife and failure to fulfil their contractual obligation of employment.

3.4.5 **Advanced Nurse Practitioner (ANP)**

3.4.6 ANPs are educated at Masters Level in advanced practice and are assessed as competent in this level of practice. As a clinical leader they have the freedom and authority to act and accept the responsibility and accountability for those actions. This level of practice is characterised by high level autonomous decision making, including assessment, diagnosis, treatment including prescribing, of patients with complex multi-dimensional problems. Decisions are made using high level expert, knowledge and skills. This includes the authority to refer, admit and discharge within appropriate clinical areas.

3.4.7 Working as part of the multidisciplinary team ANPs work in or across all clinical settings, dependant on their area of expertise. There is recognition that ANPs make a significant contribution to supporting services which are under pressure and to support across seven day service.

3.4.8 They potentially have an even bigger role to play in assessing, treating and diagnosing people in the community – during the day and out of hours. By doing so, they can help to provide better primary care for individuals and tackle delayed discharge rates.

3.4.9 Applying the Advanced Nursing Practice Roles Guidance for NHS Boards (2010)¹⁹ NHSGGC has 76 formally recorded Advanced Nurse Practitioners. Fifty per cent of these ANPs are over 50 years old and around 10% are anticipated to retire in the next 5 years.

3.4.10 NHSGGC is recruiting ANPs to support Care of the Elderly services, Oncology inpatient wards and Acute Medical Receiving areas. Existing roles are also expanding, a fourth nurse-led Minor Injuries Unit has opened at the West Glasgow Ambulatory Care Hospital and ANPs in the primary care Out of Hours service are expanding their remit to undertake some of the GP home visits.

3.4.11 To meet developing service demands, NHSGGC has appointed an Advanced Nurse Practitioner consultant who will lead the work to expand the number of Advanced Nurse Practitioners within NHSGGC. An NHSGGC plan to recruit 4 ANP trainees to both the neonatal pathway and paediatric pathway each year for the next four years is underway. Numbers for the Adult Acute Care Pathway and Ambulatory Care pathway will be approximately 10 each per year being reviewed yearly on a needs led basis.

3.4.12 **Care Assurance System (CAS)**

3.4.13 The objective of CAS is to ensure safe, effective and person centred care, which is consistently assured and sustained for every patient every time.

¹⁹ [Advanced Nursing practice Guidance 2010](#)

- 3.4.14 NHSGGC are progressing implementation of acute care standards which cover the content, context and objectives of NHSScotland's Quality agenda, NHSScotland's National Nursing and Midwifery Assurance Framework and NHSScotland's National Clinical Service improvement programmes as well as NHSScotland's Nursing and Midwifery Workload tools.
- 3.4.15 CAS is a care system and framework which involves nurses, midwives and allied health professionals in all areas of nursing and midwifery in NHSGGC's wards.
- 3.4.16 A link nurse/person framework has been developed to support Senior Charge Nurse/Midwives (SCN/M) achieve and maintain the care standards. An identified link nurse/person will be allocated to an individual standard. Their role will be to support the implementation of the care standards within the ward, become a knowledge resource and in consultation with and guidance from the SCN/M direct staff on the implementation of the standards required for care.
- 3.4.17 SCN/Ms require building time into duty rotas to allow link nurse/midwife time to undertake the link support role.
- 3.4.18 NHSGGC is extending care standards into community settings, mental health in patients, maternity, paediatrics, and health visiting.
- 3.4.19 **Getting It Right for Every Child (GIRFEC) Maternity Services**
- 3.4.20 GIRFEC is the national approach in Scotland to improving outcomes and supporting the wellbeing of our children and young people by offering the right help at the right time from the right people. It supports them and their parent(s) to work in partnership with the services that can help them.
- 3.4.21 Maternity Services are currently working to introduce GIRFEC assessment and care planning in the antenatal period. An increase in midwifery time is required to undertake the SHANARRI (Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included) assessment and an additional one hour per woman has been identified as part of testing the tool. Implementing SHANARRI will require a review of midwifery staff's workforce and workload in order to accommodate increasing clinics and extending current clinic times.
- 3.4.22 There has been an increase in the past year in the number of experience midwives retiring. This trend is likely to continue and give rise to recruitment issues for the service.
- 3.4.23 **Student Training and Newly Qualified Registrants (NQRs)**
- 3.4.24 The Cabinet Secretary for Health announced a 3% increase in nursing intake numbers for Nursing and Midwifery programmes for pre-registration nursing for the 2015-16 academic year. This is the third successive rise in the number of places for trainee nurses and midwives and will see this year's recommended intake rise above 3,000 students.
- 3.4.25 NHSGGC Nurse bank Service working closely with senior nursing colleagues and in partnership with Universities and Colleges intakes approximately 300 newly qualified nurses and midwives each year with most achieving substantive posts. This work contributes towards sustaining our workforce through effective workforce planning.

3.5 Nursing and Midwifery – Acute Services

- 3.5.1 Within NHSGGC, an acute inpatient review is currently underway to provide an overview of the current nursing workforce provision within inpatient settings in acute hospitals across the NHSGGC area. The review will ensure the nationally-validated workforce tools are being used and applied where available and appropriate to deliver safe, effective, high-quality care within these clinical areas, in-line with national guidance where available. This work will drive consistency across NHSGGC's inpatient areas and ensure appropriate staffing levels are established.
- 3.5.2 This review will also consider skill-mix within inpatient wards to ensure the appropriate level of registered and unregistered nursing resource is deployed dependent upon the speciality of each ward and the acuity of the patients within.
- 3.5.3 It is anticipated that both of these initiatives will see an investment in registered nursing (Bands 5+) within NHSGGC's Acute hospitals and this is reflected within the 2016/17 projections.
- 3.5.4 A 'Making a Difference' Management Programme aimed at Band 5 to Band 8A nurses and midwives who work in acute inpatients, maternity or Mental Health inpatient wards has been introduced. The programme is mandatory for senior nurses and midwives. The programme is delivered over two days and incorporates nursing and midwifery workload and workforce planning including hints and tips and tools to support and improve roster Management. This is supported by a rolling programme of 'Spotlight sessions' hosted by NHSGGC Nurse Director. Resources from the sessions will be hosted on the NHSGGC nursing and midwifery pages.
- 3.5.5 The Chief Nursing Officer (CNO) for Scotland, in collaboration with NHSGGC, has commissioned work to assess the change in workload of single-room accommodation versus traditional ward layouts in light of the development of the new single bedded accommodation model in the QEUH adult hospital.
- 3.5.6 The SGHD are supporting a review of nurse rostering arrangements to make sure our current systems are fit for purpose before a potential move to e-rostering. The review should provide NHSGGC with a robust action plan for e-rostering implementation.

3.6 Nursing and Midwifery - Partnerships

3.6.1 District Nursing

- 3.6.2 The District Nursing Workload Tool is a national tool which enables teams to demonstrate the wide range of activity in which they are regularly involved. It also helps to reflect on the range of knowledge and skills that are required for district nursing practice within a skill mixed team:
- Application of the national workload tool is mandatory as prescribed in CEL 13 (April 2014). It must be applied on an annual basis as a minimum;
 - District nurses complete the workload tool for 10 days over a 15 day period;
 - The tool collects information on all aspects of the district nursing workload including face to face contact, non face to face contact, associated workload, planned home visits, clinic hours, travel and exceptions;
 - Measures workload based on intensity of work and time taken;
 - There are four levels of interventions ranging from level one, straightforward, to level four, complex. Each patient intervention is given a level of complexity;
 - This is a workload tool, not a caseload profiling tool, which would capture workload on given days and more accurately reflects the complexity of care;

- The most recent application of the national workload tool across District Nursing Services in NHSGGC was completed by staff in October/November 2015 and the final results were made available by the Information Services Division (ISD) in March 2016.
- 3.6.3 The results demonstrate a positive change in the proportion of time spent in patient facing activity and associated clinical management.
- 3.6.4 The results of the latest application of the national workload tool reflect the significant efforts of clinicians, over the past three years, to apply the recommendations of workforce planning methodologies applied to the District Nursing (DN) Service.
- 3.6.5 In 2013 the NHSGGC District Nursing Review Programme Board identified a future workforce model for the service of 1 WTE Band 6 per 9,000 registered population. The new model saw a proposed reduction in the number of band 6 posts across NHSGGC with an associated increase in band 5 and band 3 support workers to create a wider skill mix team of staff nurses and health care assistants. The workforce planning rationale used an analysis of workforce and workload (using national tools) and a benchmarking exercise comparing NHSGGC to similarly sized urban NHS Boards/Authorities across the UK.
- 3.6.6 The redesigned DN workforce model associated with this exercise was predicted to be completed by March 2017 using turnover as the primary change mechanism. This was agreed in 2013 by the then HSCP Directors and the health Board, in partnership, with staff side colleagues. Since that time, services have moved towards the agreed model as opportunities have arisen to replace posts vacated through natural turnover.
- 3.6.7 NHSGGC has noted an increase over the past two years in the number of experienced district nurses retiring or moving to other areas of work which has resulted in recruitment and retention issues within the service. In order to ensure the supply of adequately qualified district nurses HSCPs committed to recruit to and train staff for in the Post Graduate Diploma Advanced Practice in District Nursing on a part time and full time training programme at Glasgow Caledonian University 2013/15. The initial cohorts of students from these programmes will graduate in September 2016.
- 3.6.8 As part of ongoing workforce planning activities an exercise was undertaken by local service managers to predict vacancy levels as at September 2016. In January 2016 agreement was reached by the Area Partnership Forum that graduating students would be offered vacant Band 6 posts across NHSGGC's HSCPs which would be taken up on successful completion of the course.
- 3.6.9 NHSGGC's workforce data metrics illustrate that recruitment to posts at Band 5 and Band 3 is not a significant risk. However it should be noted that many new appointments to the band 5 role are new graduates or staff with little experience of community services and therefore require a higher level of support and supervision. NHSGGC has worked to ensure that a key element of the existing band six role is the provision of supervision and support to other members of the team.
- 3.6.10 Staff due to graduate from the district nurse course in September 2016 have been aligned to identified vacancies across the six Health and Social Care Partnerships (see table below).

NHS Greater Glasgow and Clyde	
District Nursing Workforce Allocation 2016/17	
HSCP	Graduate DN Allocation (WTE)
West Dunbartonshire	2.50
East Dunbartonshire	1.00
East Renfrewshire	2.20
Inverclyde	1.00
Glasgow City North West	3.60
Glasgow City North East	2.00
Glasgow City South	4.60
Renfrewshire	1.00
Total	17.90

3.6.11 Within the NHSGGC area HSCPs are either currently at or will be at the agreed workforce model when they are in receipt of the allocation of new DN graduates in September 2016. While this represents a positive outcome of the workforce planning activity which commenced several years ago there is a need to continually address turnover and availability issues due to the demographic profile of the DN workforce.

3.6.12 It has been agreed that each HSCP will make local arrangements to ensure a sufficient supply of staff through investment in training. The identified training requirements for entry year 2016/17 are noted below by HSCP area.

NHS Greater Glasgow and Clyde	
District Nursing Workforce Student Training Allocation 2016/17	
HSCP	DN Students
Glasgow City	14
East Dumbartonshire	1
Renfrewshire	3

3.6.13 In future there is a need to consider the potential increase in demand for community nursing services as a result of new ways of working for GPs which will place additional pressures on the existing workforce.

3.6.14 It is anticipated that the national review of District Nursing due to report findings in the summer of 2016 will promote a more flexible method of educational preparation for the band six role in order to ensure a fit for purpose workforce.

2016/17 Workforce Actions – District Nursing
<ul style="list-style-type: none"> Align graduating DN student to existing HSCP DN team vacancies (September 2016); Monitor DN Workforce Trends and assess required student training numbers for induction onto 2017/18 training cohort; Assess the impact of recommendations of the national review of District Nursing Monitor the results of future applications of the workload tool to the DN workforce Explore the opportunities available to widen access to the Post Graduate Diploma Advanced Practice in District Nursing through flexible education and training routes

3.6.15 Health Visiting

3.6.16 The Scottish Government issued guidance in March 2015 which outlined its expectations for how the health visitor workforce should be developed over the next four years. The Government required all Boards to respond with a local action plan that outlined the steps to be taken to meet with the requirements of the guidance.

3.6.17 This workforce plan has been updated to reflect progress to date and ongoing actions required to deliver the increased HV numbers and related practice changes.

3.6.18 In summary the Scottish Government's programme includes:

- An increase in the overall number of health visitors across Scotland by 500 WTE, over a four year period through an investment of £20m;
- The use of a Caseload Weighting Tool to calculate the number of health visitors required for each area, to ensure that there is a consistent methodology used across Scotland;
- An increase in the number of placements at university to ensure that the increased recruitment targets are achieved;
- The adaptation of the current university training programmes to focus on health visiting as a distinct discipline from School Nursing, with a programme devoted to the 0 to 5 years;
- The introduction of a new universal child health pathway (pre-birth to school entry), which will increase the number of contacts/assessments undertaken by health visitors;
- The introduction of the Named Person Service as a consequence of the Children and Young People (Scotland) Act 2014.

3.6.19 The Scottish Government guidance stipulated that each Board must run the Caseload Weighting Tool during May 2015 to "identify any gap in resources needed to deliver the future vision".

3.6.20 NHSGGC completed The Caseload Weighting Tool exercise, and Scottish Government subsequently confirmed, in June 2015, resource totaling £7.2m to fund the projected 200 WTE Health Visitors required to support additional activity.

3.6.21 NHSGGC has prioritised the development of community children and family services, based on the national policy directives such as **Health for All Children**²⁰, the **Early Years' Framework**²¹ and **getting it Right for Every Child** and our own local policy paper **Mind the Gaps**²². Key deliverables from this work have included:

- Enhancing the capacity and infrastructure of our children and family teams to support delivery particularly to vulnerable children;
- Developing Leadership and Increasing Management Capacity;
- Introducing an NHSGGC GIRFEC framework.

3.6.22 NHSGGC has a recruitment plan in place to support students through the Specialist Community Public Health Nursing (SCPHN) Health Visiting Programme in order to increase our Health Visiting capacity by 200 WTE posts in line with the SG Health Visitor Investment Programme.

²⁰ Health for all children: <http://www.gov.scot/Resource/Doc/37432/0011167.pdf>

²¹ Early years framework: <http://www.gov.scot/resource/doc/257007/0076309.pdf>

²² Mind the gaps: <http://www.gov.scot/Publications/2003/10/18358/28082>

3.6.23 Whilst the funding allocation of £4.6m is in the 2016/17 financial year planning cycle, and allows us to fund SCPHN students at University, the students will not graduate into Health Visitors and additional posts until the year after i.e. 2017/18.

3.6.24 The table below splits out into historic and projected future graduates per financial year:

NHS Greater Glasgow and Clyde				
Health Visiting Workforce Allocation 2015/19				
Graduating Year	2015	2016	2017	2018
Students Graduating	10	54	80	56

3.6.25 By 2019 NHSGGC expect to deliver:

- A cap on caseloads to 350 children;
- A reduction in caseloads to 100 children for those health visitors who have the largest proportions of deprived children;
- Capacity to undertake targeted interventions for vulnerable children;
- Leadership/Supervisory ratios maintained at 1:10.

