



**Greater Glasgow
and Clyde**

**Workforce Plan
2017/18**

2017/18 NHS Greater Glasgow and Clyde Workforce Plan

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1 Section One

Background to the NHS Greater Glasgow and Clyde (NHSGGC) Workforce Plan

1.1 Introduction to the Workforce Plan

- 1.1.1 The Scottish Government vision for healthcare in Scotland is outlined in the National Clinical Strategy¹ which notes.

“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 to their home or community environment as soon as appropriate, with minimal risk of re-admission.”

- 1.1.2 This frames the delivery of services within NHSGGC and the Board’s purpose which is to:

“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.”

- 1.1.3 Health and social care services are experiencing demand driven by demographic changes, advancing medical science and new technologies, at a time of constrained resources.

- 1.1.4 As people live longer, healthy life expectancy is not advancing at the same pace. This means that we will have more people, many of whom are older, living with multiple long-term conditions and often complex needs, more reliant on support and intervention from health and social care services.

- 1.1.5 In December 2016 the Scottish Government published the Health and Social Care Delivery Plan² (HSCDP).

- 1.1.6 The plan set out an aspiration for high quality health and social care services in Scotland which is focussed on prevention, early intervention and supported self-management. The plan sets out a programme to further improve health and social care services and ensure we have a health and social care system that:

- Is integrated;
- Focuses on prevention, anticipation and supported self-management;
- Will make day-case treatment the norm, where hospital treatment is required and cannot be provided in a community setting;
- Focuses on care being provided to the highest standards of quality and safety, whatever the setting;
- Ensures people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

¹ <http://www.gov.scot/Resource/0049/00494144.pdf>

² <http://www.gov.scot/Resource/0051/00511950.pdf>

- 1.1.7 The HSCDP will support an evolution of the health and social care system building on the excellence of NHS Scotland, recognising the critical role that services beyond the health sector must play. It prioritises the actions which will have the greatest impact and outlines a focus on three areas described as “The Triple Aim”:
- **Better Care** - improving the quality of care for people by targeting investment at improving services, which will be organised and delivered to provide the best, most effective support for all;
 - **Better Health** - improving everyone’s health and wellbeing by promoting and supporting healthier lives from the earliest years, reducing health inequalities and adopting an approach based on anticipation, prevention and self-management;
 - **Better Value** - increasing the value from, and financial sustainability of, care by making the most effective use of the resources available to us and the most efficient and consistent delivery.
- 1.1.8 To this, NHSGGC has added a workplace specific objective of “**Better Workplace**” which focuses specifically on our culture.

1.2 How will NHSGGC support the delivery of “Better Care”

- 1.2.1 NHSGGC needs to ensure that everyone receives the right help at the right time, not just now, but in the years to come as our society continues to change. This requires a change in our approach, we need to move away from services ‘doing things’ to people to involving them in all aspects of their care and support. People should be regularly involved in, and responsible for, their own health and wellbeing.
- 1.2.2 Care planning should anticipate individuals’ health and care needs both by helping those with chronic and other complex conditions to manage their needs more proactively, and by focusing on a prevention and early intervention.
- 1.2.3 NHSGGC is working to develop a service that has the capacity, focus and workforce to continue to address the increasing pressures of a changing society. Our approach to primary and community care on the one hand, and acute and hospital services on the other, should support the critical health challenges our society faces.
- 1.2.4 For community based services, this will mean that everyone should be able to see a wide range of professionals and will receive high quality, timely and sustainable support throughout their lives.
- 1.2.5 NHSGGC’s Corporate Objectives include specific actions to:
- Develop a new five year Transformational Plan for the NHS Board, working in partnership with other key stakeholders and taking cognisance of the key local and national strategies, including the Health and Social Care Delivery Plan;
 - Ensure the service reviews, as outlined in the Local Delivery Plan (LDP), are completed and reported to the NHS Board;
 - Work with the NHS Board’s key stakeholders to describe the vision for health within NHSGGC and seek to make positive contributions to joint working opportunities with key partners;
 - Develop a Quality Strategy for the NHS Board, identifying key priorities and prepare an Implementation Plan;
 - Implement the revised midwifery supervision arrangements;

- Deliver 4 hour target at 90% level across all sites and agree and implement trajectories to move towards the 95% level;
- Redesign the service across hospital, care home and community settings to reduce inappropriate use of hospital services, with a view to reducing demand by 10% this year;
- Deliver a 10% reduction in unscheduled bed days through the implementation of the Unscheduled care Programme to reduce admissions and to ensure the timely discharge of patients from hospital;
- In conjunction with the Health & Social Care Partnerships (HSCPs), review the GP Out of Hours arrangements to ensure a sustainable service model is developed and implemented.

1.3 How will NHSGGC support the delivery of “Better Health”

- 1.3.1 The NHS HSCDP proposes a fundamental move away from a ‘fix and treat’ approach to our health and care to one based on anticipation, prevention and self-management.
- 1.3.2 The plan notes that the key causes of preventable ill health should be tackled at an early stage. There must be a more comprehensive, cross-sector approach to create a culture in which healthy behaviours are the norm, starting from the earliest years and persisting throughout our lives. The approach must acknowledge the equal importance of physical and mental health as well as the need to address the underlying conditions that affect health.
- 1.3.3 All services must be sensitive to individual health and care needs, with a clear focus on early intervention. Moreover, it will not just be what services can provide, but what individuals themselves want and what those around them – not least families and carers – can provide with support. Services need to be designed around how best to support individuals, families and their communities and promote and maintain health and healthy living.
- 1.3.4 The HSCPs will deliver this by working closely with key partners such as social care, primary care, education, housing and the third and voluntary care sector.
- 1.3.5 NHSGGC’s Corporate Objectives include specific actions to:
- Develop a Public Health Strategy for the Board, in conjunction with the forthcoming national health priorities;
 - Develop and deliver the Board’s prevention programme in respect of alcohol brief interventions, smoking cessation, obesity and physical exercise and breastfeeding initiatives, in conjunction with the Chief Officers;
 - Review the current arrangements to support community planning to ensure appropriate input from NHS Board and HSCPs;
 - Strengthen the current interface and relationships between the NHS Board and HSCPs in order to ensure whole system benefits are delivered;
 - Further develop and implement the Mental Health Strategy for NHS Greater Glasgow and Clyde.

1.4 How will NHSGGC support the delivery of “Better Value”

- 1.4.1 “Better Value” means improving outcomes by delivering value from all our resources, not just increasing the efficiency of what we currently do, but doing the right things in different ways.
- 1.4.2 Achieving this will require an integrated approach to our strategic plan so that the service and its constituent parts work seamlessly for patients and service users.
- 1.4.3 For better integrated care to become a reality, NHSGGC must plan and deliver well-coordinated care that is timely and appropriate to people’s needs. We are integrating health and social care in Glasgow and Clyde to ensure people get the right care, at the right time and in the right place, and are supported to live well and as independently as possible.
- 1.4.4 An important aspect of this will be ensuring that people’s care needs are better anticipated, so that fewer people are inappropriately admitted to hospital or long-term care. NHSGGC along with its partner organisations are focussing on actions around three key areas:
- Reducing inappropriate use of hospital services;
 - Shifting resources to primary and community care;
 - Supporting capacity of community care.
- 1.4.5 We will be shifting the balance of where care and support is delivered from hospital to community care settings, and to individual homes when that is the best thing to do for our patients. Good quality community care should mean less unscheduled care in hospitals, and people in hospitals only for as long as they need specific treatment.
- 1.4.6 Through our workforce planning processes NHSGGC will design services around communities and ensure that they have the right capacity, resources and workforce.
- 1.4.7 Service redesign activities should support a culture of improvement. Sustainable improvements in care, health and value will only be achieved by a strong and continued focus on innovation, improvement and accountability across the whole health and social care workforce.
- 1.4.8 We acknowledge the urgency of workforce planning issues in light of a variety of demographic and labour market challenges (such as increasing demand from an ageing population aligned with an ageing workforce and increasing recruitment challenges).
- 1.4.9 While the HSCPs are not the employing body for the NHS (or Social Care) workforce, they are responsible for managing joint budgets to provide integrated health and community care services in the most effective way possible. The HSCPs have an important role in shaping workforce demand and developing and infrastructure to forecast service needs.
- 1.4.10 The workforce planning process will recognise and address the challenges faced by both the NHS and for our partners in the social services sector. The plan will need to be relevant in different contexts, and align with existing workforce plans within health and social care.

1.4.11 NHSGGC's Corporate Objectives include specific actions to:

- Meet the key Financial Targets for 2017/18 within an agreed profile
- Develop a five year Financial and Capital Plan for the NHS Board, outlining plans to ensure the best use of available resources to return NHS Greater Glasgow and Clyde to recurring balance.
- Deliver recurring efficiency savings as outlined in the (LDP).
- Review current arrangements for risk management and draft revised Risk Management Strategy.
- Develop a local approach to the national Sustainability and Value initiatives, including those outlined in the LDP.
- Undertake a review of the effectiveness of the NHS Board.

1.5 How will NHSGGC support the delivery of “Better Workplace”

1.5.1 Creating a better workplace means supporting our workforce to deliver the services our patients need now and in the future.

1.5.2 The 2017/18 NHSGGC Workforce Plan for is the first phase of this approach and a longer term workforce plan will be developed to support the new Transformational Programme.

1.5.3 A better workplace will require new and innovative approaches to team working designed to support the new health and social care integration process. As part of this work we will review leadership development and succession planning.

1.5.4 The NHSGGC workforce will continue to have access to systematic training which identifies and fulfils statutory and mandatory training through the electronic Knowledge and Skills Framework (e-KSF).

1.5.5 To develop a “Better Workplace” NHSGGC's Corporate Objectives include specific actions to:

- Launch the Staff Health Strategy across the NHS Board and deliver the Action Plan for 2017/18;
- Ensure i-Matter is fully implemented across the NHS Board;
- Develop a succession planning and talent management process for the organisation;
- Establish a Duty of Candour Policy and Implementation Plan for the NHS Board, including training for a wide range of staff;
- Review and implement a revised NHS Board mission, vision and values statement;
- In conjunction with the Area Partnership Forum, review staff communication and engagement processes.

1.6 Workforce Planning

1.6.1 NHSGGC is required by the Scottish Government to develop and publish an annual workforce plan which sets out the strategic direction for workforce development over the next year and beyond.

- 1.6.2 The Workforce Plan has been developed using the NHSScotland six steps methodology³.
- 1.6.3 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.
- 1.6.4 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.
- 1.6.5 It is critical 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.
- 1.6.6 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.
- 1.6.7 Regular updates on progress against the aims and targets set out in the Workforce Plan will be provided to the Corporate Management Team (CMT), Area Partnership Forum (APF), Staff Governance Committee (SGC) and other stakeholder forums.

1.7 Actions arising from this Workforce Plan

- 1.7.1 The 2017/18 workforce actions are noted within this workforce plan under each relevant heading/topic.
- 1.7.2 These actions are summarised in an action plan which is attached to this document as appendix one.
- 1.7.3 Progress against these actions will be reported in the 2018/19 workforce plan.

1.8 An overview of NHS Greater Glasgow and Clyde

- 1.8.1 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 £3.3billion and we employ 39,500 substantive staff.

³ <http://www.skillsforhealth.org.uk/resources/guidance-documents/120-six-steps-methodology-to-integrated-workforce-planning>

- 1.8.2 The table below shows the breakdown of NHSGGC staff by Job Family as at the end of March 2017 as a percentage of the total whole time equivalent workforce:

Staff in Post as at 31st March 2017		
Job Family	WTE	as a% of WTE Workforce
Administrative Services	5,214.02	15.3%
Allied Health Profession	2,780.53	8.1%
Dental Support	290.36	0.9%
Executive	139.30	0.4%
Healthcare Sciences	1,774.88	5.2%
Medical and Dental	3,582.89	10.5%
Medical Support	63.06	0.2%
Nursing and Midwifery	15,393.48	45.1%
Other Therapeutic	1,144.37	3.4%
Personal and Social Care	270.67	0.8%
Support Services	3,494.64	10.2%
Grand Total	34,148.19	100.0%

* Note – Due to natural turnover the in-post workforce will fluctuate each month

1.9 Local Delivery Plan (LDP)

- 1.9.1 NHSGGC has developed a Local Delivery Plan (LDP) for 2017/18. The LDP brings together:

- An appraisal of our strategic position and context;
- Our strategic direction and priorities;
- The detailed service, financial and workforce planning action we have undertaken to deliver the LDP and an outline of service and financial risks and challenges.

- 1.9.2 The LDP has been developed in alignment with 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.

- 1.9.3 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.

- 1.9.4 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 savings programme is underway to achieve financial balance in 2017/18.

1.10 Principles for Planning

- 1.10.1 To ensure our service planning and financial and workforce decisions align with our strategic direction NHSGGC agreed the following principles. We will:

- Make financial decisions which will be 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.

1.10.2 NHSGGC recognises that the board is entering a period of significant change and challenge. The 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.

1.11 NHSGGC Workforce Planning Processes & Outputs

1.11.1 The workforce planning process reflects the NHSGGC Local Delivery Plan and other key plans such as the Quality Framework. These plans acknowledge the challenges of meeting goals and priorities within the financial constraints faced by all NHS Boards.

1.11.2 As with NHSGGC's Corporate Plan⁴ the Workforce Plan will respond to these issues and provide a strategic framework for managing workforce change during this period.

⁴ [NHSGGC Corporate Plan](#)

- 1.11.3 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.
- 1.11.4 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.
- 1.11.5 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.
- 1.11.6 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.
- 1.11.7 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.
- 1.11.8 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.
- 1.11.9 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.
- 1.11.10 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"⁵.
- 1.11.11 This document provided NHS Boards with a base for establishing workforce planning as a key element of their planning process.
- 1.11.12 In December 2011 the Scottish Government Published CEL (2011)326 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”.

⁵ http://www.sehd.scot.nhs.uk/mels/HDL2005_52.pdf

⁶ http://www.sehd.scot.nhs.uk/mels/CEL2011_32.pdf

- 1.11.13 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 Methodology 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.
- 1.11.14 CEL32 requires NHSGGC to:
- Develop a Board Workforce Plan to be available on NHSGGC's website by end of August;
 - 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.
- 1.11.15 NHSGGC's workforce planning processes 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.
- 1.11.16 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.
- 1.11.17 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.
- 1.11.18 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, Acute and HSCP Senior Management Teams and Staff Governance Committee of the Board.
- 1.11.19 While the single system plan is in development, local service and workforce plans are also being prepared in HSCPs and the Acute Services Division.
- 1.11.20 The Draft Workforce Plan is then reviewed by:
- Senior Management Teams;
 - The Area Partnership Forum;
 - The Staff Governance Committee.
- 1.11.21 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.

1.12 Future NHSGGC Workforce Planning Processes

- 1.12.1 The 2017/18 NHSGGC Workforce Plan is likely to be the last developed using the guidance outlined within CEL (2011)³².
- 1.12.2 In June 2017 the Scottish Government published Part 1 of its National Health and Social Care Workforce Plan⁷. The National Health and Social Care Workforce Plan will be published in three separate parts:
- Part 1 of the Plan, focuses on supporting workforce planning in NHS Scotland;
 - Part 2 of the Plan will consider ways to address the challenges facing social care workforce planning post integration and will be published jointly with COSLA in autumn 2017;
 - Part 3 of the Plan (due late 2017 to follow the conclusion of GMS contract negotiations) will set the government's approach to delivering primary care.
- 1.12.3 In the first year (2017/18), it is expected that an incremental approach to developing workforce planning capacity will enable different systems undertake initial work to support the activity which will deliver a second, full, Health and Social Care Workforce Plan in 2018. From 2018 onwards future editions of the Plan will have greater capacity to address the size and diversity of the health and social care workforce, and its workforce planning needs.
- 1.12.4 Part 1 of the 2017/18 National Workforce Plan has been developed to:
- Support NHS Scotland organisations, including independent NHS contractors in the community, to identify, develop, retain and support the workforce they need to deliver safe and sustainable services to Scotland's people;
 - Support NHS Scotland organisations to deliver a whole system approach to health and social care;
 - Set out how improved workforce planning can benefit NHS Scotland services at national, regional and local levels.
- 1.12.5 During summer 2017 a new National Workforce Planning Group will be established with representation from across health and social care, including NHS Scotland, local authorities, IJBs and third and independent sector and their staff side and trade union representatives.
- 1.12.6 Part of the remit of this new group will be to provide high quality workforce planning support to NHS Boards throughout this period of change.
- 1.12.7 The Scottish Government will work with NHS Scotland stakeholders to refresh workforce planning guidance for NHS Scotland by end of 2017.
- 1.12.8 The refreshed guidance will reflect the post-integration environment, complementing and supporting workforce planning undertaken within Primary Care, Integrated Joint Boards, local authorities and other health and social care providers.
- 1.12.9 NHS Education for Scotland will develop training resources to assist adoption of the new workforce planning guidance in NHS Boards.

⁷ <http://www.gov.scot/Resource/0052/00521803.pdf>

- 1.12.10 NHSGGC awaits the publication of the new workforce planning guidance and will implement any changes to our workforce planning process as required.

1.13 Regional Workforce Planning

- 1.13.1 Regional workforce planning is progressed through the Regional Planning infrastructure, with workforce planning manager input as required being co-ordinated by the West Region Human Resources Directors.
- 1.13.2 Successful regional workforce planning in future will depend upon the development of a clear and sustainable workforce planning infrastructure to progress regional issues.
- 1.13.3 From September 2017 NHS Board Regional Delivery Plans arising from the National Delivery Plan for Health and Social Care will include workforce planning.
- 1.13.4 In future NHS Boards will undertake joint regional workforce planning (also through the refocused National Forum for NHS Workforce Planners), to ensure patients' needs are met and resources allocated effectively, responding to and meeting the needs of IJBs and others as required.

1.14 Other Agencies & Stakeholders

- 1.14.1 NHSGGC has previously worked with a variety of partner organisations as part of our service redesign and workforce planning processes. Local authority partners have been members of community based workforce planning activities for some time.
- 1.14.2 As key stakeholders in the workforce planning process, our structures ensure that as required, a variety of groups are sighted on the impact of our workforce plans e.g. Independent Sector, Carers' Groups, Housing Sector.
- 1.14.3 Following the establishment of the National Workforce Planning Group work will begin to share development of existing workforce tools and new resources with employers.
- 1.14.4 Included in this process will be further clarification of the roles expected for NHS Boards, IJBs, local authorities and third and independent sector employers.

2017/18 Workforce Actions – Workforce Planning Processes and Governance

NHSGGC representatives will contribute as required to:

- The National Workforce Planning Group;
- The NHS National Workforce Planning Group.

NHSGGC will await the publication of any revised workforce planning guidance for health and social care services and:

- Will review/revise existing workforce processes to reflect the new guidance;
- Contribute as appropriate to any new regional Workforce Planning structure or processes.

1.15 Workforce Change 1st April 2016 to 31st March 2017

1.15.1 A summary of the workforce change in 2016/17 can be found in appendix two.

2 Section Two

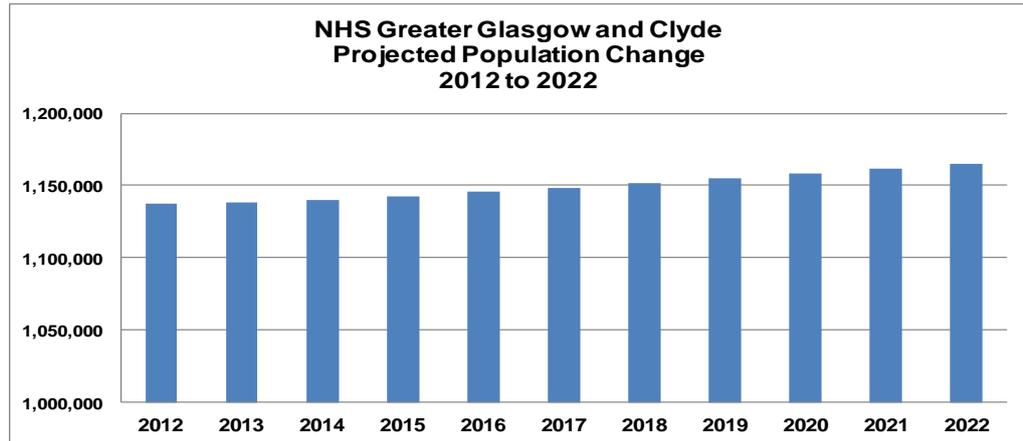
Demand Drivers & Service Change

2.1 The NHSGGC Population and Age 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). During this period, the populations of Inverclyde and West Dunbartonshire declined by 2.4% and 1.8% respectively.

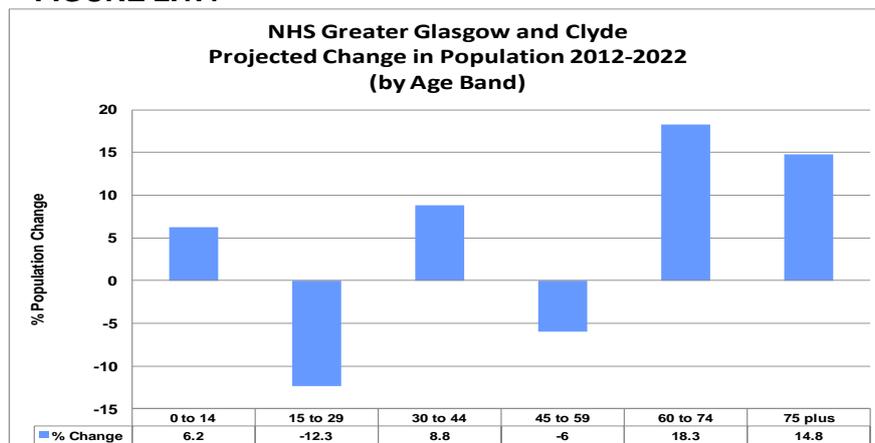
FIGURE 2.1.2



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 within 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).

