**NHS**
**HDL (2005) 52**

SCOTTISH EXECUTIVE

Health Department
Human Resources Directorate

Workforce and Pay Policy Division
St Andrew's House
Regent Road
EDINBURGH
EH1 3DG

Dear Colleague

**NATIONAL WORKFORCE PLANNING FRAMEWORK 2005 - GUIDANCE**

**Summary**

This HDL:

- confirms the approach to be taken by NHS and Special Health Boards, individually and working together collaboratively as regions, in preparing workforce plans, a requirement established by the *National Workforce Planning Framework 2005*, published in August 2005;
- provides guidance to support the preparation of workforce plans and outlines the timetable for production;
- gives direction on *minimum* intelligence and data required in NHSBoard and regional plans to inform the National Workforce Plan 2006;
- confirms that Board Chief Executives are accountable for the delivery of Board workforce plans and collaboration on regional workforce plans.

It is recognised that the development of workforce plans is challenging and charts new territory. It is also acknowledged that workforce plans will need to be developed and refined over the long term and that in this initial year they will necessarily be subject to the level of expertise and data which currently exists with regard to strategic workforce planning. For example, with regard to the primary care workforce, the information base is less well developed and initially will likely be limited to general practice and those employed by the Boards working in primary care.

**16th November 2005**

**Addresses**

For action
NHS Board Chief Executives

For information
HR Directors
Regional Workforce Planning Directors

**Enquiries to:**

Marilyn Barrett
St Andrew's House
EDINBURGH EH1 3DG

Tel: 0131-244 2478
Fax: 0131-244 2837

INVESTOR IN PEOPLE

SE Approved
Version 1.1

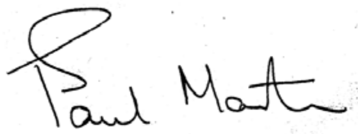
However, workforce capacity planning is already being carried out in a number of ways, including through SNIP and MMC impact assessments, and Boards should utilise and build on this work in producing their plans.

To support this work in Boards and regions the Head of the National Workforce Unit will between now and the end of the year meet HR Directors in NHS Boards individually to discuss the workforce planning framework and the implications for their Boards.

**Action**

Chief Executives should take forward and deliver the actions identified in the *National Workforce Planning Framework 2005* for Boards. Chief Executives should ensure completed workforce plans are submitted to Scottish Executive Health Department according to the timetable outlined in this guidance.

Yours sincerely



**PAUL MARTIN**
Chief Nursing Officer & Interim Director of Human Resources

## GUIDANCE FOR PRODUCING WORKFORCE PLANS

### Background

1. The workforce agenda is one of the key challenges currently facing NHSScotland. It is a complex and demanding agenda that requires the systematic and sustainable approach outlined by the framework for workforce planning. Getting the workforce right is pivotal to achieving a step change in service delivery and improvements in health and health care in Scotland. *The Scottish Health Workforce Plan 2004 Baseline*[1] began the process by setting out the national picture of the NHS workforce. All Boards have now produced their individual baseline reports as their starting point.

2. *The National Workforce Planning Framework 2005*[2] takes this work forward by enabling action at national, regional and NHS Board level that connects up service and financial planning, education and training support and regulatory requirements. *Building a Health Service Fit for the Future*[3] sets out a challenging vision for NHSScotland and the actions outlined in *Delivering for Health*[4] will shape healthcare in Scotland over the next 20 years. This will be central to integrated planning to identify the services required and the size and shape of the workforce in NHSScotland.

### Timetable

3. The timetable for producing workforce plans in 2005/06 at regional and NHSBoard levels is as follows:

- NHSBoards working collaboratively as **regions** are required to produce regional workforce plans by **31 January 2006** and **30 September 2006**
- **NHSBoard**s are required to produce workforce plans by **30 April 2006**
- the next **National Workforce Plan** will be produced in **December 2006**.

4. Thereafter the timetable will be for Boards' plans to be produced in April, regional plans in September and the national plan in December. This workforce planning cycle aligns with other planning cycles which will assist NHS Boards to integrate their workforce planning function with other planning functions including the process of preparing Local Delivery Plans, which will be in place by April 2006. The forthcoming guidance on Local Delivery Plans will be issued shortly. For the National Workforce Plan this will ensure that a bottom up evidence-based approach on workforce demand will be available to inform national decisions on training numbers and supply.