3.6.26 NHSGGC has made provision for, and has included in their recruitment and retention plans, an average of 30 WTE staff turnover per annum (natural staff turnover and retirements). This 30 WTE is built into our workforce planning to ensure that the baseline funded establishment of 236 WTE is maintained each year, plus the growth of 200 new Health Visitors from Scottish Government investment which will result in a total workforce of 436 WTE at endpoint.

3.6.27 In preparation for the implementation of the Named Person and the revised Universal Pathway Health Visitors, Practice Development Nurses and Team Leaders require continuing professional education with focus on the five nationally agreed priority areas below, which is currently being delivered by Higher Education Institutions and NHS Education:

- Named Person;
- Leadership and Management;
- Quality Improvement Methodology;
- Strength/Asset Based approaches;
- Child Development, Illness and Assessment Tools.

3.6.28 In addition to the Continuous Professional Development (CPD) requirement there are other key areas for training as part of the GIRFEC NPM including:

- Outcome Analysis Training;
- Graded Care Profile/Neglect Tool;
- New Universal Pathway Training;
- New NMC Registration.

3.6.29 To support the workforce the GIRFEC group has developed training based around the relevant topics outlined below:

- Named Person; Lead Professional; Single Childs Plan; Request for assistance;
- Information management, sharing and transfer;
- Communication Strategy; Complaints process;

- Links with colleagues in the wider Community Services, Acute Services and Women & Children Service.

2016/17 Workforce Actions – Health Visiting
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- | |
|--|
| <ul style="list-style-type: none"> • Continue to monitor the level of Health Visitor vacancies to mitigate risk to service provision • Ensure future retiral projection numbers are returned on a regular basis to SGHD in order to inform future recruitment requirements |
|--|

3.6.30 School Nursing

3.6.31 The current NHSGGC staffing levels within the school nursing service fall short of the resource allocation model, with vacancies in most areas. The recent national scoping exercise of the school nursing workforce highlighted the significant variance across NHS Boards in relation to the number of staff within the service and those who hold the Specialist Community Public Health Nursing (SCPHN) qualification.

3.6.32 At present there are 14.11 WTE band six nurses working in school health within NHSGGC with 2.9 WTE holding the requisite SCPHN qualification.

3.6.33 An NHSGGC School Nursing Steering Group has been established which has scoped current resource associated with school nursing practice and has developed recommendations for consideration.

2016/17 Workforce Actions – School Nursing

- | |
|---|
| <ul style="list-style-type: none"> • Asses impact of recommendations arising from the NHSGGC School Nurse Steering Group |
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3.6.34 Learning Disability Nursing

3.6.35 In light of the Learning Disability Change Programme 'A Strategy for the Future'²³ there has been a significant focus on future sustainability of the learning disability nursing profession within NHSGGC which faces significant challenges due to an ageing learning disability workforce and a need to address succession planning.

3.6.36 Historically, large scale redesign of NHSGGC's learning disability services (such as the closure of the Long Stay Lennox Castle and Merchiston Hospitals) had resulted in a redeployment legacy.

3.6.37 Due to the projected increase in staff leavers associated with the existing cohort of staff reaching retirement age NHSGGC will, in future, be able to address and establish a workforce profile which includes greater opportunity for recruitment; a clearer future career framework which links to national approaches for the profession; and a workforce profile which is line with the role and function of specialist teams and their relationships with other NHS and Partnership services.

3.6.38 A revised workforce profile is being implemented across all HSCPs. A workforce implementation group is supporting all HSCP partners in this process and providing system wide governance. Practice development and Professional Leadership roles are now in place, alongside revised local leadership arrangements.

²³ LD Change Programme: <http://www.nhsggc.org.uk/your-health/health-services/learning-disability-change-programme/>

- 3.6.39 In line with the national career framework for Learning Disability Nursing and our 'Strategy for the future,' NHSGGC is reshaping its nursing workforce to better reflect the range and different levels of health provision we deliver to people with learning disabilities and their spectrum of evolving care needs.
- 3.6.40 We are introducing band five nursing staff to our community services in order to better support the quality of care we deliver to our patients and their families; to develop competencies and enhance skills' acquisition in this area of professional practice; to facilitate shared learning between newly qualified and experienced practitioner levels and form the basis for clear succession planning. This will develop a flexible, sustainable nursing workforce capable of meeting the current and future needs of the service.

2016/17 Workforce Actions – Learning Disability Nursing
<ul style="list-style-type: none"> • Continue to review the registered nursing skill mix within Learning Disabilities

3.7 Mental Health Nursing

- 3.7.1 As part of NHSGGC's Clinical Services Review to consider how best to deliver services to meet the changing needs of patients beyond 2015 to 2020 work was undertaken to review the future shape of mental health services. Within Mental Health Service (MHS) this focused on the models of care for:
- Adult Mental Health;
 - Dementia;
 - Drug and Alcohol Services.
- 3.7.2 An overarching framework for mental health services was outlined together with defined personal outcomes for service users and carers; a summary of changes required to meet the model and potential implementation challenges.
- 3.7.3 Inpatient MH Services**
- 3.7.4 The current MHS inpatient nurse workforce configuration is modelled on the recommendations of the Nurse Director's 2011 review which provided an agreed service model for clinical areas (actual and transitional) and was summarised and updated in the October 2015 Mental Health Service nursing workforce paper.
- 3.7.5 The 2015 paper provides service workforce summaries for mental health, learning disability, forensic, police healthcare; both inpatient and community and will be refreshed for October 2016.
- 3.7.6 From an inpatient perspective, the agreed 2011 service model of 1 Senior Charge Nurse and 2 Charge Nurses has been implemented across all inpatient services.
- 3.7.7 Recommendations are given with regards to nurse to bed ratios based on published evidence which advises between 1:5 and 1:7 nurses per bed with a minimum of 2 registrants on duty at any time.

- 3.7.8 In reviewing workforce deployment, information was sorted by geographic location and service area. National workload tool outcomes, funded establishments, “in-post” and “augmented” ratios are also considered. The objective being that each clinical area would work towards a staffing profile that was safe, efficient and affordable.
- 3.7.9 Outline plans for mandatory annual run of the Nursing & Midwifery Workload & Workforce (NMWWPT) Planning tools, analysis and integration of outcomes in terms of ward staffing recommendations are also included.
- 3.7.10 Development and implementation of rostering practice support sessions are being progressed with a view to delivering to all SCNs, charge Nurse, Inpatient Service Managers and Workforce Co-ordinators from October 2016.
- 3.7.11 **Community MH Services**
- 3.7.12 There is no available underpinning evidence base which informs the nurse workforce and skill mix for developing NHSGGC’s Community Mental Health Teams (CMHTs). CMHTs and Resource Centres have been created over a period of time in response to major hospital closures, assessment of local population need and gaps in provision of care balanced against available finances. Further specialist community teams have developed to complement and augment the provision of local community services and recent activity has been undertaken to ensure parity of population access to such specialist services across the Board area.
- 3.7.13 Under the auspices of the Adult Mental Health Planning Group, the Community Services Review Group was formed to take forward a review of Community Mental Health Services (incorporating Community Mental Health Teams and Specialist Teams) and functions across NHSGGC. As a result, the service-wide spread of identified specialist services was achieved in order to ensure equity of access across the Board area. The group also seeks to define standards for service operation, the measurement of effective and efficient service activity and patient outcomes
- 3.7.14 The MHS Community Service and Specialist Review group has been working to identify CMHT service specific performance measures and to provide an evidence based audit tool to support teams to understand their productivity and efficiency.
- 3.7.15 The outcome of this work has been a recommendation that individual teams utilise the Mental Health Activity Tracker tool, within a service improvement framework, such as the Demand, Capacity, Activity and Queue (DCAQ) Tool in order to assist teams to identify opportunities, collectively and individually, to reduce bureaucracy and activities that do not add value.
- 3.7.16 Overall, through the work of the Community Service & Specialist Review group work has been undertaken to define the high level service principles and frameworks for the delivery of well functioning, patient centred community mental health services, as informed by the views of service users as outlined in the NHSGGC Clinical Services Review “Case for Change”. It is recognised that there is a need for further work to be undertaken to support the implementation of this framework at a service level, with the key requirements being the preparation of:
- An operational policy for CMHTs and for Specialist Services;
 - A system wide Access Policy;
 - A system wide Shared Care Policy;
 - A system wide Transfer / Discharge Policy;
 - A DNA/CNA Policy for CMHTs and for Specialist Services.

3.7.17 **Recruitment & Retention**

3.7.18 To date, within NHSGGC MHS we have not encountered difficulty in recruiting registered staff, in particular, newly qualified registrants (NQR) although this picture varies across Scotland. In order to ensure ongoing successful recruitment we require to ensure equitable access to vacancies for this staff group across inpatient and community areas. To this end a review of recruitment practice and standardising nursing family job descriptions is underway.

3.7.19 A review of staffing age profiles and staff turnover highlights an aging workforce, in particular within smaller, specialist services which require targeted succession planning.

3.7.20 **Supplementary Staffing**

3.7.21 The use of additional hours has always been a part of staffing be it in the form of overtime, extra to contracted hours and more recently use of the nurse bank and occasionally agency staff. Supplementary staffing capacity is provided by the Board Nurse Bank and provides registered and unregistered nurses to supplement short term absences in the established workforce and to provide support for increased patient acuity and /or dependency.

3.7.22 Within mental health services the majority of supplementary staffing is deployed to cover enhanced observation levels, sickness and vacancies.

3.7.23 The use of Bank within nursing services is not exclusive to inpatient mental health services; however, the bulk of the use can be attributed to these clinical areas. When the Bank is unable to provide staff, cover may be sought from a Nursing Agency although MHS use of agency staff is relatively low and there is a desire to reduce and remove agency nurse use.

3.7.24 There is strong evidence from workload informatics to suggest ongoing increases inpatient acuity and dependency and full to overfull bed occupancy levels. As a result, existing funded staffing models may require to be reviewed in line with consideration of supplementary staffing usage and outputs from the National Nursing & Midwifery Workforce & Workload Management tools.

3.7.25 In recent years Nurse Bank rates of use have increased for both registered and unregistered staff provisions. The use of supplementary staffing represents an additional cost pressure on workforce costs for which there is not identified budget.

2016/17 Workforce Actions – Mental Health Nursing

- Annually apply the mandatory workload tools for Mental Health Service Inpatient areas to include addiction and Learning Disability service wards
- Continue to review the impact of staff turnover due to ageing workforce and Mental Health Officer and Special Class pension status
- Continue to review skill mix, workforce profiles and use of supplementary staffing in the context of the application of the nationally-validated workload tools

3.8 Allied Health Professions

- 3.8.1 The Allied Health Professions (AHPs) include 12 professions regulated by the Health and Care Professions Council (HCPC), which collectively make up the third largest workforce in the NHS. AHPs work across a range of sectors including health, social care and education, across the life course. The 12 professions include physiotherapists, occupational therapists, podiatrists, dieticians, speech and language therapists, paramedics, radiographers, orthoptists, prosthetists and orthotists, art therapists, music therapists and drama therapists.
- 3.8.2 AHP input plays a major role in the initial diagnosis and clinical management of acute and elective patient presentation. The AHP workforce helps patients regain functional independence in all areas of life and as a result its central involvement in patient care impacts on the ability of hospitals to prevent admissions and re-admissions, transfers of care and discharge of patients; an issue particularly for older patients.
- 3.8.3 AHPs also have a crucial role in government policy priorities for service transformation, such as those which focus on preventing ill-health and supporting healthier lives, on a safe, high-quality, seven-day health service and supporting improvements in efficiency and productivity.
- 3.8.4 AHPs are also heavily involved in care planning, care co-ordination, self-management and in anticipatory care for older people living with frailty. Diagnostic access plays a key role in enabling other AHPs to perform their roles in patient care and treatments.
- 3.8.5 The AHPs, to-date, have limited standardised national and local data to evidence the value they add to health and social care in Scotland. Despite a steady national increase in some AHP staff numbers over the past decade there is still significant geographical variation in numbers per 1,000 population, difficulty in recruiting to some posts and inconsistency in matching provision to need.
- 3.8.6 Action point 6.1 of the AHP National Delivery plan advocates capturing national data for display in dashboard format across health and social care particularly in the therapeutic professions outside of radiography. Work is underway to improve the underlying definitions and accuracy of AHP workforce and activity data which will allow comparisons of staffing ratios across Scotland and improve the accuracy of workforce predictions.
- 3.8.7 When considering staffing needs for new or existing health and care services, unlike the medical or nursing workforce, AHPs have no comparable workload tool to assist in workforce predictions. There are rising vacancy rates of medical consultant posts where AHPs can be part of the solution in meeting people's needs. There is a growing body of evidence to support the use of AHPs in advanced practitioner roles to provide cost effective services and reduce medical costs, e.g. use of reporting radiographers in the delivery of diagnostic imaging services and AHP administered injection therapy.

- 3.8.8 AHP services offer much more than direct patient care interventions. The AHP contribution to ill-health prevention and promoting a healthier Scotland must also be recognised in workforce planning using suitable workforce and workload measurement tools. With rising demand for NHS services, the development of an AHP workload measurement and workforce tool will make a major contribution to AHP Directors, Chief Executives and managers' ability to confidently plan for an effective workforce that fully embraces the contribution of AHPs alongside the medical, nursing and other health care workers that are required to support a healthier Scotland. A draft prototype gap analysis and workforce comparator tool is planned for September 2016 alongside a ready to test measurement tool adapted from the existing Nursing and Midwifery Community Workforce and Workload Measurement Tool.

3.9 Physiotherapy

- 3.9.1 NHSGGC have been developing a band seven musculoskeletal (MSK) advanced practitioner job description and aim to have an equitable spread across each geographical area.
- 3.9.2 Within MSK there are some minor changes planned to the workforce but these would be through natural turnover and skill mix. Band six posts are reviewed on a case by case basis and the skill mix is considered within the quadrant and service however, there would be no reduction in the number of established posts. There are no anticipated changes within band five, band three or admin support posts anticipated during 2016/17.
- 3.9.3 There are ongoing developments within Primary Care examining the role of Physiotherapists as first point of contact in GP surgeries and this development could see a change in workforce. However, this is only at pilot stage and it is too early to measure impact. Sustainability could be an issue as the current pilot is looking for advanced levels of MSK expertise which could have considerable impact on the current MSK service.
- 3.9.4 The Physiotherapy workforce within acute has previously been driven by a model for rehabilitation where an increased utilisation of health care support workers has been the norm. However with the shift in the balance of care, reduced length of inpatient stay and early discharge incorporating discharge-to-assess approaches, a change in emphasis in physiotherapy practice is required.
- 3.9.5 Whilst physiotherapists are experts in rehabilitation, particularly early rehabilitation even in acutely unwell patients, their role is now increasingly focused on assessment and complex discharge planning. This is particularly true in meeting unscheduled care demands. These roles require highly skilled, experienced physiotherapists therefore a further review of skill mix is also required.
- 3.9.6 Seven day service delivery is an aspiration and there is increasing evidence to support the cost effectiveness, quality and person centred approach of seven day physiotherapy services. Whilst in many specialties there is some physiotherapy presence at weekend / out of hours this is limited and further redesign is unlikely to allow development of these without investment.
- 3.9.7 Further developments include independent prescribing for physiotherapists; NHSGGC have supported physiotherapists in Women's Health, respiratory care and neuro-rehabilitation to undertake training to allow them to become independent prescribers with further staff about to commence in other specialties including elderly care medicine and neurology.

