NHS National Waiting Times Centre

NHS SCOTLAND

Workforce Monitoring Report

1st October 2011 – 31st March 2012

EXECUTIVE SUMMARY

Introduction

This Workforce Monitoring Report covers the period 1 October 2011 to 31 March 2012, and it should be noted that whilst there are comparisons to the previous period as a result of an organisational restructure the normal levels of comparison have not been possible.

Summary of Key Employee Information	Mar-10	Mar-11	Mar-12
Headcount	1423	1445	1430
Male/Female ratio	1 to 3	1 to 3	1 to 3
Percentage of staff with a disability	0.77%	1.04%	1.04%
Age bracket containing highest number of staff	40-49	40-49	40-49
Percentage of staff in an ethnic minority group	4.43%	5.47%	3.92%
Sickness Absence	4.84%	4.49%	4.20%

Current Workforce

Staffing levels have been monitored closely and in this six month reporting period the Board headcount has decreased by 6 (WTE) to 1430 substantive staff. Over the 12 month period 1st April 2011 to 31st March 2012 a reduction of 15 (WTE) has taken place.

New National Workforce System

The implementation of a new National HR System – EESS has been ongoing for some time. Every board in Scotland has been involved in the implementation and design of the system.

The NWTCB is in phase 2 of the implementation plan which is currently scheduled to take place in October 2012. An internal Operational Group has been formed involving key people from a number of teams to prepare for this.

The group meet on a regular basis and considerable work has taken place in respect of data cleansing in preparation for the first test data migration exercise in May 2012.

Recruitment Activity

The workforce review group continues to meet on a fortnightly basis and whilst it approves the majority of posts that go before it, this is a reflection of the work carried out by individual managers prior to seeking approval for vacancies. Managers are giving serious consideration of their requirements prior to submission and have used the opportunity to redesign posts in a number of areas.

Sickness Absence

Sickness absence has remained at around 4% throughout the current reporting period and for the full 12 month period 1st April 2011 to 31st March 2012 was 4.2%. Whilst this is slightly higher than the 4% Board target it is not significantly higher and is a reflection of the continued focus on managing both long and short term absence throughout the Board.

The revised sickness absence guidelines reported on in the last report have now been embedded and solutions continue to be sought. The HR team are currently developing an Individual Stress Risk Assessment and in preparation for the integration of this into our normal absence management processes, a pilot with a small sample of cases will be conducted to assess its usefulness.

Knowledge and Skills Framework (KSF)

KSF has been absorbed into business as usual across the Board and whilst we were successful in exceeding the HEAT target in 2010/11 of 80%, the current reporting period has ended with a final year figure of 26% of staff having a current PDR. This has been a difficult period for the business with organisational review, voluntary severance and an increase in activity to support other NHS Boards and despite considerable efforts by both the HR team and Learning and Development providing support for managers and staff, results have been extremely disappointing.

Plans are being developed to ensure that managers have a greater focus in this area in the next 12 months. A number of initiatives are planned including open surgeries, targeted training, specific training within departments and teams and one to one coaching where required for managers. A communications plan is also being developed with the Communications team to re-energise and remind managers and staff of the benefits of carrying out PDR's.

Equality and Diversity

The National Waiting Times Centre is currently working toward achieving Investor In Diversity status. At present the Board is recruiting Diversity Champions and plans to train successful applicants by the end of May 2012. The role of the Diversity Champion is to promote equality and value diversity within the organisation. They will support the organisation in its aim to empower staff to challenge inappropriate behaviours and reinforce positive attitudes to equality, diversity and dignity at work.

Stonewall Workplace Equality Index

For the second year in a row, we have been ranked the best Scottish NHS Board in Stonewall's Workplace Equality Index (WEI).

This year we came seventh of all organisations in Scotland, and have moved up 58 places to be 166th in the United Kingdom.

- The WEI is a measure of how an organisation meets the needs of Lesbian, Gay and Bisexual (LGB) staff and service users and is a good indicator for equality generally.

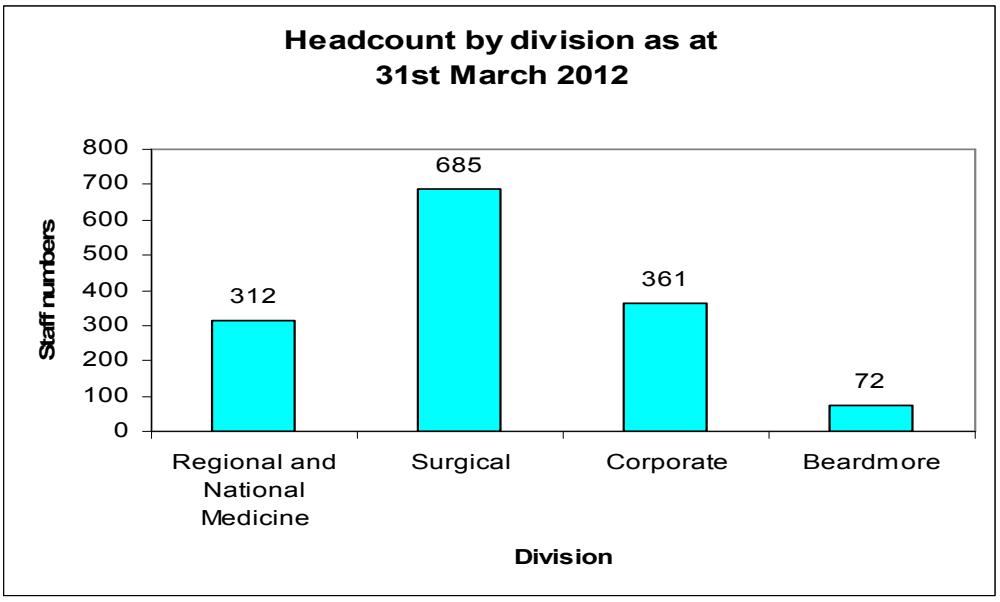
Elaine Barr
HR Manager
12th April 2012
APPROVED: 3RD MAY 2012

SECTION 1

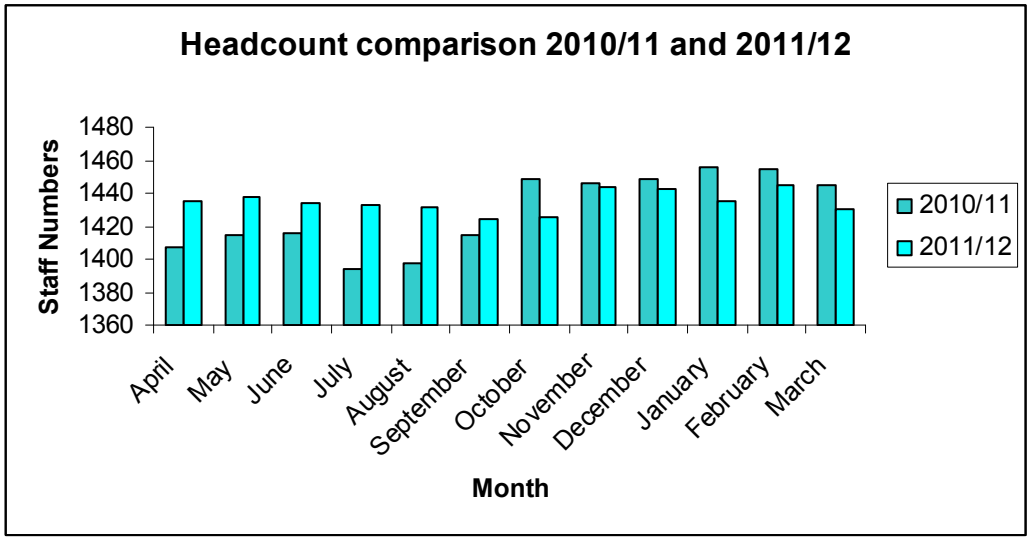
CURRENT WORKFORCE

1.1 Board Headcount and Whole Time Equivalent

The number of substantive staff employed by the Board at the end of March 2012 is shown below by Division. Staff headcount has fallen slightly in the past 6 months by 15 to a total of 1,430. This was expected as a number of posts had not been filled whilst a review of the skills mix was carried out following phase one of the organisational review.



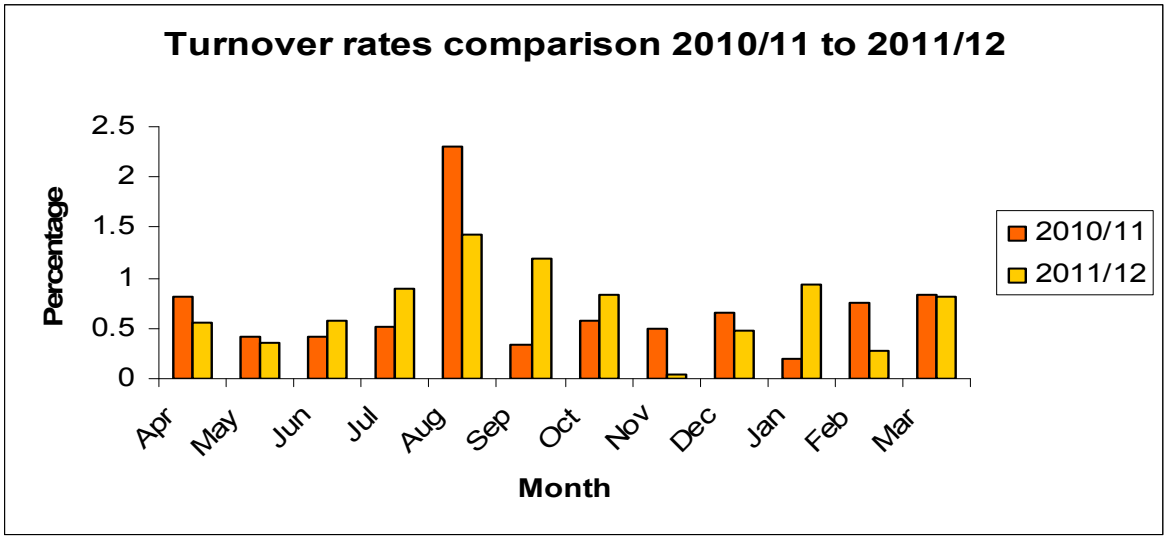
Comparing the headcount across the last two years, there has been a slight fall in headcount which has been maintained consistently across the second half of the period. It is likely that these numbers have reached their lowest point with higher levels of recruitment expected early in the next reporting period due to reorganised posts continuing to be fill together with increased clinical activity being secured for the Board.