### Principles of workforce planning

5. In Chapter 1 of the *National Workforce Planning Framework 2005* the guiding principles for workforce planning established by the Workforce Numbers Group are described. It is clear that workforce planning must reflect the key components which shape the demand for the workforce; must strive to horizon scan and more effectively align supply with demand; and must meet the tests of affordability, availability and adaptability.

---

[1] Scottish Health Workforce Plan 2004 Baseline – Scottish Executive (April 2004)
[2] National Workforce Planning Framework 2005 – Scottish Executive (August 2005)
[3] Building a Health Service Fit for the Future – Scottish Executive (May 2005)
[4] *Delivering for Health* – Scottish Executive (October 2005)

6. Underpinning these guiding principles are the earlier recommendations of the Scottish Integrated Workforce Planning Group which have been updated and reproduced at Annex A. Boards should apply these guiding principles to determine their approach to workforce planning and when preparing their workforce plans, both individually and collaboratively as regions.

**Roles and responsibilities**

7. This year the national picture has been set out first in the *National Workforce Planning Framework 2005* to provide overall direction for workforce planning but in the next planning cycle (2006/2007) this will shift into a bottom up approach informed by regional and Board plans. The **Scottish Executive Health Department** has a role in:

- setting out the vision for the future of NHSScotland;
- determining the training numbers that are needed to support regional and Board plans;
- setting the regulatory framework that will provide for the workforce of the future; and
- commissioning the education and training (where this is commissioned nationally) required to generate the future workforce.

8. **NHSBoards** are pivotal in the workforce planning process. They employ the staff, directly and indirectly, and are responsible for deciding and delivering healthcare services to their resident populations. From 30 September 2004 the NHS Reform (Scotland) Act 2004 made it a statutory duty for all Boards to have in place arrangements for workforce planning which supports Boards' direct remit to secure the staff necessary to deliver required health services to their populations.

9. The NHS Reform (Scotland) Act 2004 also obliges Boards to work across boundaries where appropriate, and in line with this **regional workforce planning arrangements** have been established. These arrangements take forward effective partnership working among Boards and underpin the development of regional service planning. HDL (2004) 46 on Regional Planning should therefore be read in conjunction with this guidance.

**Approach and general guidance**

10. Boards, individually and collaboratively as regions, should set their workforce plans within the context of the health of their respective populations, the healthcare services required and activity to achieve the "core targets", along with the size and composition of the workforce to deliver those services. Detailing the diversity of the workforce will assist the planning process and also help Boards demonstrate progress against the requirements of current (and emerging) equalities legislation.

11. Workforce planning and the requirement to produce annual workforce plans should not be seen as simply a number crunching exercise or as a task confined to Human Resources Departments. It is for all managers across services to engage with, but particularly those involved in service planning and redesign. As part of this process and in the spirit of partnership there should be engagement with staff and their representative groups. While carrying out the workforce planning function, Boards should be mindful of their obligations regarding diversity.

12. Boards, individually and collaboratively as regions, should begin to organise their workforce planning around the service themes outlined in *Building a Health Service Fit for the Future*, for example:

- care of older people
- care in local settings
- unscheduled care
- planned care
- diagnostics
- specialised care
- children and young people's services.

13. Boards, particularly working collaboratively as regions, may already have organised their approach to planning the workforce into clinical priorities such as cancer and coronary heart disease, which are equally valid from the perspective of patient needs. It will be important for Boards to work back from what the service *outputs* and benefits to patients under these service streams will be, rather than working from the basis of staff *inputs*. This approach will develop over time and we recognise there will remain a need for the time being to categorise staff according to their professional groups, ensuring that all staff groups are covered. However, regardless of the way in which staff are badged, the analysis of the future capacity required to meet outcomes and deliver priorities should increasingly be based on the multi-professional teams which Boards envisage will be needed to provide sustainable services through a redesigned workforce.

14. In preparing their plans Boards need to take account of the drivers for change which impact the workforce and its delivery of the services required in the future. The significance of these drivers and how they apply in each NHS Board and regional area should be considered and described in workforce plans. Many of the drivers for change are set out in detail in Chapter 2 of the *National Workforce Planning Framework 2005.*

15. In addition, Boards will need to consider the implications for the workforce of changes that will result from *Delivering for Health*, the Executive's response to *Building a Health Service Fit for the Future,* published on 27 October 2005. There may also be other drivers for change that Boards identify as particular to their areas.

