Portsmouth Hospitals NHS
NHS Trust

TRUST BOARD PART I - SEPTEMBER 2011

Agenda Item Number: 145/11
Enclosure Number: (4)

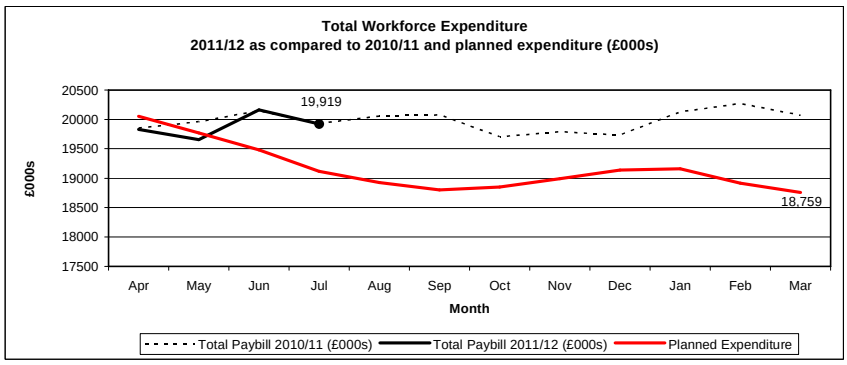
Subject:	Workforce Performance Report
Prepared by: **Sponsored by:** **Presented by:**	Abi Williams, Workforce Planning & Intelligence Manager Tony Short, Director of Workforce and Organisational Development Tony Short, Director of Workforce and Organisational Development
Purpose of paper *Why is this paper going to the Trust Board?*	Regular Reporting
Key points for Trust Board members *Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals*	The Board is asked to note: ▪ Key workforce indicators for Month 4 (July 2011)
Options and decisions required *Clearly identify options that are to be considered and any decisions required*	Board members are asked to note the performance issues highlighted in the report when considering the specific actions being presented separately by individual Executive Directors.
Next steps / future actions: *Clearly identify what will follow the Trust Board's discussion*	NA
Consideration of legal issues (including Equality Impact Assessment)?	Considered but not applicable
Consideration of Public and Patient Involvement and Communications Implications?	Considered but not applicable

1 Workforce Expenditure

1.1 The overall paybill (all pay elements) decreased by £243k to £19.92m in July as detailed in figure 1 below. However the total cumulative paybill is £1.1m greater than the planned position for July 2011. This is approximately 1.5% over planned position, are PHT are ranked sixth of the nine acute trusts in terms of percentage adherence to plan.

1.2 This compares favourably with Oxford Radcliffe who are ninth of nine (5.3% over plan) and SUHT eighth of nine (3.6% over plan) as displayed in the SHA performance report in Appendix 1a. Further details of split by Clinical Service Centre are provided in Appendix 1b and 1c.

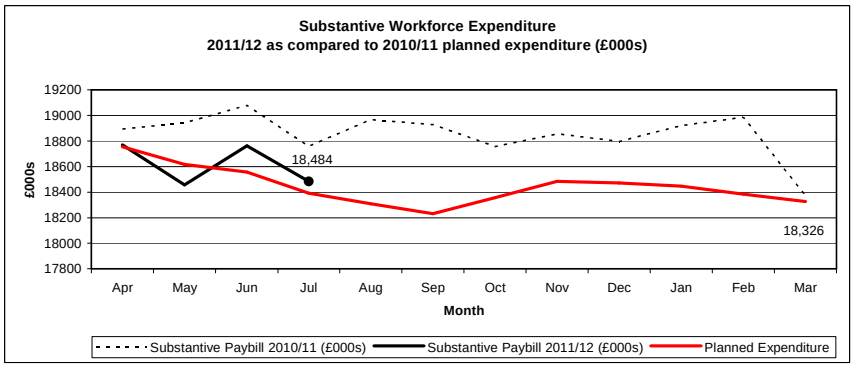
Figure 1



1.3 Substantive workforce expenditure (i.e. NHS and Military) decreased by £279k, to £18.48m in July, as detailed in figure 2 below. However cumulative substantive paybill is £153k above the planned position for July.