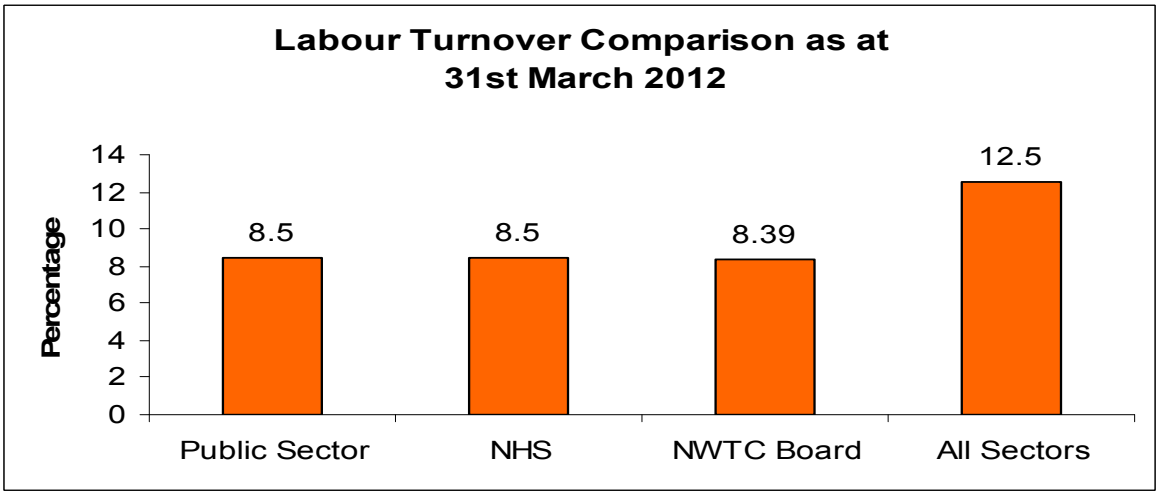
1.2 Employee Turnover

1.2 Turnover

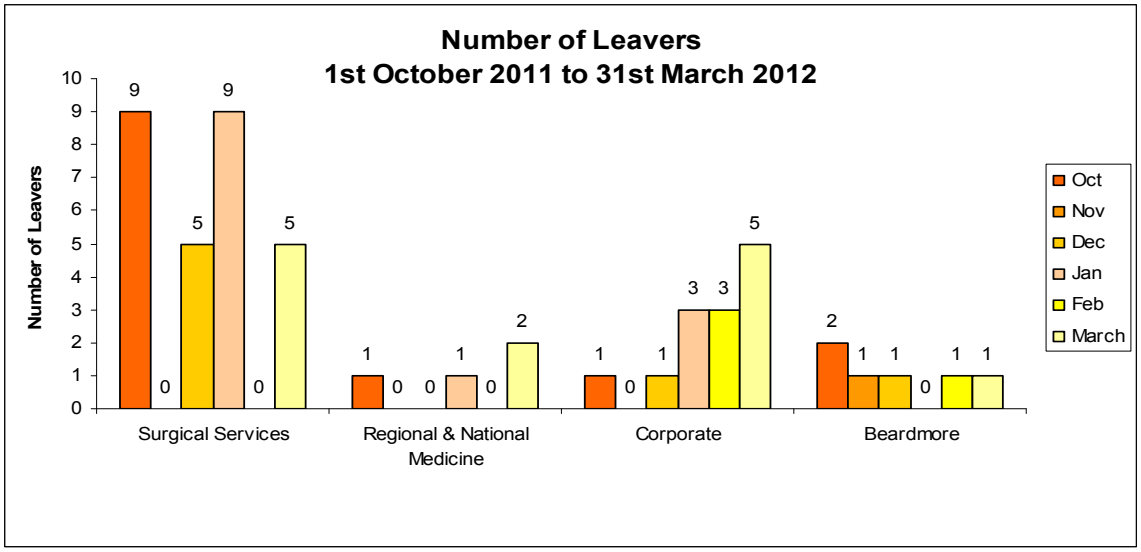
The percentage turnover by division in the last 12 months is shown below. This is consistently under 1% with the exception of August which can be attributed in the main to the junior doctor's rotation and September where there is no obvious explanation for higher than normal turnover rates. The cumulative total for the last six months is 3.36% with an annualised figure for 2011/12 of 8.17%. This is marginally higher, 0.05%, than the previous 12 months but includes elements of enforced retirement and voluntary severance.

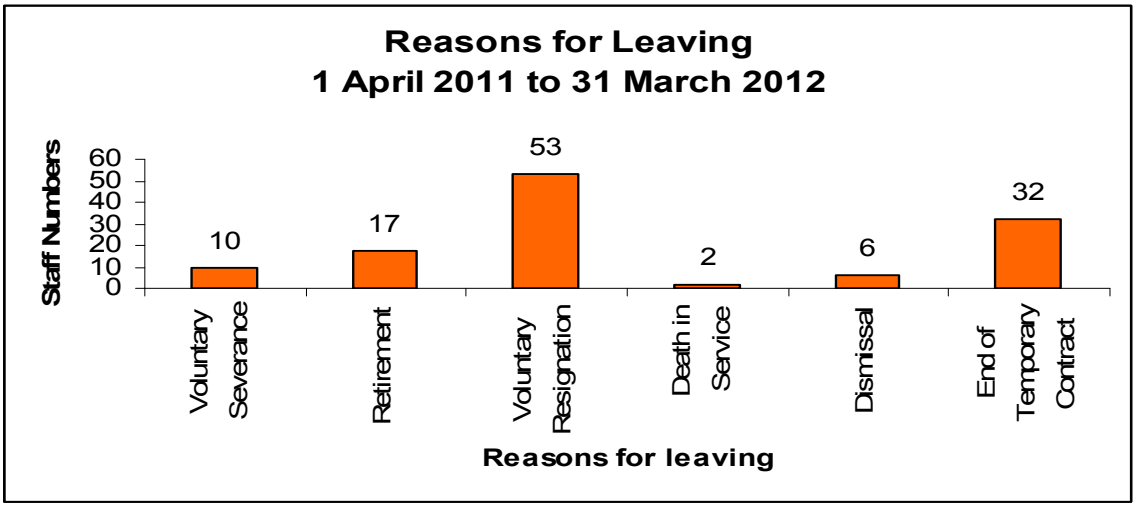


Information relating to the labour turnover in other organisations is illustrated below. This information has been taken from a combination of the CIPD website and the ISD NHS Scotland Workforce Report. The figure shown for NHS Scotland is for the previous 12 month period as only 9 months are available for the current reporting period. You will see from this that our turnover is slightly lower than NHS Scotland and the Public Sector.

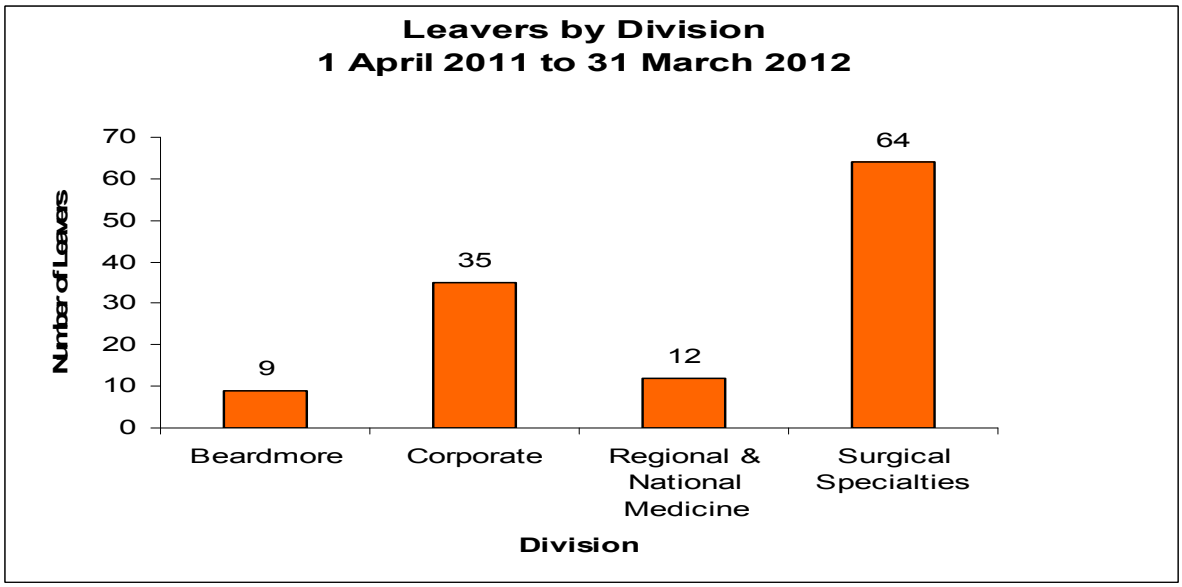


The number of leavers together with the reasons for leaving and length of service are illustrated. The category "end of temporary contract" covers junior doctor's rotation and other fixed term contracts including the Nurse Intern Rotation.





While it appears that the number of leavers in Surgical Specialties is significantly higher than the other divisions, when calculated as a percentage of staff the number is broadly proportionate to the numbers across the other divisions with no specific trends being identified.



As stated earlier, the number of junior doctor's who leave as part of their rotation coupled with the number of people on fixed term contracts impacts significantly the number of staff leaving during their first 5 years. Also included in this figure are a number of nurse interns who joined the organisation as part of a national initiative and remain for a maximum period of 12 months. The remainder were, in the main for personal reasons including career development however a small number had performance issues and resigned whilst in the capability process.

1.3 RETENTION

1.3 Retention

The table below shows the number of leavers with over 1 year's service.

Quarter	Number of Leavers With over 1 year's service
April 2011 - September 2011	48
October 2011 – March 2012	41
TOTAL	89

The skill sets for those leaving are widely spread as follows:

Nurses	22
Health Care Support Workers	8
Admin and Clerical	23
Medical	10
AHP's	8
Ancillary	18

We have no concerns that any one skill set has significantly higher leavers than others. We have embarked on a number of different initiatives including compulsory retirement and voluntary severance which when added to performance management and the number of fixed term contracts we have used in the last 12 months would explain some of data. We will however continue to monitor this closely over the next 12 months.

Voluntary Severance

In December 2012 the Partnership Forum and Senior Management Team approved a new Voluntary Severance Scheme. The scheme was open to every employee in the Board if they met the basic criteria which was:

- They were permanently employed or on a fixed term contract where redundancy rights apply
- They had at least 2 years continuous NHS service
- They were not designated for a future transfer to another NHS organisation

The scheme was introduced to assist the Board deliver the savings it requires over the next two years in a manner that was well planned, increased efficiency and safeguarded the high quality of the business. It was also anticipated that the scheme would allow for further redesign to take place within the Board.

One hundred expressions of interest were received and after receiving estimates of the severance package on offer, fifty nine signed applications were submitted.

Twenty nine posts were approved for receipt of a severance package the majority of whom were female aged between 50 and 59. These have now been processed with the majority of these leaving by the end of March 2012. A small number have been extended beyond this date to ensure that the required redesign has taken place.

2.0 Recruitment

In this reporting period we were successful in appointing to several specialised medical posts including a Consultant Physiologist, a Consultant Haematologist, two Speciality Doctors in Transplantation and a Post CCT position for Anaesthesia. The recruitment for the Consultant Haematologist was carried out by Greater Glasgow & Clyde with the post-holder supporting the service at The Golden Jubilee National Hospital, Gartnavel General Hospital and the Western Infirmary.