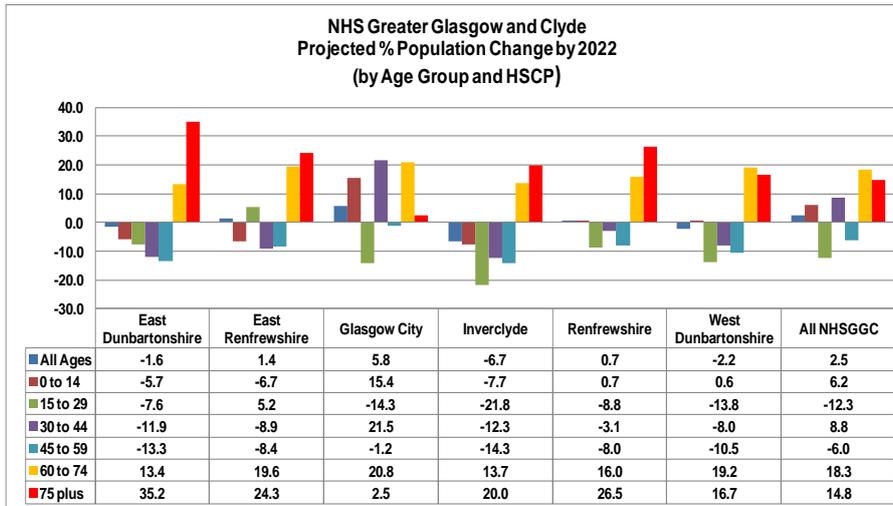
FIGURE 2.1.4



2.1.5 As the population ages it is anticipated that 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 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%).⁸

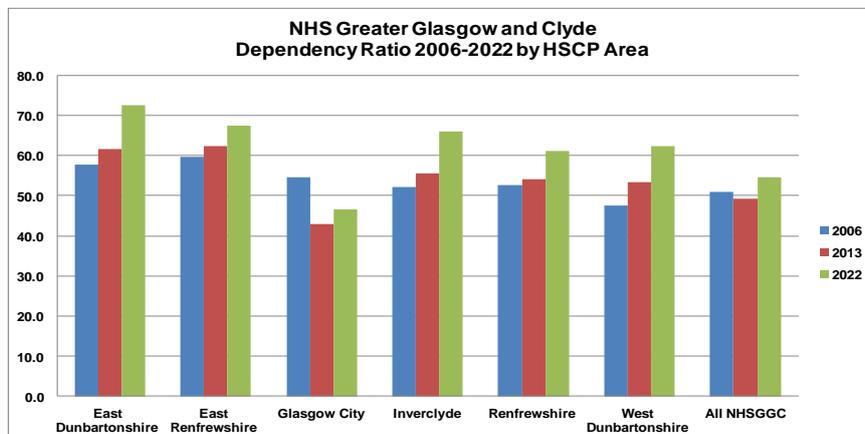
2.1.8 There is considerable variation in the older population by HSCP, with 13% of the North West Glasgow population aged over 65 years, compared to just over one fifth of the East Dunbartonshire population. There is far less variation in the under 20 year olds.

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



⁸ <http://www.nhs.gov.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 Healthy Life Expectancy

- 2.2.1 Overall, average life expectancy in NHSGGC is well below the Scottish average (see below). Again, there is considerable variation between different parts of NHSGGC.

FIGURE 2.2.1

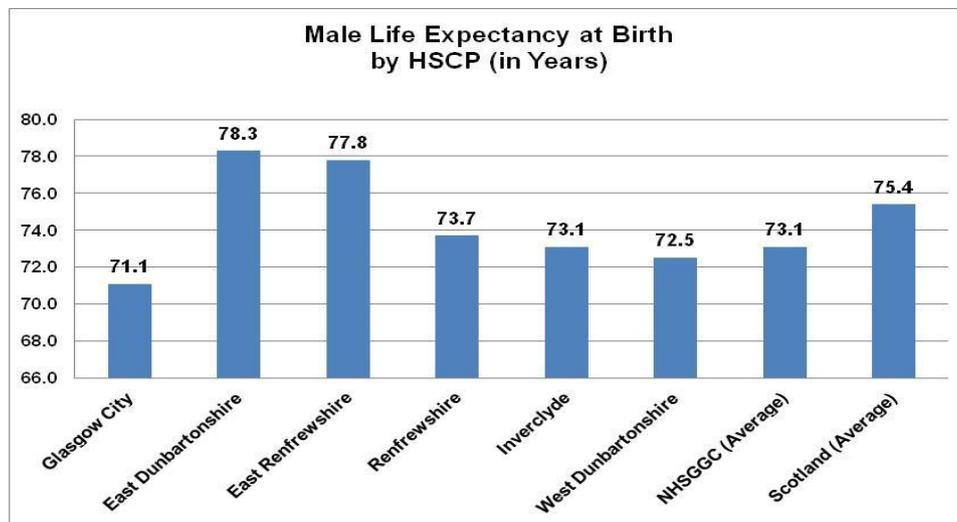
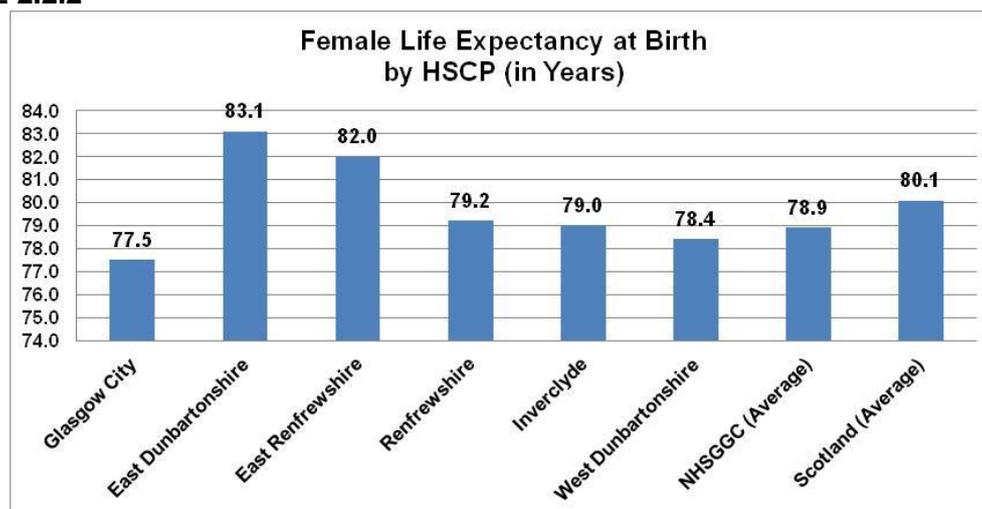


FIGURE 2.2.2



2.2.2 Healthy life expectancy in NHSGGC is even lower compared to the Scottish average. People in NHSGGC live for many years in ill health, with the consequent impact on quality of life, economic and societal contribution and need for services. Over the past 10 years, the gap in healthy life expectancy between the 20% most deprived and the 20% least deprived areas has increased from 8 to 13 years.

2.3 Public Health Drivers

2.3.1 While there have been improvements in health outcomes in recent years there remain many significant health challenges and marked inequality across NHSGGC.

2.3.2 These present a number of major health and health behaviour challenges in NHSGGC. In almost every indicator, the same marked inequalities in health outcomes can be seen between the most affluent and most deprived areas. Factors which contribute to this include:

- Growing numbers of people with long term conditions, including those with multiple long term conditions;
- Rising levels of dementia and depression;
- High levels of alcohol consumption and alcohol related health problems;
- High rates of drug dependency;
- Growing rates of obesity;
- Despite significant success in supporting people to stop smoking, smoking rates remain high particularly in deprived areas and in some particularly vulnerable groups such as pregnant women.

2.3.3 NHSGGC will see a significant increase in the number of people with more than one long-term condition, resulting in approximately 80 per cent of all GP consultations relating to those long-term conditions.

2.3.4 In the area of older people's mental health, there will be challenges for the service to meet with increasing numbers of people with dementia.

2.3.5 Alcohol related deaths and hospital related morbidity are higher in NHSGGC than the rest of Scotland.

- 2.3.6 Smoking is responsible for 29% of all deaths in NHSGGC; although smoking is declining around a third of our population still smoke. Even modest reductions in smoking are associated with significant health benefits.
- 2.3.7 Physical inactivity is responsible for 15-16% of heart disease. A minority of our population use active methods of transport and less than half of adults take the recommended amount of physical activity. Recent work suggests physical inactivity is as significant as smoking in its contribution to poor health.
- 2.3.8 Lifestyle factors are placing a huge an increasing burden on the NHSGGC. Even modest improvements in lifestyle (particularly smoking) are likely to yield significant benefits for the NHSGGC population
- 2.3.9 A strong message from patients and clinical teams is that better information on what patients can expect from their condition and more involvement in their care planning can empower a patient to manage their own illness and health.
- 2.3.10 NHSGGC faces challenges in a number of key determinants of health. Most significantly:
- Children and families living in poverty;
 - High levels of unemployment, including youth unemployment;
 - Impact of the recession and tax and benefit changes, particularly disability benefits;
 - Isolation and loneliness with high numbers of people living on their own.
- 2.3.11 Issues of poverty and vulnerability are major factors in health with 35% of the NHSGGC population in the most deprived section of our community and, with the onset of more than one chronic illness within this group happening 10-15 years earlier than in the least deprived areas.

2.4 Service Change Drivers

- 2.4.1 Through dialogue with clinical staff and patient and public engagement, NHSGGC have identified drivers for change. These also reflect the direction provided by the National Clinical Strategy and are as follows:
- **Prevention and early intervention:** We need to do more to prevent disease through addressing the determinants of health and supporting healthy lifestyles. We also need to better support people to manage their own health and prevent crisis. Inadequate focus on prevention and support for people at an early stage in their illness can lead to poorer health outcomes, and to people accessing services and support at crisis points or at later stages of illness. Prioritising development of resources for preventative and anticipatory care and for primary care and community services is essential to address these issues;
 - **Shifting the balance of care:** NHSGGC provide more acute care to people who live in Greater Glasgow and Clyde than in the rest of Scotland and comparable parts of the UK:
 - NHSGGC must redesign services to deliver more care in the communities close to people's homes. We need to do more to make sure that care is always provided in the most appropriate setting and to address the growing pressure on primary care and community services;
 - The objective is to deliver more care at home or in a homely setting; admitting people to hospital only where there is no alternative way to deliver care and achieving the most rapid clinically appropriate discharge;

- The growing complexity of need, including multi morbidity and a wide range of care and support needs, mean that patients and carers can feel inadequately supported and services can feel complex and fragmented.
- **Clinical quality and service delivery:** NHSGGC need to provide the highest quality specialist care. The aim is to deliver care locally as possible but to balance local delivery with clinical quality and productivity;
- **Primary Care:** Developing the services provided by GPs will be a critical part of reshaping our system of care. The pressures on GP services continue to increase. Different ways of delivering services need to be designed including integrated working between GPs and community teams. The Scottish Government has committed to major additional funding for the GP contract from within the current health allocation. NHSGGC need to plan for the changes to acute services to release those resources;
- **Resources:** There are real pressures on the resources available to provide health and social care and we need to ensure that our services are organised to deliver value for money and achieve the highest level of care for our patients within available resources;
- **Capital funding:** Capital funding is constrained for the foreseeable future, we need to be realistic about delivering service change and focus on the most important clinical priorities including further investment in community facilities to support shifting the balance of care.

2.4.2 In summary, NHSGGC deliver services differently by:

- Preventing ill health in the first place;
- Supporting patients with multiple conditions more effectively;
- Enabling older people to live more independently;
- Hospitals ensure that high quality care is consistently available;
- Access for all patients to specialist and emergency care.

2.4.3 NHSGGC needs to change our approach by:

- Shifting the balance of care away from acute hospital-focused care;
- Develop services focused on prevention and community-based intervention.

2.4.4 The role and relationships of HSCPs will be critical to the development and delivery of acute services change. In addition to developing the arrangements to transform acute services the full Board needs arrangements to develop a picture of what the complete range of health and social care services and wider NHS responsibilities might look like from 2020 onwards. The workforce challenges NHSGGC faces have amplified in the last few years and we need to plan for a different workforce and less staff working in acute services with more staff in HSCP services, including specialist staff who might previously have worked in hospitals.

2.4.5 These changes are complex, and require consideration of workforce resources, potential outcomes, inter-relationships between specialties.

2.5 A new system of care

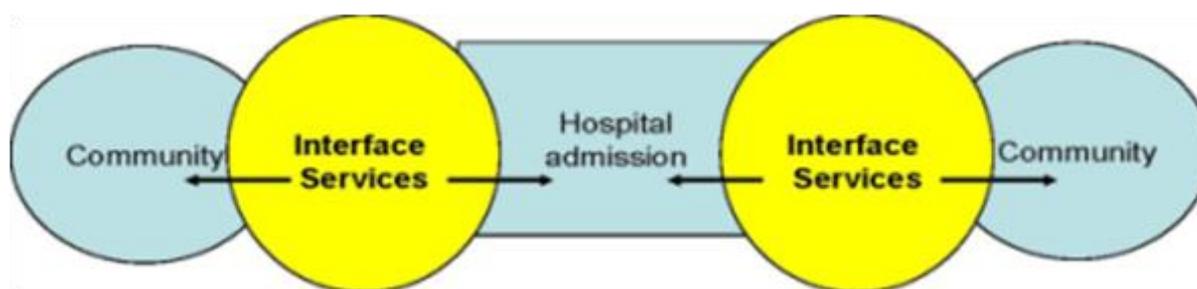
2.5.1 Service redesign is required to shift the balance of care away from hospital treatment to treatment at home or in a homely setting.

2.5.2 Integrated Joint Boards are now fully in place and are:

- Developing their commissioning intentions for their acute service responsibilities, these intentions need to direct and enable the reduction in demand for acute care by delivering new and accessible community services;
- Developing their delivery plans for community and primary care services which will enable a shift in the balance of care. We need to ensure the rate and pace of the work enables and integrates with the changes we need to make to acute care;
- Partners in the development of the transformation plan for acute services with a critical leadership role for local engagement and enabling local people to be involved in the shaping of local services;
- Partners in developing the Board's financial plans, we need to change the balance of financing between acute and IJB delivered services to deliver an affordable and effective system of care.

2.5.3 Meeting the challenge across the whole system

2.5.4 The diagrams below illustrates our aim of moving from separate 'hospital' and 'community' services to a system which has services integrated between acute and HSCP services.



2.5.5 This system of care is based on strengthened, round the clock community services, acute services focused on assessment and management of acute episodes, and a range of services being developed at the interface including shared management of high risk patients and a range of alternatives to face to face hospital visits.

2.5.6 Working differently at the interface will involve new services, extending existing services, creating new ways of working through in-reach, outreach and shared care, as well as changes to the way we communicate and share information across the system.

2.5.7 NHSGGC has started to develop the integrated acute and HSCPs services which this joined up system of care requires. Examples include:

- A range of services in care homes, delivered with the support of acute services consultants, enabling early discharge from hospital or direct admission by GPs.
- Development of community rehabilitation teams which enable early discharge from hospital;
- Single point of access to HSCP services enabling GPs to avoid referrals to hospitals;
- HSCP staff working at the front door of acute hospitals to plan HSCP care and avoid admission;

2.5.8 **Core components of the new system of care**

2.5.9 This programme of service development and change needs to accelerate to deliver a more extensive and innovative range of community health and social care services which reduce the demand for hospital care and meet the needs of patients who are currently admitted to hospital; while remaining safe and efficient.

2.5.10 The aim is to ensure people get care in the right place from people with the right skills, working across the artificial boundary of 'hospital' and 'community' services by providing:

- High quality public health services to improve the health of the population;
- A system giving timely access to high quality primary care providing a comprehensive service that deals with the whole person in the context of their socio-economic environment:
 - Building on universal access to primary care;
 - The focal point for prevention, anticipatory care and early intervention;
 - Management where possible within a primary care setting;
 - Focus for continuity of care, and co-ordination of care for multiple conditions.
- A comprehensive range of community services, integrated across health and social care and working with the third sector to provide increased support at home:
 - Single point of access, accessible 24/7 from acute and community settings;
 - Focused on preventing deterioration and supporting independence;
 - Multi-disciplinary care plans in place to respond in a timely way to crisis;
 - Working as part of a team with primary care providers for a defined patient population.
- Co-ordinated care at crisis and transition points, and for those most at risk;
- Access to specialist advice by phone, in community settings or through rapid access to outpatients;
- Jointly agreed care plans with input from GPs, community teams, specialist nurses and consultants, with shared responsibility for implementation;
- Rapid escalation of support, on a 24 / 7 basis.

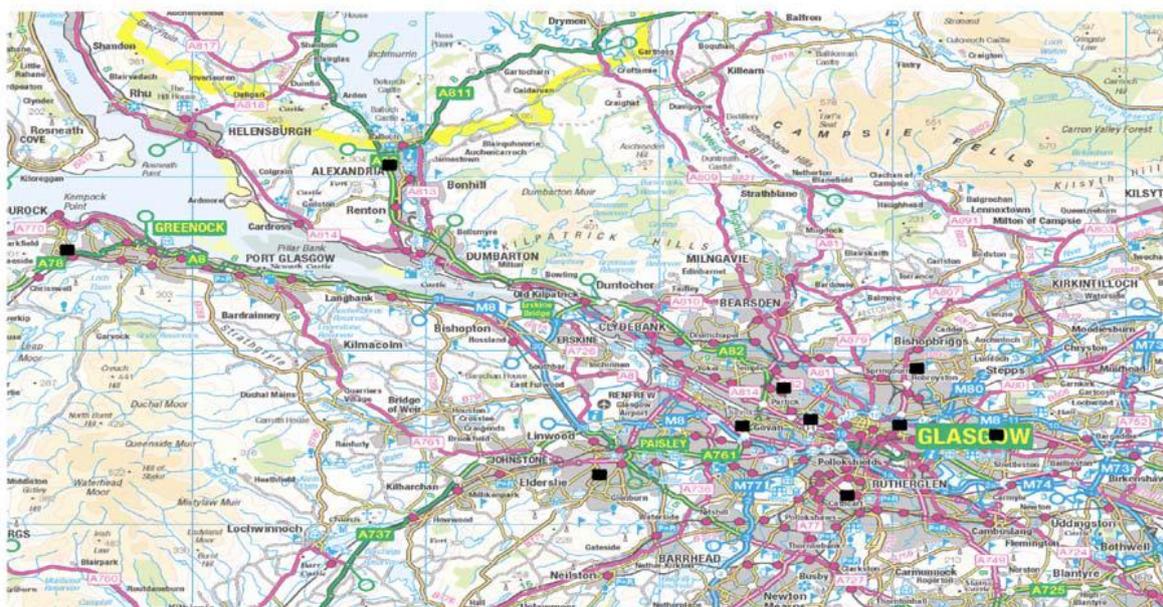
2.5.11 This would enable us to transform the delivery of acute services including:-

- **Hospital assessment** which focuses on early comprehensive assessment driving care in the right setting:
 - Senior clinical decision makers at the front door;
 - Specialist care available 24/7 where required;
 - Rapid transfer to appropriate place of care, following assessment;
 - In-patient care for the acute period of care only;
 - Early supported discharge to home or step down care;
 - Early involvement of primary and community care team in planning for discharge.
- **Planned care** which is locally accessible on an outpatient and ambulatory care basis where possible or short stay:
 - Wider range of specialist clinics in the community, working as part of a team with primary care and community services;
 - Appropriate follow-up;
 - Diagnostic services organised around patient needs;
 - Interventions provided as day case where possible;
 - Rapid access as an alternative to emergency admission or to facilitate discharge.

- 2.5.12 **Inpatient hospital care organised** into centres of excellence to provide specialised clinical services for patients whose needs cannot be met elsewhere, with the shortest possible stays and early transfer to reshaped local services delivered by HSCPs.
- 2.5.13 **Low volume and high complexity care** provided in defined units equipped to meet the care needs driven by clear evidence of the relationship between volume and outcome.
- 2.5.14 The development of more of these services requires:
- Additional resources and staffing for community services;
 - Shared IT systems and records which are accessible to different professionals across the care system;
 - Jointly agreed protocols and care pathways, supported by IT tools;
 - Effective anticipatory care planning;
 - Ensuring that national contractual arrangements with independent contractors support the changes required.
- 2.5.15 To achieve these changes NHSGGC need to reduce the costs of delivering care across the whole system, with an imperative to reduce the costs of acute services by delivering that care in different ways and by reducing the volume of care delivered.
- 2.5.16 This transformation approach and our shorter term plans, need to deliver high quality care at reduced cost. NHSGGC need to express a realistic financial framework for acute services, which will be substantially less than the Board currently spends on acute care.
- 2.5.17 This is the only way in which NHSGGC can ensure that the increased primary and community care services can be funded within the overall resources and the NHS can continue to fund new services and clinical innovations. The risk if this is not achieved is that more and more people are treated in an unaffordable acute hospital model when their needs would be better met in their local HSCP services.

2.6 Implications for Hospital services and sites

- 2.6.1 Shifting the balance of care, reducing demand and developing a new system of care will be reflected in how NHSGGC provide acute services.