1.4 Reductions in paybill have now commenced relating to the completed voluntary redundancies, with the full monthly effect of the 5 staff having left in June, and part month affect of the 6 leaving in July being felt. The remaining 15 staff leave between August and October.

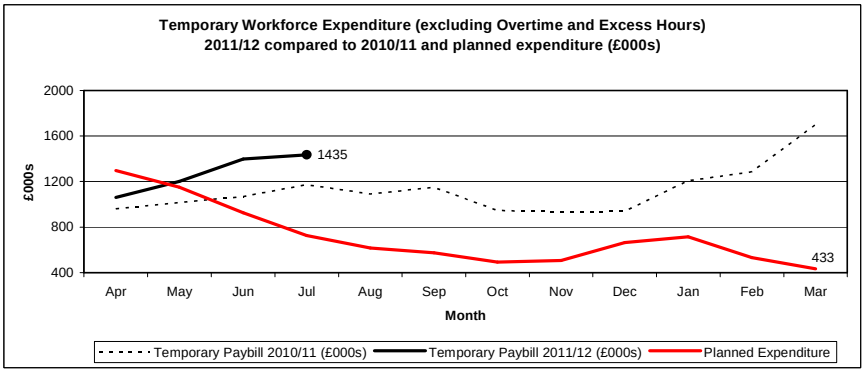
Figure 2



1.5 Temporary workforce expenditure (i.e. combined bank, agency, and all premium payments) increased by £36k to £1.43m in July, as shown below in Figure 3. Small increases have occurred particularly within medical staff in MOPRS as locum capacity continues to be used to cover vacancies caused by sickness and Maternity leave and increases in backfill for the new Stroke service.

1.6 Increases have also been observed in Emergency Nursing staff to maintain capacity to respond to additional demand, and cover absence. Demand continues to be above contracted levels agreed as detailed in the operational section of the reports.

Figure 3



1.7 Appendix 1d indicates a more detailed breakdown of temporary staffing type, with increases observed in July of £44k in Bank/NHSP costs and £66k in Trust Locum costs.

1.8 Overtime costs have decreased by £22k to £58k in July, and Excess hours payments have increased by £2k to £54k as detailed in Figure 4 and 5 below respectively. Further details are available in Appendix 1e.

Figure 4

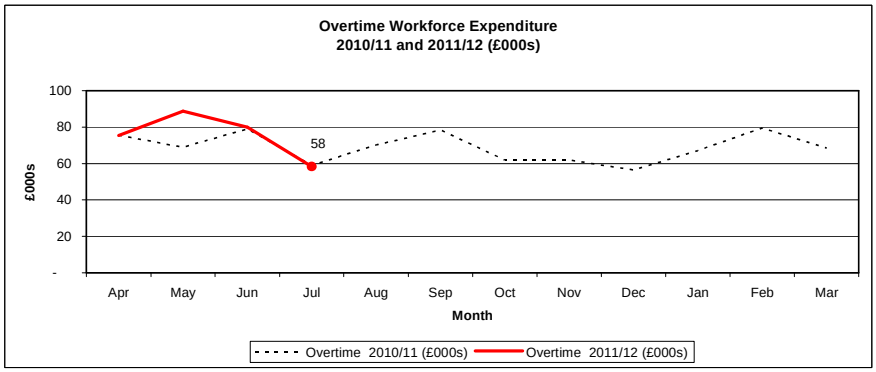
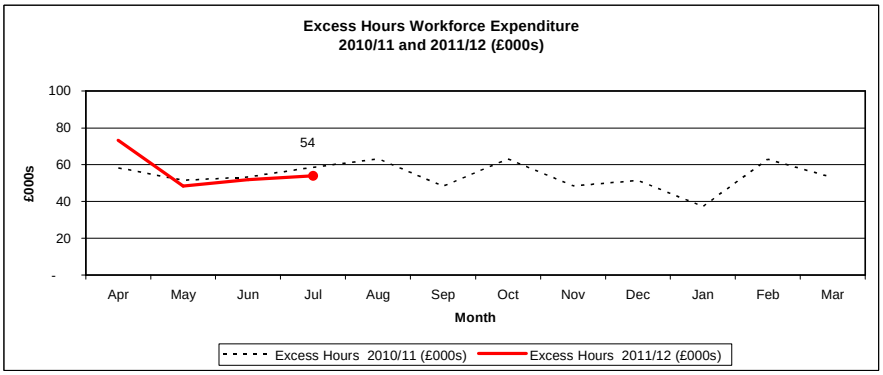