During February and March we advertised for a Consultant Cardiothoracic & Critical Care Anaesthetist and a Consultant Cardiothoracic Transplant Surgeon. These posts will be recruited using the selection process for Consultant and Senior Management appointments.

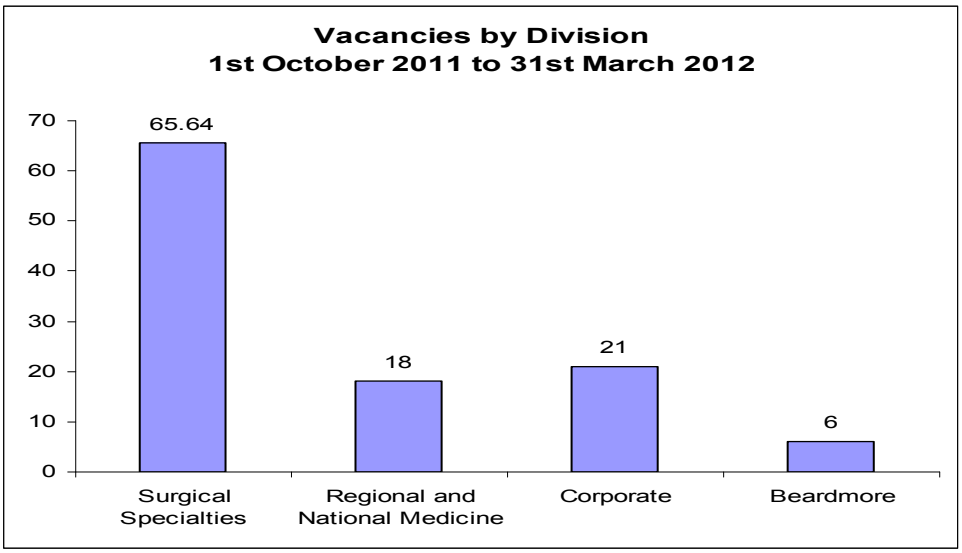
Our most recent group of junior doctors commenced in February with all gaps being successfully filled. The recruitment process for the August intake was commenced earlier than in previous years allowing us to appoint to all our gaps and we are currently working through the pre-employment checks in preparation for the August start date.

Under the Scottish Government 'One Year Job Guarantee Scheme' for nurses we have filled seventeen of the eighteen allocated intern placements. Internship positions are available across our range of clinical settings and involve structured rotations across different clinical areas.

Current Recruitment Activity

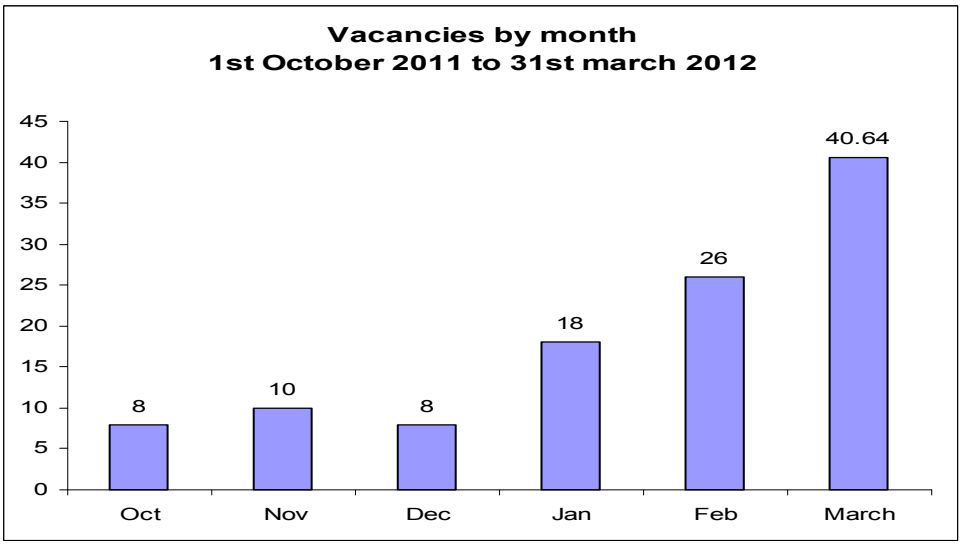
Despite the continued difficult economic climate and the ongoing drive within the Board to realise financial savings, 110.64 (WTE) posts were advertised in the last 6 months. This is broadly similar to the number advertised in the first half of the financial year. It should be noted that whilst other sections of the report exclude bank posts, this section reports on all vacancies including bank and temporary.

The workforce review group continues to meet on a fortnightly basis and whilst it approves the majority of posts that go before it, this is a reflection of the work carried out by individual managers prior to seeking approval for vacancies. Managers are now seriously reviewing their requirements prior to submission and have used the opportunity to redesign posts in a number of areas.



The volume of applicants continues to be high and for the majority of posts we advertise for only one week. Where necessary we will close the post early allowing us to more effectively manage the number of applicants. The result of this is that we no longer ask managers to short list excessive numbers of candidates. We have no reported reduction in the quality of candidates available for short listing.

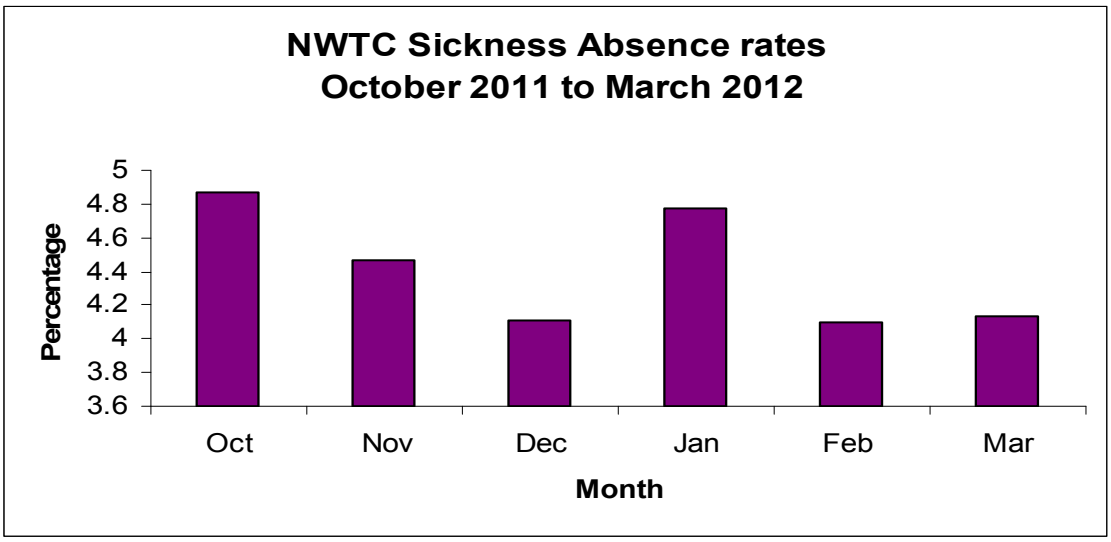
The table below shows the progressive increase in the number of vacancies each month culminating with a significant increase in March 2012. This is a result of a both the significant expansion in orthopaedic work being undertaken within the board and the completion of the voluntary severance exercise which allowed redesign in a number of different parts of the organisation. The posts relating to the redesign were either posts that had been held back pending a skills mix review or were significantly changed.



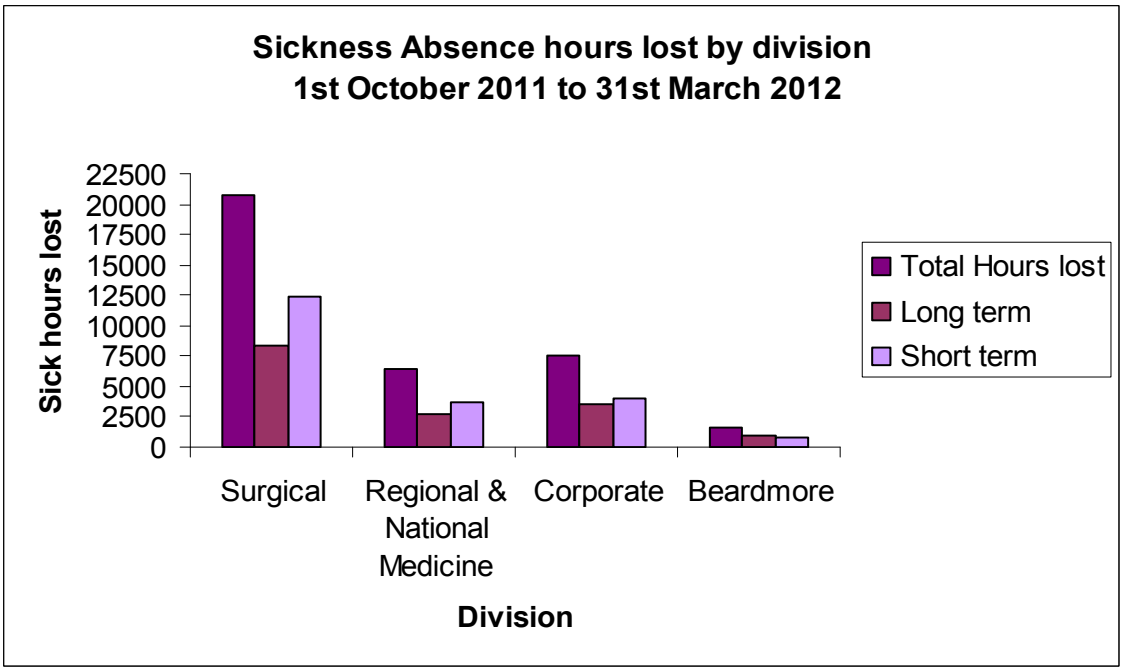
3. SICKNESS ABSENCE

The overall sickness absence figure was maintained close to the 4% board target figure with the average percentage for the 12 months being 4.2%. The following chart shows the monthly figures for the six months October to March which when compared with the same period last year represent a reduction in absence levels.

The estimated cost of absence across the last 12 months excluding employer costs, unsocial hours, on-call etc exceeds £1.3 million pounds (based on a mid point Band 5 salary). It is important that focus remains on this area to ensure that all absences are managed consistently and that every support is given to support staff returning to work and to minimise the effects to their absence.