16. In this first year of the workforce planning framework, it is recognised that it will not necessarily be possible to quantify the implications of all the drivers for change across all staff groups. However, this should be attempted where possible, even if estimations are based only on initial judgements and views from managers and staff, rather than sound mathematical analysis.

17. Building on the baseline reports produced earlier in 2005, Boards should describe in their workforce plans the current workforce supply for all staff groups (regional workforce plans should do this for the service they cover.) This information should include equality strands and provide an evidence base to enable Boards to develop appropriate actions to tackle any employment inequalities. The Scottish Workforce Information Standard System (SWISS) currently in development will give Boards access to up-to-date workforce information, but in the meantime the latest data from ISD should be used. Boards should note that the September census data will be available to them in early January.

18. Boards should also project future demand for each staff group to meet their anticipated needs for delivering services, using their analysis and judgements on the implications of the drivers for change that they have identified. This look ahead should be for the short term (3 years), medium

INVESTOR IN PEOPLE

POSITIVE ABOUT DISABLED PEOPLE

term (5 years) and the long term (10+ years). In preparing projections for each staff group it is recognised that some will be evidenced from fairly robust workforce planning methodologies, while others will be solely based on judgments and collected views and opinions. Nevertheless all staff groups should be included in this first year in order to provide comprehensive groundwork for developing and refining methods for projecting future demand. The approach Boards already take to predict their future demand for nursing and midwifery (as part of SNIP) may be useful as an approach to adopt for other staff groups.

19. Boards should develop arrangements for applying the tests of affordability, availability and adaptability that have been accepted as the key principles for credible workforce planning that is fit for purpose. These are described more fully in the *National Workforce Planning Framework 2005.* The opportunity to challenge and test out assumptions, judgements and draft conclusions will improve understanding of workforce planning, its robustness and its limitations. This should be done for both individual Board workforce plans and regional plans.

20. Workforce plans, at Board and regional levels, should identify actions necessary to secure the predicted workforce required to deliver the services that are planned at Board and regional levels for example meeting the "core targets". These could include:

- redesign of services
- development of new and/or enhanced roles
- development of the current workforce through enhanced skills and competencies
- retention rate improvement
- recruitment initiatives
- new ways of working through pay modernisation
- productivity improvement measures (targets published by the Scottish Executive this year focus on reducing staff absence and increasing consultant productivity)
- identification of issues that need to be addressed at regional and national levels (such as any need for new regulatory, accreditation or educational initiatives).

21. Actions should also include how Boards intend to improve their workforce planning function and plans must report on progress in delivering previously agreed actions - in this first year this should be the actions identified for NHSScotland in the *National Workforce Planning Framework 2005*.

22. All workforce plans will be available publicly, in line with Freedom of Information legislation. Board workforce plans should be agreed by the Staff Governance Committee and signed off by Board Chairs and Chief Executives to demonstrate their commitment to deliver. Regional workforce plans should be signed off by the Chair or lead of the regional planning group that takes forward workforce planning. Board Chief Executives are ultimately accountable for the delivery of Board workforce plans and collaboratively for regional workforce plans. This sits alongside their responsibility for financial probity and the delivery of quality clinical services to their populations.

23. It is important to note that workforce planning should be an on-going process which is of genuine and ongoing benefit to Boards' strategic planning - not a one-off annual event when a plan is issued. While the plans will be an annual publication the function of workforce planning should be ongoing, with plans being monitored and reviewed on an iterative basis as changes take place and knowledge increases, revising predictions and actions on the best available knowledge at the time, and continually informing and underpinning service planning and redesign. Boards, individually and collaboratively as regions, will wish to consider how to manage this process in order that robust planning mechanisms are developed.

**Specific requirements**

24. The general outline of Board workforce plans should be along the following lines:

- *Section 1: Introduction,* including the context of the population being served.
- *Section 2: Drivers for change* including those required for meeting the "core targets"
- *Section 3:Themes from Building a Health Service Fit for the Future and Delivering for Health* including how services will alter through drivers for change and *Delivering for Health*
- *Section 4: Staff group projections,* utilising the template at Annex C.
- *Section 5: Actions*, proposals for aligning supply and demand; improving workforce planning by moving towards projections based on a redesigned workforce organised around the service themes outlined at paragraph 12; reporting on previous actions and those set out in the *National Workforce Planning Framework 2005*.
- *Section 6: Regulatory, educational, and/or workforce redesign requirements to be addressed*, underpinning projected developments in the workforce (for example, new or extended roles.)