2.6.2 The clinical services strategy set out models of care for the following areas:-

- Frail Elderly and Chronic Disease
- Emergency Care and Trauma
- Planned Care
- Cancer services
- Children’s services
- Maternity Services

2.6.3 NHSGGC is undertaking a number of service changes to support this transformation programme, as outlined within the Local Delivery Plan, including:

- **Obstetrics:** NHSGGC will adopt the key principles of “The Best Start”⁹ the five year national maternity and neonatal strategy and develop an implementation plan, evaluate the impact of the new plan on maternity care and associated workforce outcomes;
- **Specialist disability and acquired brain injury:** a full review of this service is underway to develop:
 - Services where patients fit for discharge are flagged to enable HSCPs to develop appropriate commissioning;
 - a new model of specialist rehabilitation within the Acute Division.
- **Improving rehabilitation services in the North East of Glasgow and East Dunbartonshire.** NHGGC is proposing the transfer of the services currently provided at Lightburn Hospital to other sites in the North East of Glasgow. (this is subject to Cabinet Secretary for Health and Sport approval);
- **Review of Community Midwifery Units:** Consultation has paused on the proposal to transfer birthing services from the IRH and Vale CMUs while the Board considers the implications of the national review of maternity services;
- **Changes to paediatrics services at the Royal Alexandra Hospital:** A proposal to transfer acute children’s services from the RAH to the RHC was submitted to the Scottish Government for consideration in March 2017;
- **Changes to GP Out of Hours Service:** HSCPs are conducting an overall review of OOH services and, as a priority within that, reviewing the future delivery of GP OOH service. This service is under pressure due to GP

⁹ <http://www.gov.scot/Resource/0051/00513175.pdf>

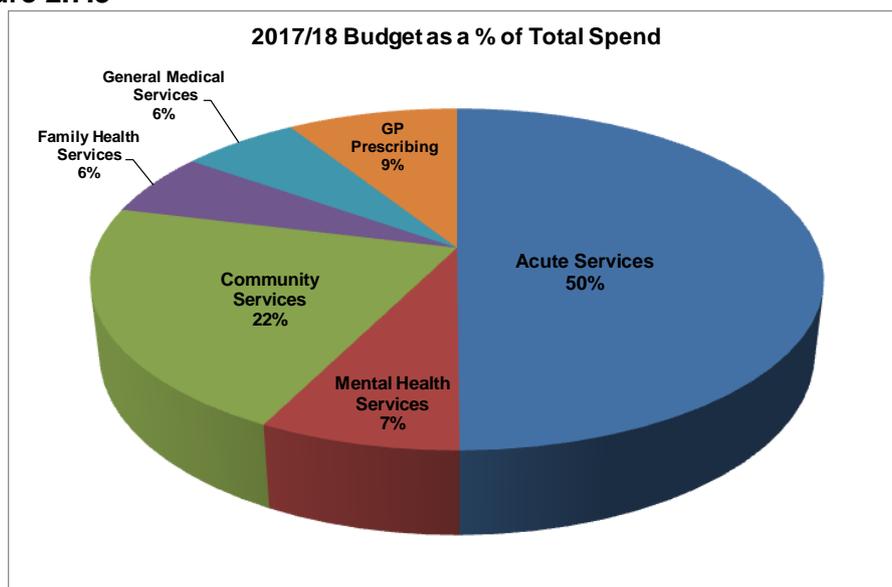
availability and excess demand for the service; regular contingency arrangements are often required. In the short term the Acute Division, which is responsible for operational delivery of the service, is reviewing the potential service redesign across the OOH service;

- **Review of unscheduled care:** A full review is now completed and recommends extensive changes to the delivery of care which will enable us to improve performance and reshape resources within the Acute Division and HSCPs;
- **Improving scheduled care:** NHSGGC are working to assess how improved efficiency, including reducing length of stay; improving day case rates and theatre utilisation; improvements to booking and DNA systems can achieve maximum throughput with the available resources. NHSGGC are also planning the implementation of a major programme of outpatient redesign in line with the national approach. This work will be underpinned by a programme to transform patient administration which is now underway;
- **Gynaecology:** NHSGGC are reviewing arrangements for delivery of gynaecology across the Board area as interventions have moved from inpatient delivered to a day service and outpatient based model;
- **Stroke services:** A comprehensive review of stroke services across the Acute Division has been completed during 2016/17 making detailed recommendations to improve the quality of care. The key elements of service change are to ensure patients across Greater Glasgow and Clyde have access to:
 - Hyper acute stroke care without delay before returning to their local hospital stroke service.
 - Urgent specialist assessment and investigation if they experience a “mini stroke” or TIA.
 - Optimal rehabilitation in hospital and in the community to maximise their return to functioning
- **Review of frail older peoples care:** As part of the Acute Division Delivery Plan NHSGGC will review the systems and resources around care for older people. The review will focus is on the design of acute specialist elderly care; the interface between general acute services and acute specialist elderly care and the interface from acute specialist elderly care with services in HSCPs;
- **Review of imaging and laboratory services:** programme of benchmarking and demand management is underway to address issues of excess demand and use;
- **Surgical Services:** NHSGGC are developing reviews of urology and orthopaedics across the Acute Division and will bring forward proposals for service redesign during 2017/18;
- **Review of Major Trauma services:** Planning work is underway to assess the delivery of the West of Scotland regional trauma centre at QEUH and required changes to other services in NHSGGC and across the region;
- **Drugs and alcohol services:** NHSGGC has identified across our acute services increasing challenges in caring for patients with drug and alcohol problems, we need to look at whether we have the right systems and models of care to meet the needs of these patients in acute settings;
- **Clinical productivity and variation:** we need to agree a process into which our initial analysis of variation can feed for action across the Acute Division and further develop this work accessing a wide range of sources of service and clinical indicators. At present this is being picked up by each Director through PRG process.

2.7 Financial Planning

- 2.7.1 As noted in Section 1 of this plan NHSGGC has an annual budget in excess of £3 billion.
- 2.7.2 Figure 2.7.3 outlines the budget split by care group areas as a percentage of the overall NHSGGC budget.
- 2.7.3 Currently spending on our Acute services represents 50% of the overall budget, but as outlined in the previous text we anticipate that, over the coming years, the proportion spend in primary care settings will increase.

Figure 2.7.3



- 2.7.4 The Scottish Government draft budget was announced on 15th December 2016. This announcement revised the baseline uplift to 1.5% for territorial boards, of which 1.1% was earmarked for Social Care Funding and was to flow to the IJBs. Local Authorities have been given the flexibility to reduce their contribution to the IJB by their relative share of £80m, to offset the national allocation of £100m from the NHS uplift.
- 2.7.5 The Chief Executive has written to each HSCP Chief Officer outlining the settlement from the Board. The Board remains in discussions with our six HSCP partners to finalise the 2017/18 budget allocation.
- 2.7.6 In addition, funding of £50m for NHSScotland Resource Allocation Committee (NRAC) parity across Scotland was identified (NHSGGC does not receive any of this allocation) along with £127m of transformational funds, in the main for Primary Care and Mental Health services.
- 2.7.7 For NHSGGC, this resulted in a gross funding uplift of £31.1m. Of this £23.7m was Social Care Funding and was “passed straight through” to the six IJBs, leaving a net uplift of 7.4m (1.7%) to NHSGGC.
- 2.7.8 By applying an agreed general inflationary uplift to the value of service level agreements with other NHS Boards related to patient services provided, NHSGGC can reasonably expect to receive further income of around £2.4m in 2017/18.

2.7.9 The Scottish Government has challenged Boards to deliver a 5% savings target and drive efficiencies underpinning principles of value and sustainability. There is a requirement to produce detailed plans to minimise waste, reduce variation, standardise and to share including:

- Implementation of the Effective Prescribing programme;
- A quality & cost assessed improvement plan to respond to productive opportunities identified from benchmarked performance;
- Reducing medical & nursing agency and locum expenditure as part of a national drive to reduce this spend by at least 25% in-year, and;
- Implementation of opportunities identified by the national Shared Services Programme.

2.7.10 The Board is anticipating a recurring deficit of £29.6m carried forward from 2016/17. The IJB budget allocation of £23.7m means the remaining financial gap must therefore be allocated across the remaining parts of the Board – the Corporate and Acute Divisions.

2.8 Addressing the Financial Challenge in 2017/18

2.8.1 The 2017/18 financial position presents a significant challenge to NHSGGC. It is critical the Board identifies and actions the removal of costs from the business in early 2017/18. The Boards reliance on non-recurring funding and reserves in 2016/17 to achieve financial break-even means the Board has entered 2017/18 with minimal reserves or funds and as such, savings must be made in the early part of the financial year.

2.8.2 The 2017/18 Financial Planning process began mid way through 2016/17. The Corporate and Acute Directors continue to identify and quantify savings schemes, and the Board is fully engaged in national initiatives. Since 1st April, the Chief Executive has contributed to increased focus, drive and vigour around the identification of additional savings initiatives.

2.8.3 As a result, the following table highlights the updated and current financial position and projection for 2017/18.

NHS Greater Glasgow & Clyde	
2017/18 Savings identified to date (£million)	
Corporate Budgets	23
Acute Budgets	21
Additional Organisational Initiatives	
Procurement & Supply Chain	5
Prescribing & Drugs	5
Locum & Agency	2.5
Productivity & Efficiency	5
Additional Income & Accounting Adjustments	19
Total	80.5
Remaining Gap	18.5

2.8.4 In line with previous years, savings schemes were identified within the Board and allocated a “risk rating” (green, amber or red) in terms of;

- its achievability/likelihood;
- accuracy of the projected saving;
- extent of impact and consequences;

- requirement for Board approval / public consultation.
- 2.8.5 Whilst significant progress had been made to identify the full savings required, there remains a financial gap of £18.5m (Full Year Equivalent).
- 2.8.6 All savings schemes have been risk rated based on achievability, timing and estimate of saving. A number of the schemes identified have been classed as "red risk". In addition, many of these schemes may not be realised until the later part of the financial year, which may create additional pressure in the early part of the financial. As such, the Board is currently unable to predict a break-even position for 2017/18.
- 2.8.7 NHSGGC is continuing work to;
- Identify additional savings schemes (both locally and nationally);
 - Bring savings schemes forward into the earlier part of the financial year;
 - Focus on the delivery of currently identified schemes and reduce the risk rating;
 - Identify additional sources of income and balance sheet management;
 - Manage the capital allocation to ensure an optimal out-turn for the Board;
 - Identify options and propositions to negotiate the budget settlement with IJBs.
- 2.8.8 The Board is also in continuing dialogue with the Scottish Government around its financial position, and the possibilities of additional in-year support.

3 Section Three

Defining the Required Workforce

3.1 Workforce Projections 2017/18

3.1.1 This section sets out the workforce change projections, by job family, with some supporting narrative.

3.2 Medical and Dental

3.2.1 Since the publication of the 2016/17 NHSGGC Board Workforce Plan we have developed a series of medical workforce plans for:

- Acute Services¹⁰
- Community Partnership¹¹
- Oral Health Medical¹²

3.2.2 A summary of workforce issues for this job sub family is provided in the following text. Copies of the full Workforce Plans, which provide detailed information on the workforce drivers, demographic issues and workforce actions for each area can be accessed using the footnote hyperlinks provided. A variety of Medical and Dental Service Drivers have been identified although it is important to note that all drivers do not necessarily affecting each of the three areas to the same degree). Drivers include:

3.2.3 Seven Day Services

3.2.4 Both Scottish and UK Governments are committed to working with NHS Boards to ensure patients access high quality and safe care during evenings and weekends. There is a clear link between poorer outcomes for patients and uneven service provision at the weekend. This includes access to diagnostic tests which are not consistently available in all hospitals during evenings and weekends.

3.2.5 Across our Specialties the vast majority of junior doctors already work shifts with Consultants being able to opt out of non emergency work at the weekends and in the evenings.

3.2.6 In some Acute specialties local services have developed an extended working day model with Consultants participating in a shift pattern during evenings and weekends. NHSGGC recognises that the further development and extension of 7 day services will be based on patient demand, available funding and is influenced by contractual negotiations to determine remuneration and terms and conditions for 7 day working.

3.2.7 Introduction of maximum 7 day consecutive shift working

3.2.8 Following the Temple Report¹³, the Scottish Government stipulated that no junior doctor would be rostered to work more than 7 consecutive shifts. 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.

¹⁰ <http://www.nhsggc.org.uk/media/243797/nhsggc-acute-medical-staff-workforce-plan.pdf>

¹¹

¹²

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

- 3.2.9 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.
- 3.2.10 NHSGGC achieved 97% compliance however there remain some areas which are problematic.
- 3.2.11 **Changes to the General Practice Training Scheme**
- 3.2.12 In response to the recognised national shortage of participants in the GP training scheme, the Scottish Government have confirmed the creation of 100 extra 3-year GP training schemes. These are to be implemented in February 2017. This will take the total number of GP trainees in Scotland being employed each year to 400. 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.
- 3.2.13 With current trainees in 4 year schemes the full effect of this will take a further 3 years to implement. 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. At present there are 123 GP vacancies which were left after Round 1 recruitment in 2016. 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.
- 3.2.14 The full impact of this change is hard to predict and it is unclear how this change will influence specialty placements and where new posts will be established across Scotland. It has been confirmed, however, that 59 placements will be hosted in the West of Scotland and that NHSGGC has been allocated 30 rotations over 4 programmes.
- 3.2.15 The rotations are still to be defined but NES will work collaboratively with NHS Boards in creating the rotations. These posts should be valuable and attractive to potential applicants and provide quality training experiences.
- 3.2.16 **Realistic Medicine**
- 3.2.17 The publication of the Chief Medical Officer's Annual Report "Realistic Medicine" poses key challenges for clinicians about the application of modern medicine within a dynamic and changing healthcare environment.
- 3.2.18 The report describes the limitations on the current healthcare model which does not always suit the needs of patients, their carers or the aspirations of the workforce. The report highlights the importance of effective patient and clinician communication; this theme is a key element of the Acute Delivery Plan and will require a focus on clinical leadership development and communication skills. Within NHSGGC this workforce plan will support clinicians to deliver person centred care.

3.2.19 **Expansion of training Grades within NHS Scotland**

3.2.20 The Reshaping Project Board in January 2014 initiated an expansion in training posts for the hard to fill specialties. In total an additional 58 trainee posts per year were allocated across Scotland; 29 of which were located in the West of Scotland.

3.2.21 During the period 2014 to 2017 the Scottish Government and NES contributed £0.9 million per annum to assist fund the expansion posts. The remaining costs were to be met by the individual NHS Boards. On average NHSGGC have had 10.5 posts filled each year.

3.2.22 NES will no longer provide funding for the 58 posts from 2017/18. A regional decision has yet to be agreed for 2017 on whether these posts will be supported in the longer term since failure to do so may create further vacancies and potential impact on clinical service delivery.

3.2.23 The Scottish Shape of Training Transition Group (SSTTG) is responsible for making annual recommendations to the Scottish Government on training numbers. The setting of establishment numbers is essential to the sustainability of Services to patients and, by gathering specific medical workforce information, it supports NHS Boards in the development of national, regional and local workforce planning tools and solutions.

3.2.24 The table below indicates the changes to NHSGGC establishment figures to the 2017/18 intake:

Scottish Shape of Training Transition Group	
NHSGGC Impact of Specialty Trainee Growth 2017/18	
Specialty Area	NHSGGC Trainee Posts (WTE)
Diagnostic Radiography	4.00
Interventional Radiology	1.00
Intensive Care Medicine	2.00
Histopathology	2.00
Broad Based Training	3.00
Total	12.00

3.2.25 Following the significant increase in training numbers since 2014 the default position for 2018 will be to replace all vacancies that arise in the annual cycle. However SSTTG will assess any evidence from the boards which would support a case of training establishment through adjustment of the 2018/19 intake

3.2.26 **Demographic Drivers**

3.2.27 30% of the Consultant workforce are currently aged 51 or over, similar to the Other Grades, with Training Grades reflecting less than 1% aged over 51.

- 3.2.28 Looking ahead to the next five years there are major challenges in relation to clinical posts with a number of senior medical staff projected to retire. The impact of age retirements will be compounded by changes to the NHS Pension Scheme which has resulted in turnover across senior medical posts. In managing turnover and retirements individual staff discussions with regard to staff wishes in relation to retirement are essential and during these discussions consideration of flexible working arrangements e.g. part time working or phased retirement will be explored.
- 3.2.29 The Acute, Community Partnership and Oral Health Medical Workforce Plans provide a full summary of projected retirements by specialty.
- 3.2.30 Regardless of employee age, discussing their future aims and aspirations can assist in planning the workforce to meet future service needs. Whilst the Equality Act 2010 made it unlawful to discriminate against individuals approaching retirement age, it is still permissible to ask about future plans in general. Working in partnership with the LNC, Medical Staffing have developed a standardised letter to be sent out to all career grades to capture any plans regarding changes to their working arrangements e.g. reduction in hours, leaving the service.
- 3.2.31 Using the last 6 years of data NHSGGC has identified that Medical Consultants generally retire 5 years ahead of their default retirement age and that male consultants typically retire 1 year earlier than females.
- 3.2.32 Other factors which have contributed to turnover include the initial use of use of 9:1 contracts as part of the job application pack for new consultants. This is despite final job plans being agreed which are related to individual experience and service needs.
- 3.2.33 Improving staff attendance at work is a priority for all Boards who work towards a 4% sickness absence rate. The correlation between levels of staff attendance and patient outcomes is well established with high levels of attendance associated with improved patient experience and positive staff morale (Professor Michael West)¹⁴.
- 3.2.34 In analysing Medical staff absence, there is work underway to review and improve how medical staff absence is recorded, monitored and reported across Acute Sectors and Directorates. In addition, there is potential to improve core attendance processes including return to work interviews and supporting staff on long term absence, including their phased return to work. A standardised approach to the recording, monitoring and management of staff absence has been developed by the Medical Staffing Team
- 3.2.35 **Unsustainable medical staffing rotas**
- 3.2.36 Pay Bandings across all rotas within NHSGGC have remained stable over the last 3 years with the majority of rotas at a 50% supplement or less. The majority of rotas are 'full shift' and the lowest banding available is 1B (40% supplement) so little scope for any further financial savings.
- 3.2.37 Over Specialisation of the Medical Workforce

¹⁴https://www.researchgate.net/publication/304032216_Saving_Lives_A_Meta-Analysis_of_Team_Training_in_Healthcare

- 3.2.38 Over the past 10 years, modern medicine has moved towards an increasing specialised service to improve the delivery of highly specialised care. To support the delivery of this service model, specialty training programmes through Modernising Medical Careers (MMC) and subsequently Scottish Medical Training (SMT) has been developed.
- 3.2.39 The current training model may inadvertently disadvantage patients who present with multiple chronic diseases and are required to see a number of specialists to treat their conditions. This approach often results in multiple hospital appointments or increased length of stay.
- 3.2.40 The Greenaway report recommends that doctors are more broadly trained within a shorter time period. It implies that a re-balance is required in moving away from over specialisation to a more generalist doctor. The Shape of Training review will be implemented over the next 6-8 years. NHSGGC will require to review services in preparation for the changes.
- 3.2.41 **Consultant Productivity and Job Planning**
- 3.2.42 NHSGGC have job planning guidance to assist Managers and doctors in agreeing job plans which reflect both NHSGGC and individual objectives. The Guidance is currently under review in partnership by a short life working group, who will provide a final draft document to the MSF.
- 3.2.43 In order to clarify and assist the process with the governance and Board objectives NHSGGC agreed to purchase and implement E-Job Planning software (Allocate) in April 2014.
- 3.2.44 The E-Job Plan system has been implemented in 3 Phases.
- Phase 1 commenced April 2014, included approximately 850 doctors who were affected by the opening of the new Queen Elizabeth University Hospital;
 - Phase 2 commenced in June 2015, included the remaining 500 doctors within the Acute Sector (excluding Clyde Sector).the system was redesigned to incorporate changes to the Acute structure;
 - Phase 3 includes the Dentists and the remainder of the Career Grade doctors (approx 550) from within HSCP and Corporate Directorates. The structures and information for these doctors has been added to the system and they will shortly be given access so they can add their Job Plan for review and agreement from 1 April 2017.
- 3.2.45 The benefits include:
- Standardised job plan, ensuring the format of a job plan, and the way PAs are calculated, is consistent across the entire health board;
 - Flexible and transparent job planning. The system encourages a 'hub and spoke' model whereby the process can be monitored centrally and clinical managers drive the job planning process locally;
 - Group job planning which allows managers and to create a Template job plan containing generic departmental activities;
 - Improved reporting function and analysis;
 - Accurate service planning;
 - The ability to monitor EPA activity to inform annual job plan review.

- 3.2.46 The Medical Workforce Plans and associated actions will be managed and monitored via the Strategic Management Group, the Medical Staff Forum, the Acute Partnership Forum and Staff Governance Committee. The key actions for the Medical and Dental staff group are summarised below:-

2017/18 Workforce Actions – Medical and Dental Staff

- Maximise medical staffing recruitment and retention by ensuring NHSGGC is an attractive Board to work in. Promote the ability to work flexibly to encourage applications from a wider pool, including part-time workers and retired consultants;
- Identify the interrelationships across professional groups which impact on the Medical Workforce and take forward a detailed exercise regarding the role of Advanced Nurse Practitioners (ANP) and Physician Assistants roles across specialties to fill gaps in junior doctor rotas particularly within the Clyde area;
- To assist with future workforce planning contact all career grade medical staff, who are within 10 years of what has previously been viewed as a 'normal' retiral age, to enquire about any plans they may have regarding their working arrangements;
- Promote the importance of job planning through Managing Consultant and SDAS Grade Job Planning events for medical managers, emphasising the responsibility of the Consultants/ SDAS grade to produce evidence at the job planning review meeting to support maintaining status quo or planned change to the number of programmed activities (PAs) in the forthcoming year;
- Continue to develop NHSGGC E-Job Plans to ensure a single, transparent and authoritative data source. This would enable the Board to have more robust control of job planning information, leading to better alignment of activity with both organisational and departmental objectives;
- Develop the current NHSGGC Medical Locum Bank to improve its capacity, and expertise to supply the temporary medical workforce required;
- Implement the 'Temporary Medical Workforce Guidance' to ensure there is a consistent approach to the access of locum cover to ensure alternative 'cost saving' options have been considered in the first instance;
- Increase the pool of career grade medical staff on the NHSGGC Medical Locum Bank by actively encouraging retired consultants and specialty doctors to join the bank upon leaving their substantive posts;
- Promote the use of the Exit Interview process, part of the Board-wide strategy Facing the Future Together.

3.3 Nursing and Midwifery

- 3.3.1 The NHSScotland 2020 Workforce Vision¹⁵ 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 Strategy¹⁶ 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.

¹⁵ [Everyone Matters: 2020 Workforce Vision, SGHD, 2013](#)

¹⁶ [The Healthcare Quality Strategy, SGHD 2010](#)

- 3.3.2 NHSScotland published CEL 32 (2011)¹⁷ 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 where they are available. 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.
- 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 Toolkit¹⁸.
- 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 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.
- 3.3.9 It is expected that as of April 2018 use of the NMWWP tools will become a statutory requirement under the proposed legislation on safe staffing levels within the NHS
- 3.3.10 **Advanced Nurse Practitioners (ANPs)**
- 3.3.11 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.