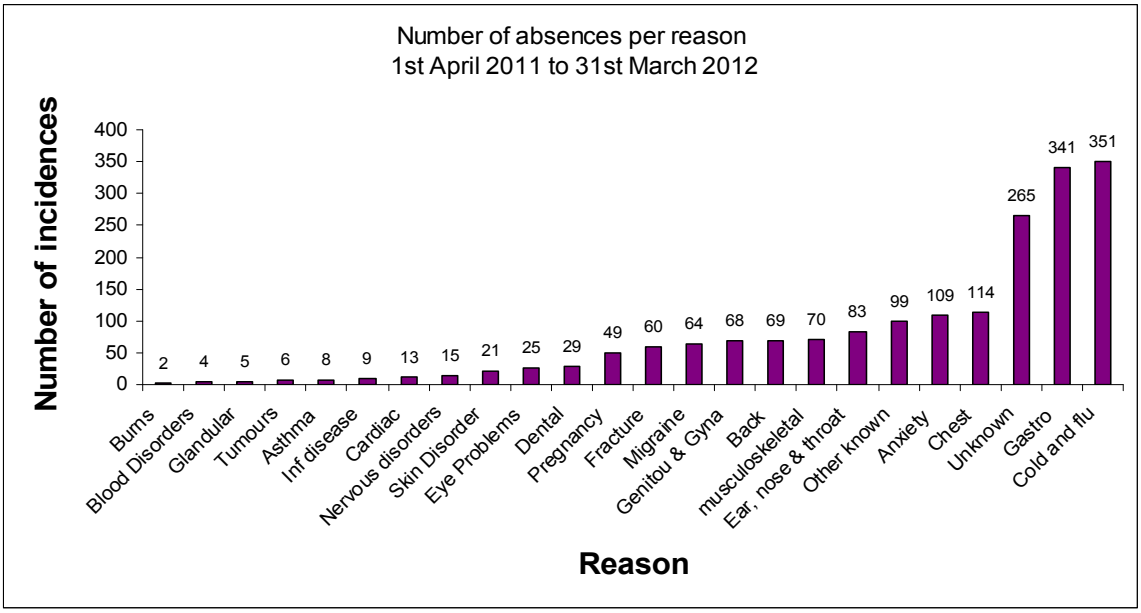


It is clear that Short Term Absence represents the highest number of hours lost and work continues to identify areas for improvement.



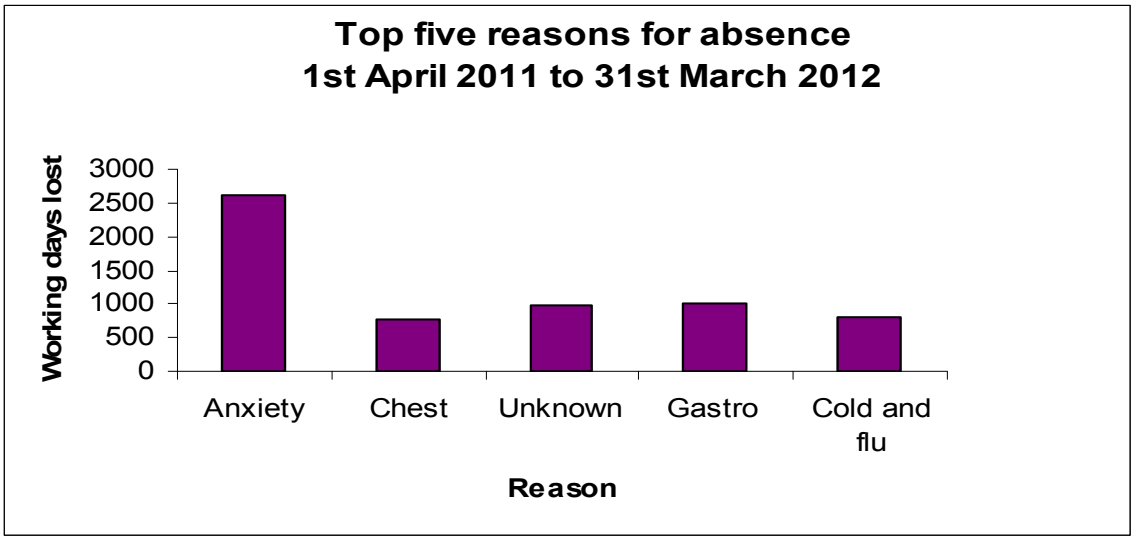
The level of unknown absence recorded has grown and work is being undertaken by the HR team to remind managers of the importance of recording all absence reasons. The evidence provided by managers suggests that when members of their team are absent for short periods, they are not always able to record the reason until they have completed their return to work interview. They then fail to return to the payroll system to retrospectively record the information.

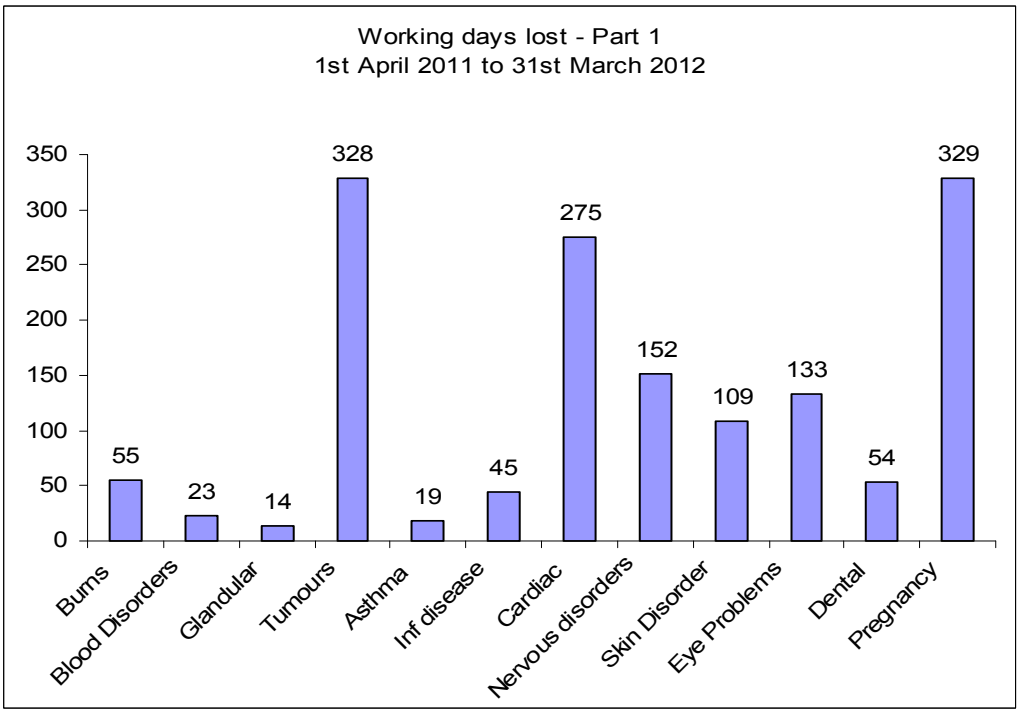
Additionally some staff members are do not have the appropriate permissions to enable them to record reasons for absence through the SSTS system for reasons of confidentiality (e.g. where a member of the admin team inputs the data for authorisation). A more senior member of that particular team would then revisit the absence entry to correct this. A further area for concern is the use of the category "other known" it is surprising that 99 incidences of absence during the last 12 months were known but unable to be recorded in the categories provided. The HR team are discussing this with line managers to ensure that they are clear about what information should be captured in each category.

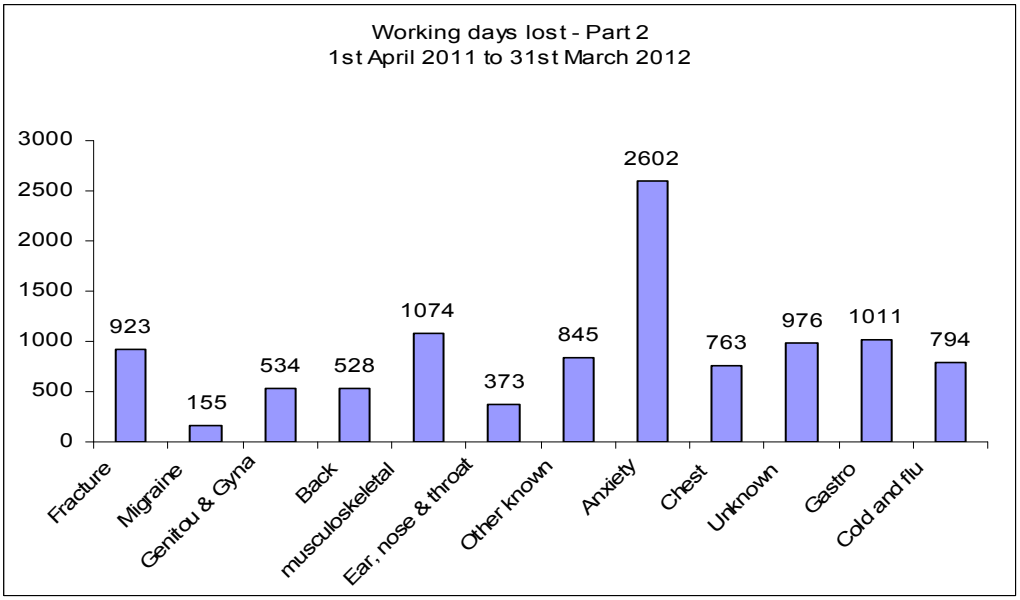


The top five reasons for absence are shown on the following page. Anxiety is a significant reason for absence and some of the levels of absence can be associated with the organisational change programmes that have taken place during the last 12 months. Alongside the senior management review there has also been restructuring within our nursing staff in Critical Care, streamlining of the ward areas resulting in realigning of staff groups and a restructuring within an Admin Group as a result of the Phase 1 review.

As anxiety is at such a high level, early discussions have begun about the introduction of an Individual Stress Risk Assessment which will help to identify issues at an early stage and allow solutions to be developed where appropriate. This will enhance the early interventions already in place where all members of staff who report mental health conditions or stress and anxiety are referred to Occupational Health in the first two weeks of their absence. Additionally, staff can self-refer to the OH team.


Top five reasons for absence
1st April 2011 to 31st March 2012
Working days lost
3000
2500
2000
1500
1000
500
0
Anxiety
Chest
Unknown
Gastro
Cold and flu
Reason


Working days lost - Part 1
1st April 2011 to 31st March 2012
350
300
250
200
150
100
50
0
55
23
14
328
19
45
275
152
109
133
54
329
Burns
Blood Disorders
Glandular
Tumours
Asthma
Inf disease
Cardiac
Nervous disorders
Skin Disorder
Eye Problems
Dental
Pregnancy

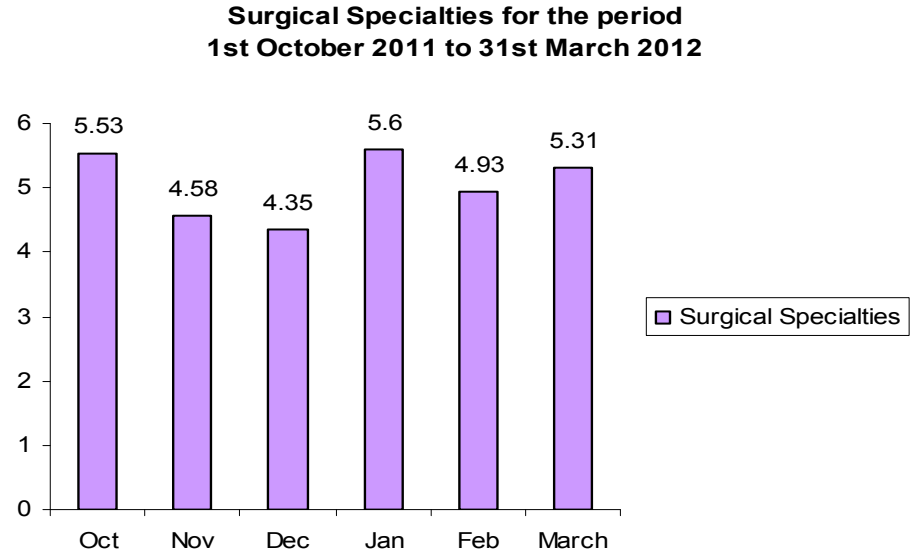

Working days lost - Part 2
1st April 2011 to 31st March 2012
3000
2500
2000
1500
1000
500
0
923
155
534
528
1074
373
845
2602
763
976
1011
794
Fracture
Migraine
Genitou & Gyna
Back
musculoskeletal
Ear, nose & throat
Other known
Anxiety
Chest
Unknown
Gastro
Cold and flu

3.1 Divisional Absence Reports

3.1.1 Surgical Specialties Absence

Sickness absence within the Division has remained above the 4% target during this reporting period. The highest absence rate of 5.6% was recorded in January 2012. There is no identifiable trend when comparing figures with the corresponding reporting period in 2010/11.