25. Within this common format we would wish to develop a consistent approach to projecting workforce numbers across NHSScotland. The principal concepts of developing demand and supply estimates are outlined at Annex B, and a workforce planning template is set out in Annex C. **All Boards are asked to use the template at Annex C, for their staff projections (section 4 of their plans).** Definitions for the terms that appear in this guidance are listed at Annex D.

*Board workforce plans*

26. All Board workforce plans should identify current workforce supply as **staff in post at 30 September 2005**. Information on the following must be included in each Board's workforce plan, by staff group wherever possible:

- recruitment rates – new joiners and re-joiners
- vacancies - overall and long term, as defined by ISD
- age profile – as a minimum in 5 year blocks
- diversity - gender mix and where possible, ethnicity, disability.
- flexible working – full time/ part-time, average number of part time hours worked
- turnover – leavers in relation to staff in post
- absence rates – as defined by ISD

27. Board workforce plans should contain projections of the workforce numbers across all of the different staff groups. These should be for Year 1 (which will be 2006 in this first round of workforce plans), Year 2, Year 3, Year 5 and Year 10. They should be expressed in whole time equivalent (WTE) with projections of the average WTE staff required in the future. The assumptions made in determining projections should be described.

28. As already indicated, all staff groups should be covered in Board workforce plans. Data and projections for consultants should be broken down by specialty and for AHPs by discipline. .

29. These requirements and the above guidance apply equally to Special Health Boards. The workforce plans prepared by Special Health Boards should describe current workforce supply, assess the drivers for change, project future demand and identify actions to be taken towards aligning

supply and demand and for improving their workforce planning. Where Special Boards have professional staff, such as nurses or consultants, using professional expertise and knowledge - albeit in activities other than delivery of clinical services - these staff should be identified within the appropriate professional staff group.

30. Further detail on **minimum data requirements** for Boards to include in their plans are set out at Annex C.

*NHS regional workforce plans*

31. Regional plans should **not** be an aggregation of Board plans – rather they should concentrate on planning workforce requirements for regional services which are planned regionally but delivered locally.

32. Regional workforce plans should address the priorities already identified in Board workforce plans as regional concerns (in this first year these will be as identified in Boards' baseline reports), as well as nationally recognised service priorities identified through *Delivering for Health*. They should also address the tertiary services that are in place or planned at regional level with clear linkage to the host Board's plan for delivery of the service.

33. Regional workforce plans should provide the same information as Board plans but only for those services identified as regional. It must be made clear whether projections for future workforce requirement are in addition to or are included in individual Board workforce plans (and if so which ones).

**Submission to SEHD**

Boards should submit their final workforce plans by 30 April 2006; and regional plans by 31 January and again 30 September 2006.

Further support and advice is available from the **National Workforce Unit** by contacting:

Katharine Sharpe for analytical advice 0131 244 4098 Katharine.sharpe@scotland.gsi.gov.uk
Marilyn Barrett for advice on implementation 0131 244 2478 marilyn.barrett@scotland.gsi.gov.uk

Information on statistics including information on how the data are collected and notes to aid interpretation, is given on the ISD Scotland website at www.isdscotland.org/workforce.

Nicola Fleming on 0131 275 6719 will answer specific queries Nicola.fleming@isd.csa.scot.nhs.uk

General queries should be directed to workforce.info@isd.csa.scot.nhs.uk

**ANNEX A**

**Guiding Principles of Workforce Planning - operational**

Workforce planning should:

- be integrated with service planning and preparing Local Delivery Plans and with financial planning, as well as other planning systems such as educational and training planning

- improve the balance or alignment of demand and supply, by understanding, assessing and managing workforce demand and the factors that affect it, as well as workforce supply

- do this across the multiple dimensions of
  - time – looking long term to 10+ years ahead as well as medium and short term
  - organisation – looking at services and patient pathways, including where these stretch across to other organisations such as social care providers
  - geography - looking across Board areas and beyond, considering factors such as remote and rural; and
  - staff group – looking at *all* staff groups, including employees and independent contractors.

- use an appropriate approach that is efficient and effective

- be a continuous and iterative process that includes monitoring and evaluation of the process to facilitate refinement year on year

- maximise flexibility to accommodate the inexactness of predicting and projecting into the future and to manage the risks in the decision making process

- recognise that services are delivered by teams and new roles and new skill mixes will emerge

- involve managers and staff across the organisation and be recognised and supported by the Chair, Chief Executive and senior team.