Figure 5

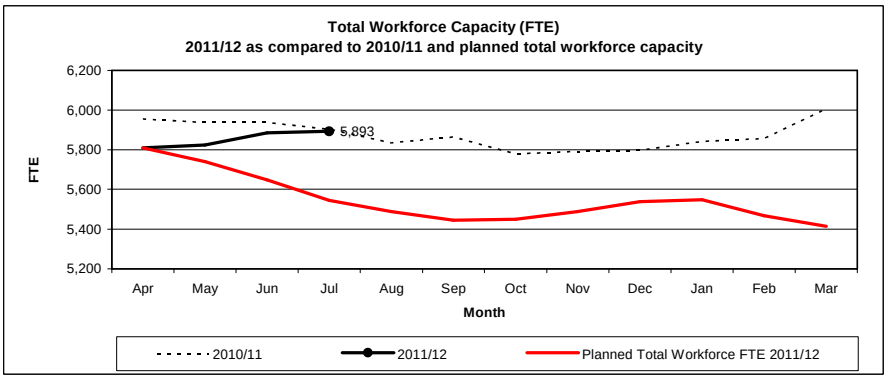


1.9 Unit staff costs are calculated by dividing the total workforce paybill by the Total Workforce FTE, and multiplied by 12 (months) to provide an annual figure which is an indicative gross cost per employee. Unit staff costs have decreased by £0.6k in July to £44.4k as the total paybill has decreased, whilst FTE has increased. This is mainly caused by reductions in nursing expenditure resulting from better utilisation of temporary staffing. Excess hours and NHSP have been used instead of higher costing Agency and Overtime capacity.

2 Workforce Capacity – Full Time Equivalent (FTE) Staff

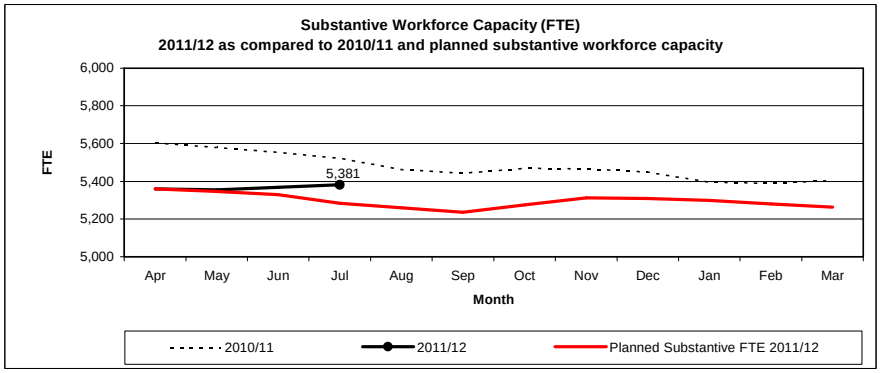
2.1 In July, total workforce capacity (i.e. substantive staff plus temporary capacity) increased by 8 FTE, to 5,893 FTE as a result of both substantive and temporary staffing increases as shown below in Figure 6. Since March 2011, there has been a 113 FTE reduction, however is 245 FTE above planned position for July.