Long term sickness absence peaked in October 2011 at 2.47%. This was due to staff undergoing surgery for musculoskeletal problems, treatment for chronic conditions and anxiety/stress related illnesses. These absences were all managed in line with the absence management procedures to ensure that staff received appropriate levels of support.

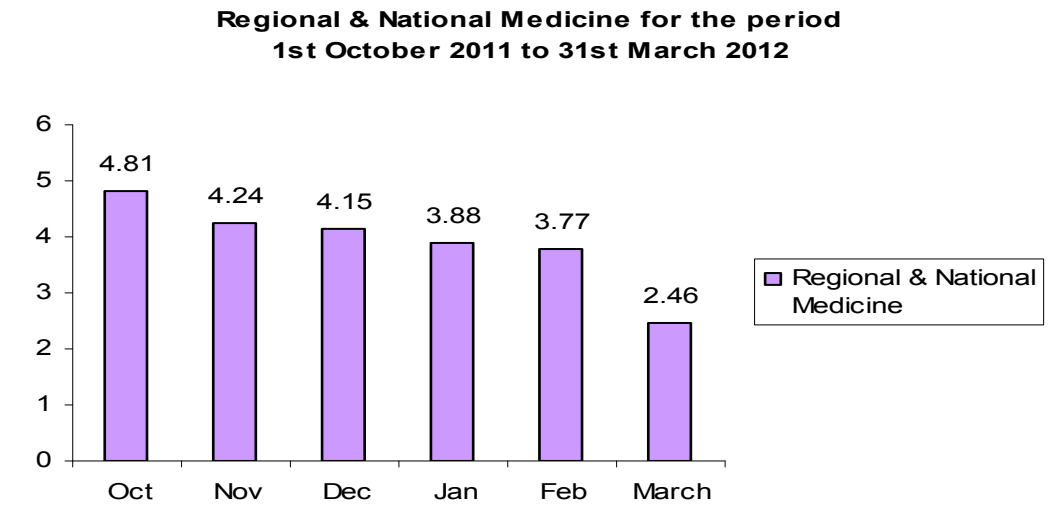


3.1.2 Regional & National Medicine

Sickness absence rates for this reporting period were 3.44% in comparison to the previous reporting period when they were 3.32%. This is an increase of 0.12%, over 1800 sickness hours.

Absence rates peaked in October 2010 at 4.81% and have dropped down to slightly below 2.5% in March 2012. Long-term sickness absence was at its highest in October 2011 and has reduced by over 50% since then with the highest reason attributed to Anxiety/Stress/Depression. Staff who are absent long-term continue to be supported and monitored by Occupational Health, HR and department managers in line with the appropriate guidance.

Short-term sickness absence was particularly high in January 2012 with the most common identifiable reason being recorded as “cold and flu”. By comparison, the reason which incurred the highest number of days lost was recorded as “other known causes” and as stated earlier, work is ongoing to explore the reasons for the high use of this category.



3.1.3 Corporate Absence

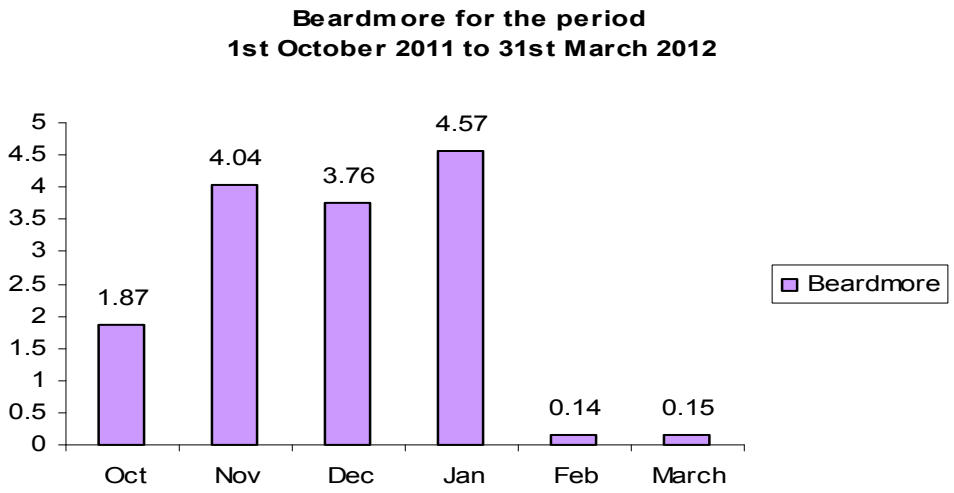
The average sickness absence rates for this reporting period were 4.03% in comparison to the previous reporting period when they were 3.59%. Whilst this represents an increase in sickness absence, it is considerably lower than the same period last year which was reported as 5.55%.

This increase is mainly due to short term sickness absence, whilst long term sickness absence has decreased from the previous reporting period. Both types of absence continue to be managed in line with the absence management guidelines.

3.1.4 Beardmore Hotel Absence

The average sickness absence percentage for the period October 2011 to March 2012 was 2.43%, a decrease of 1.60% from the previous six months. Absence rates have decreased significantly since February 2012, with no long term absences recorded in February and March 2012 and notably just over 2 days absence reported during March. The management of absence

continues to be a priority with managers carrying out regular review meetings to ensure that this progress is maintained.



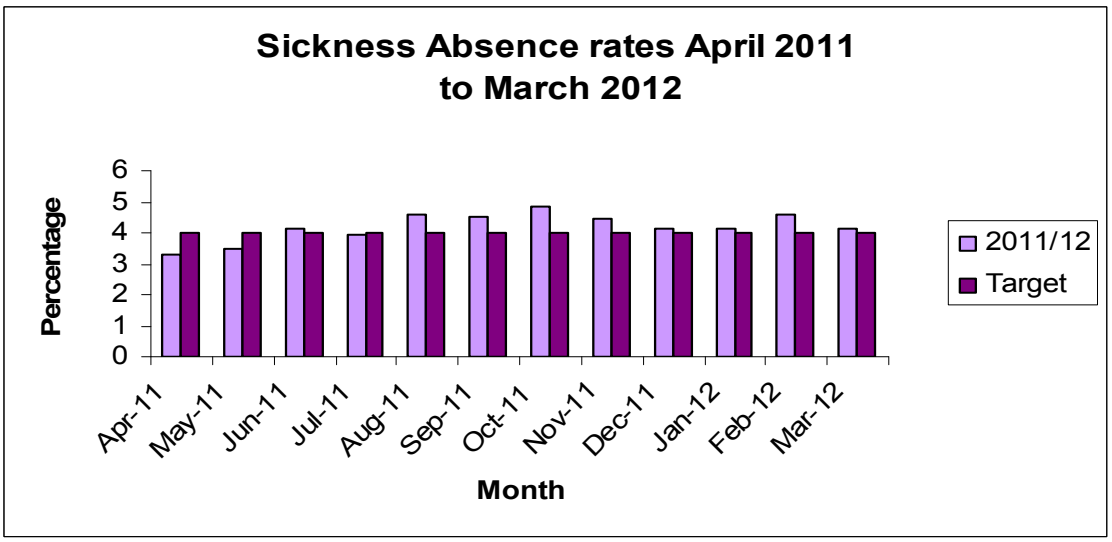
3.1.5 Disciplinary Action due to Sickness Absence

In this reporting period, the number of disciplinary cases due to unacceptable sickness absence levels has reduced to a total of 5 disciplinary cases these all resulted first written warnings. This represents a slight reduction in the number of cases reaching the disciplinary stage however the focus on managing attendance at work continues.

Staff who have an underlying health condition that may be covered under the Equalities Act are managed in line with the capability policy. Currently 12 people are being managed in this way and are at various stages in the process.

3.2 Board Sickness Absence Levels

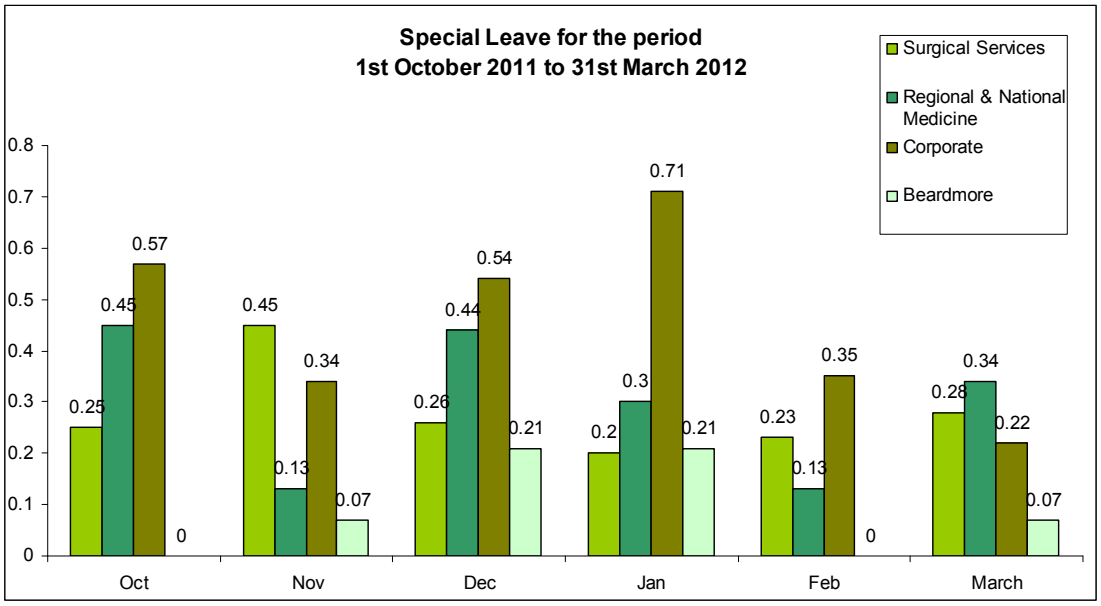
The chart below shows the levels of sickness absence in the past 12 months. Ongoing management of sickness absence has helped to maintain a level of just over the 4% target.