INVESTOR IN PEOPLE
POSITIVE ABOUT DISABLED PEOPLE

**Principal Concepts for Developing Workforce Demand and Supply**

General Principles:

1 **Demand**

a. There are *different types of demand* which can be described as replacement demand or expansion (contraction) demand.

*Replacement demand*
This occurs as a result of leavers. It can also be created when average WTE falls and there is the need for more individuals to provide the same WTE demand.

*Expansion (Contraction) demand*
Demand is also created through expansion demand, for example new additional demand. *Expansion demand* may only exist for a specific period of time (such as the non recurring waiting list demand required to address the back log of patients). Demand may also be *contracting;* in this case assumptions may be made in achieving the reduction through natural wastage.

b. There are various possible *approaches for estimating* demand which we describe as Bottom Up, Service Specific, Global or Combination. Each is defined below.

*Bottom up*
In this approach, demand is estimated by operational units taking into consideration local knowledge such as vacancy rates, anticipated retirements, use of temporary staff (i.e. desire to reduce reliance on agency staff), promotions, service developments, service redesign, and policy initiatives such as waiting time targets. This information is aggregated to provide a national demand picture. The unit demand for consultants by September 2006 and the Student Nurse Intake Planning exercise are examples.

*Service specific*
The implications of the Mental Health (Care & Treatment) (Scotland) Act 2003 is one example of service specific demand estimates. These estimates rely on an understanding of the service changes or developments resulting from the Act and implications in terms of new or extended responsibilities for a staff group. Estimates of expected patient activity and current productivity are required in order to project the future additional requirement in WTE.

*Combination*
The *National Workforce Planning Framework 2005* has used a combination of approaches. The mix reflects the level of current maturity of our workforce planning. In the future it is expected the balance will shift to greater reliance on bottom up demand. Within a staff group, multiple approaches may be used.

Regardless of the approach adopted demand is measured in terms of WTE. This is to reflect the fact that WTE is a better measure of contribution and requirement than headcount. A WTE measure recognises part time working patterns (which are generally expected to increase in the future). Currently, WTE is based on contracted hours relative to conditioned hours. Although the best definition currently available, this measure does not capture actual

hours worked. Future workforce information developments through the SWISS initiative will address this limitation in time.

2 **Supply**

a. The first step in modelling supply is to understand the size and shape of the current workforce. Trends on characteristics of the workforce are evaluated to design the model and shape the assumptions. Assumptions for these factors will generally include maintenance of historical trends (i.e. the status quo) and various scenarios where the trends are modified.

b. Key characteristics are analysed and are the primary factors used in modelling supply.

*Age distribution*
Age distribution is important for anticipating leavers. It is useful to analyse the age of the workforce today and to compare that to say 10 years ago. If, for example, the age curve is shifting to the right, indicating an ageing workforce, strategies are likely to be focused on succession planning and retention of older staff.

*Average WTE*
As differences in traditional male/female career patterns become more blurred, average WTE is a useful measure for assessing current patterns of flexible working and how that has changed over time. The average WTE takes into consideration the *proportion of workforce working part time* and the *average contracted hours for part time staff*. However, it is useful to understand these two factors over time as an underlying explanation of average WTE trends.

*Gender mix*
Historically, males and females have had different work patterns. Understanding the gender mix and how that is changing over time is valuable to understanding different career patterns. Gender mix is used to describe the characteristics of the workforce. However, modelling is done on the whole workforce population. Average WTE recognises the desire for both males and females to achieve work / life balance.

c. Developing Supply Projections

   a. Because we are talking about individuals and their movement over their career, supply projections are initially done in terms of people or headcount. This movement or flow is measured by comparing censuses between two successive years.

   b. This is made possible through a unique staff identifier. For medical and dental staff this unique identifier is GMC or GDC number. For non medical and dental staff it is National Insurance Number. From the linked census files, the number of leavers, joiners and rejoiners between censuses are identified. Those staff with temporary National Insurance Numbers are excluded from the leaver and joiner analysis for two reasons. Firstly, temporary National Insurance Numbers are not unique because they are based on birthdate and gender. As a result, linkage is more difficult. Secondly, it is possible that these individuals are moving between NHS organisations within Scotland and therefore not a *national* joiner or leaver. Through the development of a

national repository and sharing relevant information, the SWISS initiative will assist in eliminating these two issues in the future.