- 3.9.8 Challenges in medical workforce recruitment in specific specialties also afford further opportunities for advanced practice physiotherapists to offer solutions to some of these challenges. The model is already well established in some clinical specialties e.g. orthopaedics, however support for further training and role development in other specialties will be required.

2016/17 Workforce Actions – Physiotherapy

- Develop MSK Advanced Practitioner roles
- Assess results/recommendations of pilot programme *Physiotherapists as First Point of Contact* in GP Surgeries
- Monitor number of independent prescribing physiotherapists and ensure maximum utilisation of these skills
- Explore use of Advanced Practitioner Physiotherapists in areas impact by medical staff recruitment difficulties

3.10 Dietetics

- 3.10.1 **Intestinal Failure.** Over the last decade an increasing number of people with intestinal failure (IF) are being managed in NHSGGC. People with IF are unable to absorb sufficient nutrients and or fluid from the intestinal tract to maintain their health and therefore require intravenous feed (parenteral nutrition) and or electrolytes on a regular basis.
- 3.10.2 The incidence of intestinal failure is estimated to be 2.7/100,000. NHSGGC currently supports 56 adults on Home Parenteral Nutrition (HPN) delivered by a multidisciplinary out patient service and, where necessary, in an expert inpatient facility.
- 3.10.3 Year on year there has been a significant increase in the number of adults living at home and during 2016/17 additional resource (0.5 WTE at Band 7) has been identified to support this increased demand.
- 3.10.4 **Community Enteral Feeding** - The number of home enteral tube feeding patients will increase as a direct result of the NHSGGC Clinical Service Review. As we move towards an integrated health and social care system with the aim of allowing people to live longer at home, patients will be discharged from acute services earlier and with more complex needs.
- 3.10.5 It is therefore important that HSCP staff are appropriately trained to provide clinically safe and effective patient centred care and have access to enteral feeding specialists to ensure patients are supported to remain at home and minimise any risk of readmission. One WTE Band 6 post has been resourced for his purpose.
- 3.10.6 **The Bone Marrow Transplant (BMT)** unit move to the Queen Elizabeth University Hospital (QEUH) coincided with the national centralisation of all Allogenic Transplants at the QEUH. This new development recognised the significant nutritional risks this patient group present with and the benefit of specialist nutritional care pre and post transplant.
- 3.10.7 Based on best practice from other UK centres of excellence such as the Royal Marsden, provision of specialist nutritional assessment and care is indicated from the onset and throughout the patients' treatment trajectory. During 2016/17 three part-time posts will be recruited which will support this service deliver care in both the Multi-disciplinary out/inpatient setting at QEUH.

2016/17 Workforce Actions – Dietetics

- Develop the dietetics workforce as set out in the workforce plan and workforce projections

3.11 Speech & Language Therapy

- 3.11.1 SLT Acute Service: The recently completed migration of services to the QEUH provided SLT Services with the opportunity to reorganise the service away from condition-focussed teams with high levels of specialism and resultant challenges to flexibility, to teams aligned to the patient journey through acute, rehabilitation and on to out-patient services for longer term follow up. This has broadened the skill base of the workforce and permitted greater flexibility in rotating staff to meet fluctuating levels of activity and demand across hospitals.
- 3.11.2 Patient pathways are under constant review to consider new ways of working to relieve demand and utilise the workforce in the most effective and efficient way. A review of HCSW job plans is underway to ensure full clinical focus. This may result in a need for more administrative staff to support clinicians and release time to care.
- 3.11.3 SLT in Partnerships: The recent appointment of the first professional lead for SLT within HSCPs provides an opportunity to review the current workforce and develop a robust workforce plan for the coming years.
- 3.11.4 NHSGGC currently hold seven service level agreements (SLA) with local authorities to provide SLT services to education. The associated staff are employed by NHSGGC to deliver the service stipulated in the SLA. These service level agreements are constantly under review in relation to service delivery and contract value. This presents as an ongoing challenge for workforce numbers and configuration. There is currently national scoping work underway, in conjunction with the Royal College of Speech and Language Therapists, to consider multi-agency funding stream for SLT.

2016/17 Workforce Actions – Speech and Language Therapy

- Continue to review patient pathways and explore new ways of working with particular reference to the SLT role in anticipatory care and acute admissions
- Review the current SLT workforce within HSCPs to ensure a fit-for-purpose workforce

3.12 Orthoptics

- 3.12.1 As a small profession the Orthoptist workforce is vulnerable to relatively small changes to in-post staffing. Historically the service has been affected by recruitment problems.
- 3.12.2 Across the timeframe of this workforce plan this issue is likely to be resolved when NHSGGC's first cohorts of undergraduate students qualify from Glasgow Caledonian University in 2016. The Orthoptic service will require to plan carefully across NHSGGC for mentoring purposes.

- 3.12.3 The opening of the QEUH has necessitated some service redesign and the associated redeployment of staff due to the merging of children's Orthoptic services from Yorkhill and SGH.

2016/17 Workforce Actions – Orthoptics

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| <ul style="list-style-type: none">• Recruit to existing vacant posts from NHSGGC graduating cohort one |
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3.13 Diagnostic Radiography

- 3.13.1 Demand for imaging across all modalities has increased each year over the previous four years by 10-15%. This increasing workload challenges the ability to acquire and report imaging within the 6 week window of the 18 week referral to treat pathway. Diagnostics Directorate has responded to this challenge by way of planning and developing the workforce and service delivery plan that operates in strategic recognition of these changing needs.

3.13.2 Plain Film Imaging

Plain film imaging constitutes 80% of activity within an Imaging Department and service provision follows a 24/7 pattern. Radiographers and assistant practitioners (AP) provide this service. There is potential for the role of the AP to be further developed, expanding the scope and range of image acquisition thus freeing up the radiographer to develop in accordance with service redesign needs.

- 3.13.3 There is a Consultant Radiographer plain film led service with seven advanced practitioners and two trainees. The reporting output from this team has increased from 20,000 to 80,000 X-ray reports/year over a period of four years.

- 3.13.4 In line with service needs, educational support and additional revenue is required for the provision of a radiographer led reporting service over seven days with a potential to also broaden the scope and range of the reporting radiographer remit.

- 3.13.5 In order to fulfil AHP delivery expectations there is a need to develop new pathways that demonstrate linkage within the AHPs to support their diagnostic and reporting requirements, e.g. non medical referrals from AHP led clinics, meet governance needs by way of all referrals being reported in a timely fashion. A further example could be by way of radiographer onward referral to podiatry such as diabetic changes in GP foot imaging referrals.

- 3.13.6 A radiographer led X-ray commenting service has been extended across NHSGGC having completed evaluation of a pilot carried out in the Vale of Leven Hospital. The benefits accrued from this service are of particular relevance to minor injury units.

3.13.7 Ultrasound

- 3.13.8 Significant investment has been provided to make diagnostic ultrasound (non obstetric) a predominately sonographer-led service in recognition of a national shortage of radiologists and their role development in emergent technologies.

- 3.13.9 There are two Consultant Sonographers leading a team of 37 Sonographers (non obstetric) across NHSGGC.

3.13.10 Currently the sonographic team is developing advanced practice in ENT such as Fine Needle Aspiration of thyroid nodules and musculoskeletal ultrasound. To maintain this potential and allow inclusion of other sub-specialty areas in seven day working, a rolling programme of education and clinical training has to be secured.

3.13.11 Assistant Practitioners (AP) perform Abdominal Aortic Aneurysm screening across NHSGGC. Currently screening targets have been successfully achieved, however to ensure ongoing delivery, funding should continue to support an AP programme of education and mentorship.

3.13.12 **Breast Services**

3.13.13 The West of Scotland Breast Screening Program and Acute Breast Symptomatic Service are situated within the NHSGGC Diagnostics Directorate. Currently there is a recognised shortage of radiologists specialising in breast imaging across the UK. This contributes to significant pressure in meeting service needs. There is significant scope for development of the role of the radiographer in all aspects of breast imaging and intervention. This includes mammography reporting, breast ultrasound, localisations and biopsies.

3.13.14 Currently within the breast screening programme, there are many radiographers with advanced practice skills with five radiographers funded to report mammograms and four to provide biopsy. These radiographers have attained postgraduate qualifications, including MSc in Mammography, through the collaborative programme delivered by Queen Margaret University Edinburgh and the Scottish Mammography Education sector. This is based in West of Scotland Breast screening unit, Glasgow, co-ordinated by the superintendent radiographer for breast screening.

3.13.15 To develop, integrate and provide a common standard of practice in both screening and symptomatic breast services we will aim to appoint 2 Consultant Radiographers to act as professional leads.

3.13.16 To enable service continuity and meet service demand across all symptomatic breast units there is a need for an additional 8 radiographers to provide a reporting and biopsy service.

3.13.17 **Magnetic Resonance Imaging**

3.13.18 In recognition of the annual 10-15% increasing demand for MRI studies, the Diagnostics Directorate secured funding for an additional 12 radiographers, specifically for extended working over seven days.

3.13.19 Service delivery has been supported with input from an MRI practice educator who has enabled development and implementation of an education programme to support this utilising a combination of band five and band six radiographers.

3.13.20 Due to a restricted availability of MSK radiologists, radiographer advanced roles have been developed to include pre MRI arthrogram contrast injections under fluoroscopic control into the hip and shoulder joints. This has had a significant impact on reducing the waiting time for these procedures.

3.13.21 To support the increased demand for acute in-patient MRI referral, such as cauda equina symptoms, we are assessing the workforce requirements of an MRI 24-hour service.

3.13.22 The radiographer role in the reporting of MRI examinations of the knee is being developed. Funding has been secured for an evaluation of reporting accuracy to occur during 2016-17.

3.13.23 **Computed Tomography (CT)**

3.13.24 CT has become an integral component of clinical management of the acute patient. In recognition of this, a shift working pattern was piloted at QEUH. Feedback from service users was very positive.

3.13.25 Due to the age profile of the workforce in this modality NHSGGC have plans in place for succession planning with a need for post graduate education and professional lead development.

2016/17 Workforce Actions – Diagnostic Radiography

Radiographer plain film reporting

- Assess impact of extending service over seven days and broadening of scope and range of practice

Assistant Practitioners

- Broaden scope and range of image acquisition remit

Ultrasound

- Assess impact of extending the working week over seven days
- Rolling programme of education to develop specialty expertise in MSK and ENT provision
- Maintain and develop AP skill set to support AAA screening programme

Breast Imaging

- Provide support to a review of breast services across imaging and surgery

Magnetic Resonance Imaging

- Identify and progress workforce requirements to deliver a 24 hour service

Computed tomography

- Work with local education providers to develop post graduate education provision to ensure a suitably qualified supply for this workforce

3.14 Therapeutic Radiography

3.14.1 All Therapeutic Radiographers within NHSGGC are managed as part of a single service within Specialist Oncology Services. All staff work in the Radiotherapy Department of the Beatson West of Scotland Cancer Centre or at the satellite department, the Lanarkshire Beatson at Monklands Hospital which opened at the end of 2015. There is no input to primary care or HSCPs.

3.14.2 Core services are provided Monday to Friday, with on-call provision for planning and treating emergency patients at weekends. Additionally, up to four patients with a diagnosis of Non Small Cell Lung Cancer (NSCLC) receive treatment three times per day, necessitating an additional rota of radiographers available to deliver these treatments. Currently, throughout the UK, most radiotherapy treatment regimes are delivered on the basis of five sessions per week.

3.14.3 As radiotherapy techniques become more complex and more accurate, there is scope in some tumour sites for dose escalation with an associated reduction in the number of fractions delivered. However, there is a corresponding increase in the time that needs to be allocated to each appointment, to allow for complex imaging prior to each treatment session.

- 3.14.4 The workforce has adapted and will continue to adapt to changes. In addition to technical developments, Radiographers participate in research, clinical trials, on-treatment clinical review, administer intravenous contrast for CT scanning and undertake treatment planning for specific groups of patients. Advance Practitioners and Consultant Radiographers carry out many tasks which would traditionally have been the remit of the Consultant Clinical Oncologist, thus offering a solution to the challenge of recruiting sufficient trained medical staff.
- 3.14.5 There are two Scottish Universities (Glasgow Caledonian and Queen Margaret) providing degree courses in Radiotherapy and Oncology. QMU also provides a 2 year post-graduate diploma for students with appropriate science degrees. Until last year, Therapeutic Radiographers were on the UK Government list of shortage occupations, but this reflected particular recruitment difficulties in England. Within Scotland, and particularly at the Beatson, we have always been fortunate in recruiting adequate staff. The 5 Scottish radiotherapy centres work closely with the Higher Education institutions in this regard and we were able to recruit all the staff we required for the Lanarkshire Beatson, with no real detriment to the workforce of the cancer centres in either Glasgow or Edinburgh.

3.15 Occupational Therapy

- 3.15.1 There is continued pressure within acute services due to increasing admission levels and this has been exacerbated due to an increase in turnover of band 5 staff group moving to community based posts, or promotion/secondments. Replacement posts are subject to review on a case by case basis. These factors present challenges in supporting the development of 7 day Occupational Therapy services.
- 3.15.2 Integration will present an opportunity for OTs to connect more effectively across Health and Social Care Partnerships, roles need to be reviewed in order to ensure, where clinically safe, that service users receive all required OT intervention from the same OT. This should reduce duplication across the system and release additional capacity. Within current integrated Partnerships this has proved most successful within older people and adults with physical disabilities services.
- 3.15.3 Another opportunity with integration and with the Active and Independent Living and Improvement Programme (AILIP) is to review where OTs are placed within the care pathway. With a greater emphasis on early intervention and anticipatory care there is a strong argument for moving OTs to Primary Care to develop small tests of change around the role of OT in vocational rehabilitation, primary care mental health and managing long term conditions.
- 3.15.4 Whilst extension of roles should be a welcome outcome of integration, the OT specialism within Care Groups e.g., Mental Health, Learning Disability and Specialist Children's Services requires to be maintained in order to sustain the unique contribution that OTs make to multidisciplinary teams in these Care Groups.

2016/17 Workforce Actions – Occupational Therapy
<ul style="list-style-type: none"> Continue to review services as integration progresses within each HSCP in NHS GGC

3.16 Podiatry

- 3.16.1 The Podiatry service anticipates a small workforce change during 2016/17 associated with the final phase of a Podiatry redesign process.