4. Work Life Balance

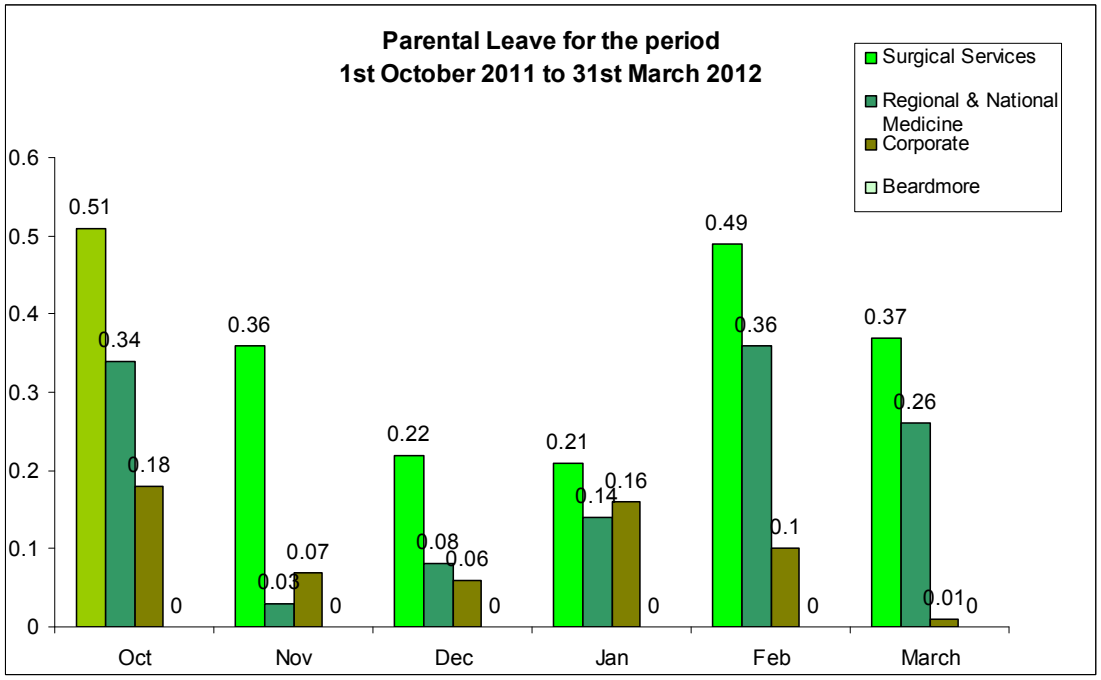
4.1 Special Leave

The percentage uptake of special leave has reduced significantly as shown below. Managers are now clear on the appropriate use of special leave are reporting it more accurately. It is therefore expected that these reduced levels will remain unchanged in future reporting periods.



4.2 Parental Leave

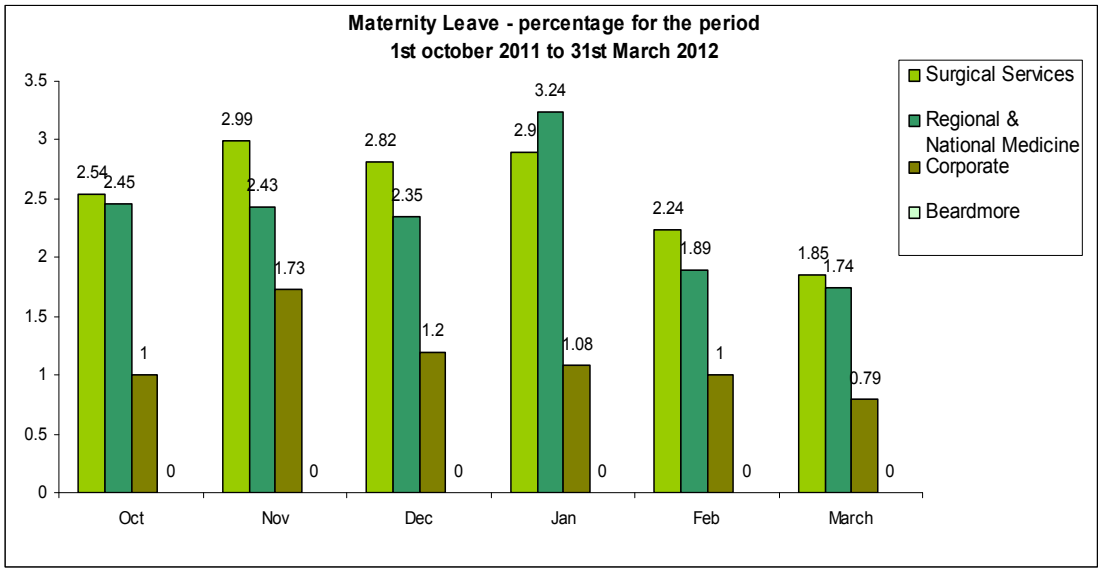
The chart below shows the percentage uptake of parental leave. It is noted that there is no uptake of this form of leave within the Beardmore and work is ongoing to ensure that staff in the Beardmore are aware of the Board's policies in relation to types of leave.



4.3 Maternity Leave

Table 4.3 shows that maternity leave is highest within Surgical Services.

As the workforce is almost three quarters female there is a likelihood of this figure increasing again in future months therefore managers must continue to consider maternity leave when planning their workforce.



5. Equality and Diversity

NWTC Board is committed to supporting and promoting dignity at work by creating an inclusive working environment.

The information presented below is based on self-reporting by NWTCB staff. Data is collected via staff engagement forms when people join or change roles within the organisation.

The protected characteristics covered by the Equality Duty are:

- Age
- Disability
- Gender Reassignment
- Marriage and Civil Partnership
- Pregnancy and Maternity
- Race
- Religion or belief
- Sex
- Sexual Orientation

Diversity Champions Programme

The National Waiting Times Centre is currently working toward achieving Investor In Diversity status. At present the Board is recruiting Diversity Champions and plans to train successful applicants by the end of May 2012. The role of the Diversity Champion is to promote equality and value diversity within the organisation. They will support the organisation in its aim to empower staff to challenge inappropriate behaviours and reinforce positive attitudes to equality, diversity and dignity at work.

Stonewall Workplace Equality Index

For the second year in a row, the NHS National Waiting Times Centre has been ranked the best Scottish NHS Board in Stonewall's Workplace Equality Index (WEI).

This year we came seventh of all organisations in Scotland, and have moved up 58 places to be 166th in the United Kingdom.

The WEI is a measure of how an organisation meets the needs of Lesbian, Gay and Bisexual (LGB) staff and service users and is a good indicator for equality generally. The Index was revised for this year to measure the extent to which employers were developing best practice approaches to their equality work.

Using this national benchmarking tool allows organisations to measure their own progress against other public and private companies and institutions within the UK.

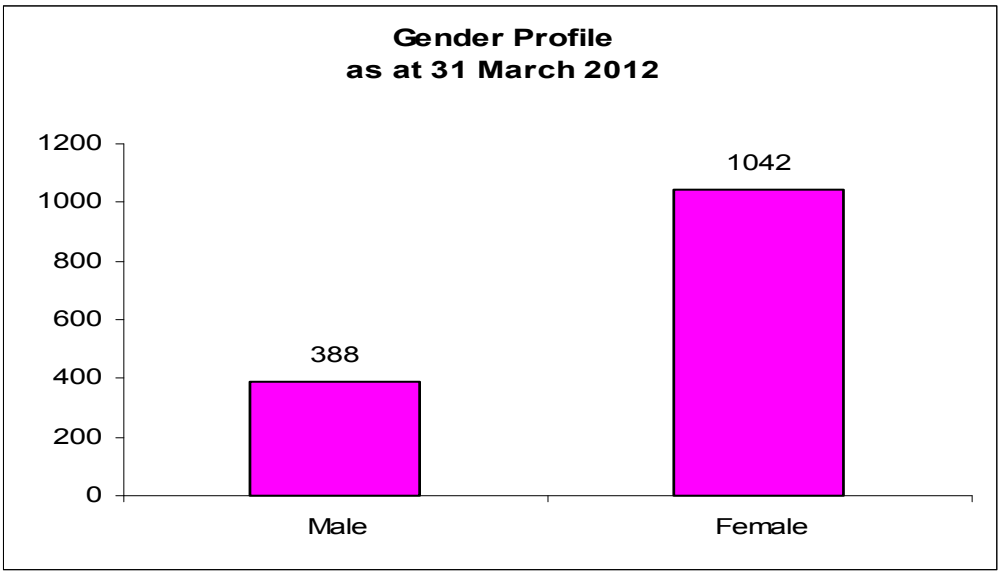
Over the last year, the NHS National Waiting Times Centre has:

- helped more staff to understand the harmful effect of bullying and harassment and made them aware of the support available from our Confidential Contacts and LGB leads;
- strengthened relationships with local community groups working on LGB issues;
- used a variety of communication methods to increase staff awareness of Equalities issues and promoted best practice for staff management and patient care; and
- been selected to present our model of community and volunteer involvement at the Stonewall Scotland best practice seminar.

Protected Characteristics Updates

5.1 Gender

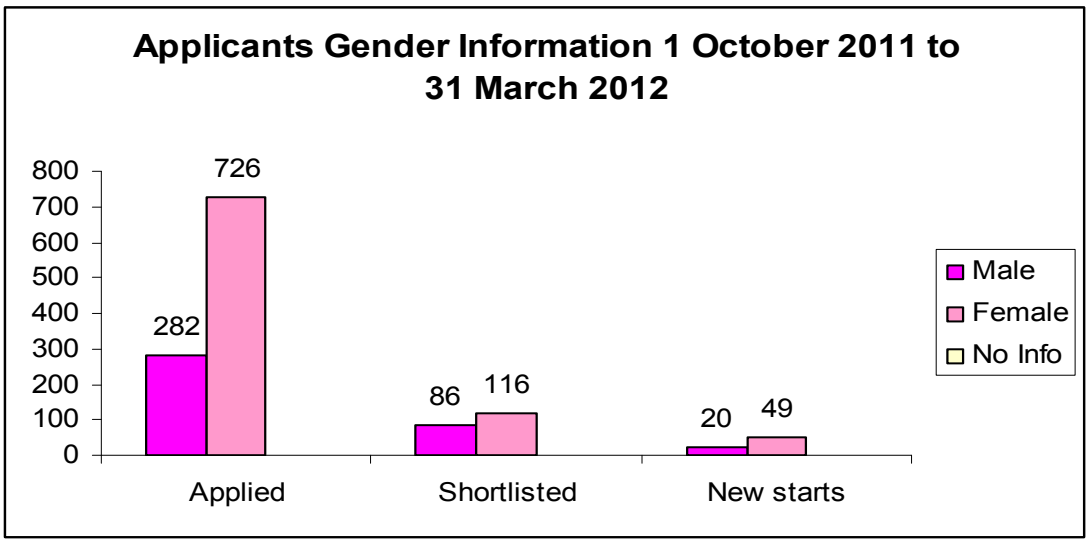
The gender split of our workforce remains approximately three quarters female as shown below. This is proportionally representative of NHS Scotland as a whole (benchmarked against ISD figures).