c. An average leaver and joiner rate or number based on 4 years data i.e. 2000-01, 2001-02, 2002-03 and 2003-04 is calculated. Various refinements may be made to this rate for different staff groups and the details can be found in the staff group specific sections. One such refinement is to consider age specific joiner and leaver rates. You may expect that the number or rate of leavers will increase for those aged 60 or older, while joiners are more likely to be younger.

d. Information on training staff is also reviewed and may include age on qualification, attrition rate, non practice rate after qualification, retention rate, and length of time to achieve qualification. Again trends are established and inform assumptions used in the model. Training staff are identified as joiners.

e. Projected supply one year on is equal to the stock in this year, plus joiners during the current year minus leavers during the current year. Mathematically, that can be described as follows:

   Stock $y_{n+1}$ = Stock $y_n$ + Joiners $y_n$ and $y_{n+1}$ – Leavers $y_n$ and $y_{n+1}$

   Depending on the staff group, this equation may be more detailed, for example, joiners may be split into newly qualified joiners, rejoiners and other joiners. Likewise Leavers may be split into Leavers under 60 and Leavers 60 and older.

f. The supply projections are converted into WTE based on trends in average WTE per person, starting with the most recent average WTE/person adjusted for any annual change in average WTE. This adjustment is made year on year.

g. If appropriate for the staff group, the projections are then adjusted to take into account the contracted hours, annual leave, public holiday entitlements and overtime resulting from implementation of Agenda for Change. The adjustment is achieved by establishing the WTE before Agenda for Change relative to the WTE following implementation. Agreed protection arrangements can be factored into this adjustment on a year on year basis. In this case, there would be a different adjustment factor for each year during protection, thereafter there would be a constant factor.

## 3 Defining the gap

Various scenarios may be run to evaluate the effect of modifying assumptions on supply or demand. Assumptions are likely to vary for each staff group. The supply factors that may be varied include: attrition rate, retention rate (potentially age specific), leaver rate (may be age specific), average WTE, re-joiner rate, and new joiner rate. In all cases, the first scenario should be based on historical trends for each factor and is described as the 'status quo'. Demand factors can also be varied to reflect various implications, such as developing new roles, changes in productivity, and changes in the population structure.

## Taking Action

Once the gap has been identified there may be a number of solutions to close this and all of the options should be considered to bring the predicted supply and demand of the workforce into balance.

**Template for determining workforce supply and demand**

In the first instance all Boards are asked to provide staff projections for each staff group and regions for the services they cover, using the template outlined below and taking account of the minimum data requirements outlined in this Annex.

1. Categorisation of staff need - either through staff group (e.g. physiotherapists), service theme outlined at paragraph 12 of this HDL (e.g. unscheduled care), or care group (e.g. cancer services)*[5]

2. Service Demand: Anticipated Future Requirements
   - Basis of Demand – e.g. drivers for change, Partnership Agreement staff targets, *Delivering for Health*

3. Workforce Demand
   - Replacement Demand
   - Expansion Demand

4. Workforce Supply
   - Size and shape of the current workforce including skill mix
   - Description of key characteristics: e.g. gender, age

5. Defining extent of alignment between Workforce Demand and Workforce Supply

   a. Quantifying any gap
   - Define different scenarios; assumptions

   b. Options for Balance Demand / Supply
   - Retention
   - Recruitment
   - Increased training numbers
   - Skill mix – new ways of working, new roles development
   - Service Redesign

6. Recommendation
   - proposed actions to align supply with demand
   - consideration of feasibility factors

| Feasibility Factor | Description |
|---|---|
| Affordability | Sustainable resources and value for money |
| Availability | An evaluation of sources of staff including an assessment of the labour market |
| Adaptability | Capacity to train and support in the demanded timescales |

[5] NHS Boards should be aware that some information describing aspects of the primary care workforce (NHS employed and independent) is currently available. This information should be used where possible to avoid duplication of effort.

INVESTOR IN PEOPLE
POSITIVE ABOUT DISABLED PEOPLE
SE Approved
Version 1.1

* Boards are encouraged, where possible, to develop templates using the service themes outlined in paragraph 12. Templates may therefore be for care groups such as CHD or service themes as outlined at paragraph 12, for example care for older people. This is the approach that regions are already taking. We recognise that in this initial year Boards will analyse their workforce needs primarily in terms of staff groups, but they should also take the opportunity to begin to look at future capacity in terms of service outcomes and seek to develop as many templates as they can along these lines.