- 3.16.2 There is projected to be a reduction of 0.8 WTE at Band 8A associated with reduced managerial costs and a small reduction in Band 7.
- 3.16.3 Over the next two years there will be small WTE increases in the Band 6 and Band 5 workforces. The Band 3 assistant workforce has now reached the levels specified within the Podiatry Workforce Plan.
- 3.16.4 Some further small changes may take place across the next five year period predicated upon a reduction in the number of administrative staff required following TrakCare implementation and a further reduction in management roles to supplement services to high risk podiatry.

2016/17 Workforce Actions – Podiatry

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| <ul style="list-style-type: none"> • Implementation of the final stages of the Podiatry workforce plan |
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3.17 Orthotics

- 3.17.1 To support the implementation of MSK foot and ankle pathways the Orthotic service has delivered training to all staff in differential diagnosis, Ionising Radiation (Medical Exemptions) Regulations, X-ray interpretation, exercise prescription, “raising the issue”, signposting and use of “exit routes”. The amount of clinical time per episode has risen to reflect these additional processes and has reduced the need to refer on to other services. To balance this, the service, having researched the evidence base in 2015 as part of another nationally funded project, has aligned service delivery with the evidence removing treatments without sufficient evidence from the departmental portfolio.
- 3.17.2 Waiting times across the service are being actively reduced towards the 4 week MSK target. This is allowing the service to become more focussed on the treatment of acute conditions rather than simply managing the chronic conditions which historically were arriving at the service at 30 weeks post injury and beyond. To support early access to the Orthotic service the referral base has been extended from medical consultant only to include GPs and, as of 1st Nov 2015, any registered healthcare professional.
- 3.17.3 A Scottish Government National project being hosted by NHSGGC will deliver a web portal with associated algorithm through which patients will be able to re-access the Orthotic Service without the need for a healthcare referral. This will improve access and reduce the need for appointments with other healthcare professionals. To balance the demand on the service some aspects of Orthotic service delivery are moving to a protocol-based approach for delivery by Band 3 assistant practitioners.
- 3.17.4 The recent integration of the Clyde Orthotic service has enabled skill mix to be re-aligned across the department reducing Band 7 costs and increasing the Band 5 WTE. Departmental staffing is therefore not planned to change in 2016/17.
- 3.17.5 AHP opportunities to support medical teams have arisen and there are now Advanced Practitioners (Extended Scope Orthotist in Orthopaedics) and a Specialist Orthotist delivering injections in the spasticity clinic with two others in training.

2016/17 Workforce Actions – Orthotics
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| <ul style="list-style-type: none"> • Roll out of Assistant Practitioner roles to deliver protocol-based healthcare under supervision • Support the training and supervision of practitioners extending their scope |
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3.18 Other Therapeutic Staff – Psychology

- 3.18.1 NHSGGC currently performs better than most areas of Scotland in relation to access targets for psychological therapies and CAMHS community services.
- 3.18.2 The CAMHS Report²⁴ outlines the performance and improvements made during the past two years alongside the detail of how this will be maintained or further improved with access to the new Scottish Government funds and initiatives once the detail of these have been made available.
- 3.18.3 The Psychological Therapies Report²⁵ highlights actual performance during the past four years and how we will manage the risks associated with the delivery of this target. Linked to the ongoing delivery of these targets will be our work with the Mental Health Access Improvement Support Team (MHAIST) during 2016/17.
- 3.18.4 In June 2016 NHS Education for Scotland (NES) contacted NHSGGC to advise about workforce development funding being available to support services in meeting LDP access standards for Psychological Therapies and CAMHS. These resources are part of the wider package of £54 million of funding (for NHSScotland) over four years announced by the First Minister in January 2016.
- 3.18.5 NES will provide funding to support NHSGGC in a number of areas including recruitment to service posts and trainee posts as well as service backfill to enable release of staff for specific training. They will also continue to offer a range of training and education to NHSGGC staff. These resources are being offered as part of a strategic plan to help increase the capacity of the workforce to deliver evidence based interventions in Psychological Therapies and CAMHS.
- 3.18.6 Monitoring arrangements will be agreed with NES to include monitoring the growth of the workforce from the current baseline, and the wider impact on services including clinical outcomes.
- 3.18.7 A significant proportion of the funding from NES is for service posts to support stepped-care models of service delivery by providing training, coaching and supervision in evidence-based interventions.

2016/17 Workforce Actions – Psychology

- Work with NES to recruit Psychology posts to support older people's services/applied psychology and other relevant areas where there is potential to create capacity for delivering psychological interventions within primary care services

3.19 Other Therapeutic Staff - Pharmacy

- 3.19.1 The Pharmacy Prescribing & Support Unit (PPSU) will continue to develop the service in line with Scottish Government (SG) health directives including 'Prescription for Excellence' (PfE), local NHSGGC priorities including the Clinical Services Strategy and changing patient pharmaceutical care needs.

²⁴ <http://www.nhsggc.org.uk/media/237728/camhs-report.pdf>

²⁵ <http://www.nhsggc.org.uk/media/237729/psychological-therapies-report.pdf>

- 3.19.2 PfE is a ten year vision and action plan for pharmacy in Scotland with the ambition that “all patients will receive high quality pharmaceutical care from clinical pharmacist independent prescribers”. “This will be delivered through collaborative partnerships with the patient, carer, GP, social care and the independent sector so every patient gets the best possible outcomes from their medicines, avoiding waste and harm.” PPSU has developed several early actions to progress this plan.
- 3.19.3 In summer 2015 the Scottish Government announced details of Primary Care Investment Funding to support the primary care workforce across Scotland and improve patient access to service [www.sehd.scot.nhs.uk/pca/PCA2015\(P\)16.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2015(P)16.pdf). The circular detailed funding allocation for Pharmacists in GP Practices including additional Prescription for Excellence Funding to March 2018. The expectation was to recruit pharmacists to work directly with GP practices to support the delivery of care to patients with long-term conditions and free up GP time to spend with other patients. Alongside this investment, Inverclyde HSCP was identified to pilot the new GMS contract model for ‘new ways of working’. The 2016/17 Primary Care Funding Allocation for Pharmacists in GP Practices allocation (PCA (P) (2016) 2) [www.sehd.scot.nhs.uk/pca/PCA2016\(P\)2.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2016(P)2.pdf) is £1.4m inclusive of additional funding for Inverclyde HSCP GMS ‘new ways of working’ pilot.
- 3.19.4 In total 16.4WTE pharmacists and 6.8WTE prescribing support technicians have been appointed with recruitment for another 7WTE prescribing support pharmacists underway. Appointments also include joint posts between acute and primary care and a service level agreement agreed with community pharmacy on the basis of 0.4WTE prescribing support and 0.6WTE community pharmacy.
- 3.19.5 The modernisation of NHSGGC Acute Care and Mental Health services has released pharmacy staff to deliver patient focussed roles and was facilitated by the introduction of large scale robotics. Centralisation of services and the introduction of technology to redesign service delivery are in line with the PfE recommendations. This major change in practice is underpinned by ongoing skill mix review for all groups of staff, with a shift of focus from the product to the patient. Benefits are evident in improved patient facing interaction, reduced dispensing time, error reduction and cost savings. These benefits are in line with the finding of the Carter Review in NHS England that established that the efficient and effective use of medicines in hospital is directly linked to the pharmacy service. The report identified that centralisation and automation of the pharmacy service releases staff for bedside care.
- 3.19.6 The Acute Division workforce changes have focussed on developing effective ward based pharmacy teams comprising pharmacy support workers, pharmacy technicians and pharmacists who are responsible for the delivery of pharmaceutical care to patients across the managed service. This programme will evolve with support from the NHSGGC Clinical Services Strategy to include practice pharmacists and technicians in primary care settings. Pharmacists are taking on additional roles, particularly independent prescribing. Technicians are engaging in patient facing delivery of care and many are authorised to check dispensed medicines. Support workers and administrative staff are undertaking an increasing range of essential support and co-ordination functions.

- 3.19.7 NHSGGC pharmacists have developed and adopted triage and referral tools to prioritise and target the service to patients in a systematic fashion which recognises capacity limitations and manages risk. There is a political and clinical imperative for 'Whole Week Working', with an emerging evidence base that the pharmacy service should be available for an extended working day and seven days per week in some areas where there is high demand. This has been explored via partnership working and will require additional pharmacy staff to backfill current Monday to Friday services. Short term funding has been secured for two pharmacists and two pharmacy support workers.
- 3.19.8 The administrative workforce comprises a wide variety of roles spanning from Band 2 up to Band 8a. Local education initiatives are in place to support administrative staff undertaking SVQs appropriate to their role and linking to succession planning and in line with the NES Career Development Framework.
- 3.19.9 Across the Community HSCPs, PPSU has supported the development of Prescribing Support Teams which are delivering cost efficiencies and improved quality of primary care prescribing practice. Skill mix review is also a feature of this development with increasing responsibility being assigned to community pharmacists and to specialist pharmacy technicians who support the GPs and the Prescribing Support Pharmacists. Investment in this activity can demonstrate both cost and quality improvements. Lead Clinical Pharmacists working in Primary care are operating clinics to manage case loads of patients with long term conditions reducing pressure on GP appointments. This is in line with the PfE vision of "General Practice Clinical Pharmacists" and has the potential to reduce demand on GP's and offering a part solution to GP manpower shortages.
- 3.19.10 The need for ongoing efficiencies will clearly influence all aspects of service provision, with concerns about cost effectiveness and affordability in prescribing practice, driven by the ageing population, increasing prevalence of long term conditions and the emergence of innovative therapies from the pharmaceutical industry. SG has indicated that NHS Board Pharmaceutical Care Services Plans should be subject to wide ranging review and redesign with the aim of enhancing the role of the pharmacist and encouraging closer working with GPs and other community based services. This will examine the pharmaceutical needs of patients and the arrangements for providing NHS Pharmaceutical Services to ensure safe and effective care to patients in the community. In hospital practice it is known, from the Carter Report, that for every £1 invested in the Pharmacy Service £5 in greater efficiency can be realised from efficient use of medicines, shorter lengths of stay²⁶.
- 3.19.11 The PPSU Community Pharmacy Development Team is facilitating a significant programme of change in professional roles in community pharmacy through the Chronic Medication Service (CMS) which is a partnership between the GP, pharmacist and patient to improve the safe, effective and cost effective use of medicines used in long term conditions. This links directly to the vision in PfE that pharmacists working in community locations are independent prescribers, working in close partnership with the medical profession. The aim is that post diagnosis patient caseloads will be selectively allocated by GPs to the local prescribing pharmacists who will manage the patient's medicines by conducting regular consultations to review progress, monitor outcomes and prescribe the appropriate medicines.

²⁶

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/434202/carter-interim-report.pdf

3.19.12 The Scottish Government have recently announced an intention to review the Minor Ailments Service available through community pharmacy with a view to extending the range of the service. This may result in reduced demand in A&E and within GP practices in the future. It can be deduced at this early stage that an increase in patient facing services provided by community pharmacy will lead to a growing demand for pharmacists and pharmacy technicians.

3.19.13 There are many drivers for change in pharmacy workforce arrangements across all sectors of the profession, both locally and nationally. Advances in information technology are central to the safe, effective and efficient use of medicines with a focus on prescribing, medicines management and pharmaceutical care in NHS hospitals, integrating with the e-health record. We anticipate an IT infrastructure supporting the emergency care summary, medicines reconciliation, electronic prescribing / medicines administration and the immediate discharge letter. The pharmacy workforce also needs to be responsive to ambulatory care developments, the shifting balance of care from acute to primary care services, the developing health care and social care integration and the need to support integrated pharmaceutical services in hospital and the community settings as described in the SG 2020 vision for Health and Social Care.

3.19.14 The latest NHSGGC Workforce information does not highlight any particular concerns for PPSU. The number of staff working part time hours has increased gradually over the past eight years and this is reported across all the main pharmacy staff groups. The workforce includes several senior professionals in essential leadership roles and highly specialised positions in the older age ranges, such that succession planning must be prioritised. Overall, the availability of qualified pharmacists in Scotland is currently satisfactory but there are gaps in experience and knowledge base in some specialist pharmaceutical fields in particular for the technical specialities such as aseptic preparation.

2016/17 Workforce Actions – Pharmacy
<ul style="list-style-type: none">• Implement the workforce changes out in the workforce plan and workforce projections

3.20 Healthcare Sciences

3.20.1 NHSGGC continues to review its laboratory workforce to ensure it's in line with the demands of the service. Following a significant review culminating in the move into a brand new laboratory in 2012 on the Queen Elizabeth University Hospital Campus and the more recent completion of the New Lister Building at Glasgow Royal Infirmary in 2014 have ensured NHSGGC is at the forefront of emerging technology in Healthcare Sciences.

3.21 Personal and Social Care

3.21.1 NHSGGC recognises that it is essential to have a health improvement workforce that is fit for purpose and that can respond to the challenges of improving health and reducing inequalities in health.

3.21.2 The NHSGGC Health Improvement workforce is primarily employed by individual HSCPs and it will be their responsibility to develop this part of the workforce depending upon local requirements.

3.22 Support Services

- 3.22.1 The anticipated small reduction in the support services workforce reflects an ongoing trend of efficiency as the decommissioning of the NHSGGC estate continues.

3.23 Administrative Services

- 3.23.1 The projected reduction in this job family reflects a continued contraction in administration staff resulting from efficiencies achieved from ongoing reviews of administrative processes.
- 3.23.2 Extending use of technology across the service should secure productivity increases and reduce the need for replacement of administrative staff lost to the workforce via natural turnover. Economies of scale should also be possible as a result of NHSGGC's consolidation of hospital sites.

2016/17 Workforce Actions – Administrative Services

- Continue to review the requirement for administrative posts in the context of continuing technological developments and change

3.24 Senior Managers

- 3.24.1 A target of 25% reduction in senior managers was set by the Scottish Government in 2010 for completion in 2015. NHSGGC met and exceeded this target in line with the SGHD directive.
- 3.24.2 Further reductions in the senior management staff cohort are also expected to be achieved during 2016/17.

2016/17 Workforce Actions – Senior Managers

- Continue to reduce the number of Senior management posts within the organisation through natural turnover

3.25 Projections by Job Family

- 3.25.1 Table 3.25 shows the anticipated workforce changes by Job Family for 2016/17. Overall it is anticipated that there will be an increase of 58.1 WTE in the NHSGGC Workforce during 2016/17.