Figure 6



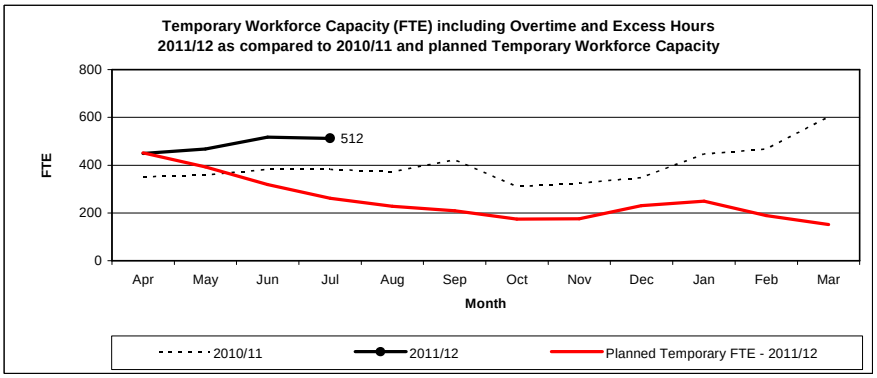
2.2 Substantive workforce capacity increased by 13 FTE to 5,381 FTE in July. This is a 23 FTE reduction since March 2011, as shown below in Figure 7, and is 51 FTE above plan for July. Whilst technically correct, these figures are skewed by the junior doctor rotations which take place at this time of year. New starters have been actioned, with some new starters starting in July, whilst those doctors leaving in August are still live on ESR. This accounts for approximately 35 FTE, the reduction of which will be observed in August figures. Further reductions are anticipated staff continue to leave via voluntary redundancy and CIP plans continue to be implemented.

Figure 7



2.3 Temporary workforce capacity (i.e. total expenditure on temporary capacity, including bank, agency, locums and overtime, converted to an indicative FTE) decreased by 5 FTE to 512 FTE in July as shown in Figure 8 below, and is 251 FTE above planned position. Further details are available in appendix 2 and 3.