**Minimum Data Requirements**

**1 Numbers of current workforce at 30 September 2005 in Whole Time Equivalent and Headcount, by ISD staff group category as follows:**

- Medical – consultants, staff and associate grades, doctors in training
- Dental – dentists and professions complementary to dentistry
- GPs
- Nursing and Midwifery
- *Scientific, Therapeutic and Technical Staff separately reported as follows,

- Therapeutic:
  i. Allied Health Professionals – qualified, in training, assistants for each of the nine recognised AHP professions

  Healthcare Science and Technical:
  i. Healthcare Science Services clinical scientists, biomedical scientists (previously described as Medical Laboratory Scientific Officers MLSOs), medical technical officers), cytology screeners, dental technicians – qualified, in training, and unqualified

  Pharmacy Services:
  i. Qualified Pharmacists
  ii. Pharmacists in training
  iii. Qualified Pharmacy Technicians
  iv. Pharmacy Technicians in training
  v. Assistant Pharmacy Technicians

  Psychologists qualified, in training and unqualified

  Optometrists qualified, in training

- Ambulance
- Administrative and Clerical
- Senior Management
- Works
- Trades
- Ancillary

*** ISD definitions for Scientific, therapeutic and technical staff are to be used in the first year but they are under review and Boards are directed to the definitions in the document Making the Change-A Strategy for the Professions in Healthcare Science (Department of Health, 2001) for the groupings of healthcare science staff**

**2 Data on the current workforce, in each of the above staff groups, as follows**:

- recruitment rates – new joiners and re-joiners
- vacancies - overall and long term (as defined by ISD)
- age profile – as a minimum in 5 year blocks
- Diversity including gender, ethnicity and disability (where available)
- flexible working – full time/ part-time, average number of part time hours worked
- turnover – leavers in relation to staff in post
- absence rates – as defined by ISD

**3 Projections for each of the above staff groups: short term (each year for first 3 years), medium term (5 years) and long term (10 years).**
**In particular, to help inform training numbers commissioned nationally, the following forecast information must be provided:**

- Consultants, by specialty and where possible, sub-specialty
- Nurses and midwives by pre-registration training category (adult, mental health, learning disability, children and midwifery); by post-registration training categories that are accredited (for example specialist practitioner qualifications)
- Dentists providing general dental, community dental and hospital services including salaried and non salaried principals
- GPs providing primary care services, not just those who are independent contractors but also salaried GPs and where possible, sessional GPs

**4 Hotspot areas**

Particular areas of concern should be identified. For example, some services may be at risk if they are provided by smaller staff groups which become vulnerable when vacancies exist.

**ANNEX D**

**Definitions**

*All medical specialties* – All medical specialties includes hospital, community and public health medical specialties, but excludes dental hospital, community and public health specialties.

*Associate Specialist* – A medical practitioner appointed to the Associate Specialist grade will have worked a minimum of four years as registrar, staff grade, clinical medical officer or senior clinical officer. Two of those years are in the relevant specialty. In total the Associate Specialist will have 10 years of medical experience since graduating from medical school.

*Average WTE* –The ratio between whole time equivalent and headcount which indicates the average WTE per individual. An average WTE less than 1 suggests that there are individuals working less than full time. This measure is used when considering flexible working and part-time working patterns.

*Certificate of Completion of Specialist Training (CCST)* – This award is given to medical trainees who have completed a higher specialist training. Under new legislation this is being replaced with a *Certificate of Completion of Training (CCT).*

*Establishment* – Number of funded posts irrespective of whether the posts are filled or not. Establishment is calculated adding the number of staff in post and the number of vacancies at a point in time. It can be measured in WTE or headcount.

*Full timer* – A full time employee works the full weekly conditioned hours for the grade. This will be 37.5 hours per week under Agenda for Change. Under the New Consultant Contract, the 10 Programmed Activities or 40 hours are the conditioned hours for medical staff. Note that prior to the New Consultant Contract, those working a 'maximum part time contract' with 10 sessions and those working 11 sessions were recognised as 'full time'.

*GMC registration number* – A unique professional number allocated to each doctor (usually as a House Officer) once the doctor is professionally registered with the General Medical Council. The number comprises a string of characters that uniquely identify a member of the NHSScotland medical workforce (GDC for dental workforce). All doctors and dentists (training or trained) will have a GMC / GDC number.