NHS Greater Glasgow & Clyde	
2016/17 Workforce Projected Summary	
Job Family	WTE Change
Administrative Services	-92.50
Allied Health Profession	5.20
Executive	-5.00
Healthcare Sciences	-8.80
Medical and Dental	3.80
Medical and Dental Support	-0.80
Nursing and Midwifery	131.00
Other Therapeutic	34.20
Personal and Social Care	0.00
Support Services	-9.00
Grand Total	58.10

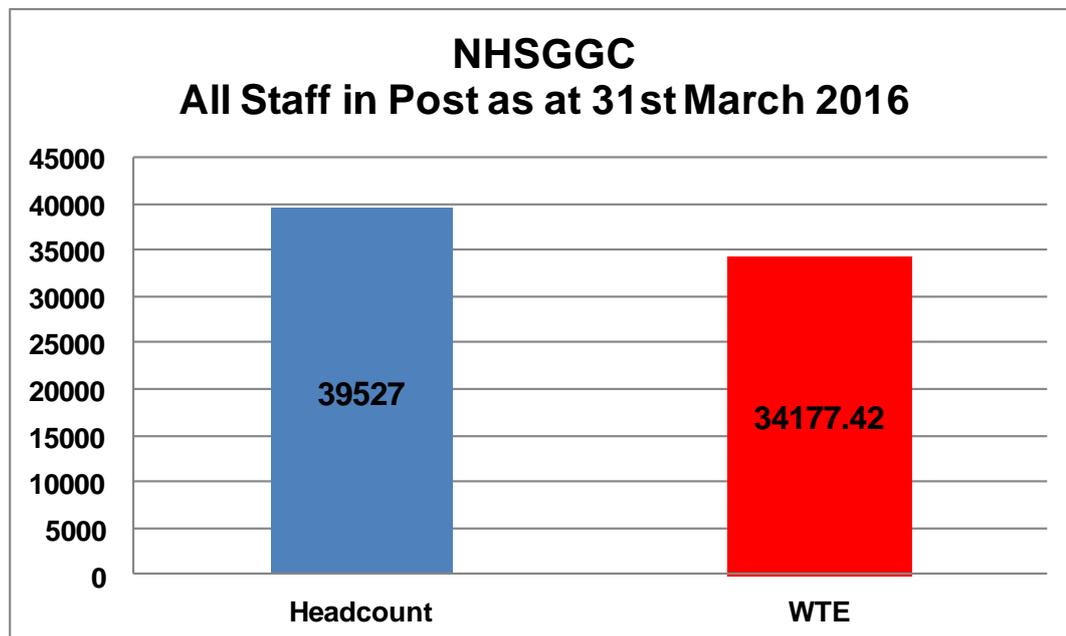
3.25.2 These changes are associated with the increases in the Nursing and Midwifery, Pharmacy and AHP job families described within this section. Additionally, there may be an increase in the Psychology workforce following the commencement of the new NES funding streams from October onwards.

4 Section Four

The NHSGGC Workforce

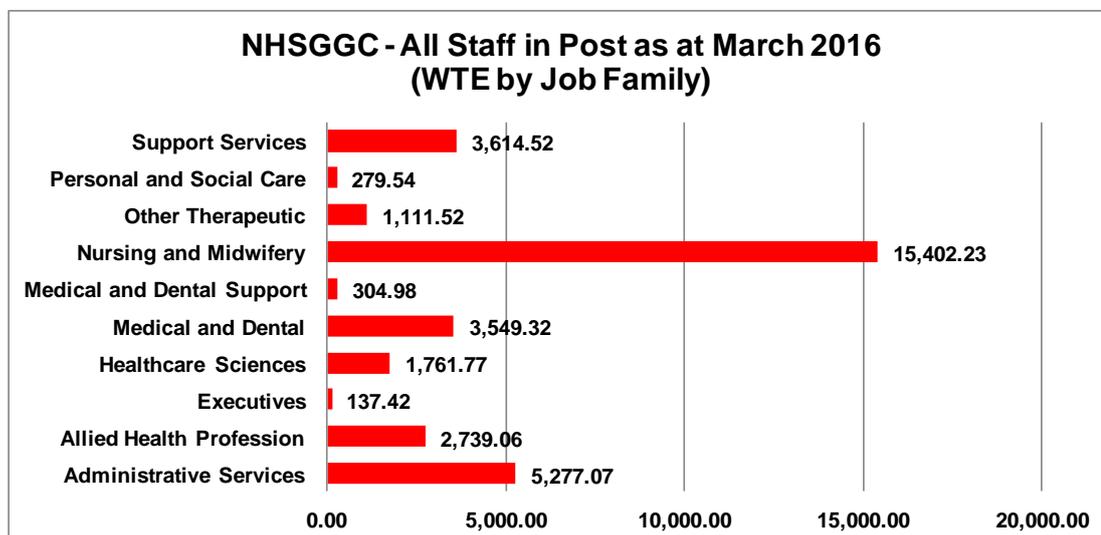
4.1 Characteristics of the NHSGGC Current Workforce

- 4.1.1 On 31 March 2016, NHSGGC employed 39,527 headcount staff, 34,177.4 Whole Time Equivalent (WTE). NHSGGC has a predominantly female (80%) workforce.



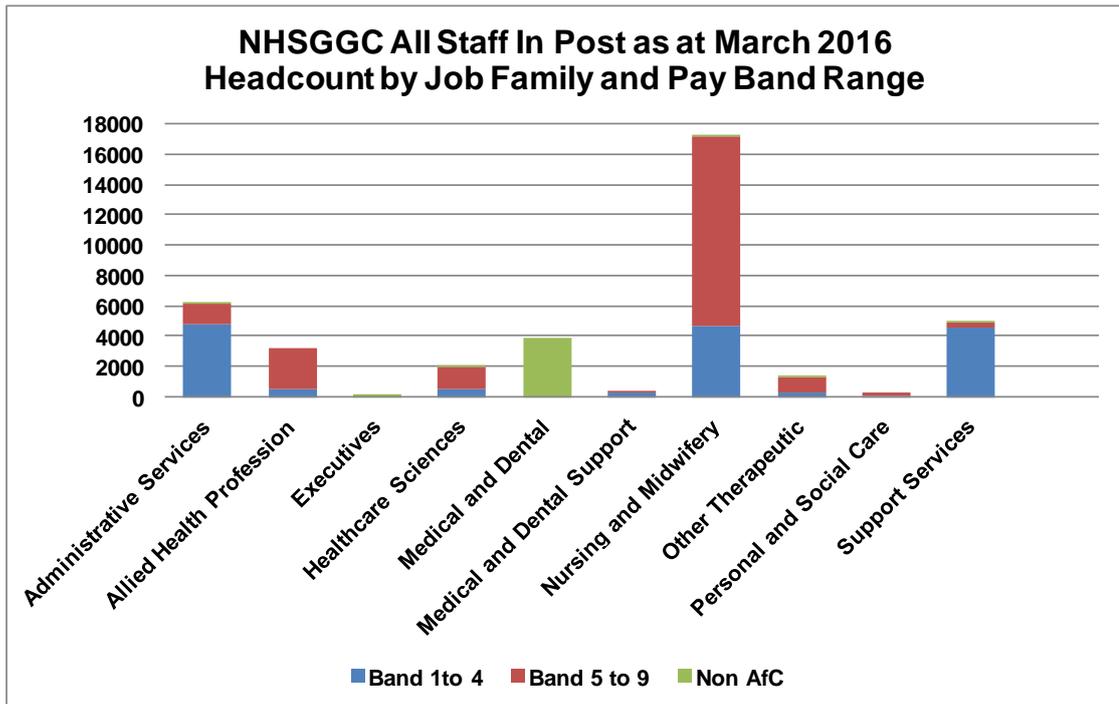
4.1.2 Job Families

- 4.1.3 A summary of the NHSGGC WTE workforce by Job Family is shown below:

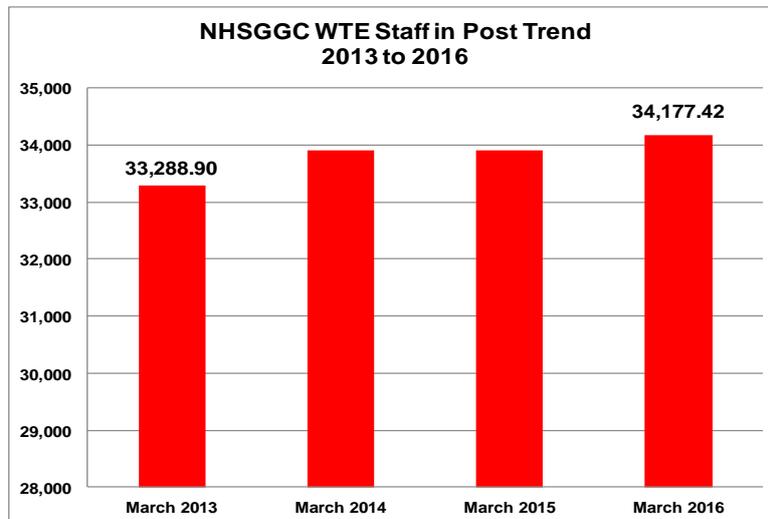


- 4.1.4 The chart below shows the workforce by job families by pay groupings. Pay bands are grouped by Agenda for Change bands 1 to 4, 5 to 9 and Non Agenda for Change bands such as medical grades, senior managers and other grades including staff from partner organisations who transferred on their existing pay arrangements under the Transfer of Undertakings and Protection of Employment (TUPE) legislation.

FIGURE 4.1.4



4.1.5 In the last four years NHSGGC has, despite an increasingly difficult financial environment, been able to deliver an increase of circa 900 WTE in the inpost workforce.



4.1.6 While these increases are to be welcomed, over the next 10 years NHSGGC faces a challenge to ensure that a suitably qualified and trained workforce is available to deliver our services.

4.1.7 In respect of our workforce our main challenges will be:

- Managing the impact of the age profile within our current workforce where many staff are aged over 55 years and may choose to retire in the coming years
- Our ability to successfully recruit to key specialties and job families
- Reducing the level of expenditure on Locum, Agency and Bank staffing

4.1.8 Ageing Workforce

4.1.9 The table below shows the NHSGGC workforce (headcount) by age-grouping:

2014 to 2016 Age Grouping Comparison				
Headcount as a % of Total Inpost				
Age Group	2014 Headcount	2015 Headcount %	2016 Headcount	2014 -2016 Variance
16 to 24	3.6%	3.8%	4.3%	0.7%
25 to 40	33.0%	32.8%	33.1%	0.1%
41 to 50	30.9%	29.3%	27.7%	-3.2%
51 to 60	26.2%	27.2%	29.4%	3.2%
Over 60	6.4%	6.8%	5.5%	-0.9%

4.1.10 The NHSGGC workforce displays a small percentage of staff aged between 16 and 24 years old (4.3%) an increase of 0.7% on the 2014 figure. This increase is encouraging given NHSGGC has for some years been actively supporting and developing programmes specifically aimed at increasing the number of younger staff within the workforce. These initiatives include Schools Engagement and Work Experience Programmes, Project Search - Training & Employment Opportunities for Young Disabled People and the Modern Apprenticeship Scheme. Further details of these programmes are contained in section five of this plan.

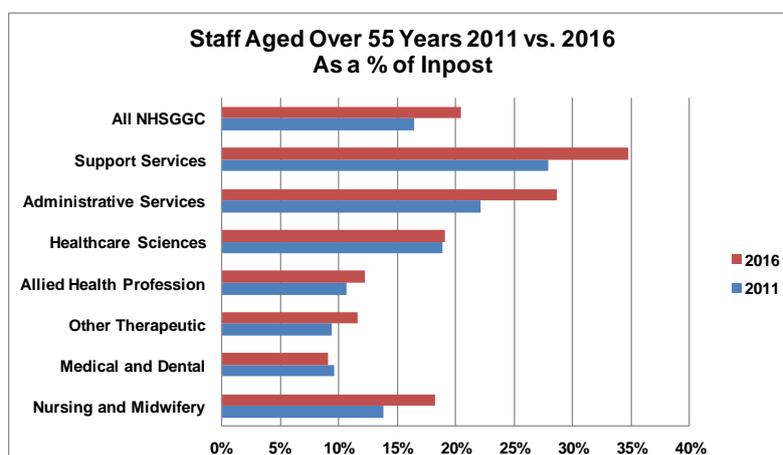
4.1.11 35% of the NHSGGC Workforce is over 50 years old. The proportion of the workforce aged over 50 has increased by 2.3% over the last two years. This is consistent with the anticipated ageing of the NHSGGC workforce.

4.1.12 The proportion of the workforce aged over 60 has reduced by 0.9% likely due to an increase in the number of/and the observed trend for earlier retireals (this figure is broadly offset by the increase in the 16 to 24 and 25 to 40 year olds within the workforce.

4.1.13 Of more concern is the 3.2% reduction in the 41-50 year age bracket which mirrors exactly the increase in the 51 to 60 year age band. This suggests that there is a “static” element to the NHSGGC workforce gradually cascading into the older age groupings.

4.1.14 Figure 4.1.15 shows the percentage change in the number of staff aged over 55 years old across the last five years (55 years identified as point where staff are approaching retiral age).

FIGURE 4.1.15

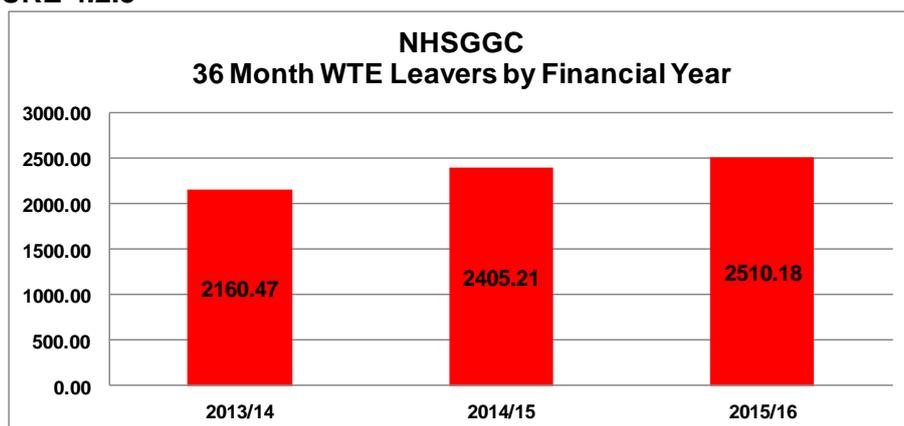


- 4.1.15 In the last 5 years, across the NHSGGC workforce there has been an increase of 4 percentage points in the number of staff aged over 55. Some Job Families are affected more than others.
- 4.1.16 Within the Support Services workforce almost 35% of staff are over 55 with 29% of Administrative Services staff in the same age bracket. 18% of our Nursing and Midwifery staff are over 55, a 4% point increase on the figure in 2011. Allied Health Professions, Healthcare Sciences and Other Therapeutic staff exhibit smaller increases.
- 4.1.17 Only the Medical and Dental workforce displays a younger workforce profile than was the case five years ago. This is likely to be the result of an increased level of retirals amongst the Medical Consultant workforce due to changes in tax and pension legislation.

4.2 Turnover

- 4.2.1 Turnover, expressed as total leaver WTE divided by in-post WTE at the beginning of the year. Within NHSGGC, for financial year 2015/16 was 7.71%. A turnover level of 7.71% for NHSGGC results in approximately 2,500 WTE leavers.
- 4.2.2 This figure has increased by almost 1.2 percentage points in comparison to the 2013/14 which was 6.5% (or 2160 WTE staff).