¹⁷ [Scottish Government CEL 32\(2011\), Revised Workforce Planning Guidance for NHS Boards](#)

¹⁸ [The Nursing and Midwifery Workload and Workforce Planning Toolkit \(2nd ed, 2013\)](#)

- 3.3.12 Functioning 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 a seven day service.
- 3.3.13 ANPs potentially have an even bigger role to play in assessing, treating and diagnosing people in the community. By doing so, they can help to provide better primary care for individuals and tackle delayed discharge rates.
- 3.3.14 “A Plan for Scotland: the Government’s Programme for Scotland 2016-17”¹⁹ included a commitment to train 500 additional ANPs by 2021 and the Scottish Government have committed £3m to support this goal. SG have already requested that Boards cleanse their data on ANP numbers and this has been done.
- 3.3.15 On 5th May 2017 the Chief Nursing Officer (CNO) wrote to Executive Nurse Directors, IJB Lead Offices, Primary Care Leads and Chief Exec of Hospices requesting that clinical areas undertake a Service and Education Needs Analysis for future Advanced Nurse Practitioners (ANPs).
- 3.3.16 This will allow NHS Boards to identify the numbers of ANPs Boards and independent contractors are likely to need trained over the term of the current Government.
- 3.3.17 To help service areas identify their own needs the Scottish Government commissioned NHS Education for Scotland (NES) to produce a Service Needs Analysis Tool and an Education Needs Analysis Tool. These were circulated with the CNOs letter. The Service Needs Analysis tool is designed to assist in identifying whether there is a need for an ANP within a service or whether a different nursing role or other professional is required. The Education Needs Analysis tool is to help identify the specific numbers of ANPs who may need trained over the next 4 years.
- 3.3.18 The clinical areas that need to undertake this Analysis are:
- Any area with existing ANPs (need to know number of ANPs who need to be trained/recruited to maintain or expand existing service).
 - Any area with definitive plans to develop an ANP service within the next 4 years
 - Any area contemplating developing an ANP service within the next 4 years
- 3.3.19 Whilst the Service Needs Analysis tool is recommended for use there is no requirement that it has to be used if a service area uses a different workforce planning tool e.g. Six-Steps methodology

2017/18 Workforce Actions – Advance Nurse Practitioners

- Service and education Needs Analysis circulated widely to all NHSGGC service areas
- Service Areas consider the requirement to employ/train ANPs (or more ANPs) over the next 4 years (the Service Needs Analysis tool to be used to facilitate that thinking and to support development of business cases)
- Education Needs Analysis completed by those areas that plan to train ANPs within the next four years
- NHS Education for Scotland and Board to analyse data to identify potential numbers for training and the education required.

¹⁹ <http://www.gov.scot/Publications/2016/09/2860>

3.3.20 **Care Assurance System (CAS)**

- 3.3.21 The objective of CAS is to ensure safe, effective and person centred care, which is consistently assured and sustained for every patient every time.
- 3.3.22 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.
- 3.3.23 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.
- 3.3.24 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.
- 3.3.25 SCN/Ms require building time into duty rotas to allow link nurse/midwife time to undertake the link support role.
- 3.3.26 NHSGGC is extending care standards into community settings, mental health in patients, maternity, paediatrics, and health visiting.

3.4 **Acute Nursing**

- 3.4.1 Requirements for additional staff across the three acute sectors are largely driven by:
- The need for 1:1 care for those patients with challenging behaviour due to Delirium, addictions, frailty and complex co morbidities;
 - Emerging issues within the adult sectors in recruiting band 5 experienced nurses specifically for medical, acute receiving and elderly care units. (The offer of rotational programmes are assisting with this);
 - Recognised UK wide recruitment issues alongside high maternity leave and turnover of 11.6% are a challenge for the paediatric nursing workforce (NHSGGC is addressing this through a national recruitment process);
 - Midwifery are experiencing recruitment challenges within the two stand alone CMUs;
 - Several areas across acute have an ageing workforce, specific hot spots being midwifery and theatres. Additional students are in place to counter the predicted retirements within midwifery and new band 5 recruitment supported by local training programmes are underway in theatres.
- 3.4.2 Work is being undertaken across some areas as part of an exercise between the Chief Nursing Officer and NHSGGC to assess single-room accommodation versus traditional ward layouts. This is in light of the development of the new single bedded accommodation model in the RHC and QEUH is underway with projected completion date October 2017.

3.4.3 **North Sector**

3.4.4 During 2016 North Sector, in collaboration with the General Managers and Finance colleagues reviewed and benchmarked all inpatient acute areas against the agreed national workforce tool and comparative sites. This exercise found a number of clinical areas did not have an uplift of 22.5%. Whilst no new monies were allocated some areas had skill mix changes to increase registered nurses within existing resources.

3.4.5 The majority of Band 7 and 8A nurses have now attended the 'making a difference' programme and the service is now concentrating on our band 5 nursing staff with an overall aspiration to actively of improving and standardising rostering practices.

3.4.6 Drivers for additional staff include 1:1 RMN/ HCSW requirements for patients with challenging behaviour due to Delirium, addictions and other complex conditions, increasing mandatory training requirements, loss of theatre technician course and patients with frailty and multiple co-morbidities.

3.4.7 There are some emerging issues with recruitment and retention in Acute Receiving and experienced theatre nurses. An age profile in theatres and a high number of newly qualified staff is generating training issues. An education programme is underway to address this. Posts within older people's wards are also challenging to fill however a rotational programme has assisted with this.

3.4.8 The Lightburn facility is currently under review as part of the wider review of rehabilitation in the North East. The facility currently holds 56 inpatient beds and a day unit. The public consultation concluded in May 2017. It is currently subject to approval by the Cabinet Secretary for Health and Sport.

3.4.9 We are in the early stages of scoping roles for ANPs specifically in areas such as Elderly Care Assessment Nurses (ECAN) due to increasingly frail population. This will result in more nurse led services and initiatives but will involve backfill in order to ensure correct supervision and support of trainee ANPs.

3.4.10 **South Sector**

3.4.11 NHSGGC and the National Workforce team are working jointly to progress the development of a valid and reliable workload tool to inform decision making on the staffing requirements of single room hospital accommodation which can be used across different specialties to provide safe, effective, person centred care. There are 7 wards QEUH which are part of the exercise to support the Chief Nursing Officer to validate the single-room element of the Adult Acuity Inpatient Tool.

3.4.12 Rostering master classes have been held in the South to improve and standardise best practice in rostering. Rosters are reviewed by Lead Nurses to ensure correct skill mix and use of staff across 7 days.

3.4.13 Recruitment challenges have been noted for Band 5 nurses in elderly care in the South Sector. Bespoke open days have been successful in obtaining applicants and this work will continue. A Band 5 nursing rotation programme across the sector has also been successful in attracting new nurses in and supporting them to become a well rounded Band 5 after 18 months.

3.4.14 Advanced practice role development for major trauma, critical care, acute receiving areas and older people are either underway or planned for the near future.

3.4.15 **Clyde Sector**

3.4.16 In line with activities in other sectors a benchmarking exercise for all inpatient acute areas against the agreed national tool and comparative sites was conducted during 2016/17. A number of wards were recognised as being below advised WTE. Additional nursing resource has been provided in order to bring these areas to an equitable establishment. Registered to unregistered nursing resource was also considered during this review with some adjustments within establishments concluded.

3.4.17 Drivers for additional staff in Clyde include 1:1 RMN/ HCSW requirements for patients with challenging behaviour due to Delirium, addictions and other complex conditions, increasing mandatory training requirements and patients with frailty and multiple co-morbidities.

3.4.18 A surgical service redesign is underway. The impact on staffing is being assessed in conjunction with workforce planning colleagues

3.4.19 There are ongoing recruitment issues within the Clyde sector for registered nurses particularly within critical care and medicine.

3.4.20 **Woman and Children's Directorate**

3.4.21 Work undertaken between the Chief Nursing Officer and NHSGGC to assess single-room accommodation versus traditional ward layouts in light of the development of the new single bedded accommodation model in the RHC and QEUH is underway with projected completion date October 2017.

3.4.22 Work is ongoing to review current establishment within midwifery and gynaecology. The midwifery workforce tool was run twice in 2016 with issues highlighted regarding data quality. Following this meeting Chief Midwife and Workforce Planners met with each individual Lead Midwife to detail the correct running of the tool and a 4 week run commenced in April 2017.

3.4.23 The Making a Difference Programme is being supported across the directorate with Registered Midwives/Nurses attending the sessions over the coming months. This has initially been target at Lead Nurses/Midwives and SCN/M but now being rolled out to band 5 and 6 midwives and nurses.

3.4.24 Rosters are reviewed by Lead nurses and midwives to ensure the correct skill mix and use of staff across 7 days. Best practice in rostering is being spread across the directorate and rostering master classes are being planned for the SCNs and SSNs responsible for roster completion. Further work is ongoing in some areas in terms of shift patterns due to some current rota systems being non compliant.

3.4.25 Within paediatrics and neonates Band 5 nursing turnover is up to 11.68% which is 55.61 wte per year. This works out at 4.6 wte per month with very little scope to recruit in-between the graduate output. A recruitment drive is underway targeting the October 2017 paediatric new graduates, however Glasgow Caldeonian University have approximately 40 WTE against a requirement of 100 WTE. Therefore we are predicting a challenging year which may drive usage of supplementary staffing.

- 3.4.26 Difficulties are being experienced in filling midwifery posts within the two stand alone Community Midwifery Units and Senior Charge Midwife posts within Labour Suites.
- 3.4.27 In Midwifery, the ageing profile of the workforce is also evident and driving an increase in student midwife numbers over the past 3-4 years. There have been no issues in terms of mentorship support within the clinical areas. A decrease in number of requests for one year job midwife guarantee has been evident over the past 3-4 years.
- 3.4.28 Maternity Services are assessing the midwifery skill mix and have worked with University of the West of Scotland to develop and revalidate the National Maternity Care Assistant (MCA) Course. This is now ready to commence in September 2017 and as part of reviewing the current skill mix within the workforce, an agreement to the number of MCAs required will be agreed. Within Gynaecology and Assisted Conception Service as part of service redesign NHSGGC will be exploring the advanced nurse practitioner roles.
- 3.4.29 The decision to transfer inpatient paediatric services from ward 15 at the Royal Alexandra Hospital (RAH) to the Royal Hospital for Children, Glasgow is currently with the Cabinet Secretary for Health and Sport for approval. If services were to transfer this would move approximately 15 WTE registered nursing staff and 6 non registered. A number of staff will be required to stay to staff the outpatient clinic which remains at RAH. However, given the uncertainty of the ward's future staff are leaving to work elsewhere which may prompt some operational challenges in the short term.
- 3.4.30 **Regional Services Directorate (RSD)**
- 3.4.31 Following previous runs of the nursing workforce tools Renal Nursing within the QEUH have been allocated financial investment to employ additional nurses. Six Band 5 Registered Nurses and two Band 2 Health Care Assistants have been recruited. The new employees are currently completing a blended workplace and supernumerary renal dialysis nursing learning programme. They will be fully functional within the unit by the end of July '17.
- 3.4.32 The 2017 run of the acute adult inpatient tool is underway within RSD utilising the triangulated approach and Renal services are also participating in a single room observation study. The outcome of this is awaited.
- 3.4.33 A review of the bed model within Burns and Plastics took place in 2016/17 as part of RSD CRES. Beds were reduced within ward 47 GRI from 26 to 18 with an associated reduction in nursing establishment of 6 wte. This was achieved through natural turnover.
- 3.4.34 A Board level decision was taken to change the service model within the centre for integrative Care (CIC) from an inpatient unit to a day unit. There has been an associated workforce reduction within nursing of 4.8 WTE registered and 0.6 WTE unregistered staff. To support the day service 2 clinical nurse specialist posts have been created and are currently in recruitment.
- 3.4.35 Within RSD there are difficulties recruiting specialist nursing staff to neurosurgery theatres and neurosurgery HDU. A review of the model of delivery within theatres is underway. However this continues to be a significant pressure and has driven some of the ongoing Premium Rate Agency spend.

- 3.4.36 Within the Institute of Neurosciences (INS) there are, on average, 7 patients per day requiring 1:1 observation with cognitive impairment and psychosis due to neurological conditions. Joint work with the forensic mental health team has supported a reduction in use of Registered Mental Health Nurse. This work includes environmental changes, staff training in de-escalation and access to the forensic nurse bank.. A proposal to include this additional workforce in core establishment figures is currently being drafted. In addition a job description for RMN/ RGN dual qualified practitioner is under development.
- 3.4.37 Also within INS neurosurgery, HDU and theatres there are sickness “hotspots” compounded by vacancies and maternity leave which are driving use of bank and agency. Professional judgement is currently being applied to the workforce tool output to ascertain whether establishments are safe a further paper will follow.
- 3.4.38 As part of the Do-IT outpatients redesign in neurology work is underway to develop the role of specialist Multiple Sclerosis (MS) nurses to enable them to review patients on first line disease modifying therapies. Learning from this exercise will inform further extension of the outpatient review into epilepsy and general neurology.

3.5 Community Nursing

3.5.1 Health Visiting

- 3.5.2 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”.
- 3.5.3 NHSGGC completed The Caseload Weighting Tool exercise, and Scottish Government subsequently confirmed, in June 2015, resource to fund a projected need of 200 WTE Health Visitors required supporting additional activity.
- 3.5.4 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 (GIRFEC)** and most recently CEL13(2013) Public Health Nursing Service Future Focus 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.
- 3.5.5 A recruitment plan has been put 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 circa 200 wte across NHSGGC (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>

Scottish Government (2013) Public Health Nursing Service Future Focus. Chief Executive Letter Edinburgh, Scottish Government.

3.5.6 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

3.5.7 By 2019 the HSCP 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.

3.5.8 In preparation for the implementation of the Named Person and the introduction of the revised 0-5 Health Visiting Universal Pathway Health Visitors, Practice Development Nurses, Practice Teachers and Team Leaders require continuing professional education with focus on the four nationally agreed priority areas below. Three of the priority CPDs sessions have been delivered and the final CPD will commence in April 2017. The CPS is being delivered by Glasgow Caledonian University colleagues.

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

3.5.9 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;

3.5.10 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.

Workforce Actions – Health Visiting

- Continue to monitor the level of Health Visitor vacancies to mitigate risk to service provision;
- Continue to monitor the additional Health Visiting posts in line with recent investment from SG;
- Ensure future retiral projection numbers are returned on a regular basis to SGHD in order to inform future recruitment requirements.

3.5.11 School Nursing

- 3.5.12 A National review of School Aged Children is underway in response to CEL 13 (2013) and the resulting change in policy and the future focus of public health nursing although it is not anticipated that there will be any funding available to implement any proposed new models of care.
- 3.5.13 A national scoping exercise commissioned by the Children, Young People and Families Nursing Advisory Group was undertaken against a backdrop of increasing concerns regarding existing school nurses with an SCPHN qualification in terms of their capacity and capability across Scotland and the inability in some areas to recruit to existing vacancies.
- 3.5.14 The results of this exercise showed that in NHSGGC our current staff baseline is very low compared to other Board areas in Scotland despite having the biggest population of children and young people of school age and levels of deprivation.
- 3.5.15 There has been significant investment across NHSGGC in Children and Family Teams with Scottish Government investment in Health Visitor numbers. NHSGGC has also invested in Enuresis/Encopresis and School Aged Children Immunisation Teams,
- 3.5.16 These changes have impacted on the activities delivered in the current School Aged Children's Service and as such it has been agreed to conduct a review of this area during 2017/18.

Workforce Actions – School Nursing
<ul style="list-style-type: none">• Conduct an NHSGGC wide review of the School Aged Children's Service and make associated service delivery and workforce recommendations

3.5.17 Family Nurse Partnership (FNP)

- 3.5.18 Family Nurse Partnership (FNP) is a voluntary programme for first time mothers aged 19 and under. It is an intensive, structured home visiting programme which is delivered by specially trained nurses to pregnant women from under 28 weeks gestation through to their child's second birthday. Family Nurses carry caseloads of no more than 25 clients.
- 3.5.19 The programme aims are:
- To improve maternal health and pregnancy outcomes;
 - To improve child health and development and;
 - To improve parents' economic self-sufficiency.
- 3.5.20 There are currently two sites in NHSGGC. One of these sites is based in the North East Sector of Glasgow City HSCP (but covering Glasgow City, East Dunbartonshire and West Dunbartonshire). The second is based in Renfrewshire and covers East Renfrewshire, Renfrewshire and Inverclyde. (this site is currently full and is about to begin to graduate their first cohort of clients. They are likely to begin recruiting again in September 2017.

- 3.5.21 The Scottish Government are committed to the further expansion of the FNP programme and are keen to examine where FNP can add specific value to the current early years landscape. NHSGGC are currently in the process of signing off an SLA for the next three years however will still be subject to the annual spending review.
- 3.5.22 **District Nursing**
- 3.5.23 The District Nursing Review Programme Board identified a future workforce model for the service of 1 Band 6 WTE per 9000 registered population supported by a wider skill mix team of staff nurses and health care assistants. This was based on an analysis of workforce and workload including a benchmarking exercise with other health boards / authorities across the UK. Achievement of the redesigned workforce model was predicted to be completed by March 2017 through natural turnover. This was agreed in 2013 by the, then, CH(C)P Directors, and the health board in partnership with staff side colleagues.
- 3.5.24 Since that time services have moved towards the agreed model as opportunities have arisen to redesign the workforce. The new model saw a reduction in the number of band 6 posts across the system with an increase in band 5 registered nurses and band 3 healthcare support workers.
- 3.5.25 The average age of the Band 6 Nursing Workforce is 53 years with 70% of the workforce over the age of 50 years.
- 3.5.26 Staff over 60 years could opt to leave the service at any time and the number of staff that have the option to leave in the next 24 months is 68.11 wte or 13% of the current workforce.
- 3.5.27 There has been an increase in the past 2 years in the number of experienced district nurses retiring and moving to other areas to work which has resulted in recruitment and retention difficulties within the service. This has resulted in a number of vacancies across the system with services required to develop risk management plans to ensure safe and effective service provision.
- 3.5.28 In a bid to ensure the supply of adequately qualified district nurses Glasgow City HSCP 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 since 2014.
- 3.5.29 A paper to HSCP Chief Officers in 2015 resulted in a decision that each HSCP would make local arrangements to ensure a sufficient supply of staff through investment in training as each partnership had different needs at that time.
- 3.5.30 There was no agreement on risk sharing across partnerships with a preference to manage the issue locally as oppose to a system wide approach to recruitment and retention.
- 3.5.31 The number of staff who will commence training in year 2017/18 are noted in the table below by individual HSCP.

NHS Greater Glasgow and Clyde	
District Nursing Workforce Student Training Allocation 2017/18	
HSCP	DN Students
Glasgow City	7
East Dunbartonshire	1
Inverclyde	1
Renfrewshire	1
West Dunbartonshire	1
Total	11

- 3.5.32 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.
- 3.5.33 It is anticipated that the national review of District Nursing due to report findings in 2017 will promote a more flexible method of educational preparation for the band six role in order to ensure a fit for purpose workforce.
- 3.5.34 The district nursing workforce is key to the emerging models of community care and the provision of high quality care at home which will be essential in supporting the increase in demand for complex care. NHSGGC committed to a workforce model in 2012 to ensure that the right number of staff were in place at the right time to deliver this service.
- 3.5.35 There have been challenges in ensuring that sufficient numbers of qualified district nurses are in place due to the demographics of the workforce which is ageing in line with the wider population. A continued commitment to the on-going education has resulted in the HSCP's being in a better position than some other parts of the country. However there is a real risk that the current financial challenges may see a shift from the agreed workforce model. Incorporated within this is the risk that individual HSCP's may have differing priorities therefore a range of models could potentially exist across the health board area.

Workforce Actions – District Nursing

- Align graduating DN student to existing HSCP DN team vacancies;
- Monitor DN Workforce Trends and assess required student training numbers for induction onto 2018 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.

3.5.36 **Mental Health Nursing**

3.5.37 As previously noted NHS Boards are mandated by SGHD to use the validated Nursing and Midwifery Workforce and Workload Planning (NMWWP) tools to assist with workforce planning and to ensure safe and effective staffing levels.

3.5.38 At the present time a tool exists for in-patient Mental Health and Learning Disability services which is used in conjunction with a formal professional judgement tool and a number of quality measures.

3.5.39 A recent system wide review of ward funded establishments demonstrated the need for this work to be completed to ensure budgetary spend for each ward is aligned to the funded establishment for each ward. The current establishments are historical and were reviewed in light of changes mental health service ward sizes have been standardised and reduced to or around 20 beds:

3.5.40 Ward designs reflect single room accommodation and additional communal and therapy areas with the associated need to ensure safe supervision of patients:

- The introduction of community and specialist services has resulted in a corresponding increase in the acuity and dependency of those patients requiring inpatient care;
- Supplementary staffing used has increased incrementally to meet patient needs most significantly to provide enhanced observation support.

3.5.41 Between October and November 2016 62 of the 63 eligible wards conducted a 2 week run period of the mandatory specialist Mental Health and Learning Disability NMWWP tools

3.5.42 Nurses comprise 55% of the total mental health workforce with 1900 working in Glasgow city. 88% are full time with an average age of 49 but with a significant proportion (either 40 or 60% aged 50-60). Average turnover is now 15% double its previous norm. 21% have MHO status with 380 eligible to retire within the next 2 years. Some services could be particularly badly affected in the coming years by retirements exceeding 30% in some cases.

3.5.43 The Workforce Planning Group's view that the majority of staff with MHO status who can retire prior to 2022 are highly likely to do so.

3.5.44 There are a number of care group areas with staff profiles which could potentially lead to retirements in excess of 12% per annum are:

- Acute adult inpatients (16%);
- Inpatient Rehabilitation/Continuing Care (28%);
- MH Inpatient support (44%);
- IPCU (21%);
- Inpatient older adult (19%);
- Inpatient older adult complex/continuing care (36%).

- 3.5.45 An analysis of current staffing ratios across the 63 inpatient wards reveals current deficits in terms of the levels of registered staff. While most wards are at around a 60:40 ratio and some recent action has been agreed to address the position of the four worst affected wards the national recommended safe staffing level of 65:35 is expected to be enshrined in legislation from 2019. At present more than half our wards are below this level. To reach the recommended level of staffing will need 140 additional registered staff.
- 3.5.46 There is an imbalance between those who may leave and those may enter the profession. Currently there are 116 pre-registration mental health students in training with only a small increase planned. Some additional funding of £3M has been provided nationally to recruit advanced nurse practitioners but this is across all nursing groups.
- 3.5.47 In light of these factors it is recommended that a review of current ward establishment budgets is undertaken to reflect this in the context of meeting the recommended registered to unregistered nurse skill mix ratio and ensuring the nursing profile model detailed in the table below is met.