Gender and Recruitment

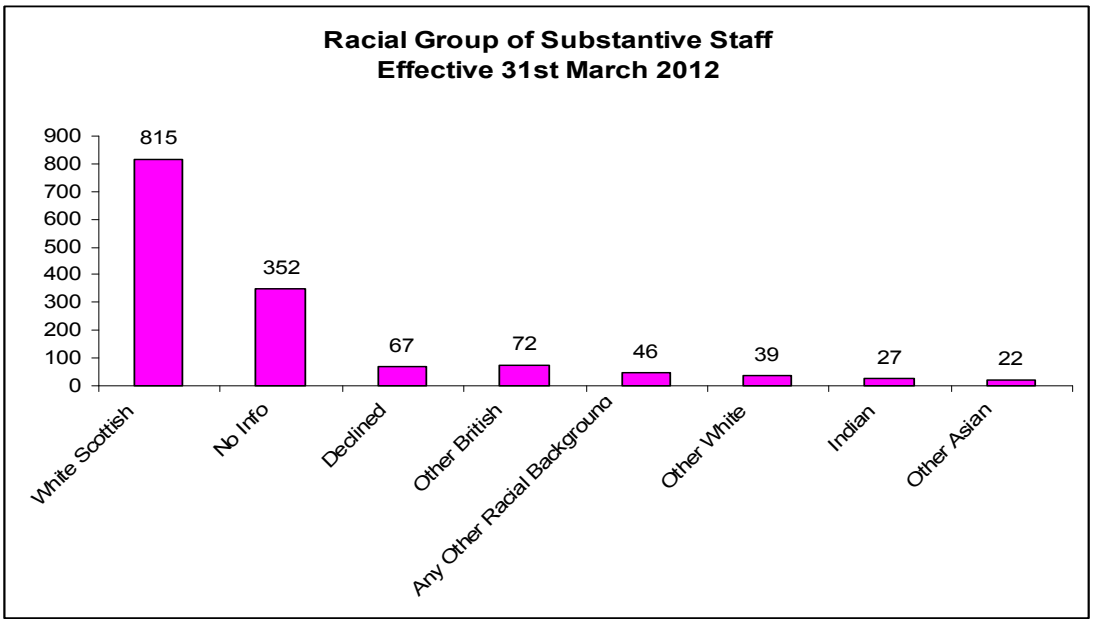
The ratio of male to female applicants reflects the current gender split within the organisation and this follows through to the number of successfully appointed male/female candidates. (see chart overleaf) This trend is not however reflected in the number of male applicants shortlisted. The HR team monitors all aspects of the recruitment process and has not identified any areas of concern.

Finally, our data does not show that any applicant has identified themselves as transgender during this reporting period.



5.2 Race

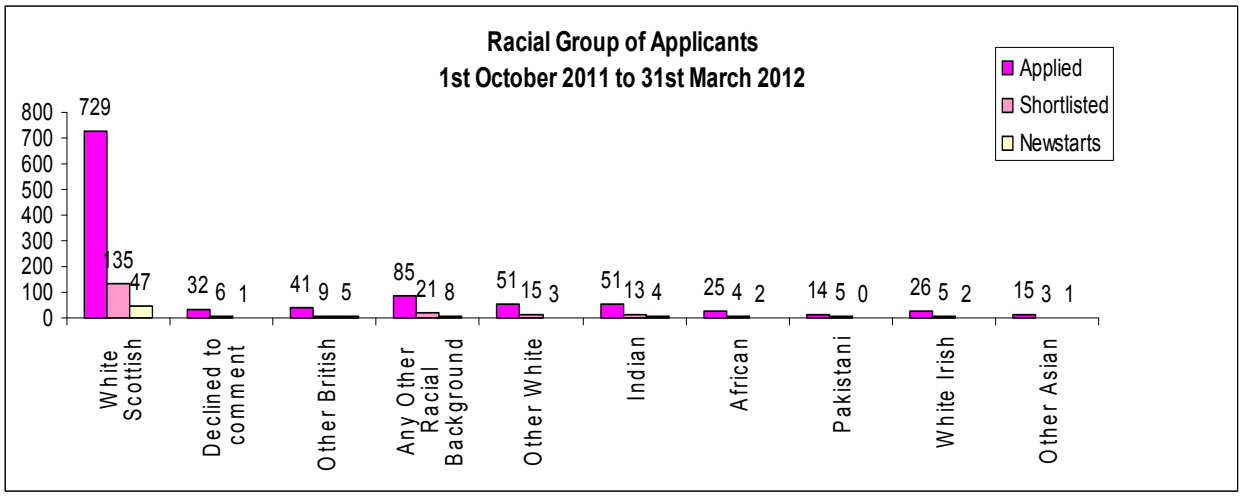
As reported previously, more than half the workforce is White Scottish (57%). This figure is higher than the results in NHS Scotland as ISD figures show that 49% of the workforce is White Scottish.



It should be noted that the following Racial Groups all have less than 5 staff members so have not been included in the graph – any Mixed Background, Caribbean, Chinese, other Black and Pakistani.

Race and Recruitment

In the current reporting period 1009 people applied for posts in the organisation, just over 200 people were interviewed with 69 people appointed.

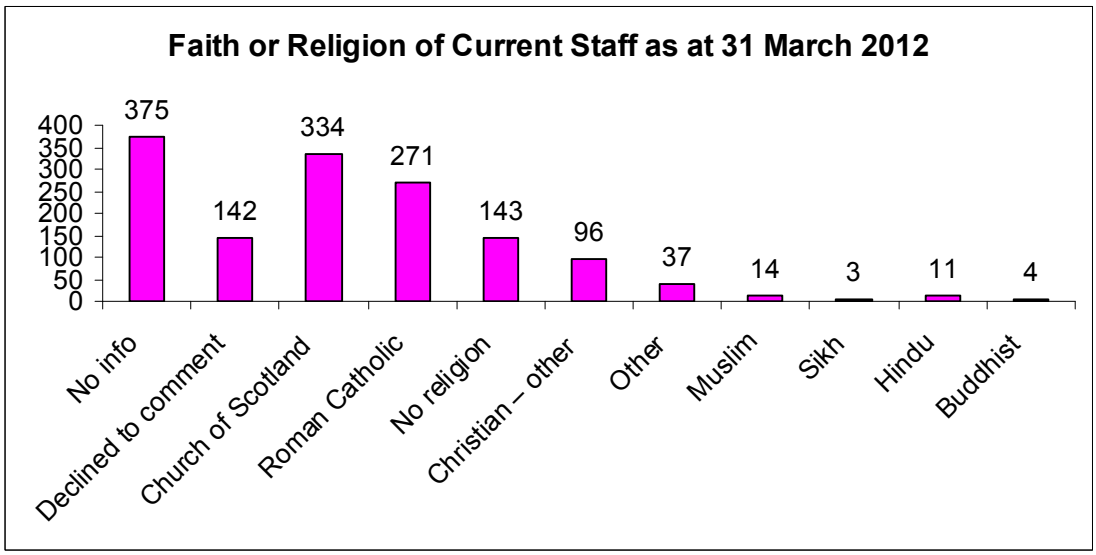


Applications, interviewees and newstarts continue to be predominantly from people who are White Scottish. The number of applicants from other racial groups remains low at approximately 38% of all applicants.

5.3 Faith & Belief

We continue to gather information in respect of the faith or religious beliefs of our staff. This has increased significantly in the last 6 months and we now hold information in respect of 73% of our staff.

No comparable period is available through the ISD information however in measuring this against ISD information for the period 2010-2011 the percentage of our workforce who are Roman Catholic continues to be much higher than that of NHS Scotland whilst the number of staff stating their religion is Church of Scotland is similar to NHS Scotland. This is unchanged from the last reporting period.

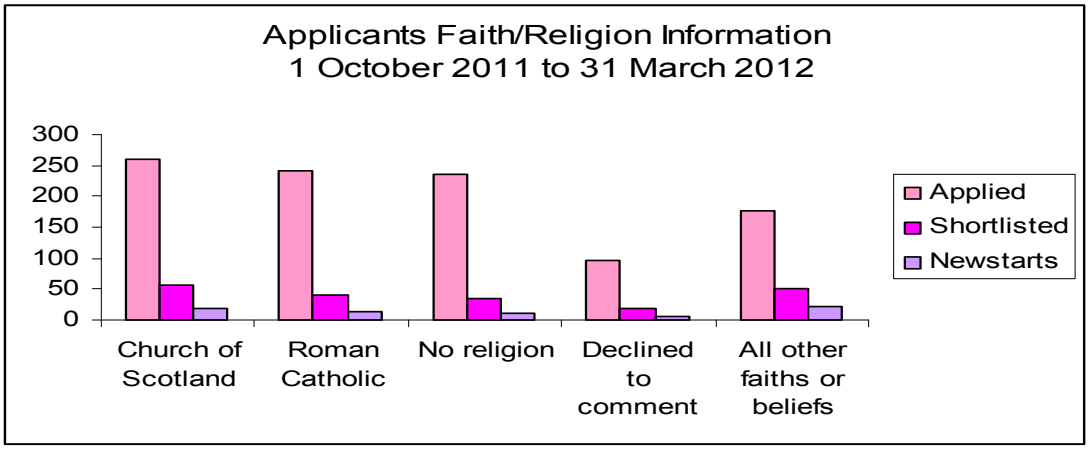


Faith & Belief and Recruitment

The number of applicants in the period October – March 2012 is 1009. The proportion of candidates applying in the first three categories outlined below is broadly similar with the number of candidates shortlisted an appointed differing slightly. More candidates who listed their religion as Church of Scotland were appointed with 7.3% of applicants successfully completing the recruitment process. The number of candidates appointed in the category "all other faiths and beliefs" was significantly higher at 12.3%. This compares with

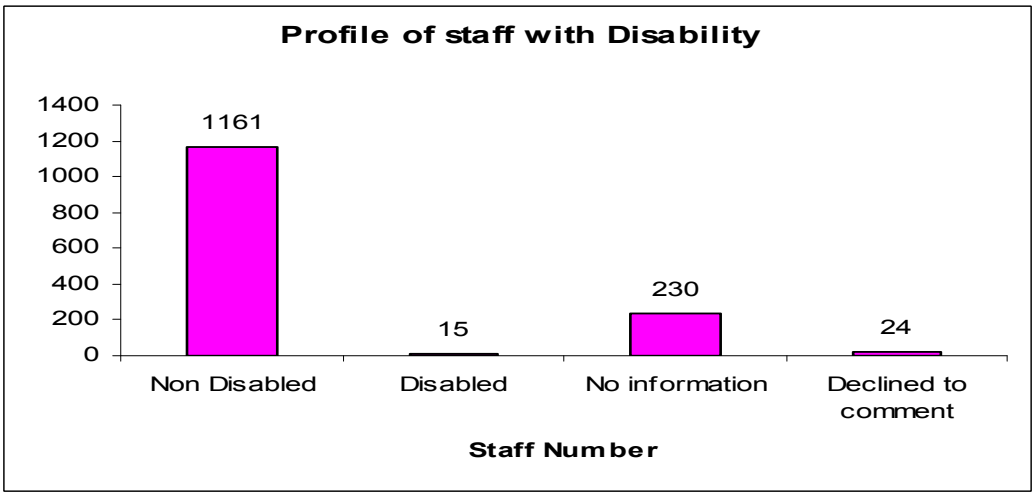
the previous reporting period and whilst monitoring of all recruitment processes takes place in an ongoing manner, no concerns have emerged that would suggest discrimination.