FIGURE 4.2.3



- 4.2.3 Turnover does vary between job families. A table summarising turnover in 2014/15 is shown below:

FIGURE 4.2.4

NHSGGC Leavers* 2015/16			
Job Family	Average WTE Inpost	WTE Leavers	% Turnover
Administrative Services	5,277.07	423.41	8.02%
Allied Health Profession	2,739.06	218.27	7.97%
Executives	137.42	16.00	11.64%
Healthcare Sciences	1,761.77	137.50	7.80%
Medical and Dental - Career Grades	445.08	26.99	6.06%
Medical and Dental - Consultant	1,505.44	99.26	6.59%
Medical and Dental Support	304.98	14.10	4.62%
Nursing and Midwifery	15,402.23	1,220.49	7.92%
Other Therapeutic	1,111.52	115.04	10.35%
Personal and Social Care	279.54	18.69	6.69%
Support Services	3,614.52	220.44	6.10%
Total	32,578.62	2,510.18	7.71%

* Excludes Medical and Dental Training Grades

- 4.2.4 Turnover levels within the majority of job families is within accepted norms (i.e. under 10%) with only the Executive and Other Therapeutic job families exceeding this figure.
- 4.2.5 Turnover in the Nursing & Midwifery workforce (the largest job family) rose by 1.2% points in 2014/15 compared to the previous year.
- 4.2.6 Increases in turnover were also noted in the Allied Health Professions (+0.41%) and Healthcare Sciences workforce (+2.05%).

4.3 Reasons for Leaving

- 4.3.1 Reasons for leaving have been grouped into a series of broad headings based on the information provided by managers completing information Notification of Termination Forms.
- 4.3.2 The primary reason for leaving during 2015/16 was “resignation” followed by “retiral” (this includes normal age pension retirals and early retirals with actuarial reductions in pensions received). The number of resignations and retirals showed an increase on the 2014/15 figures.
- 4.3.3 Smaller numbers were noted as End of Fixed term Contracts and Ill Health terminations. Again there were small increases in the figures when compared to last year.

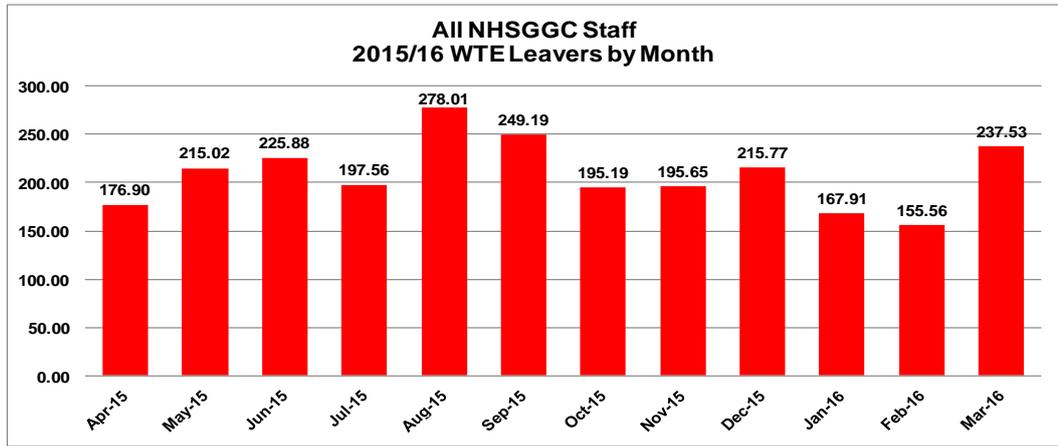
FIGURE 4.3.3

NHS Greater Glasgow and Clyde								
2015/16 Leavers by Month and Reason for Leaving (WTE)								
Month	Resignation	Retiral	End of Fixed Term Contract	Ill Health	Death in service	Dismissal	Leaving Reason not provided	Grand Total
Apr-15	79.46	48.47	5.90	17.90	2.92	2.62	19.62	176.90
May-15	103.95	69.93	1.32	11.73	4.59	2.00	21.49	215.02
Jun-15	92.22	80.14	8.90	11.07	2.80	2.77	27.98	225.88
Jul-15	86.16	60.20	15.76	5.41	0.40	2.44	27.20	197.56
Aug-15	118.00	74.50	23.46	21.04	2.57	5.42	33.01	278.01
Sep-15	118.43	66.18	16.86	13.80	1.99	1.57	30.36	249.19
Oct-15	103.45	51.52	3.47	13.69	0.92	2.00	20.14	195.19
Nov-15	91.80	45.34	3.50	16.44	4.59	1.77	32.20	195.65
Dec-15	113.57	48.76	18.60	9.21	1.49	2.80	21.34	215.77
Jan-16	87.47	41.67	2.00	12.56	2.60	2.67	18.94	167.91
Feb-16	69.69	45.42	4.95	12.63	3.00	7.17	12.69	155.56
Mar-16	92.55	91.72	13.48	10.97	1.00	1.80	26.01	237.53
2015/16 Total	1,156.76	723.86	118.20	156.45	28.87	35.03	291.00	2,510.18

- 4.3.4 Approximately 12% of Notification of Termination forms submitted by managers failed to provide a reason for staff exiting the organisation. Human Resources and Organisational Development will be rolling out a more structured exit information process during 2016/17.

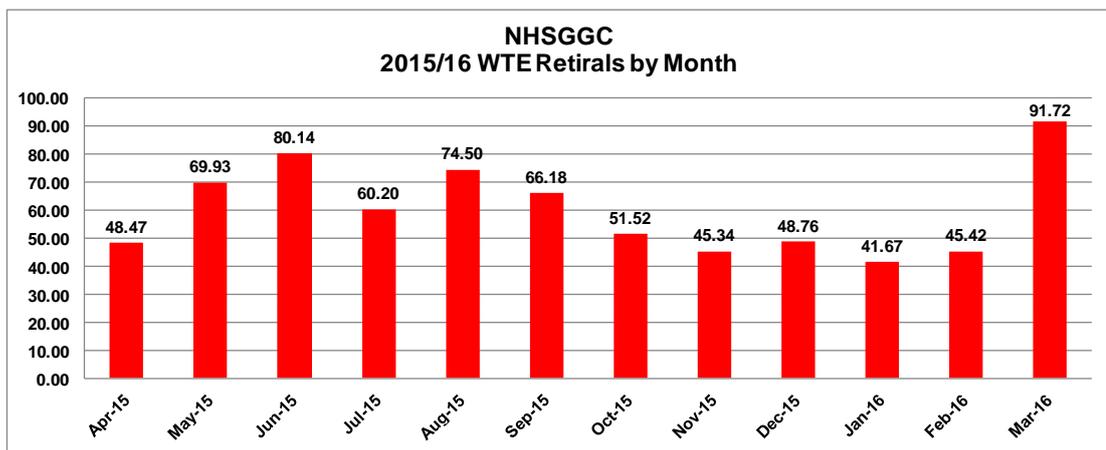
4.4 Monthly Leavers Trends

- 4.4.1 Leavers activity remained relatively consistent during most months of the financial year however distinct “peaks” in leaver activity were noted in the summer months of August/September and there was a noticeable rise in March 2016 the final month of the financial year. This mirrors the pattern of leavers observed in previous years although the variance between “peak” and standard months was smaller in 2015/16 than in previous years.

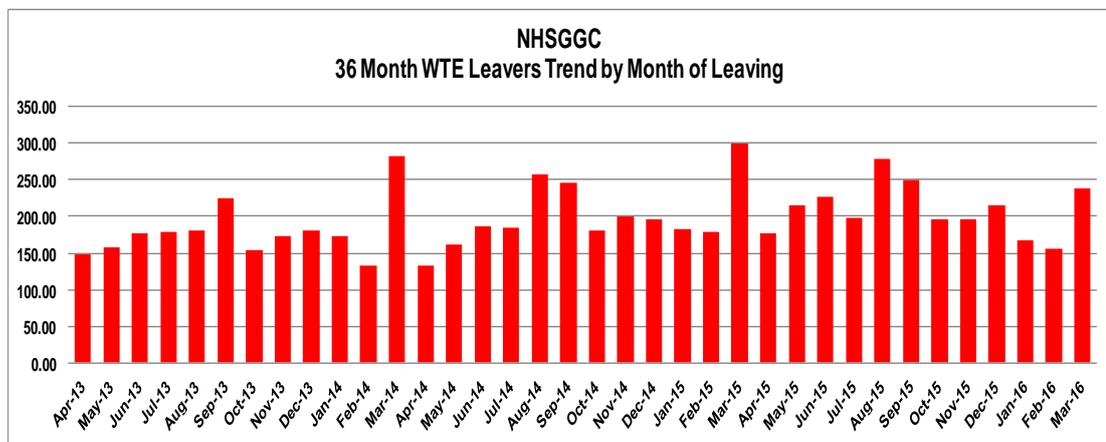


4.4.2 In the 2015/16 workforce plan NHSGGC observed a peak in retiral activity in March 2015 where the level of retirals more than double compared to other months within the year.

4.4.3 This pattern has been observed across the last twelve months and the retiral figure for March 2016 is, again higher than the figures during the rest of the year however the variance in the number of retirals in March is not as high noted in the previous financial year.

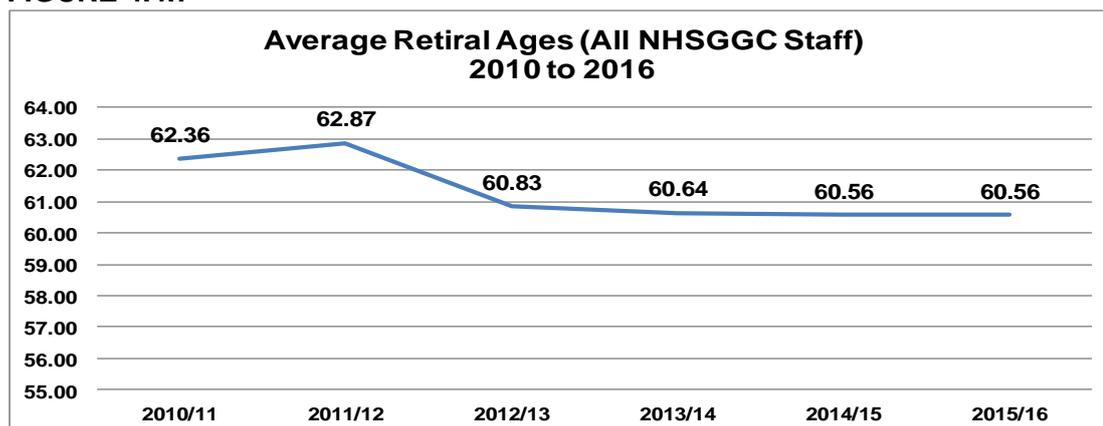


4.4.4 An analysis of the 36 month trends across the last three full financial years suggests that the summer increase in resignations and March retirals seems to be a consistent trend.



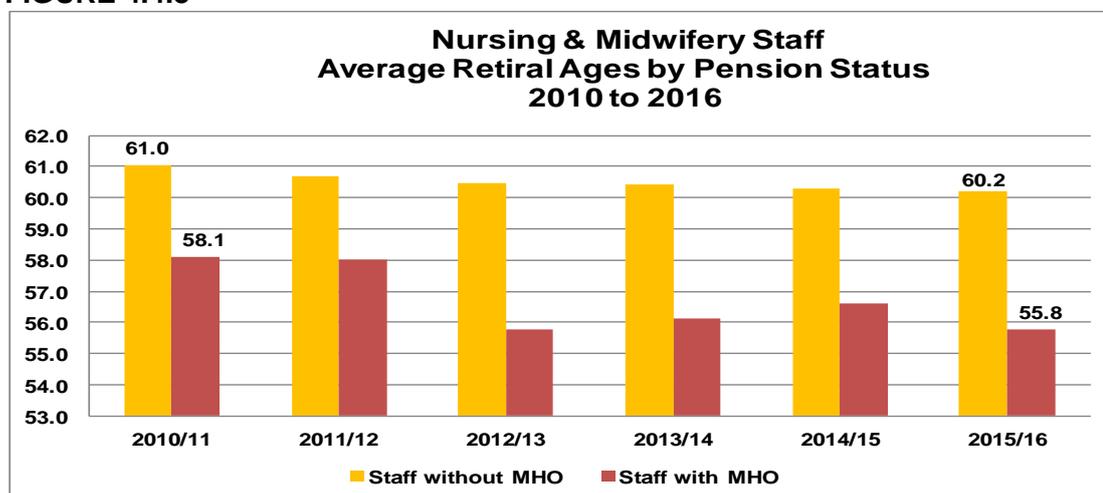
- 4.4.5 The changes observed in retiral behaviour may be due to recent amendments to the NHS pension scheme which require additional pension contributions from staff and a move to a career average contribution calculation.
- 4.4.6 In last year's workforce plan NHSGGC speculated that these changes may prompt staff reaching retiral age to leave the organisation rather than work additional years.
- 4.4.7 The Workforce Analytics team has undertaken an analysis and identified an underlying trend which shows that the average age of staff leaving the organisation through retiral has decreased by approximately 2 years since the 2011/12 financial year.

FIGURE 4.4.7



- 4.4.8 Some NHS Job Families are affected to a greater degree by this trend. Figure 4.4.8 below shows the trend the retiral ages for NHSGGC's nursing and Midwifery workforce since 2010.

FIGURE 4.4.8



- 4.4.9 Whilst the average retiral age for Nursing and Midwifery staff has reduced from 61 years old to just over 60 years old, the trend within Mental Health Nursing shows a more notable reduction.
- 4.4.10 Within our Mental Health Services workforce (especially Mental Health and Learning Disability Nursing) the issue of the ageing workforce is exacerbated by two additional factors:
 - Mental Health Officer Status which allows some staff members to retire at age 55 years with full pension benefits

- Changes to NHS pension provision

4.4.11 Mental Health Officer (MHO) status applies to certain groups of staff who were members of the pension scheme prior to 1st April 1995 and was given in recognition of the nature of the work undertaken.

4.4.12 MHO status affords staff an earlier Normal Pension Age (NPA) of 55 rather than the age 60 NPA for other members and all completed years service beyond 20 years are doubled for pensionable purposes meaning staff can reach 40 years pensionable service after 30 years reckonable employment with MHO status.

4.4.13 Under the new 2015 Pension scheme normal retiral age will increase in line with the state pension age for most NHS staff.

4.4.14 It is anticipated that the majority of staff with MHO status who can retire prior to 2022 are likely to do so as it would be financially favourable.

4.4.15 A significant proportion of the NHSGGC Mental Health Services workforce has MHO status and are approaching (or have already reached) 55 years old when they can retire. Across the next five year period the workforce plan projects that the level of retirements across Mental Health Services will increase given that the revised pension provision will effectively mean that staff currently aged 50 and above who possess MHO status will have to retire at 55 years old or otherwise work to the new normal pension age of 67 years old.

4.4.16 Leavers, resignation and retiral numbers will continue to be monitored in order to establish whether there is any discernible pattern which will assist in improving projection for workforce planning purposes.