NHSGGC Mental Health Services	
Possible Staffing Profile for 20-24 Bedded Ward*	
Band	WTE
Senior Charge Nurse (Band 7)	1.00
Charge Nurse (Band 6)	2.00
Band 5	13 – 17 WTE (depending on bed numbers)
Unregistered staff	10 – 14 WTE (depending on bed numbers)

- 3.5.48 At present inpatient wards have an indicative “funded establishment” aligned to budget. The only expected variation to this budget is the additional monies to support pay awards and/or incremental appreciation. Every ward requires supplementary additional staffing to meet clinical need the main reasons relate to enhanced observation, sickness and vacancy cover.
- 3.5.49 In total, this supplementary staffing approximates to over 300 WTE per week (i.e. 20%) of the current inpatient nursing workforce. The additional resources are made up from Agency, Bank, Overtime and Extra to Contracted hours. Mental Health has always relied upon additional hours to supplement services.
- 3.5.50 The results of the NMWWT suggest that the current ward funded establishments are not sufficient to meet the increasing complexity and acuity of patient need. The current funded establishment staff figures were established circa thirty years ago in response to the perceived population need at that point.
- 3.5.51 The result of the recent NMWWT tool showed that in excess of 50% of the supplementary staff was used to provide enhanced observations, it is further evidence that the nature of the severity of condition for mental health patients on admission has changed. Amongst other factors, improved access to Community Services and the work of the Crisis teams are enabling patients to be maintained in the community for longer, but experiencing greater severity in their symptoms at the point of admission.

- 3.5.52 It was also noted that out of the 62 participating wards, 10 had skill mixes lower than 50:50. The lowest skill mix was 38% registered WTE to 62% unregistered WTE. Many of these skill mixes are historical in nature and do not meet the recommended RCN 65:35 % skill mix for registered to unregistered nursing staff.
- 3.5.53 The current skill mix for inpatient wards is 56:44% (730 wte to 580 wte). In order to meet a 65:35% skill mix the service would require to recruit an additional 140 wte (note that this does not take into account the replacement requirements generated by retirements and other leavers).
- 3.5.54 The high numbers of potential retirees not only creates gaps in workforce capacity, but also represents a significant diminution in organisational knowledge, skills and experience which cannot be remedied solely by the appointment of newly qualified registrants. It would be prudent to consider how the experience and quality relationships with service users and their families can most effectively be “handed over” to the next generation of nurses.
- 3.5.55 Within NHSGGC Nursing and Midwifery leavers rates are, on average around 8%. The figure for mental health nursing is now averaging around 15% (with retirement accounting for up to 40% of MHS leavers and rising). There are almost 400 staff who will be able to retire under MHO criteria during financial years 2017-19.
- 3.5.56 It is estimated that the replacement need for the service to compensate for retirements is circa 190 wte during 2017/18 alone.
- 3.5.57 Within NHSGGC, Mental Health Services have not encountered difficulty in recruiting registered staff. This picture varies across HSCP areas and in order to ensure ongoing successful recruitment we require to ensure equitable access to vacancies for this staff group.
- 3.5.58 The Nursing and Midwifery Student Intake Reference Group recommendations to Ministers resulted in confirmation of a 4.7% increase in the intakes to pre-registration nursing and midwifery programmes in the 2017/18 Academic Year. Local Higher Education Institutions (HEIs) in the West of Scotland (WoS) will recruit to a total of 123 pre-registration mental health nurse training places (note that this pool of graduate staff will be available for recruitment in 2020 to all WoS NHS Boards).
- 3.5.59 Over the next three years the Scottish Government will provide an additional £450,000 (nationally) for a Return to Practice scheme to encourage former nurses and midwives back into the profession. This will enable around 75 former nurse and midwives to retrain each year and re-enter employment. This is hoped to address short term recruitment challenges, while at the same time helping address a more cost-effective way to meet projected requirements for more qualified staff in the medium term.

2017/18 Workforce Actions – Mental Health Nursing

- Complete the review of current ward establishment budgets;
- Implement Nurse Director recommended registered to unregistered skill mix of 65:35% for all wards;
- Promote more efficient use of resources:
 - Improved Rostering through running more “Rostering Master classes”;

- Application of 25% Predicted Absence Allowance when rostering;
- Advance Nurse Practitioners training/recruitment.
- Recruitment Actions to mitigate the impact of ageing workforce and increased MHO retirements:
 - Focus on ward areas with potential high levels of retirements;
 - Progress recruitment of Newly Qualified Recruits (e.g. 123 places at WoS HEIs).

3.5.60 **Learning Disability Nursing**

- 3.5.61 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.
- 3.5.62 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.
- 3.5.63 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 in line with the role and function of specialist teams and their relationships with other NHS and Partnership services.
- 3.5.64 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.
- 3.5.65 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.
- 3.5.66 NHSGGC 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.

Workforce Actions – Learning Disability Nursing

- Implementation of a NHSGGC-wide resource allocation model (RAM) and associated workforce changes;
- Continue to review the registered nursing skill mix within Learning Disabilities.

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

3.6 Allied Health Professions

- 3.6.1 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.
- 3.6.2 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.
- 3.6.3 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.
- 3.6.4 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.
- 3.6.5 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.
- 3.6.6 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 and 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.
- 3.6.7 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.

3.7 Physiotherapy

3.7.1 Community Partnerships

3.7.2 The service has recently developed an Advanced Practitioner (APP) Physiotherapist role in Primary Care. This is a unique, first point of contact post which is being piloted within Inverclyde HSCP. Discussions have taken place with Glasgow Caledonian University around the requirement for a recognised Advanced Practice post graduation qualification and training to enhance these advanced practice skills.

3.7.3 The impact of New Ways in Primary Care and the current pressures including GP recruitment and retention is likely to have an impact on MSK Physiotherapy Service and the APP role.

3.7.4 Any future savings/CRES will impact on MSK staffing as the service budget consists predominantly of staff costs.

3.7.5 Recruitment of Physiotherapists to community rehab teams and to some Learning Disability posts has been difficult as no suitable candidates applying for these posts.

2017/18 Workforce Actions – Community Physiotherapy
<ul style="list-style-type: none"> • A number of Band 5 rotational posts have been made permanent in MSK as overall staff numbers have reduced resulting in less staff to support these rotational posts; • Band 6 development work – programme of development covering clinical, research, leadership and education to maximise potential within current role & for succession planning within the service; • Assess the recommendations of AILIP, Modernising out Patient and NHSGGC Orthopaedic Review which may have potential impact on workforce; • Explore opportunities to mitigate difficulty in recruiting to Band 5 & 6 staff within Community Rehab and Learning Disability Teams.

3.7.6 Acute Services Physiotherapy

3.7.7 Increasing levels of frailty, especially at front door services, has potential for impact of physiotherapy workforce; increasing demand and evidence to support reduced length of stay however challenge to shift resource accordingly.

3.7.8 Across the service each vacancy scrutinised for opportunity to skill mix; focus on releasing registered staff from less complex work however previous work in this area in addition to increasing complexity of clinical presentations / decision making required means the opportunity to skill mix are reduced.

3.7.9 Changes to Tier 2 Visa terms which came into force on the 1st of April 2017, increasing the minimum earning threshold for applicants, pose a significant risk to retention of newly qualified staff as this is now outside of the Band 5 pay scale.

- 3.7.10 This new criteria necessitates those staff who are employed under the terms of a youth mobility visa (up to 24 months) to leave the country to seek alternative employment. Given that Higher Education institutes appear to have an increasing percentage of overseas students, this policy change has the potential to create a significant pressure for future recruitment and in particular retention of newly qualified Physiotherapists.
- 3.7.11 During the first two years post graduation, physiotherapists receive significant investment in training and development and this investment will potentially be lost to NHS Scotland and will have an impact on succession planning for senior, specialist physiotherapy posts in future.
- 3.7.12 The recent changes also imposed a £1000 per person, per year fee for those employed on a Tier 2 visa, meaning employing staff who meet the earning threshold and are eligible for tier 2 visa will be more costly to the organisation.
- 3.7.13 The Development of Advanced practice roles remains priority; discussion with Glasgow Caledonian University (GCU) regarding post graduate education for same and in house work on competency framework based on four pillars of practice.

2017/18 Workforce Actions – Acute Physiotherapy
<ul style="list-style-type: none">• Develop first contact practitioner posts in Pain service and possibly Respiratory Service;• Explore the potential for the development of Physiotherapy (or other AHP) consultant post to support regional approach to Specialist Rehabilitation;• Assess the workforce impact of the development of Major Trauma centre.

3.8 Dietetics

- 3.8.1 Metabolic Services
- 3.8.2 The National Services Division (NSD) has undertaken a review of Metabolic Services across Scotland as the current model of service delivery is not sustainable given the likely increase in workloads and issues around maintaining a sufficient workforce to look after existing and new patients. Overall the prevalence is increasing due to the discovery of new disorders, improved clinical recognition as a result of newborn screening and management of known IMDs, and as more patients survive into adulthood.
- 3.8.3 Treating IMD requires multi-disciplinary teams comprised of consultants, dieticians and nurses who have received specialist training and for many of the disorders dietary management is the main treatment
- 3.8.4 The current model is delivered from three Regional Specialist Paediatric Centres with out-patient services at other general hospitals.
- 3.8.5 The National Review Group recommended a designation of an integrated IMD service for Scotland with a consideration of extending the roles of dieticians to free up Paediatric and Adult Consultant time.
- 3.8.6 Gastroenterology Coeliac Out-patient Service

- 3.8.7 The Modernising Out Patient Programme, is a Scottish Government led programme aiming to reduce the number of patients who attend hospital appointments by providing appropriate services close to the patient's home. This is a Scotland wide programme.
- 3.8.8 The main focus of this programme of work thus far has been Coeliac Disease, of which the corner stone of management is Dietary Treatment.
- 3.8.9 The Scottish Government led programme has identified NHSGGC as a test of change area for the proposed new clinical pathway for people with diagnoses of Coeliac Disease. The proposal will ensure that patients are directed to the most appropriate professional support, avoiding unnecessary consultant clinic attendances.
- 3.8.10 The Dietetic Service will lead on the delivery of the revised approach to the treatment of coeliac disease. Additional fixed term investment in dietetics has been agreed to test this revised patient pathway:- 0.5 wte Band 7 Dietitian, 0.2 wte Band 3
- 3.8.11 The organisation will also employ a band 4 post co-ordinator to manage patient journey through the system from referral to treatment.
- 3.8.12 Oral Nutritional Supplements in the Management of Malnutrition
- 3.8.13 Across NHS Scotland, Oral Nutritional Supplements (ONS) are now in the top ten for prescribing spends, with cost increasing year on year.
- 3.8.14 In 2015-16 the spend on ONS was £16 million. NHSGGC has been identified and agreed to implement a 'Test of Change' project to look at new ways of working for Dieticians and Community Pharmacy in the use and provision of ONS in the management of malnutrition.
- 3.8.15 To review pathways and clinical practice the board has appointed two Dieticians, 1.0 WTE Band 7 for two years and 1.0 WTE Band 6, these post holders will work in partnership with Community and Adult Dietetic Services and Pharmacy Services.
- 3.8.16 The out-put of this test of change will inform the National Model for use of ONS in the treatment of malnutrition in NHS Scotland.
- 3.8.17 **Growth & Nutrition Team (GNT)**
- 3.8.18 In 2013 in response to the Scottish Government Action Plan "Improving Maternal and Infant Nutrition; A Framework for Action" ¹ (2011) (MINF) a Board wide GNT was established to train and support Health Visitors in the early identification and management of infants and young children with growth faltering or obesity, and also in the wider aspects of infant and child nutrition. The development and the work of the GNT support the recommendations of several of the Scottish Government Action Plans to improve infant and child health in Scotland: Improving Maternal and Infant Nutrition; A Framework for Action ¹ (2011) and the AHP Ready to Act Plan 2016
- 3.8.19 The work of the GNT supports these recommendations by ensuring that children receive timely and appropriate intervention and advice for common nutritional conditions of early childhood in the best setting and has shifted care for common nutritional problems away from acute services to community.

- 3.8.20 Over the last 12 months 107 infants/children have been referred to the team. Prior to development of the GNT the majority of these referrals would have been referred to hospital medical and /or dietetic clinics for assessment and advice. As most affected children do not have major underlying medical or social issues these referrals were often unnecessary.
- 3.8.21 The model is now one of case management by the family HV with direct access to expert advice and consultation from the paediatric Dietitian, Growth & Nutrition Advisor and a GP with a special interest. In nutrition. The 0.4wte Dietitian in the team is funded by non recurring money from MINF. The funding for Dietetics has been secured for another 12 months from MINF and additional audit of the service will be undertaken to support the business case for substantive funding going forward.

3.9 Art Therapy

- 3.9.1 Art Therapy remains a very small in numbers within the organisation and the challenge will be to build on this service in the current financial climate.
- 3.9.2 At present there is no immediate opportunity to increase the workforce and as such no changes in staff workforce are predicted for 2017/18.

3.10 Speech & Language Therapy

- 3.10.1 The 2016 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 broadened the skill base of the workforce and permitted greater flexibility in rotating staff to meet fluctuating levels of activity and demand across hospitals
- 3.10.2 The reorganisation noted in the 2016/17 Workforce Plan is ongoing within adult acute services however, rising demand continues to put considerable stress on the speech and language therapy service.
- 3.10.3 While reorganisation has secured some efficiencies low turnover has prevented the opportunity to review posts on a larger scale. The service has high numbers of staff at Band 8A and above and some staff are projected to across the next 3 years. This will provide scope to review existing service delivery models and replacement needs
- 3.10.4 2017/18 will see the move of the management of new out-patient referrals to the Referral Management Centre (RMC). This will release clinical time for direct patient contact, increase efficiency of slot utilisation and reduce the DNA rates (as experienced by all other AHP services). This will be funded mainly from an expected clinical vacancy and reflects the level of commitment to making best use of clinical resource by embracing new ways of working.

2017/18 Workforce Actions – Speech and Language Therapy

- Continue to review replacement requirement for all posts as vacancies arise particularly vacancies that are being replaced at B5 or 6 and consideration always given to increasing numbers of HCSW in the service;
- Analyse retirement profiles for staff at band 8A and above and consider the potential for review of service delivery within the next 3 years.

3.11 Orthoptics

- 3.11.1 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.
- 3.11.2 During 2017/18 Orthoptic service review for is planned to facilitate the development of a professional leadership infrastructure. At present this work is at a preparatory stage and the workforce implications of the review will become apparent on commencement of the work.

2017/18 Workforce Actions – Orthoptics

- Undertake a review of service delivery within Orthoptics

3.12 Diagnostic Radiography

- 3.12.1 The service has been successful in recruiting students to vacant posts over the last few years however, it has been identified that many of these staff have subsequently moved to promoted posts or returned to Boards closer to home after a short period of employment with NHSGGC. This has created a retention issue within the service.
- 3.12.2 As a means of addressing the current high vacancy rate within the service undergraduates have been appointed to vacant positions in advance of graduation.

2017/18 Workforce Actions – Diagnostic Radiography

- Review the impact on the workforce of evaluation of TIA and DVT pathways;
- Review impact of developments in acute assessment units, increasing demand on one stop imaging requires review of staffing and equipment;
- Review on ongoing pilot at QEUH. Potentially could result in roll out of service to RAH and GRI.

3.13 Therapeutic Radiography

- 3.13.1 There are no plans in 2017/18 for any re-design of services that affect the Radiography workforce. The service not experiencing high sick leave and we do not anticipate a major change in staffing numbers due to retirement or staff leaving the department.
- 3.13.2 The Therapeutic Radiography workforce is not expected to change in 17/18 (subject to securing additional monies from outstanding business cases). The service has experience no recent difficulties in recruiting staff as evidenced when we advertised for our satellite and attracted a lot of experienced staff from other regional cancer centres.

2017/18 Workforce Actions – Therapeutic Radiography

- Exploring options to advance radiographer practice and facilitate service development in 17/18;

- Palliative Consultant Radiographer (Band 8A): this could help increase the number of Palliative patients planned and treated at the Lanarkshire Beatson and would improve the service we offer these patients at the main site;
- SABR Radiographer (Band 6/7): this technique is being used for more sites other than Lung e.g. Oligometastatic disease, Pancreas, Liver. This advanced technique has considerable imaging implications and the use of this technique is being considered for inclusion in forthcoming trials so an Advanced Practitioner role would be beneficial to our department;
- Late effects Radiographer (Band 7): We are establishing a Late Effects Clinic for patients who have late effects following Pelvic Radiotherapy. This team will include a 0.4 WTE Radiographer;
- MRI Development: a business case for a dedicated MRI scanner at the BWOSCC to facilitate advanced planning/image fusion to aid advanced Radiotherapy planning has been submitted. If successful this will require extra Therapy Radiographers to staff this scanner.

3.14 Occupational Therapy

- 3.14.1 The National Delivery Plan (NDP) for the Allied Health Professions in Scotland (2012)²⁴ identified AHPs as experts in rehabilitation at the point of registration, bringing a different perspective to the planning and delivery of services, it stated that AHPs are uniquely placed to exploit their expertise in enabling approaches through providing rehabilitation and re-ablement approaches across health and social care as well as driving integrated approaches at the point of care.
- 3.14.2 The National Active and Independent Living and Improvement Programme (AILIP), (launch date April 2017), builds on the work of the NDP and will focus on the contribution of AHPs throughout the life curve and emphasise their contribution in early intervention, rehabilitation and enablement.
- 3.14.3 A key message within the AILIP will be the importance of integrated working. Occupational Therapists are currently employed across health and social care structures. They traditionally function separately with separate management and professional leadership arrangements, and different working practices.
- 3.14.4 The establishment of Health and Social Care Partnerships (HSCPs) provides the opportunity to consider the current systems and how these can be improved to enhance service delivery. Discussions around this are already being facilitated within all of the HSCPs in NHSGGC.
- 3.14.5 There has never been a standard workforce model developed and applied for Occupational Therapy and the review is the first step in being able to develop such a model. This review aims to provide:
- The service background to workforce and workload planning within the broader strategic context;
 - A position statement regarding the Partnership Occupational Therapy profile;
 - Information on the demographics of the Occupational Therapy workforce which can be used for succession planning;

²⁴ www.gov.scot/Publications/2012/06/9095/0

- The professional context and evidence base with regards to Occupational Therapy staffing levels and skill mix.
- 3.14.6 The scope will cover all clinical areas within NHSGGC Partnership services associated with Occupational Therapy in both inpatient and community settings. The report provides an overview of Occupational Therapy services across partnerships as a collective and then for ease of clarity and structure, it provides specific data and narrative in a separate format across the 4 care group areas listed below:
- Mental Health;
 - Learning Disability;
 - Specialist Children Services;
 - Community Rehabilitation.
- 3.14.7 Workforce planning in Occupational Therapy will necessitate a drive towards integration, challenging the traditional health and social care pathways and streamlining services to minimise duplication.
- 3.14.8 The emphasis in the strategic plan around early intervention and prevention could suggest that more Occupational Therapists should work in Primary Care. The majority of the current NHSGGC workforce are deployed in secondary care services. Similarly given their skills within rehabilitation, the focus on “home is best”/organising discharge as early as possible, could recommend that a high proportion of the Occupational Therapy resource should be in the community to facilitate early discharge and provide re-ablement and rehabilitation.
- 3.14.9 The emphasis in the AILIP is also around prevention and early intervention and would support this shift in the workforce. A national piece of research will be undertaken as part of AILIP in April 2017. This will provide useful information in relation to where Allied Health Professionals, including Occupational Therapy interventions are best placed for maximum outcome.
- 3.14.10 Integration has provided the opportunity to examine the role of Occupational Therapists in traditional Health and Social Work roles and to consider how these currently distinct services can become more connected.
- 3.14.11 A valuable support staff resource exists within Occupational Therapy, both within health and social care however roles are different. Integration also provides the opportunity to consider a performance management system across the OT service.

Workforce Actions – Occupational Therapy

- Explore opportunities within acute division of advanced OT roles due to difficulty in some specialities in recruiting medical staff (New specialist roles historically automatically appointed to as Clinical Nurse Specialists may become open to AHPs);
- AILIP and associated workstreams may present the opportunity to pursue posts within “tests of change” that would specifically highlight the OT role within particular areas, e.g., Vocational Rehabilitation;
- Consider creative ways of developing OT posts at an early stage within the care pathway to evidence the impact they can make;
- Review the OT support staff role and consider where they are best placed within the care pathway;
- Develop a performance management system for OT.

3.15 Podiatry

- 3.15.1 All anticipated workforce changes noted in the 2016/17 plan took place. In addition; the service was able to redesign historically anachronistic posts into fit for purpose posts to support the creation of foot protection hubs in the community podiatry service.
- 3.15.2 Across 2017/8 and beyond a number of factors are likely to influence the composition of the workforce.
- 3.15.3 The redesign of podiatry to support patients and carers to deliver personal foot care has reduced the requirement for podiatry assistants in their traditional role. A reduction of 40% in band 3 Podiatry Assistant posts is anticipated in the NHSGGC podiatry workforce plan over the next 5 years.
- 3.15.4 Specialist learning disability podiatry services have been integrated within the wider podiatry service to provide equity of service and adequate governance in terms of sickness cover etc.
- 3.15.5 NHSGGC podiatry service anticipates a significant increase in demand for foot protection posts. The number of diabetic foot ulcers referred into the service increased by 70% between during 2016-17. The workforce needs to reflect this in specialist podiatry posts at B6 over the next 5-10 years.
- 3.15.6 There have been no difficulties experienced in recruitment to podiatry posts recently although it has been noted that fewer applications have been submitted for MSK type posts.

2017/18 Workforce Actions – Podiatry

- Review Podiatry Assistant workforce age profile and turnover to assess redesign options in light of reduced need for personal foot care;
- Monitor demand levels for diabetic foot ulcers and project potential impact of specialist podiatrist workforce.