*Headcount* – refers to the count of individuals, allowing for some to hold more than one post in different organisation. When converting WTE to headcount using average WTE, decimals are rounded up to reflect that contribution will be delivered by one individual. For example 1.2 converted headcount would be rounded to 2 individuals. Total headcount for NHSScotland will not be equal to the sum of the headcount working in the various NHS organisations. This reflects that some individuals work in more than one organisation.

*Joiners* – The number of employees that join a substantive post, from another staff group, another NHS Board or who are new to NHSScotland. The measure is taken between two census points although individuals can join at any point in time within those two censuses.

INVESTOR IN PEOPLE

POSITIVE ABOUT DISABLED PEOPLE

*SE Approved*
*Version 1.1*

*Leavers* – The number of employees that leave a substantive post to move to another staff group, another NHS Board or leave NHSScotland. The measure is taken between two census points although individuals can leave at any point in time within those two censuses.

*MIDAS* – The source of NHS General Dental Services (GDS) data, including dental workforce statistics is the Management Information and Dental Accounting System (MIDAS), which processes claims and makes payments to GDS dentists.

*National insurance number*– A unique 9-character number issued by the Contributions Agency to each member of the working population in the UK. The number remains the same throughout the person's career and can be used to identify leavers and joiners (for non medical and dental staff).

*Out of Hours*– The out-of-hours period is 18.30-08.00 on weekdays, all weekend and bank and public holidays.

*Part timer* – A part time employee works less that the full weekly conditioned hours for the grade.

*Rejoiners* – The number of employees that worked in NHSScotland, had a minimum break of one year and then came back into NHSScotland. This analysis is done by comparing at least three census points.

*SNIP* – Scottish Nurse Intake Planning models demand from units and supply data collected nationally in order to inform various workforce planning initiatives such as nurse training places to achieve the desired future supply of nurses in NHSScotland.

*Specialist Registrar* – Individuals in this training grade are allocated a National Training Number for the duration of their training programme. The programme culminates in the award of a CCT/CCST; the SpR can then enter the GMC Specialist Register and apply for Consultant posts.

*Stability index 1* - the percentage of staff who were in substantive posts at the 30 September that year and who were still in substantive posts in that organisation a year later.

*Stability index 2* - the percentage of staff who were in substantive posts at the 30 September that year and who were still in substantive posts in that organisation two years later.

*Staff Grade* – The Staff Grade doctor will have at least three years full time hospital service in the SHO or a higher grade including experience in a particular specialty.

*Staff group*–

- Clinical Staff group: This group includes Hospital doctors and dentists, GPs, GDPs, nursing and midwifery staff, allied health professionals, ambulance staff, scientific and professional and technical staff.
- Non-clinical Staff group: This group includes staff in the Administrative & Clerical, Ancillary, Senior Management, Trades and Works groups.

*Stock* - the headcount of individuals in a particular year.

*SWISS* – Scottish Workforce Information Standard System

*Temporary national insurance number* – A Temporary National Insurance number will generally begin with the letters TN, followed by the employees' date of Birth and ending with the employees gender. Staff with temporary national insurance numbers are excluded from the leavers and joiners analysis.

*Training Grades* – As a general rule trainees are not included in any analysis done on qualified staff groups with the exception of qualified radiographers undertaking further education to become sonographers.

*Turnover Rate*– The number of 'leavers' during a defined period, e.g. 2003 and 2004 divided by the average number of staff in post over the period concerned. For the 2003/04 time period, the denominator is calculated as: (staff in post at 30 Sept 2003 + staff in post at 30 Sept 2004)/2.

*Vacancies*– Any unfilled post for which funding is agreed and a decision has been made to fill it; action to fill the post may or may not include advertising the vacancy. Vacancies can be measured in terms of WTE or headcount.

*Waiting Times* – The difference in days from the date the decision was made by the referring person (GP, Consultant) that the patient should be admitted to the actual date of admission.

*WTE* –Calculated as contracted hours/conditioned hours. A widely accepted method of counting staff based on contracted hours taking into account part time working. If evaluating the overall contribution of a team of individuals who have different terms and conditions, it is necessary to measure contribution in term of contracted hours. This approach was required for the Out of Hours case study given that GPs and the other staff involved (nurses, paramedics, and allied health practitioners) had different conditioned hours.