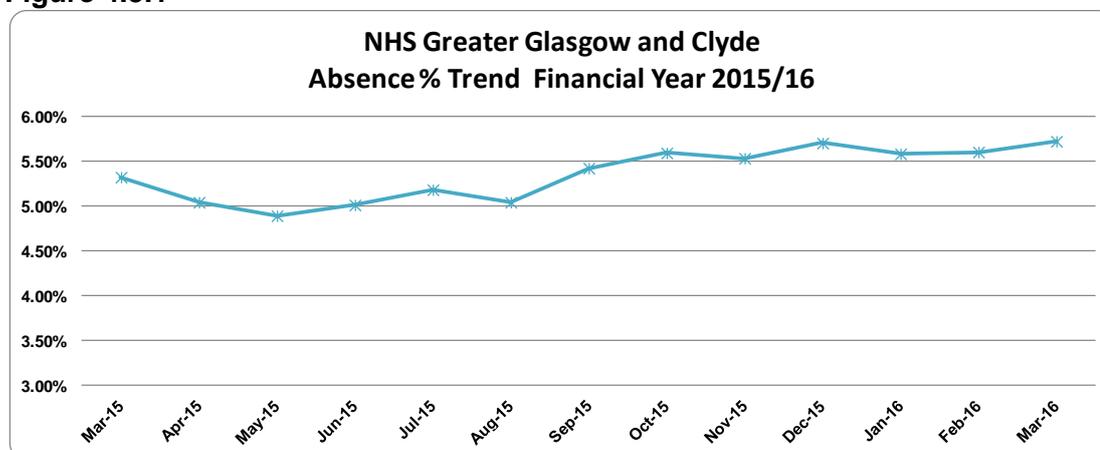
2016/17 Workforce Actions – Turnover

- Continue to monitor leavers trend data such as levels of turnover, reasons for leaving and retiral ages across the NHSGGC workforce

4.5 Sickness Absence

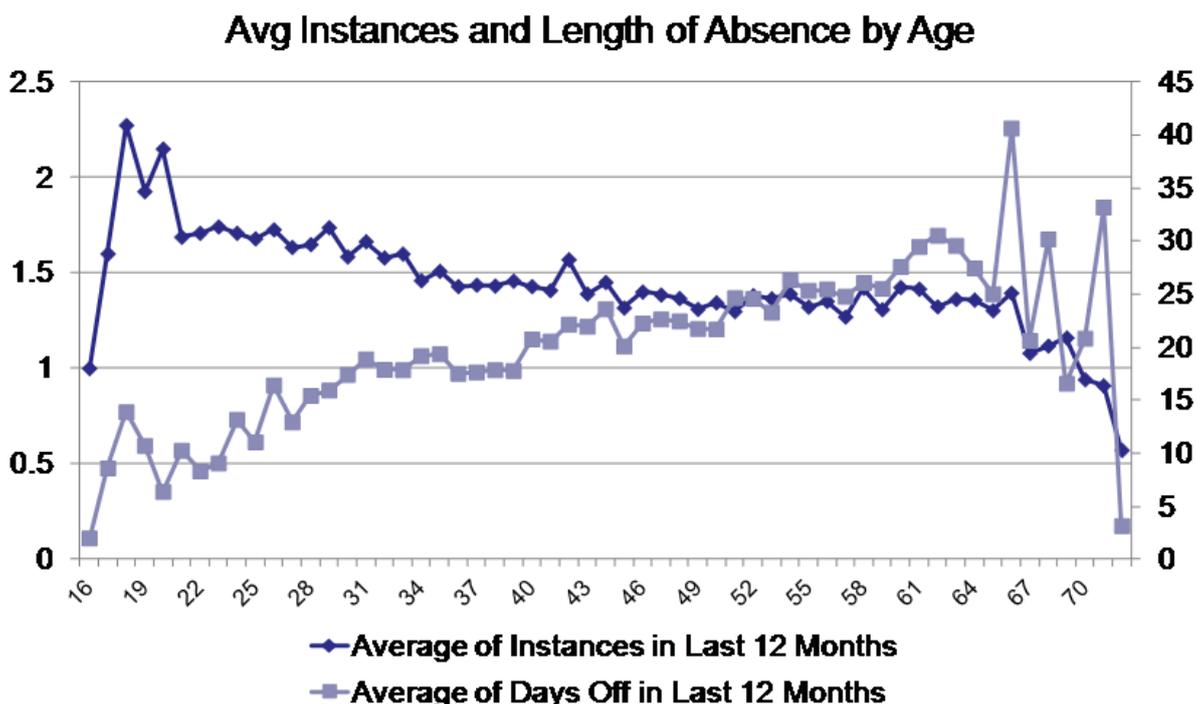
4.5.1 Figure 4.5.1 shows the sickness absence percentages observed for NHSGGC staff during financial year 2015/16. The absence levels noted are consistently above the 4% national sickness absence target.

Figure 4.5.1



- 4.5.2 NHSGGC estimates that each additional 1% sickness absence costs the organisation £10 million in lost work, and agency/locum/overtime/bank backfill expenditure. This being the case a reduction in sickness absence presents the opportunity for significant cost savings.
- 4.5.3 Paragraph 4.1.8 noted that NHSGGC has an ageing workforce and the workforce information and analytics department has identified absence patterns associated with staff age.
- 4.5.4 Figure 4.5.4 shows that younger staff have more episodes of short term absence. As staff age this pattern changes to show fewer instances of absence however the average duration of each episode is longer.

Figure 4.5.4



- 4.5.5 Service areas are supported by the Human Resources and Organisational Development Directorate to deliver appropriate interventions including Occupational Health Service involvement.
- 4.5.6 With the full establishment of the new Human Resources Support Unit, Attendance Management clinics are now in place across 'cluster' sites within the Board. Targeted support is in place in areas where continued high levels of absence remain a challenge.
- 4.5.7 A People Management Development Programme is now in place, with the first training module in Absence Management scheduled to run in the coming months. This has been widely publicised across all service areas to ensure as many managers as possible have the opportunity to attend.

5 Section Five

Supplying the Required Workforce

5.1 NHSGGC's Local Labour Market

- 5.1.1 Within the NHSGGC geographical area unemployment has begun to decrease over recent months but remains volatile as the economic recovery continues.
- 5.1.2 Glasgow, which accounts for the majority of NHSGGC's population, has had one of the highest unemployment rates of all local authorities within Scotland. Four out of the six local authority areas covered by NHSGGC are below the Scottish average employment rate.
- 5.1.3 Although recruitment generally is not difficult in the current economic environment NHSGGC still experiences some challenges when seeking to fill vacancies. The location of posts, the level of experience, specialist skills required and the nature of the contract or working pattern all impact on the ability to fill a vacancy.
- 5.1.4 Other factors which impact on NHSGGC's ability to recruit are:
- Location: NHSGGC includes a mix of urban and rural population centres and the requirement to travel significant distances can lead to a limited candidate pool;
 - Candidate availability: Certain skill sets are in high demand by both private and public sector. In the case of Sonographers, a long standing problem with recruitment was addressed by providing in-house training to develop an in-house workforce. This approach was also used in Laboratory sciences, Ophthalmology, Audiology and Medical Physics;
 - Contract Type: Flexible posts which require less than 16 hours can be challenging to fill.
- 5.1.5 When areas of difficulty are identified by services, Human Resources work in partnership to identify solutions and approaches which will alleviate recruitment difficulties.

5.2 Socially Responsible Recruitment

- 5.2.1 In NHSGGC the importance of employment in helping to tackle poverty and income inequality is well recognised and this link is articulated in the policy framework outcomes for 2016/17. This policy commitment recognises the link between worklessness and ill health which has been evidenced through research and which is set out in NHSGGC's policy paper on "Employability, Financial Inclusion and Responding to the recession".
- 5.2.2 Definition of Employability:
- "Enabling people to progress towards employment, get into employment, stay in employment and move on in the workplace".²⁷***
- 5.2.3 There is also a strong evidence base showing that work is generally good for physical and mental health and well-being. Worklessness is associated with poorer physical and mental health and well-being. Work can be therapeutic and can reverse the adverse health effects of unemployment and is generally good for health and well being.

²⁷ Scottish Government Definition

5.3 Youth Employment Plan and the NHSGGC Education Partnership

- 5.3.1 NHSGGC is committed to providing jobs, work experience and training opportunities for young people aged 16-24.
- 5.3.2 Since April 2014 NHSGGC has employed 660 new and young employees (aged 16-24 years).
- 5.3.3 A comparison of employee headcount in March 2015 and March 2016 shows an increase of 177 people within the 16-24 age range. This represents an increase of 0.43 percentage points to 4.3% of the total NHSGGC workforce.
- 5.3.4 It is our intention to continue our efforts to recruit and retain the services of young people in 2016/17 and this is reflected in the NHS Greater Glasgow and Clyde's Youth Employment Plan and the recently revised and expanded NHSGGC Education Partnership.
- 5.3.5 There are a number of work streams within the strategy, and this, along with the Education Partnership objectives, will see NHSGGC focus on the following areas:
- Raising awareness of NHS careers and jobs to ensure young people are aware of the range of jobs and careers available, and how these can be accessed. This will include activity to support job fairs, school work experience programmes and a careers information portal;
 - Development of new pathways into NHSGGC entry level posts which will include training and education as well as preparation for interviews and employment. This will be linked to a guaranteed interview scheme for appropriate entry level vacancies;
 - Further development and expansion of the NHSGGC Modern Apprenticeship Programme.
- 5.3.6 The success of the Youth Employment Plan and associated work in widening young people's access to NHS jobs relies on a multi-agency approach. This includes a range of organisations and the key partners working with NHSGGC to deliver work experience, employment and training opportunities include:
- NHSGGC Education Partnership (local FE and HE institutions, SDS, SQA, Glasgow City Council);
 - Glasgow Clyde College (MA Programme);
 - Skills Development Scotland;
 - Jobcentre Plus;
 - Local Authority Education Services;
 - Jobs & Business Glasgow.
- 5.3.7 The revised Youth Employment Plan recommendations are:
- Establishment of Phase 3 of the NHSGGC Modern Apprenticeship Programme to recruit up to a maximum of 70 apprentices in 2016/17;
 - Services will be asked to identify and implement appropriate models to increase the, work experience opportunities and pre-employment training programmes offered to 16-24 year over the next two financial years to align with SGHD aspirations. Such programmes should be delivered, where appropriate, with relevant external partner agencies;
 - Services should identify areas where, like Project Search, programmes can be established to support vulnerable young people with specific barriers to employment e.g. care leavers, learning disabilities, mental health issues. These interventions should be designed to support longer term transition to

employment and delivered in partnership with appropriate external support agencies. These programmes should include a work experience element as well as general employability skills and pastoral support.

5.3.8 To support the implementation of the above, and following the publication of the Scottish Government Youth Employment Strategy and the Wood Commission report, NHSGGC has revised and expanded the NHSGGC Education Partnership.

5.3.9 The Education Partnership will work on the following priorities:

- Review and refresh the current programme of activity which is aimed at raising awareness of NHS careers and jobs (e.g. job fairs, literature, school work experience programmes) ensuring that the young people of Glasgow and the West of Scotland are aware of the wide range of jobs and careers in the NHS and how these can be accessed;
- Design pre-employment programmes for young people which will deliver training and education for NHSGGC entry level posts and prepare them for interviews and employment;
- In tandem with the above, develop guaranteed interview schemes for young people aged 16-24 who meet the personal specification criteria set out in agreed job packs. Working with NHS managers we will identify the most appropriate service areas and geographical locations for these entry level posts
- Develop NHSGGC programmes to support young people from vulnerable groups who face barriers to employment and work with college and school partners to help young people find and keep jobs;
- Work with schools and colleges to ensure that NHS core values of care, compassion and person centeredness are infused through all health and care training/education programmes and that the young people we recruit understand and model these values;
- Continue to develop and expand the NHSGGC Modern Apprenticeship programme with the future focus on Health Care Sciences and the development of higher technical apprenticeships.

5.4 Modern Apprenticeship Programme

5.4.1 In 2015/16 NHSGGC appointed an additional 50 Modern Apprentices across Acute Services, Corporate Services and the HSCPs taking the total number appointed since the programme's inception in August 2013 to 101.

5.4.2 Of the first two apprentice intakes 27 have completed their apprenticeships and have moved into substantive employment and 5 have progressed into healthcare related university and college programmes upon completion. The remaining group of 53 are still in post and working towards completion of the programme. Upon successful completion the apprentices will move into substantive employment within NHSGGC

5.4.3 Development of the third cohort of the Modern Apprenticeship Programme is currently underway.

5.4.4 This will include an additional 75 new apprenticeship opportunities. The first appointments to this phase of the programme are scheduled for January 2017 with the remainder of the posts being filled before August 2017. This intake will cover variety of job role aligned to a broad range of Modern Apprenticeship frameworks across Acute, Corporate and Partnership services.

5.5 Schools Work Experience Programme

- 5.5.1 We continue to support a comprehensive schools engagement programme and the school work experience placements are core activities which inform important career related choices for school aged pupils while introducing the world of work.
- 5.5.2 During financial year 2014/2015 we offered 513 school pupils work experience placements within wards and departments. At present we offer c400 places per year to school pupils aged 16-18. The placements are managed and co-ordinated in conjunction with the Careers Service and School Careers Advisers and are committed to maintaining this level of support in 2016/17.
- 5.5.3 We will be working with Local Authority partners in 2015/2016 to review the work experience programmes in schools to ensure they reflect the recommendations made in Developing Scotland's Young Workforce and the Scottish Youth Employment Strategy.

5.6 Training & Employment Opportunities for Young Disabled People

- 5.6.1 Project Search is a targeted approach to help prepare young, learning disabled people to develop the necessary confidence and skills for work. This is an opportunity to combine practical work experience, with college-led input from a lecturer and specialist job coach.
- 5.6.2 The Project is a partnership between NHSGGC, Project Search, Cardonald College, Glasgow City Council and Job Centre Plus. The initial pilot project is focussing on the Facilities directorate, involving three 12 week rotations in e.g. Porterage, Catering and Domestic Services.
- 5.6.3 12 students with learning disability aged between 16-24 yrs commenced a 1 academic year programme in. The cohort was supported by two job coaches and each student has an identified 'buddy' in the workplace. The initial pilot project focused on the Facilities Directorate involving three 12 week rotations in e.g. Porterage, Catering and Domestic Services. Eight of the participants were appointed to NHSGGC Vacancies.
- 5.6.4 The second intake recruited another 12 participants in August 2014 and the programme was extended to include Health Records placements.

5.7 Work Experience Policy

- 5.7.1 NHSGGC also receive requests from adults (above school age/left school) for work experience placements. NHSGGC is committed to supporting these requests and since March 2015 have offered 154 adult work placements.
- 5.7.2 In addition to this, over the last 12 months (to June 2016), 420 senior-phase school placements have been offered.

5.8 Mental Health – Training & Employment Opportunities for Young People

- 5.8.1 Mental Health Services NHSGGC provides funding to deliver services across the employability spectrum for people with long term mental health conditions. This includes access to training, work preparation and employment opportunities.

5.9 Volunteering Policy & Programme

- 5.9.1 Although the scope of NHSGGC volunteering programme embraces people of all ages who wish to volunteer in the NHS, the policy does encourage participation from young people who are able to give a continuing commitment to a volunteer opportunity in the NHS. This programme in combination with the schools engagement programme is part of the strategy to encourage young people to come and work for the NHS.