3.16 Prosthetics

- 3.16.1 The NHSGGC Prosthetics workforce is a relatively small staff group consisting of approximately 10.5 wte Clinical and 9 wte Technical staff.
- 3.16.2 At present the workforce is not experiencing/anticipating any recruitment/vacancy issues.
- 3.16.3 Despite this the size of the workforce means that the service is vulnerable to small variations in workforce numbers and as a means of addressing this we will recruit to a modern apprentice in a technician post during 2017/18.

2017/18 Workforce Actions – Prosthetics

- Recruit new technician;
- Recruit 1 wte Modern Apprentice to aid with succession planning (3 - 4 years before becoming fully qualified).

3.17 Orthotics

- 3.17.1 Waiting times across the service are reducing towards the 4 week MSK target due to increased clinical capacity and efficiency through using the AHP referral management centre to manage appointment booking. To support early access to the Orthotic service the referral base has been extended in recent years from medical consultant only to include GPs and any registered healthcare professional. As of 1st April 2017 this has been further extended to include self referrals from patients to smooth the patient journey and allow patients access to treatment as quickly as possible.
- 3.17.2 Building on our 2016/17 workforce action to support the training and supervision of practitioners extending their scope recent Band 7 vacancies have been split between 3 posts as 0.4 WTE to allow the creation of Advanced Specialist Team Lead Posts. These will create clinical leadership in the specialist areas of MSK Foot and Ankle, Adult Neuro Rehabilitation and Diabetes. A further Specialist lead post in Rheumatology will be created later in the year. These posts will create a speciality based departmental structure which will assist in the training of the band 5 Orthotists via rotation through these specialist teams and will also allow us to succession plan these roles which is challenging with such a small staff group.
- 3.17.3 The addition of the Orthotic Clinical Assistant posts has allowed us to trial and roll out telephone reviews for all patients across NHSGGC. This should increase capacity of return slots whilst still allowing the service to collect outcome data from patients to ensure the treatment they receive is improving their health.
- 3.17.4 2 wte x Band 2 vacancies within the orthotic Service for a Technical Assistant and an Administrator have been filled with Modern Apprenticeships. This is the first time Modern Apprenticeships have been used in Orthotics and these have been used to fill current band 2 vacancies.
- 3.17.5 The orthotic administrative workforce has reduced with Orthotics move to the AHP referral management centre in July 2016 which now deals with all Orthotic new appointments. 2 x WTE members of orthotics administration staff transferred to RMC to allow this change to take place. A recent workforce review of the remaining admin staff in Orthotics has concluded that the remaining staffing is too small as leaves no resilience at times of holiday and sickness so an additional 0.4 will be added to increase capacity.
- 3.17.6 The Orthotic Clinical Lead Manager has been acting as Interim AHP director since September 2016. This has had an impact on the department as this has created 5 acting roles to fill this temporary vacancy. Temporary contracts have been used to fill the clinical vacancies this has created as other members of staff have moved into higher bandings and management roles in the interim period.

2017/18 Workforce Actions – Orthotics

- Finish training Assistant Practitioners to allow delivery of protocol-based healthcare under supervision to be implemented across NHSGGC;
- Use specialist team lead structure to redesign the training and clinical supervision of registered staff.

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 NHSGGC has an excellent track record of recruiting and retaining across Psychology staff and supporting skill mix in our Primary Care Mental Health teams (PCMHTs).
- 3.18.3 We receive NES funded Trainee Clinical Psychologists which are a financially free resource for NHSGGC although they require support in services. In areas such as LD and Older Adults it is becoming difficult to provide this support and there is a risk that we lose this valuable resource. NHSGGC also receives similar NES funded MSc Psychologists both in Adult and in CAMHS.
- 3.18.4 Currently our workforce data for Psychology staffing is currently being reviewed as part of an exercise to improve data quality.

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) directives including 'Prescription for Excellence' (PfE) www.gov.scot/publications/2013/09/3025, local NHS GGC priorities including the Clinical Services Strategy and changing patient pharmaceutical care needs where everyone is able to live longer healthier lives at home or in a homely setting.
- 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 PPSU has supported the development of Prescribing Support Teams which are delivering cost efficiencies and improved quality and safety 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 in line with the PfE vision of "General Practice Clinical Pharmacists" and also has the potential to reduce demand on GP's and offering a part solution to GP workforce shortages.

- 3.19.4 In late August 2015 the Scottish Government announced details of Primary Care Investment Funding²⁵ to support the primary care workforce across Scotland and improve patient access to services. The circular detailed funding allocation for pharmacists in GP Practices including additional Prescription for Excellence Funding to March 2018. The National expectation was to recruit up to 140 pharmacists to work directly with GP practices across Scotland. The objective was to support the delivery of care to patients with long-term conditions and free up GP time to spend with other more complex patients. This dovetailed with existing pharmacy support services in primary care. 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)²⁶ was £1.467m inclusive of additional funding for Inverclyde HSCP GMS 'new ways of working' pilot.
- 3.19.5 This funding was utilised to employ 23. WTE pharmacists and 5.4 WTE prescribing support technicians. The appointments included joint posts between acute division and primary care, a service level agreement agreed with community pharmacy on the basis of 0.4 WTE prescribing support and 0.6 WTE community pharmacy as well as appointments in primary care alone. Early indications are that the established pharmacy teams can support the delivery of care to patients, reduce GP workload with improved services for patients. An initial report on the Inverclyde pilot is available with a more extensive report of the impact of this initiative across NMSGC available by March 2018. The pharmacists within Inverclyde as part of their role in addition to prescribing support and clinics specifically focused on 4 GP workload tasks. The GPs specifically requested support in these tasks (Medicines Reconciliation, reviewing IDLs, acute requests, medicine enquiries) which has resulted in a 50% reduction in the time GPs spend on the activities.
- 3.19.6 These pharmacists and technicians continue to be employed with the funding baselined into the health Board allocation. Additional funding has been made available in the 2017-18 Primary Care Funding Allocation for Pharmacists in GP Practices - 2017-18 (PCA(P)(2017) 4)²⁷ with the funding for the new pharmacists employed baselined in the Health Board allocation from April 2018. The funding will allow the employment of 18.6 wte pharmacists. This second cohort of pharmacists will further develop the delivery of new services in GP practices.
- 3.19.7 The redesign of pharmacy services in Acute Care and Mental Health released staff to deliver patient focussed roles and was facilitated by the introduction of large scale robotics and centralisation of services. 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 where pharmacy practitioners have the greatest value.

²⁵ [www.sehd.scot.nhs.uk/pca/PCA2015\(P\)16.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2015(P)16.pdf)

²⁶ [www.sehd.scot.nhs.uk/pca/PCA2016\(P\)2.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2016(P)2.pdf)

²⁷ [www.sehd.scot.nhs.uk/pca/PCA2017\(P\)4.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2017(P)4.pdf)

- 3.19.8 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. In hospital practice it is known from the Carter Report²⁸ that for every £1 invested in the Pharmacy Service £5 in greater efficiency can be realised from the efficient use of medicines and shorter lengths of stay in hospital.
- 3.19.9 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. The SG 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 the community pharmacy network will lead to a growing demand for pharmacists and pharmacy technicians.
- 3.19.10 The latest NHSGGC Workforce information does not highlight any particular concerns for PPSU. The proportion of pharmacists working part time hours has remained the same over the past four years and this may continue given the current financial climate and the uncertainty of the impact of Brexit. The proportion of technicians working part-time hours continues to increase very slightly however this is not a concern. Overall the availability of qualified pharmacists in Scotland is currently very 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. The developing roles for pharmacy technicians in all sectors of pharmacy practice are creating some challenges in recruiting suitably qualified technicians and there needs to be an integrated approach to skill mix, training and recruitment across all sectors.

2017/18 Workforce Actions – Pharmacy

- Implement the workforce changes out in the workforce plan and workforce projections;
- In line with the 2017/18 Primary Care Funding Allocation for Pharmacists in GP Practices recruit 14 wte pharmacists and 5 wte technicians. This second cohort of pharmacists and technicians will further develop the delivery of new services in GP practices.

3.20 Healthcare Sciences

- 3.20.1 Within NHSGGC's Laboratory Medicine Service there is a comprehensive strategy which takes account of future potential changes in service provision and also keeps track of technological changes.

²⁸ www.nhsemployers.org/news/2016/02/carter-report.

- 3.20.2 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.
- 3.20.3 NHSGGC's Laboratory Strategy is in place and work progressing to explore additional opportunities that maybe provided through automation in both Microbiology and Pathology services. Staff skill mix review will result once new technologies are tested.
- 3.20.4 Such changes are likely to impact on Workforce and services regularly look to the future and consider how they can best be prepared for change.
- 3.20.5 There is national UK shortage of band 7 clinical scientists in genomic medicine and molecular pathology, and therefore a requirement for more trainees within genetics to ensure effective workforce planning over the coming years. The move to new technologies and whole genome testing will see an increased workload in this area.
- 3.20.6 Bioinformatics is a new and emerging scientific discipline for genomic medicine and the development of training for bioinformatics for genetics and the reference laboratories is required.
- 3.20.7 Pay protection within laboratory medicine makes it difficult in particular to recruit to Band 7 posts and local training programmes have been introduced to support professional development within newly recruited staff to fill these posts. Most Laboratory services have moved or are moving to extended working days to meet service requirements that causes cost pressures.
- 3.20.8 Staff turnover is not a seen as a concern in healthcare sciences and workforce age demographics reflect the population spread however there is excellent collaboration with local education institutions in order to succession plan.

2017/18 Workforce Actions – Healthcare Sciences

- Explore workforce implications arising from further automation in both Microbiology and Pathology services;
- Review staff skill mix once new technologies are tested;
 - Review the need for training programmes to support professional development within newly recruited staff.
- Explore new training requirements for the future delivery of genomic medicine and bioinformatics.

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
<ul style="list-style-type: none">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.
- 3.24.2 NHSGGC has met and exceeded this target in line with the SGHD directive. The requirement for further changes to this job family will be assessed as posts become vacant.

2017/18 Workforce Actions – Senior Managers
<ul style="list-style-type: none">Continue to review the requirement for Senior Management posts during 2017/18 posts in relation to turnover and the associated vacancies which arise.

3.25 Projections by Job Family

- 3.25.1 Table below shows the anticipated workforce changes by Job Family for 2017/18. Overall it is anticipated that there will be a reduction of 62.5 WTE in the NHSGGC Workforce during 2017/18.

2017/18 NHS Greater Glasgow and Clyde Workforce Plan

NHS Greater Glasgow and Clyde		
Projected Workforce Changes 2017/18		
Job Family	March 2017 Baseline	Workforce Change
Administrative Services	5,214.00	-85
Allied Health Profession	2,780.50	-6.5
Senior Managers (Exec Grades Only)	139.30	-5
Healthcare Sciences	1,774.90	-3
Medical and Dental	3,582.90	12
Medical and Dental Support	290.40	0
Nursing and Midwifery	15,456.50	56
Other Therapeutic	1,144.40	19
Personal and Social Care	270.70	0
Support Services	3,494.60	-50
TOTAL	34,148.20	-62.5

- 3.25.2 These changes are associated with the increases in the Medical, Nursing and Midwifery, Pharmacy and Pharmacy job families which will be offset by anticipated efficiency savings in the Administrative, Senior Management and Support Services workforces as described within this section.

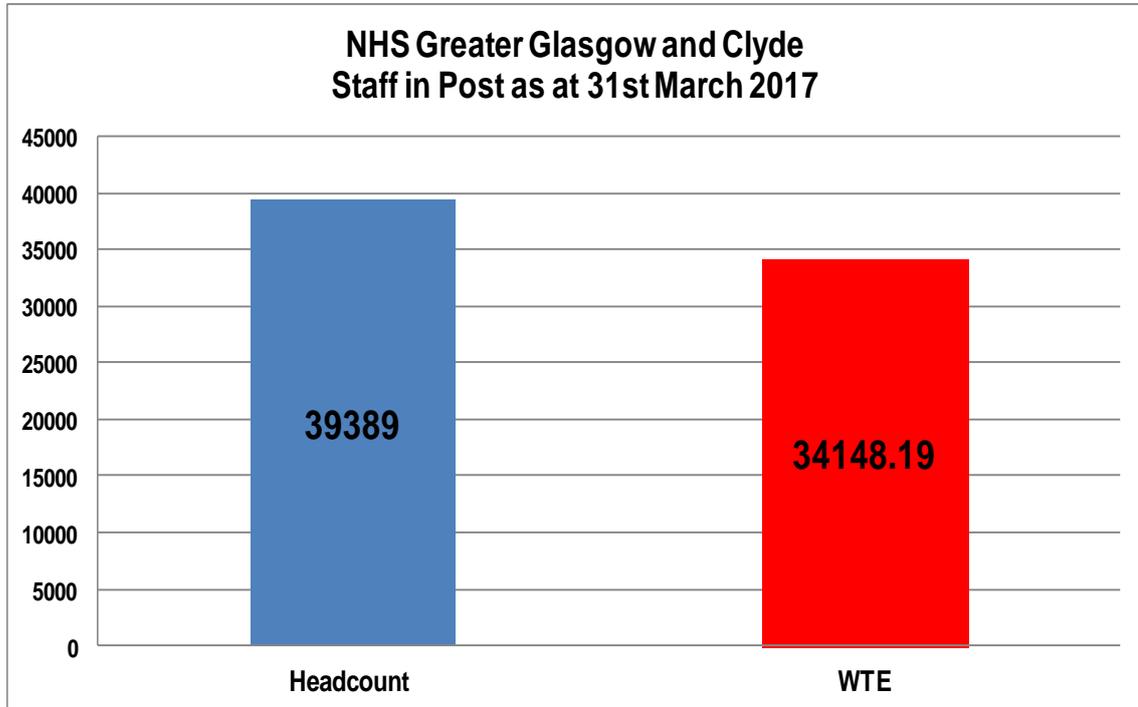
4 Section Four

The NHSGGC Workforce

4.1 Characteristics of the NHSGGC Current Workforce

4.1.1 As at 31st March 2017, NHSGGC employed 39,389 headcount staff, 34,148.2 Whole Time Equivalent (WTE). NHSGGC has a predominantly female (80%) workforce.

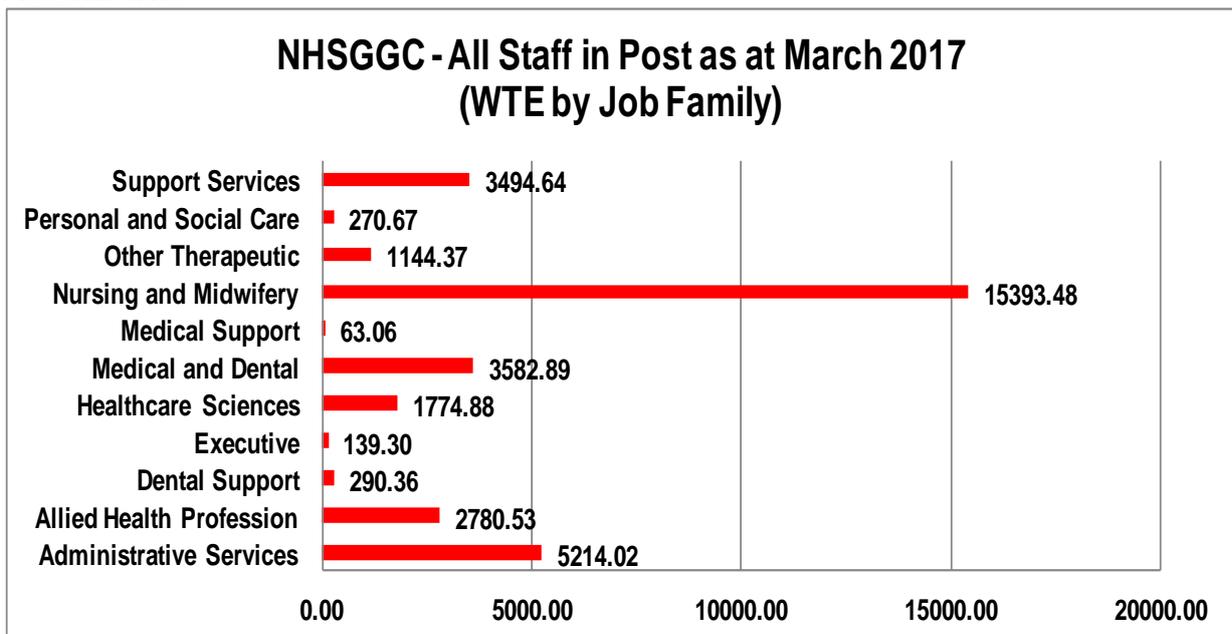
FIGURE 4.1.1



4.1.2 Job Families

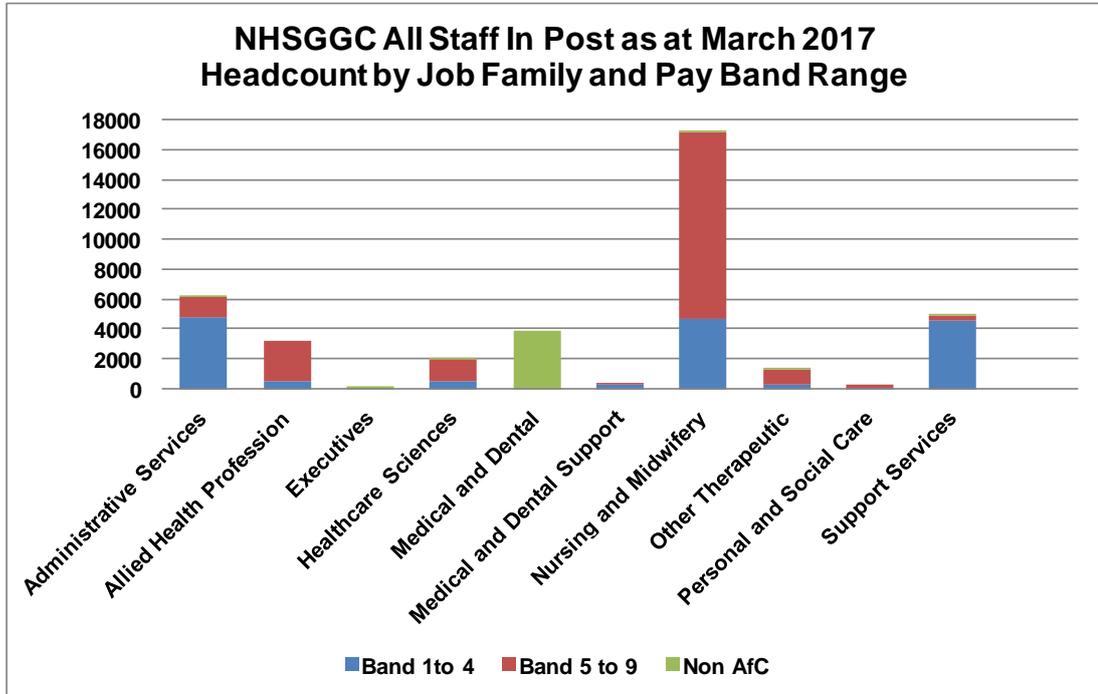
4.1.3 A summary of the NHSGGC WTE workforce by Job Family is shown below:

FIGURE 4.1.3



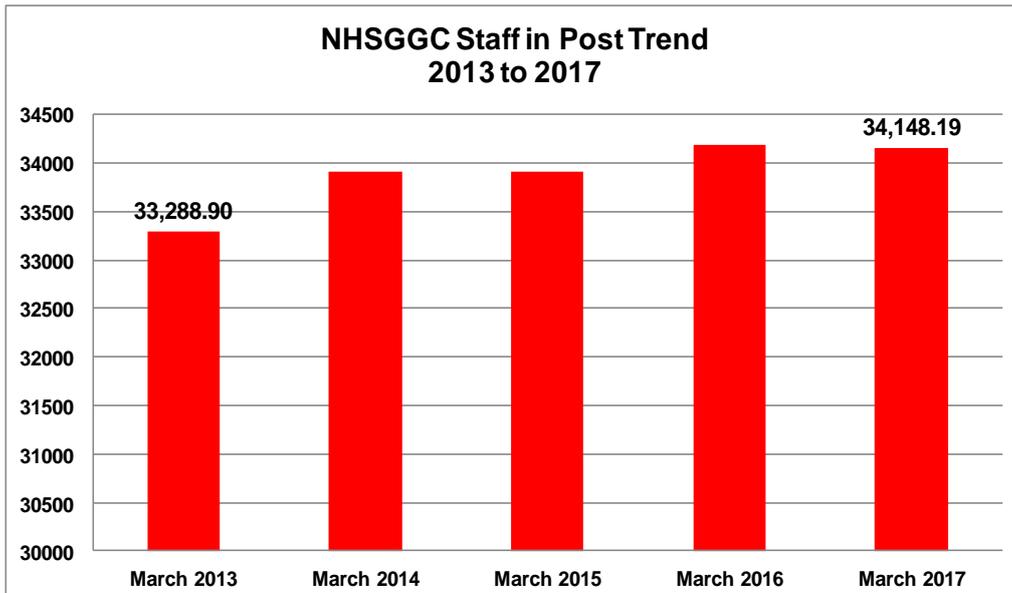
4.1.4 The chart below shows the workforce by job families by pay groupings. Pay bands are grouped by Agenda for Change bands 1 to 4, 5 to 9 and Non Agenda for Change bands such as medical grades, senior managers and other grades including staff from partner organisations who transferred on their existing 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.