At all stages of the recruitment process the equality and diversity information is held confidentially within the HR Department and is not disclosed to managers therefore it is difficult to identify any potential discrimination during the process.



5.4 Disability

The following chart illustrates the information currently held with regards to staff. We have significantly improved the data held in relation to this equality strand and have reduced the number of staff for whom no information was held by over half.



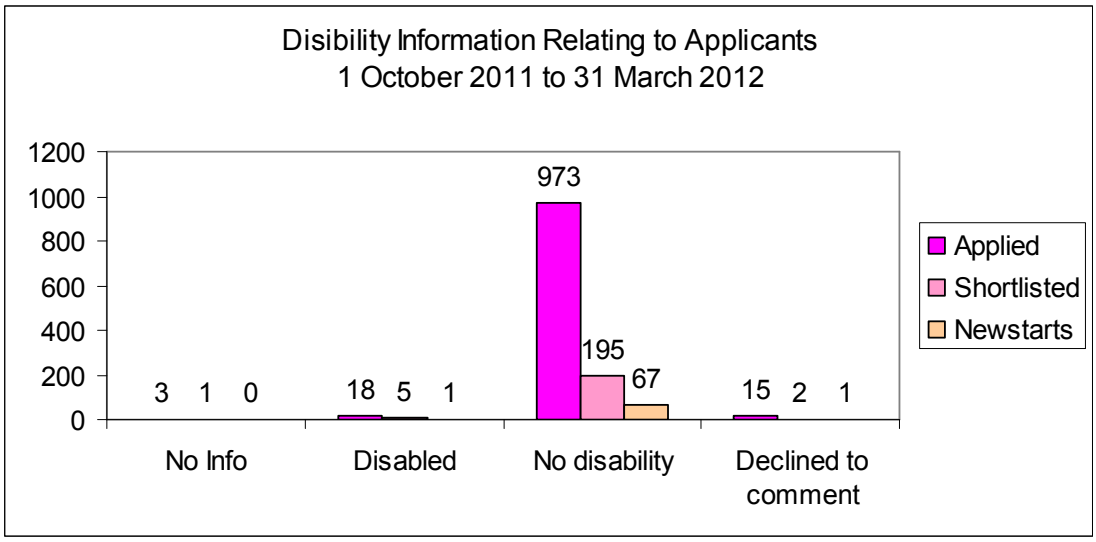
Disability and Recruitment

Of the 18 applicants who stated that they had a disability, 5 were shortlisted and 1 was appointed.

The Disability Symbol Scheme continues to be implemented fairly and consistently and is regularly monitored as part of the normal recruitment process.

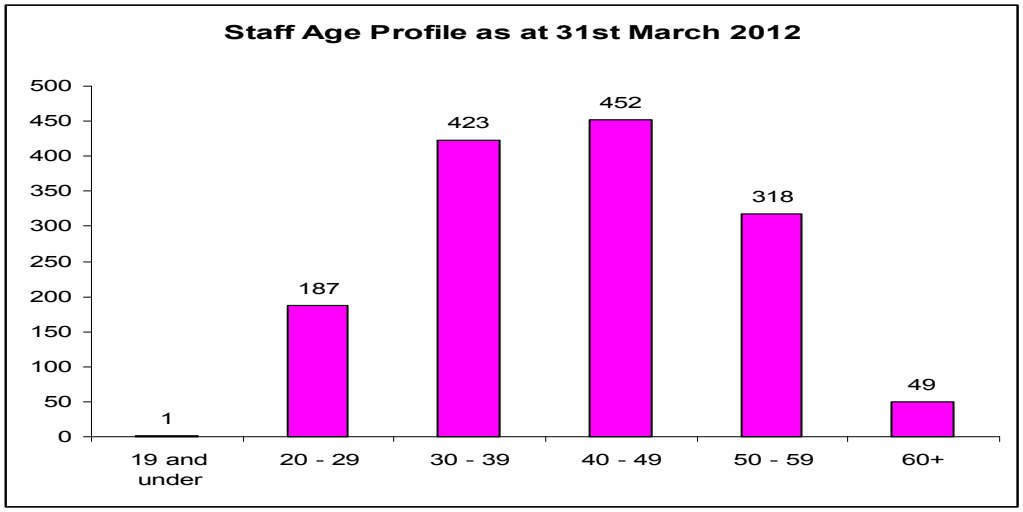
We currently advertise vacancies on the SHOW website for financial reasons and also because of the number of applicants we receive in the current UK

economic climate. We are open however to discussions about how we can increase applicants with disabilities.

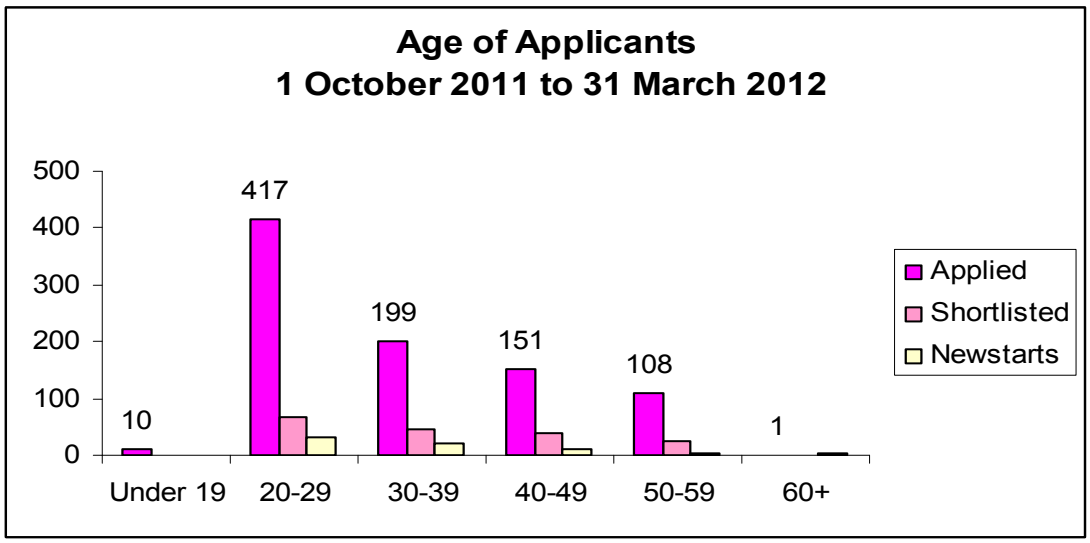


5.5 Age

The following chart illustrates the age profile of staff. There is little change since the last reporting period with the trend that was previously reported of increased numbers in the range 30 to 49 having stabilised.

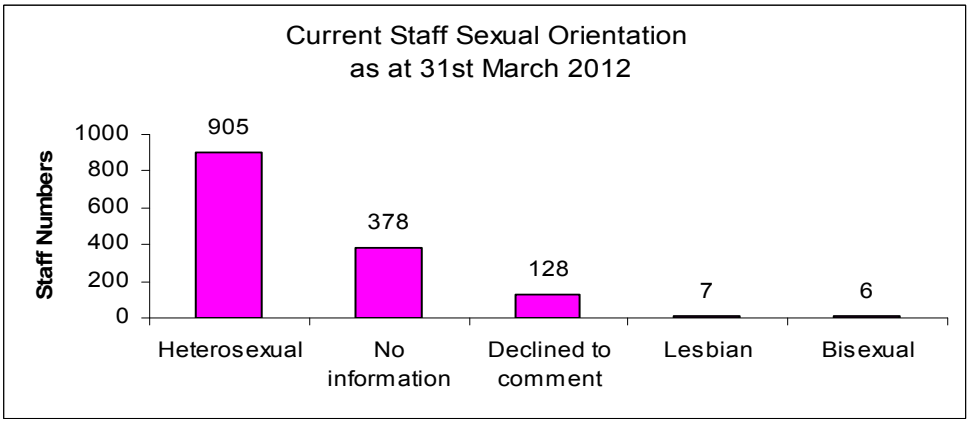


As illustrated on below, the age ranges of the applicants do not match those of the current staff with a significantly higher number of applicants in the 20 to 29 age range. This trend will be monitored over the coming months to confirm that there is no discrimination relating to this particular equalities strand.



5.6 Sexual Orientation

The number of our staff who stated they are heterosexual has increased slightly to 63% whilst we have reduced the number of staff with no information and now have only 26% of staff in this category. This information is shown overleaf. The categories "Gay Man" and "Other" both contain less than 5 members of staff and are therefore not reported.



5.7 Discipline, Grievance & Equality

During the past 6 months there have been approximately 11 disciplinary cases. All disciplinary cases are monitored for trends with regards to the equality. By analysing the available data there is no suggestion of any issues with regards to discrimination.

Between 1 April 2011 and 30 September 2011 there were 3 new individual grievances and one collective grievance. As with the disciplinary cases, these are monitored with regards to equality and at present there is no evidence to suggest discrimination of any kind.

6. ORGANISATIONAL REVIEW

In September 2011 the Senior Management Team and Partnership Forum approved the process to be used during Phase 2 of the organisational review.

The purpose of this phase was to review all management (clinical and non clinical) posts in Band 8a and above who were not affected during phase one. Phase two reviewed job content and management responsibilities in relation to direct care services (where appropriate).

The key drivers for the review were:

- The NHS Scotland Quality Strategy
- Patient experience and pathways
- Continuous improvement and service redesign
- Greater emphasis on efficiency and productivity
- Challenging financial environment
- Management of corporate risk
- Clinical Strategy

The information collected by the Heads of Operations or Executive Directors resulted in a number of job descriptions being rewritten. A number required minor changes including adjustments to the reporting structure and where appropriate these were progressed through the normal job matching process. This process was completed on schedule by 31st March 2012.

In other areas more significant redesign work was required and this has been progressed through the organisation's normal processes. In the Regional and National Medicine Division the proposed redesign work was submitted to the Strategic Projects Group for agreement before being rolled out further. Information relating to the impact on the staff groups within the division will be included in future reports.