5.10 Educational/ Development Placements

- 5.10.1 In addition to all of the above activity NHSGGC provides clinical placements for students from local higher education and further education establishments to support achievement of professional qualifications.
- 5.10.2 In recent years NHSGGC have supported the Scottish Government's scheme to provide work experience to newly qualified nursing graduates through the intern/one-year job guarantee scheme and have appointed 500 to date.
- 5.10.3 The one-year job guarantee scheme is a national scheme which was agreed by the SGHD in partnership with staff side. Its purpose is to enable newly qualified nursing staff, who have not yet secured permanent employment, to consolidate their training and skills.
- 5.10.4 The nurses are deployed as registered practitioners but are over and above the funded establishment and are not used as cover for permanent vacancies. The posts are also rotational to maximise the experience for the interns. On completion of the year's internship the nurses can apply for any available vacancies.
- 5.10.5 It is evident that there is a wide range of valuable activity underway within NHSGGC which supports young people towards employment ranging from capacity building to transitions into NHSGGC jobs.
- 5.10.6 In this time of economic and financial difficulty in the economy as a whole, and subsequently the public sector, there is a significant risk that young people will be particularly disadvantaged in securing employment. As a major employer in the west of Scotland NHSGGC has made a policy commitment to employability and will continue to support the Scottish Government Youth Strategy with an effective package of support for unemployed young people via the Youth Employment Plan.
- 5.10.7 In NHSGGC we are committed to ensuring that all our employees have access to training, learning and educational opportunities which will help them do their jobs, keep up to date with changing skill needs and new technology and develop new skills and competences which will enable them to move on in their careers if they wish.

5.11 Learning and Education

- 5.11.1 Learning and Education Advisers from Human Resources are located in all services and in addition to the specialist advice they can offer, many staff and managers also deliver training, education and development as part of their role. Some training is delivered by the Practice Development Teams and Practice Education Facilitators across NHSGGC and others by functional experts working in areas such as Health and Safety and Infection Control.
- 5.11.2 In respect of individual employees we support individual and team learning needs including:

- Induction for new staff - we see induction not as an event, but as a process that starts before the staff member takes up post and continues after he or she moves into the service setting; each new staff member will have an induction programme tailored specifically to his or her needs;
- The statutory and mandatory training appropriate to job roles;
- Formal education leading to academic credit and SVQs;
- Clinical skills training – for all professions in clinical areas;
- Role development – new and changing services mean new and changing roles for staff, and we will support role changes with the right education;
- Service-user safety and managing risk – we offer learning and education to help provide services that are safe and sound;
- Promoting equality and diversity – activity aimed at ensuring high-quality services are provided for all;
- Encouraging integrated working – supporting the development of new teams and new ways of working;
- Management and leadership – developing potential in this key area of service.

5.11.3 Some of this learning and education activity is provided in-house, but NHSGGC also works with universities, colleges and external agencies to provide the widest options for employees.

5.11.4 NHSGGC continue to maintain and develop working relationships with our social work partners to deliver joint training and learning and education initiatives.

5.11.5 NHSGGC is committed to ensuring that every employee has a Personal Development Plan which looks at current and future development needs. For staff on AfC terms and conditions of service this PDP is linked to the Knowledge and Skills Framework and is recorded on e-KSF, the electronic monitoring system which all Scottish Boards use.

5.11.6 In NHSGGC as at April 2016 69% of staff on AfC terms and conditions had an up to date Personal Development Review recorded on e-KSF. NHSGGC is dedicated to improving this position month-on-month.

5.11.7 To support the fulfilment of KSF Personal Development Plans, employees have access to a wide range of learning and education resources including:

- The NHSGGC SVQ Centre which can provide advice and support in identifying an appropriate SVQ for services and employees;
- Open learning sites – there are a number of these across the service where employees can access learning materials;
- E-learning – employees can access online learning material direct from their work computer at a time of their choosing. Employees can also use the NHSScotland e-Library, which provides access to thousands of learning and education sources;
- Bursaries – these are awarded every year to successful applicants who want to take an education course linked to their work.

5.11.8 NHSGGC has committed to:

- Ensuring equal access to learning and education opportunities for all, regardless of staff grade, gender, race, creed, age and sexual orientation;
- Promoting learning methods that reflect different learning styles;
- Fitting in with staff availability;
- Supporting difference groups of staff to learn together;
- Providing high-quality learning and teaching facilities;
- Making best use of the skills, knowledge and talents of all staff.

6 Section Six

Implementation, Monitoring & Review

6.1 Workforce Plan Governance & Monitoring

- 6.1.1 Monitoring of progress with the actions and intentions set out in the 2016/17 Workforce Plan will be carried out within the governance framework described in Section 1, paragraph 1.8 of this document.
- 6.1.2 The Workforce Plan will be published on the NHSGGC website after it has been approved by the Staff Governance Committee.
- 6.1.3 The NHSGGC Area Partnership Forum and the NHSGGC Senior Management Team receive monitoring reports on the implementation of the Workforce Plan at their regular meetings.
- 6.1.4 At local level the initiation and implementation of service plans and redesigns and the consequent workforce implications are also closely monitored and progress reported to local management and partnership groups as appropriate.
- 6.1.5 It should be recognised by all stakeholders that the redesign and service change plans set out in this Workforce Plan are at varying stages of development and implementation. In addition a number of the projects are still the subject of continuing discussion with Staff Side and therefore outcomes may change as consultations are completed. This flexibility is reflected in the narrative of the plan. Some of these plans will change in response to external influences and events and this may affect projected workforce change.
- 6.1.6 The achievement and implementation of specific actions within the 2016/17 Workforce Plan will be reported in the 2017/18 plan using the action plan at appendix one of this document.

6.2 Appendix 1: 2016/17 Workforce Plan Action Log

Workforce Plan Section	Service Area	2016/17 Action
1.5	NHSGGC Change Plan 2017/20	<ul style="list-style-type: none"> Review the 2017/20 change plan and identify any workforce implications
3.2	Medical and Dental	<ul style="list-style-type: none"> Analyse and improve NHSGGC recruitment and advertising strategies, with the aim of reaching a wider pool of potential medical staff in Scotland, the UK and further afield – with a focus on hard-to-fill posts Develop the current NHSGGC Medical Locum Bank to improve its capacity, and expertise to supply the temporary medical workforce required Continue the implementation of the e-Job Planning system, completing Phase 2 in 2016 and Phase 3 by the end of 2017 Identify and develop extended and advanced practitioner roles across professions and disciplines which have the potential to release workload and support medical practitioners within multi-disciplinary teams Recruit to GP student training position numbers identified as part of the wider Scottish Government exercise to increase training numbers
3.6	District Nursing	<ul style="list-style-type: none"> Align graduating DN student to existing HSCP DN team vacancies (September 2016); Monitor DN Workforce Trends and assess required student training numbers for induction onto 2017/18 training cohort; Assess the impact of recommendations of the national review of District Nursing Monitor the results of future applications of the workload tool to the DN workforce Explore the opportunities available to widen access to the Post Graduate Diploma Advanced Practice in District Nursing through flexible education and training routes
3.6	Health Visiting	<ul style="list-style-type: none"> Continue to monitor the level of Health Visitor vacancies to mitigate risk to service provision Ensure future retiral projection numbers are returned on a regular basis to SGHD in order to inform future recruitment requirements
3.6	School Nursing	<ul style="list-style-type: none"> Asses impact of recommendations arising from the NHSGGC School Nurse Steering Group
3.6	Learning Disability Nursing	<ul style="list-style-type: none"> Continue to review the registered nursing skill mix within Learning Disabilities

Workforce Plan Section	Service Area	2016/17 Action
3.7	Mental Health Nursing	<ul style="list-style-type: none"> Annually apply the mandatory workload tools for Mental Health Service inpatient areas to include Addiction and Learning Disability Service wards Continue to review the impact of staff turnover due to ageing workforce and Mental Health Officer and Special Class pension status Continue to review skill mix, workforce profiles and use of supplementary staffing in the context of the application of the nationally-validated workload tools
3.9	Physiotherapy	<ul style="list-style-type: none"> Develop MSK Advanced Practitioner roles Assess results/recommendations of pilot programme <i>Physiotherapists as First Point of Contact</i> in GP Surgeries Monitor number of independent prescribing physiotherapists and ensure maximum utilisation of these skills Explore use of Advanced Practitioner Physiotherapists in areas impact by medical staff recruitment difficulties
3.10	Dietetics	<ul style="list-style-type: none"> Develop the Dietetics workforce as set out in the workforce plan and workforce projections
3.11	Speech and language Therapy	<ul style="list-style-type: none"> Continue to review patient pathways and explore new ways of working with particular reference to the SLT role in anticipatory care and acute admissions Review the current SLT workforce within HSCPs to ensure a fit-for-purpose workforce
3.12	Orthoptics	<ul style="list-style-type: none"> Recruit to existing vacant posts from NHSGGC graduating cohort one
3.13	Diagnostic Radiography	<p>Radiographer plain film reporting</p> <ul style="list-style-type: none"> Assess impact of extending service over seven days and broadening of scope and range of practice <p>Assistant Practitioners</p> <ul style="list-style-type: none"> Broaden scope and range of image acquisition remit <p>Ultrasound</p> <ul style="list-style-type: none"> Assess impact of extending the working week over seven days Rolling programme of education to develop specialty expertise in MSK and ENT provision Maintain and develop AP skill set to support AAA screening programme <p>Breast Imaging</p> <ul style="list-style-type: none"> Provide support to a review of breast services across imaging and surgery

Workforce Plan Section	Service Area	2016/17 Action
		<p>Magnetic Resonance Imaging</p> <ul style="list-style-type: none"> Identify and progress workforce requirements to deliver a 24 hour service <p>Computed tomography</p> <ul style="list-style-type: none"> Work with local education providers to develop post graduate education provision to ensure a suitably qualified supply for this workforce
3.15	Occupational Therapy	<ul style="list-style-type: none"> Continue to review services as integration progresses within each HSCP in NHSGGC
3.16	Podiatry	<ul style="list-style-type: none"> Implementation of the final stages of the Podiatry workforce plan
3.17	Orthotics	<ul style="list-style-type: none"> Roll out of Assistant Practitioner roles to deliver protocol-based healthcare under supervision Support the training and supervision of practitioners in extending their scope
3.18	Psychology	<ul style="list-style-type: none"> Work with NES to recruit Psychology posts to support older people's services/applied psychology and other relevant areas where there is potential to create capacity for delivering psychological interventions within primary care services
3.19	Pharmacy	<ul style="list-style-type: none"> Implement the workforce changes out in the workforce plan and workforce projections
3.23	Administrative Services	<ul style="list-style-type: none"> Continue to review the requirement for administrative posts in the context of continuing technological development and change
3.24	Senior Managers	<ul style="list-style-type: none"> Continue to reduce the number of senior management posts within the organisation through natural turnover
4.4	Leavers and Turnover	<ul style="list-style-type: none"> Continue to monitor leavers trend data such as levels of turnover, reasons for leaving and retiral ages across the NHSGGC workforce

6.3 Appendix 2 - 2015/16 Update on Projections

	Mar-15	Original Projections	Mar-16	Year to Date Change	Variance Against Projection
Administrative Services	5,397.6	0.0	5,283.9	-113.7	-113.7
Allied Health Profession	2,689.3	19.5	2,728.1	38.8	19.3
Executive	155.6	0.0	138.4	-17.2	-17.2
Healthcare Sciences	1,728.3	0.0	1,761.1	32.8	32.8
Medical and Dental - Consultant	1,441.9	0.0	1,502.7	60.8	93.5
Medical and Dental - Career Grades	323.1		449.4	126.3	
Medical and Dental - Training Grades	1,679.7		1,586.0	-93.7	
Medical and Dental Support	294.3	0.0	303.0	8.6	8.6
Nursing and Midwifery	15,212.7	73.1	15,396.9	184.2	111.1
Other Therapeutic	1,106.8	0.0	1,110.0	3.2	3.2
Personal and Social Care	287.8	0.0	282.0	-5.8	-5.8
Support Services	3,587.0	0.0	3,614.5	27.5	27.5
TOTAL	33,903.9	92.6	34,156.0	251.9	159.3

Correcting for Junior Doctor Fluctuation:

	Mar-15	Original Projections	Mar-16	Year to Date Change	Variance Against Projection
Administrative Services	5,397.6	0.0	5,283.9	-113.7	-113.7
Allied Health Profession	2,689.3	19.5	2,728.1	38.8	19.3
Executive	155.6	0.0	138.4	-17.2	-17.2
Healthcare Sciences	1,728.3	0.0	1,761.1	32.8	32.8
Medical and Dental - Consultant	1,441.9	0.0	1,502.7	60.8	45.4
Medical and Dental - Career Grades	323.1		449.4	-15.4	
Medical and Dental - Training Grades	1,679.7		1,679.7	0.0	
Medical and Dental Support	294.3	0.0	303.0	8.6	8.6
Nursing and Midwifery	15,212.7	73.1	15,396.9	184.2	111.1
Other Therapeutic	1,106.8	0.0	1,110.0	3.2	3.2
Personal and Social Care	287.8	0.0	282.0	-5.8	-5.8
Support Services	3,587.0	0.0	3,614.5	27.5	27.5
TOTAL	33,903.9	92.6	34,249.7	203.9	111.3

6.4 Appendix 3: Description of Job Families

Job Family	Sub Job Family
Administrative Services	Office Services
	Patient Services
	Executives
Allied Health Profession	Arts Therapies
	Dietetics
	Generic Therapies
	Occupational Therapy
	Orthoptics
	Orthotics
	Physiotherapy
	Podiatry
	Prosthetics
	Speech and Language Therapy
	Diagnostic Radiography
	Therapeutic Radiography
Healthcare Sciences	Biomedical Sciences
	Clinical Sciences
	Clinical Technology
Medical and Dental	Consultant
	Other
	Training Grade
Dental Support	Dental Hygienist
	Dental Nursing
	Dental Technician
	Oral Health
Medical Support	Operating Department
	Physicians Assistant
	Theatre Services
Nursing and Midwifery	Care Of The Elderly Nursing
	Community Children's Nursing
	District Nursing
	General Acute Nursing
	Health Visitor Nursing
	Learning Disabilities Nursing
	Mental Health Nursing
	Midwifery
	Neonatal
	Paediatric Nursing
	Practice Nursing
	Public Health Nursing
	School Nursing
	Sexual and Reproductive Health
	Specialist Nursing
Staff Nursery	
Treatment Room Nursing	
Other Therapeutic	Genetic Counselling
	Optometry
	Pharmacy
	Pharmacy Technicians
	Play Specialist
Personal and Social Care	Psychology
	Health Promotion
Support Services	Hospital Chaplaincy
	Catering Services
	Domestic Services
	Estates
	Grounds Services
	Hotel Services
	Laundry/Linen Services
	Portering Services
	Security Services
	Sterile Services
	Stores Services
	Transport Services