FIGURE 4.1.5



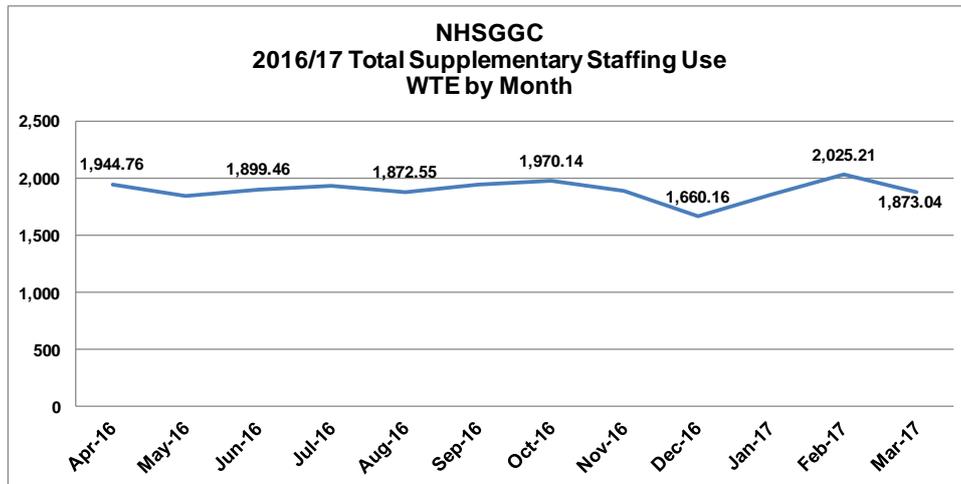
4.1.6 While these increases are to be welcomed, over the next 10 years NHSGGC faces a challenge to ensure that a suitably qualified and trained workforce is available to deliver our services.

4.2 Supplementary Staffing

4.2.1 In addition to the “core” staff identify in the previous chart NHSGGC was able to utilise supplementary staffing resources drawn from overtime and excess hours worked by staff along with extra input provided by the various NHSGGC Staff Banks.

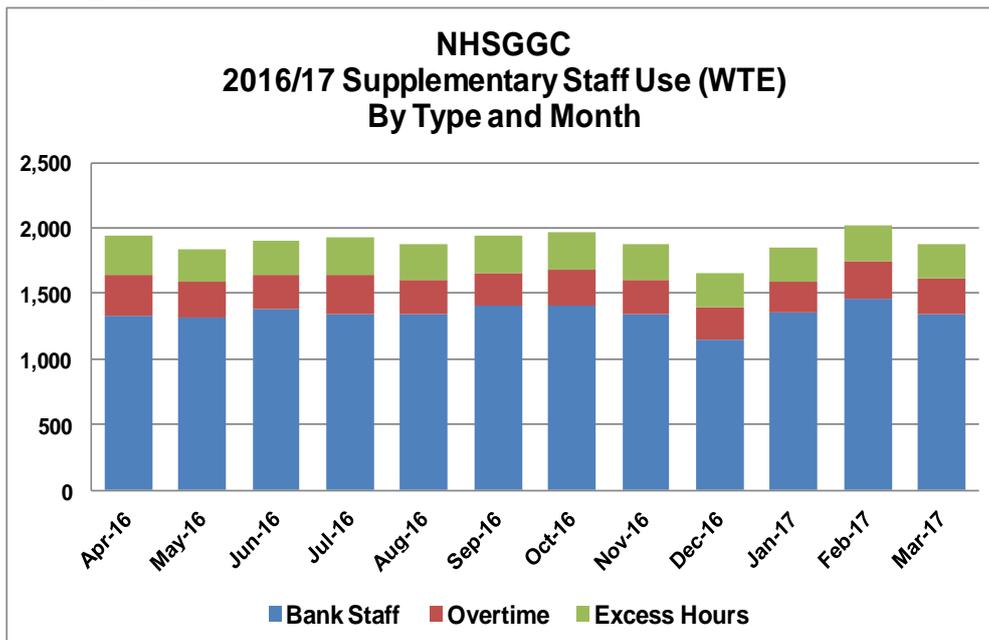
4.2.2 The figure below shows the total supplementary staffing input in WTEs by month across the 2016/17 financial year.

FIGURE 4.2.2



4.2.3 Figure 4.2.3 shows 2016/17 supplementary staffing use broken down by bank, overtime and excess hours use.

FIGURE 4.2.3



4.2.4 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 supplementary staffing.

4.3 Workforce Age Demographics

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

FIGURE 4.3.1

2014 to 2017 Age Group Comparison					
Headcount as a % of Total Inpost					
Age Group	2014 Headcount	2015 Headcount %	2016 Headcount %	2017 Headcount %	2014 -2017 Variance
16 to 24	3.6%	3.8%	4.3%	4.3%	0.7%
25 to 40	33.0%	32.8%	33.1%	33.7%	0.7%
41 to 50	30.9%	29.3%	27.7%	26.6%	-4.3%
51 to 60	26.2%	27.2%	29.4%	29.5%	3.3%
Over 60	6.4%	6.8%	5.5%	5.9%	-0.5%

4.3.2 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.

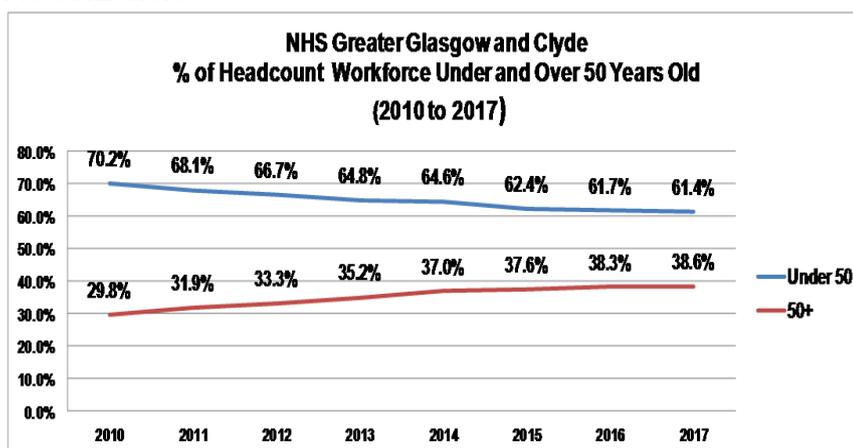
4.3.3 35.5% of the NHSGGC Workforce is over 50 years old. The proportion of the workforce aged over 50 has increased by 2.3% over the last two years. This is consistent with the anticipated ageing of the NHSGGC workforce.

4.3.4 The proportion of the workforce aged over 60 has reduced by 0.5% likely due to an increase in the number of/and the observed trend for earlier retireals (this figure is offset by the increase in the 16 to 24 and 25 to 40 year olds within the workforce).

4.3.5 Of more concern is the 4.3% reduction in the 41-50 year age bracket with the majority of this reduction moving in to the 51-60 age bracket. This suggests that there is a 'static' element to the NHSGGC workforce gradually cascading into the older age groupings.

4.3.6 Figure below 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 4.3.6



- 4.3.7 In the last 7 years, across the NHSGGC workforce there has been an increase of 8.8% percentage points in the number of staff aged over 50. Some Job Families are affected more than others.
- 4.3.8 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.
- 4.3.9 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 retirements amongst the Medical Consultant workforce due to changes in tax and pension legislation.

2017/18 Workforce Actions – Ageing Workforce

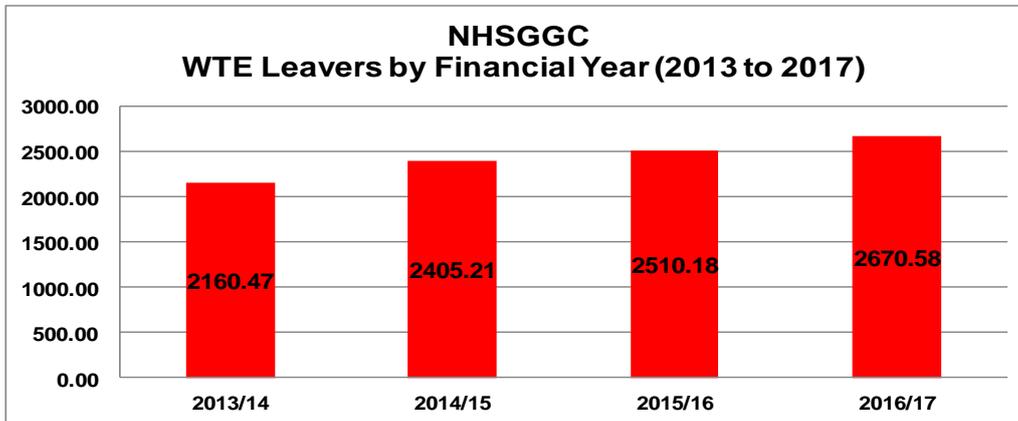
- Establish Short Life Working Group to examine the implications of the “Working” Longer agenda:
 - Identify implications for staff who will be working longer in line with Government pension changes;
 - Consider workplace adjustments that could be implemented to support staff;
 - Identify any specific trends that are likely to impact on the health and wellbeing of the workforce;
 - Access local data from Human Resources, Occupational Health and Health and Safety regarding age profiling and risk assessment.
- Develop an Action Plan to explore anticipated health trends and to implement measures to reduce any adverse impact and set out clear outcomes and recommendations.

4.4 Turnover

4.4.1 Turnover, expressed as total leaver WTE divided by in-post WTE. Within NHSGGC, for financial year 2016/17 was 7.82%. A turnover level of 7.82% for NHSGGC results in approximately 2,670 WTE leavers.

4.4.2 This figure represents a small increased on the previous year (+0.11%) although it should be noted that overall turnover has increased year on year for several years and is now up 1.3 percentage points in comparison to the 2013/14 which was 6.5%.

FIGURE 4.4.2



4.4.3 Turnover does vary between job families. A table summarising turnover in 2016/17 is shown below:

FIGURE 4.4.3

NHSGGC Leavers 2016/17*			
Job Family	WTE Inpost	WTE Leavers	% Turnover
Administrative Services	5,214.02	401.41	7.70%
Allied Health Profession	2,780.53	191.05	6.87%
Dental Support	290.36	15.00	5.17%
Executive	139.30	20.43	14.66%
Healthcare Sciences	1,774.88	144.93	8.17%
Medical and Dental	3,582.89	144.47	4.03%
Medical Support	63.06	1.00	1.59%
Nursing and Midwifery	15,393.48	1380.66	8.97%
Other Therapeutic	1,144.37	99.54	8.70%
Personal and Social Care	270.67	26.79	9.90%
Support Services	3,494.64	227.38	6.51%
Grand Total	34,148.19	2670.58	7.82%

* Excludes Medical and Dental Training Grades

4.4.4 Turnover levels within the majority of job families is within accepted norms (i.e. under 10%) with only the Executive job family exceeding this figure.

- 4.4.5 Turnover in the Nursing & Midwifery workforce (the largest job family) rose by 1% points in 2015/16 compared to the previous year.
- 4.4.6 Increases in turnover were also noted in the Support Services (+0.41%) and Healthcare Sciences workforce (+0.37%).

4.5 Reasons for Leaving

- 4.5.1 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.
- 4.5.2 The primary reason for leaving during 2016/17 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 and 2015/16 figures.
- 4.5.3 Smaller numbers were noted as End of Fixed Term Contracts and Ill Health terminations.

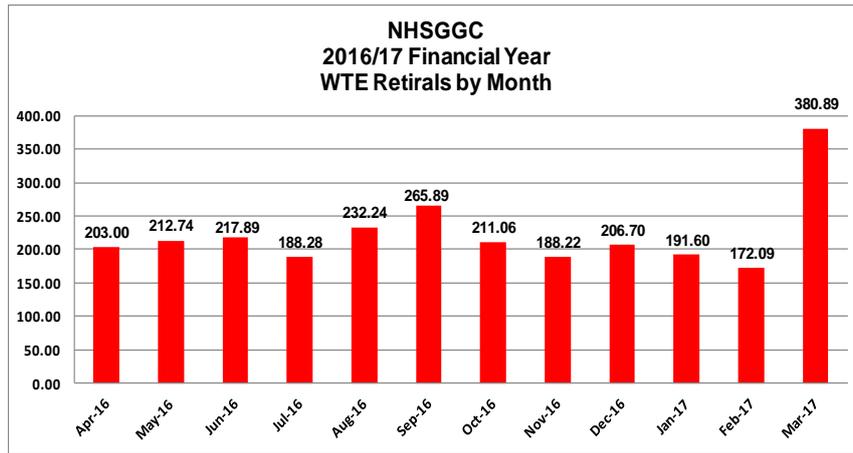
FIGURE 4.5.3

NHSGCC							
2016/17 Leavers by Month and Reason for Leaving (WTE)							
Month	Resignation	Retirement	End of Fixed Term	Ill Health	Death in Service	Dismissal	Grand Total
April	119.67	62.21	5.32	13.33	0.67	1.80	203.00
May	104.08	73.82	14.05	14.01	3.00	3.77	212.74
June	112.72	77.43	6.50	12.68	2.92	5.63	217.89
July	105.69	55.91	9.15	12.89	0.64	4.00	188.28
August	130.23	64.20	14.94	16.00	3.87	3.00	232.24
September	151.24	73.23	16.30	18.10	3.01	4.00	265.89
October	125.51	66.54	6.95	9.04	1.56	1.46	211.06
November	96.04	74.15	2.90	7.43	3.96	3.73	188.22
December	123.60	68.86	4.73	4.71	2.00	2.81	206.70
January	114.05	50.24	11.45	8.73	4.13	3.00	191.60
February	88.33	52.47	12.49	10.93	1.85	6.00	172.09
March	169.57	160.51	21.42	21.79	3.60	4.00	380.89
2016/17 Total	1,439.73	879.56	126.21	149.66	31.21	43.20	2,670.58

4.6 Monthly Leavers Trends

- 4.6.1 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 2017 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 much larger in 2016/17 than in previous years.

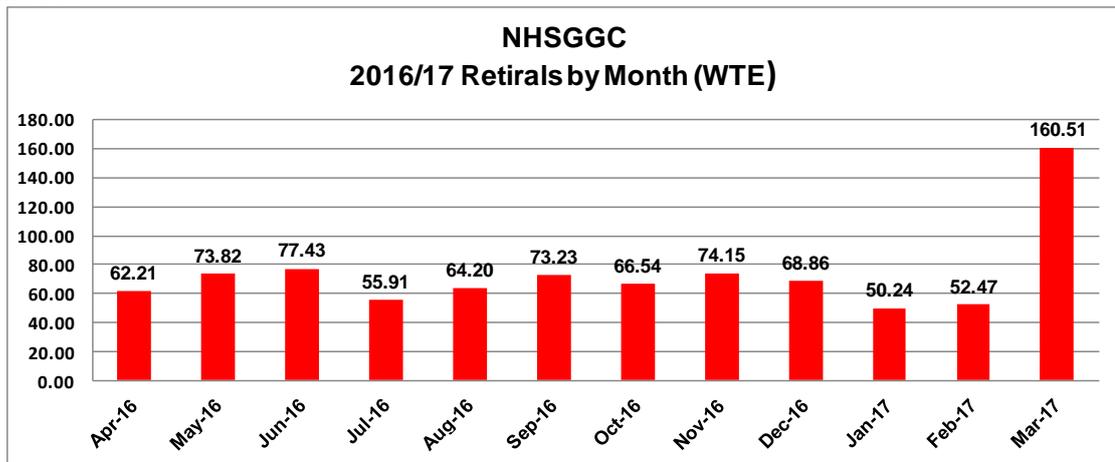
FIGURE 4.6.1



4.6.2 The 2015/16 and 2016/17 NHSGGC workforce plans observed a peak in retiral activity in March of each year where the level of retirals more than double compared to other months within the year.

4.6.3 This pattern has been observed across the last twelve months and the retiral figure for March 2017 is, significantly higher than the figures during the rest of the year (N.B improvements to data quality during 2016/17 have resulted in more staff being classified as correctly retirals instead of “unknown” reasons for leaving).

FIGURE 4.6.3



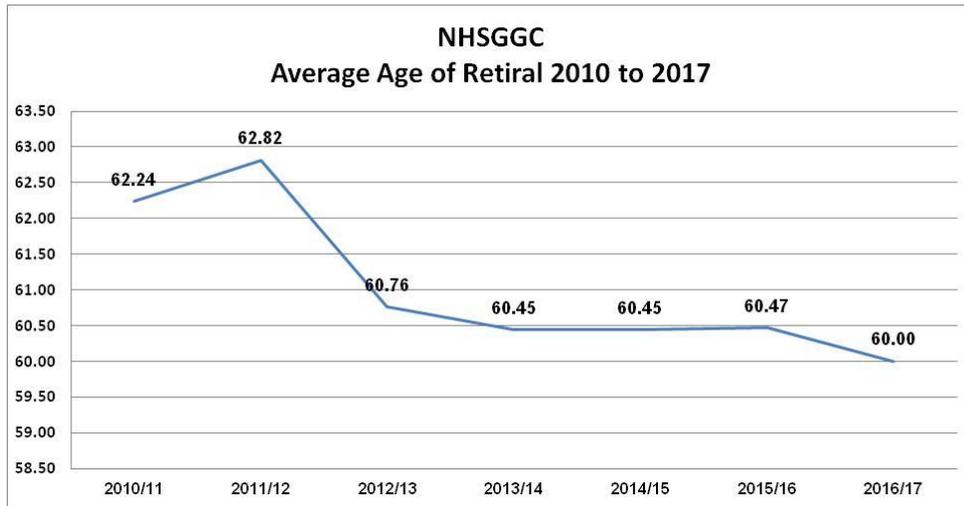
4.6.4 An analysis of the trends across the last four full financial years suggests that the summer increase in resignations and March retirals seems to be a consistent trend.

4.6.5 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.

4.6.6 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.

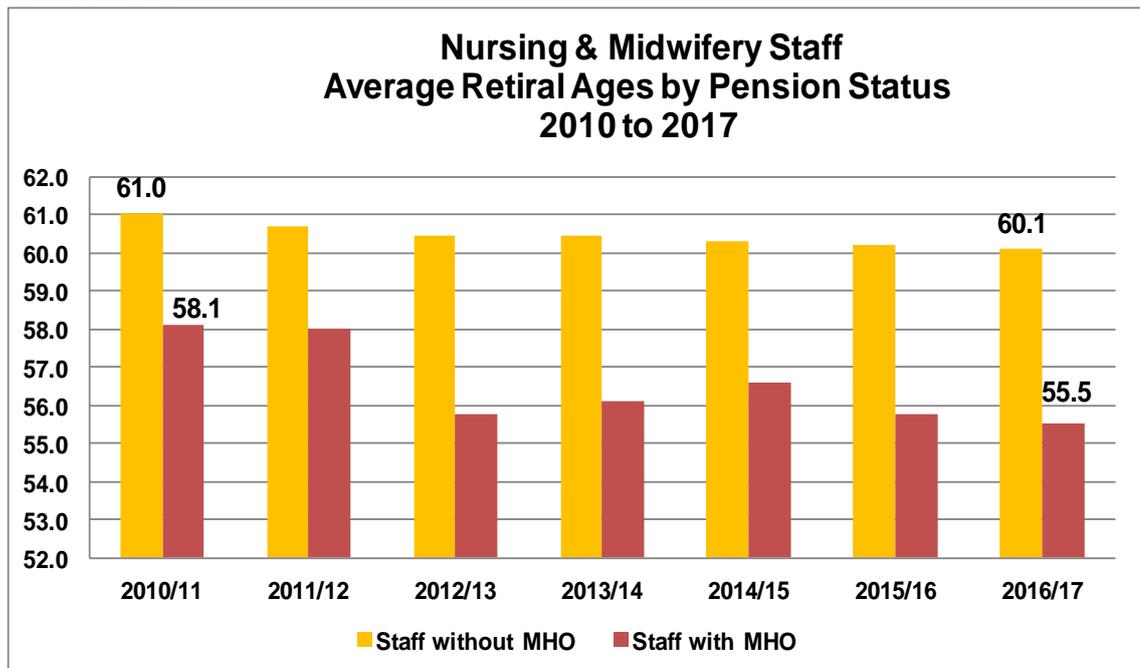
4.6.7 The Workforce Analytics team has undertaken an analysis and identified an underlying trend which shows that the average age of staff leaving the organisation through retiral has decreased by approximately 3 years since the 2011/12 financial year.

FIGURE 4.6.7



4.6.8 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 4.6.8



4.6.9 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.

4.6.10 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.

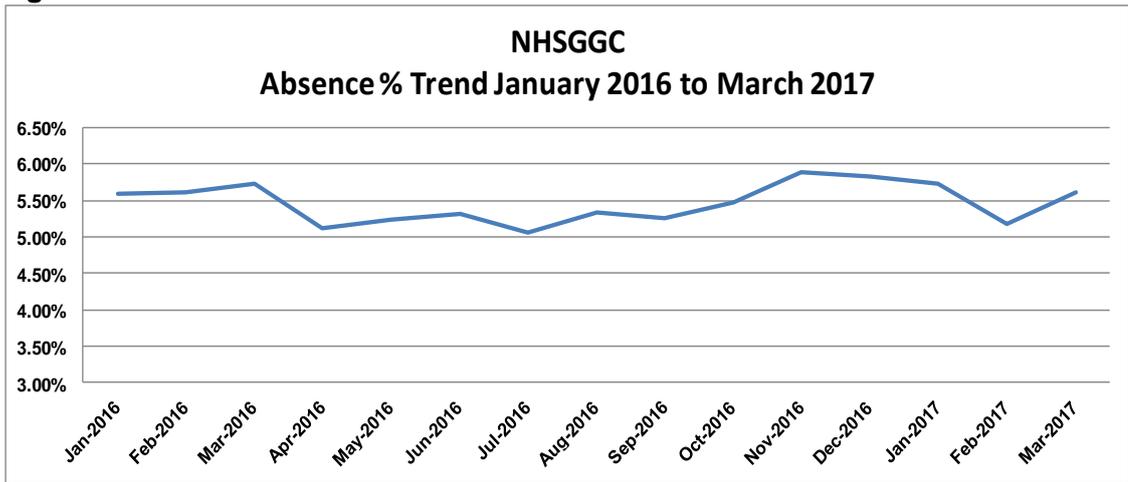
- 4.6.11 Mental Health Officer (MHO) status applies to certain groups of staff who were members of the pension scheme prior to 1st April 1995 and was given in recognition of the nature of the work undertaken.
- 4.6.12 MHO status affords staff an earlier Normal Pension Age (NPA) of 55 rather than the 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.
- 4.6.13 Under the new 2015 Pension scheme normal retiral age will increase in line with the state pension age for most NHS staff.
- 4.6.14 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.
- 4.6.15 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.
- 4.6.16 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.
- 4.6.17 It is however anticipated that the reduction in average retiral ages for staff will begin to reverse after the end of the current ten year pension protection period introduced as part of the 2012 NHS pension revisions.

2017/18 Workforce Actions – 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

4.7 Staff Health and Wellbeing

- 4.7.1 Figure 4.7.1 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 4.7.1

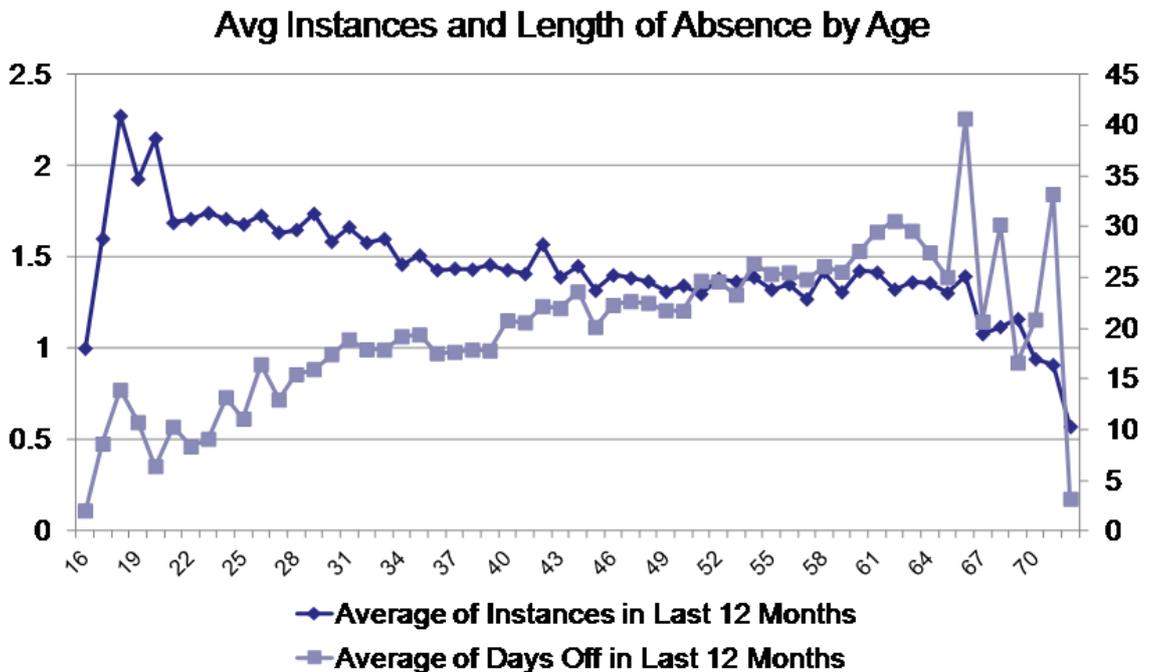


4.7.2 NHSGGC estimates that each additional 1% sickness absence costs the organisation £10 million in lost work, and agency/locum/overtime/bank backfill expenditure. This being the case a reduction in sickness absence presents the opportunity for significant cost savings.

4.7.3 Paragraph 4.3.1 noted that NHSGGC has an ageing workforce and the workforce information and analytics department has identified absence patterns associated with staff age.

4.7.4 Figure 4.7.2 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 4.7.2



- 4.7.5 Service areas are supported by the Human Resources and Organisational Development Directorate to deliver appropriate interventions including Occupational Health Service involvement.
- 4.7.6 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.
- 4.7.7 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.

2017/18 Workforce Actions – Staff Health and Wellbeing

- Roll out the NHSGGC Staff Health Strategy (2017 – 2020)
- Establish the Staff Health Strategy Group with objectives to show
 - Committed to improving staff health
 - Exemplary approach to staff health and wellbeing
 - Supporting attendance
 - Supporting 'fair work'
 - Support for staff with long term health conditions
- Develop Strategic Programmes to support our workforces'
 - Mental health and wellbeing
 - Physical health
 - Health protection
 - Wellbeing

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 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 for most job families 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.
 - Contract Type: part time 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 2017/18. 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".²⁹***
- 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.

²⁹ Scottish Government Definition

5.3 The Employability Plan and the NHSGGC Education Partnership

- 5.3.1 In order to ensure a sustainable and highly skilled workforce within NHSGGC it is critical that the Board has a long term strategy for increasing the number of young people in the organisation and for ensuring that we attract and recruit people from all sections of our population including those who currently face difficulties in accessing employment. This includes, disabled people, care experienced young people and long term adult unemployed
- 5.3.2 NHSGGC is committed to providing jobs, work experience and training opportunities for young people aged 16-24 and for people from all sections of society.
- 5.3.3 A comparison of employee headcount in March 2013 and March 2017 shows an increase of 496 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 people from all sections of our population in 2017/18 and this is reflected in the NHS Greater Glasgow and Clyde's Employability Plan and the 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 people are aware of the range of jobs and careers available, and how these can be accessed. This will include activity to support job centres, school work experience programmes and a careers and jobs 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;
 - Working with a number of external partners to create pathways into employment.
- 5.3.6 The success of the Employability Plan and associated work in widening 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;
 - The College and University sector;
 - Local Authorities
 - Skills Development Scotland;
 - Jobcentre Plus;
 - Jobs & Business Glasgow;
 - Partner agencies such as The Prince's Trust and Clyde Gateway
- 5.3.7 To support the implementation of the above, NHSGGC has revised and expanded the NHSGGC Education Partnership.
- 5.3.8 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 ensuring that the 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 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 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 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 agencies, colleges and schools 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 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 Apprentice Levy

- 5.4.1 In April 2017, the UK Government will introduce the new Modern Apprenticeship Levy on all employers with an annual pay bill of £3million or more, which will be deducted via the PAYE system at a rate of 0.5%.
- 5.4.2 This is likely to represent a tax of between £6m and £7m per annum to NHSGGC, and approximately £30m per annum to NHSScotland.
- 5.4.3 The Scottish Government outlined its response to the levy in December 2016. This includes:
- Provision for public sector employers to have the same access to funded training as private sector employers;
 - An expansion of the apprenticeship programme to include new graduate level opportunities;
 - A new workforce development delivered by colleges to support the up skilling and re-skilling of employees;
 - The implementation of a new programme of activity for pre-employment programmes to support those with barriers to employment enters the workforce.
- 5.4.4 Full details of the plans for the funding allocated to these projects, and the details for implementation, have yet to be confirmed.
- 5.4.5 As a result of the levy NHSGGC will now have access to:
- Scottish Government funded places for apprenticeship qualifications for all staff regardless of age or length of employment;
 - the new Flexible Workforce Dev Fund, delivered by colleges, to up skill and deskill employees;
 - new Pre-employment Support package.

- 5.4.6 All of these developments will support the recommendations above, and provide potential funding streams. Although it should be noted that employers may not be able to access these funds directly, but through identified colleges or training providers. This makes it critical that we continue to develop the Strategic Education Partnership which already exists.

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 2016/2017 we offered over 500 school pupils work experience placements within wards and departments. 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 future years.
- 5.5.3 We will be working with Local Authority partners 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.

2017/18 Workforce Actions – Schools Work Experience

- Review of School Work Experience programme with possible move away from the current ad-hoc, reactive model which can be onerous on departments, results in many requests being refused due to lack of availability, and is not aligned to the new Education Scotland Work Placement Standards.
- Roll out of the piloted NHS Careers Insight (generic) programme for senior phase pupils
- Establishment of role/specialty specific placement programmes for S5 & S6 pupils preparing for FE/HE health related programmes e.g. Physio, Nursing, Midwifery etc.
- Ongoing support for self-found placements

5.6 Training & Employment Opportunities for 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. Portering, Catering and Domestic Services.

2017/18 Workforce Actions – Opportunities for Disabled People

- Development and implementation of up to three pre-employment programmes per annum linked to entry level vacancies. This would be based on the tested Get Into model with a guaranteed interview scheme

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.

5.8 Volunteering Policy & Programme

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

5.9 Educational/ Development Placements

- 5.9.1 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.
- 5.9.2 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..
- 5.9.3 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.
- 5.9.4 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.
- 5.9.5 It is evident that there is a wide range of valuable activity underway within NHSGGC which supports people towards employment ranging from capacity building to transitions into NHSGGC jobs.
- 5.9.6 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 people who face particular barriers to securing employment will be disadvantaged. 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 with an effective package of support for unemployed young people via the Employability Plan.
- 5.9.7 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.

5.10 Learning and Education

- 5.10.1 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.
- 5.10.2 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.
- 5.10.3 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.
- 5.10.4 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.
- 5.10.5 In NHSGGC as at July 2017 61% 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.
- 5.10.6 To support the fulfilment of KSF Personal Development Plans, employees have access to a wide range of learning and education resources including:
- Libraries and Open learning sites – there are a number of these across the service where employees can access learning materials;
 - Digital 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.

- The NHSGGC SVQ Centre which can provide advice and support in identifying an appropriate SVQ for services and employees;
-

5.10.7 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 2017/18 Workforce Plan will be carried out within the governance framework described in Section 1, paragraph 1.7 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 2017/18 Workforce Plan will be reported in the 2018/19 plan.

7 Appendices

7.1 Appendix 1 NHSGGC 2017/18 Workforce Actions Summary

Workforce Plan Section	Service Area	2017/18 Action
1.12	National Health and Social Care Workforce Plan	<ul style="list-style-type: none"> • NHSGGC representatives will contribute as required to: <ul style="list-style-type: none"> ○ The National Workforce Planning Group. ○ The NHS National Workforce Planners Forum. • NHSGGC will await the publication of any revised national workforce planning guidance for health and social care services and: <ul style="list-style-type: none"> ○ Will review/revise existing workforce processes to reflect the new guidance. ○ Contribute as appropriate to any new regional Workforce Planning structure or processes.
3.2	Medical and Dental	<ul style="list-style-type: none"> • Maximise medical staffing recruitment and retention by ensuring NHSGGC is an attractive Board to work in. Promote the ability to work flexibly to encourage applications from a wider pool, including part-time workers and retired consultants • Identify the interrelationships across professional groups which impact on the Medical Workforce and take forward a detailed exercise regarding the role of Advanced Nurse Practitioners (ANP) and Physician Assistants roles across specialties to fill gaps in junior doctor rotas particularly within the Clyde area. • To assist with future workforce planning contact all career grade medical staff, who are within 10 years of what has previously been viewed as a 'normal' retiral age, to enquire about any plans they may have regarding their working arrangements • Promote the importance of job planning through Managing Consultant and SDAS Grade Job Planning events for medical managers, emphasising the responsibility of the Consultants/ SDAS grade to produce evidence at the job planning review meeting to support maintaining status quo or planned change to the number of programmed activities (PAs) in the forthcoming year • Continue to develop NHSGGC E-Job Plans to ensure a single, transparent and authoritative data source. This would enable the Board to have more robust control of job planning information, leading to better alignment of activity with both organisational and departmental objectives. • Develop the current NHSGGC Medical Locum Bank to improve its capacity, and expertise to supply the temporary medical workforce required

2017/18 NHS Greater Glasgow and Clyde Workforce Plan

Workforce Plan Section	Service Area	2017/18 Action
		<ul style="list-style-type: none"> • Implement the 'Temporary Medical Workforce Guidance' to ensure there is a consistent approach to the access of locum cover to ensure alternative 'cost saving' options have been considered in the first instance • Increase the pool of career grade medical staff on the NHSGGC Medical Locum Bank by actively encouraging retired consultants and specialty doctors to join the bank upon leaving their substantive posts
3.3.10	Advanced Nurse Practitioners	<ul style="list-style-type: none"> • Service and Education Needs Analysis to be circulated widely to all NHSGGC service areas; • Service Areas to consider the requirement to employ/train ANPs (or more ANPs) over the next 4 years (the Service Needs Analysis tool to be used to facilitate that thinking); • Education Needs Analysis should be completed by those service areas that plan to train ANPs within the next four years.
3.5.1	Health Visiting	<ul style="list-style-type: none"> • Continue to monitor the level of Health Visitor vacancies to mitigate risk to service provision; • Continue to monitor the additional Health Visiting posts in line with recent investment from SG; • Ensure future retiral projection numbers are returned on a regular basis to SGHD in order to inform future recruitment requirements.
3.5.11	School Nursing	<ul style="list-style-type: none"> • Conduct an NHSGGC wide review of the School Aged Children's Service and make associated service delivery and workforce recommendations
3.5.22	District Nursing	<ul style="list-style-type: none"> • Align graduating DN student to existing HSCP DN team vacancies • Monitor DN Workforce Trends and assess required student training numbers for induction onto 2018 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
3.5.60	Learning Disability Nursing	<ul style="list-style-type: none"> • Implementation of a NHSGGC-wide resource allocation model (RAM) and associated workforce changes

2017/18 NHS Greater Glasgow and Clyde Workforce Plan

Workforce Plan Section	Service Area	2017/18 Action
		<ul style="list-style-type: none"> • Continue to review the registered nursing skill mix within Learning Disabilities
3.5.36	Mental Health Nursing	<ul style="list-style-type: none"> • Complete the review of current ward establishment budgets • Implement Nurse Director recommended registered to unregistered skill mix of 65:35% for all wards • Promote more efficient use of resources <ul style="list-style-type: none"> ○ Improved Rostering through running more “Rostering Master classes” ○ Application of 25% Predicted Absence Allowance when rostering ○ Advance Nurse Practitioners training/recruitment • Recruitment Actions to mitigate the impact of ageing workforce and increased MHO retirements <ul style="list-style-type: none"> ○ Focus on ward areas with potential high levels of retirements • Progress recruitment of Newly Qualified Recruits (e.g.123 places at WoS HEIs)
3.7	Physiotherapy	<ul style="list-style-type: none"> • A number of Band 5 rotational posts have been made permanent in MSK as overall staff numbers have reduced resulting in less staff to support these rotational posts • Band 6 development work – programme of development covering clinical, research, leadership and education to maximise potential within current role & for succession planning within the service. • Assess the recommendations of AILIP, Modernising out Patient and NHSGGC Orthopaedic Review which may have potential impact on workforce. • Explore opportunities to mitigate difficulty in recruiting to Band 5 & 6 staff within Community Rehab and Learning Disability Teams. • Develop first contact practitioner posts in Pain service and possibly Respiratory Service. • Explore the potential for the development of Physiotherapy (or other AHP) consultant post to support regional approach to Specialist Rehabilitation • Assess the workforce impact of the development of Major Trauma centre
3.10	Speech and Language Therapy	<ul style="list-style-type: none"> • Continue to review replacement requirement for all posts as vacancies arise particularly vacancies that are being replaced at B5 or 6 and consideration always given to increasing numbers of HCSW in the service

2017/18 NHS Greater Glasgow and Clyde Workforce Plan

Workforce Plan Section	Service Area	2017/18 Action
		<ul style="list-style-type: none"> Analyse retirement profiles for staff at band 8A and above and consider the potential for review of service delivery within the next 3 years
3.11	Orthoptics	<ul style="list-style-type: none"> Undertake a review of service delivery within Orthoptics
3.12	Diagnostic Radiography	<ul style="list-style-type: none"> Review the impact on the workforce of evaluation of TIA and DVT pathways; Review impact of developments in acute assessment units, increasing demand on one stop imaging requires review of staffing and equipment; Review on ongoing pilot at QEUH. Potentially could result in roll out of service to RAH and GRI.
3.13	Therapeutic Radiography	<ul style="list-style-type: none"> Exploring options to advance radiographer practice and facilitate service development in 17/18; Palliative Consultant Radiographer (Band 8A): this could help increase the number of Palliative patients planned and treated at the Lanarkshire Beatson and would improve the service we offer these patients at the main site; SABR Radiographer (Band 6/7): this technique is being used for more sites other than Lung e.g. Oligometastatic disease, Pancreas, Liver. This advanced technique has considerable imaging implications and the use of this technique is being considered for inclusion in forthcoming trials so an Advanced Practitioner role would be beneficial to our department; Late effects Radiographer (Band 7): We are establishing a Late Effects Clinic for patients who have late effects following Pelvic Radiotherapy. This team will include a 0.4 WTE Radiographer; MRI Development: a business case for a dedicated MRI scanner at the BWOSCC to facilitate advanced planning/image fusion to aid advanced Radiotherapy planning has been submitted. If successful this will require extra Therapy Radiographers to staff this scanner.
3.14	Occupational Therapy	<ul style="list-style-type: none"> Focus on profile raising, building on evidence base and identifying potential areas of clinical work that may benefit from this strand of AHP, such as Dementia, Children's mental health; Explore opportunities within acute division of advanced OT roles due to difficulty in some specialities in recruiting medical staff (New specialist roles historically

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Workforce Plan Section	Service Area	2017/18 Action
		<p>automatically appointed to as Clinical Nurse Specialists may become open to AHP's);</p> <ul style="list-style-type: none"> • AILIP and associated workstreams may present the opportunity to pursue posts within "tests of change" that would specifically highlight the OT role within particular areas, e.g., Vocational Rehabilitation; • Consider creative ways of developing OT posts at an early stage within the care pathway to evidence the impact they can make; • Review the OT support staff role and consider where they are best placed within the care pathway; • Develop a performance management system for OT.
3.15	Podiatry	<ul style="list-style-type: none"> • Review Podiatry Assistant workforce age profile and turnover to assess redesign options in light of reduced need for personal foot care. • Monitor demand levels for diabetic foot ulcers and project potential impact of specialist podiatrist workforce
3.16	Prosthetics	<ul style="list-style-type: none"> • Recruit to new technician post • Recruit 1 wte Modern Apprentice to aid with succession planning (3 - 4 years before becoming fully qualified)
3.17	Orthotics	<ul style="list-style-type: none"> • Finish training Assistant Practitioners to allow delivery of protocol-based healthcare under supervision to be implemented across NHSGGC. • Use specialist team lead structure to redesign the training and clinical supervision of registered staff
3.19	Pharmacy	<ul style="list-style-type: none"> • Implement the workforce changes out in the workforce plan and workforce projections • In line with the 2017/18 Primary Care Funding Allocation for Pharmacists in GP Practices recruit 14 wte pharmacists and 5 wte technicians. This second cohort of pharmacists and technicians will further develop the delivery of new services in GP practices. •
3.20	Healthcare Sciences	<ul style="list-style-type: none"> • Explore workforce implications arising from further automation in both Microbiology and Pathology services; • Review staff skill mix once new technologies are tested; <ul style="list-style-type: none"> ○ Review the need for training programmes to support professional development within newly recruited staff.

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Workforce Plan Section	Service Area	2017/18 Action
3.23	Administrative Services	<ul style="list-style-type: none"> • Continue to review the requirement for administrative posts in the context of continuing technological developments and change
3.24	Senior Managers	<ul style="list-style-type: none"> • Continue to review the requirement for Senior Management posts during 2017/18 posts in relation to turnover and the associated vacancies which arise.
4.3	Ageing Workforce	<ul style="list-style-type: none"> • Establish Short Life Working Group to examine the implications of the “Working” Longer agenda: <ul style="list-style-type: none"> ○ Identify implications for staff who will be working longer in line with Government pension changes ○ Consider workplace adjustments that could be implemented to support staff. ○ Identify any specific trends that are likely to impact on the health and wellbeing of the workforce. ○ Access local data from Human Resources, Occupational Health and Health and Safety regarding age profiling and risk assessment • Develop an Action Plan to explore anticipated health trends and to implement measures to reduce any adverse impact and set out clear outcomes and recommendations
4.6	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
4.7	Staff Health and Wellbeing	<ul style="list-style-type: none"> • Roll out the NHSGGC Staff Health Strategy (2017 – 2020) • Establish the Staff Health Strategy Group with objectives to show <ul style="list-style-type: none"> ○ Committed to improving staff health ○ Exemplary approach to staff health and wellbeing ○ Supporting attendance ○ Supporting ‘fair work’ ○ Support for staff with long term health conditions • Develop Strategic Programmes to support our workforces’ <ul style="list-style-type: none"> ○ Mental health and wellbeing ○ Physical health

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Workforce Plan Section	Service Area	2017/18 Action
		<ul style="list-style-type: none"> ○ Health protection ○ Wellbeing
5.2	Employability	<ul style="list-style-type: none"> • Develop a refreshed NHSGGC Employability Plan which will support access to employment opportunities in health for those people who face barriers to employment. This will include disabled people, the long term unemployed, young people aged between 16 and 19 as well as care experienced young people. • NHSGGC will work with external partners and agencies to develop employment partnerships linked to entry level vacancies and will increase the number of people in employment for the groups mentioned above.

7.2 Appendix 2 - Update on 2016/17 Workforce Projections

	Mar-16	Original Projections	Mar-17	Year to Date Change	Variance to Projection
Administrative Services	5,274.9	-92.5	5,214.0	↓ -60.9	↑ 31.6
Allied Health Profession	2,740.1	5.2	2,780.5	↑ 40.4	↑ 35.2
Executives	137.4	-5.0	139.3	↑ 1.9	↑ 6.9
Healthcare Sciences	1,763.8	-8.8	1,774.9	↑ 11.1	↑ 19.9
Medical and Dental - Consultants	1,497.9		1,519.7	↑ 21.8	
Medical and Dental - Career Grades	451.6	3.8	489.7	↑ 38.1	↑ 33.6
Medical and Dental - Training Grades	1,599.8		1,573.5	↓ -26.3	
Medical and Dental Support	305.0	-0.8	353.4	↑ 48.4	↑ 49.2
Nursing and Midwifery	15,402.4	131.0	15,393.5	↓ -8.9	↓ -139.9
Other Therapeutic	1,110.5	34.2	1,144.4	↑ 33.9	↑ -0.3
Personal and Social Care	279.5	0.0	270.7	↓ -8.8	↑ -8.8
Support Services	3,614.5	-9.0	3,494.6	↓ -119.9	↓ -110.9
TOTAL	34,177.4	58.1	34,148.2	↓ -29.2	↓ -83.5

7.3 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
	Orthotics
	Orthotics
	Physiotherapy
	Podiatry
	Prosthetics
	Speech and Language Therapy
	Diagnostic Radiography
	Therapeutic Radiography
	Biomedical Sciences
Healthcare Sciences	Clinical Sciences
	Clinical Technology
	Consultant
Medical and Dental	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
Psychology	
Personal and Social Care	Health Promotion
	Hospital Chaplaincy
Support Services	Catering Services
	Domestic Services
	Estates
	Grounds Services
	Hotel Services
	Laundry/Linen Services
	Portering Services
	Security Services
	Sterile Services
	Stores Services
	Transport Services