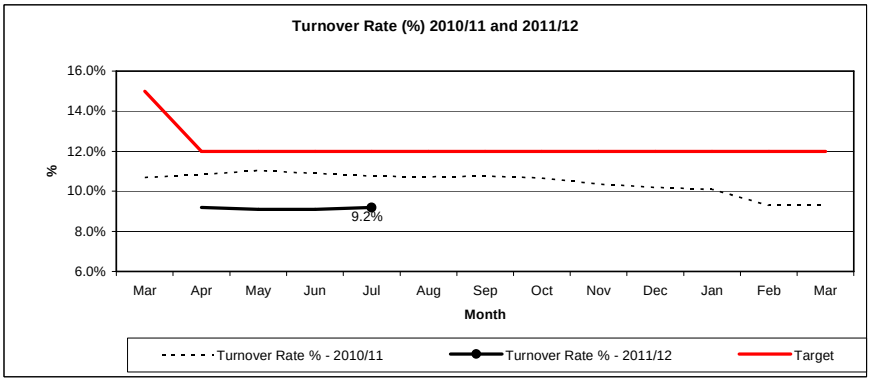
Figure 8



3 Workforce Performance

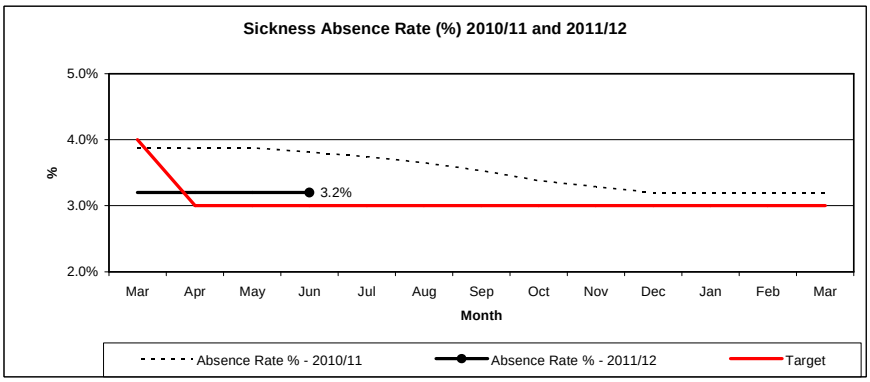
3.1 Turnover has remained stable at 9.2% in July, as shown in Figure 9, with all CSC teams below the target. Turnover is measured over a rolling 12 month period.

Figure 9



3.2 Sickness absence rate in June remained at 3.2% for the 4th consecutive month as detailed in Figure 10 below. The Trust target in 2011/12 is 3%. NB. Sickness Absence data is one month in arrears and is calculated as a rolling 12 month average. The trust is below average for sickness absence compared to both the NHS as a whole (4.8%), and acute NHS Trusts (4.5%).

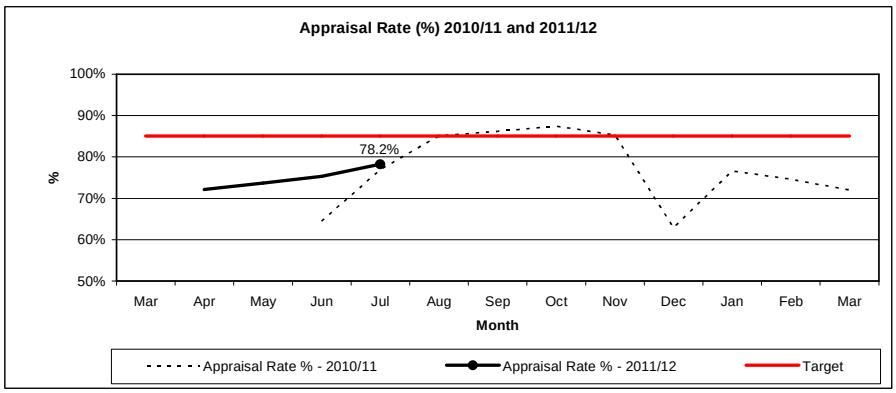
Figure 10



3.3 MOPRS continues to have the highest percentage sickness absence at 4.6%, and work in ongoing within this CSC which has enabled a further 0.2% reduction this month. Should this trend continue, MOPRS will no longer be the outlier it once was, particularly as MSK has increased to 4.5% in month. MSK, Renal, CHAT and Head & Neck have increased this month, and only Emergency, Medicine, Surgery and Corporate are below the 3% target. Work continues in all CSCs to decrease absence levels to well below this new target.

3.4 Appraisal Compliance has increased in July by a further 2.9% to 78.2% as demonstrated in figure 11 as significant emphasis on the accurate recording and completion of appraisals continues and starts to reap the benefits.

Figure 11



3.5 Of particular note, Head and Neck CSC has increased to 91.4% as demonstrated in Figure 12, and CHAT CSC has increased by over 10% to 80%. These figures are the highest since reporting via ESR began in 2010/11 and demonstrates that with appropriate management by CSC teams recorded appraisal levels can increase significantly. A significant reduction of 14.1% has been observed in Cancer CSC, and targeted support will continue here.

Figure 12

All staff groups	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Movement
Cancer	84.5%	82.1%	80.2%	80.2%	66.1%	▼
CHAT	69.1%	69.8%	69.5%	69.7%	80.0%	▲
Clinical Support	64.8%	68.3%	74.1%	86.7%	87.5%	▲
Emergency	58.5%	60.6%	55.8%	58.2%	64.7%	▲
Head & Neck	70.9%	71.8%	83.1%	86.9%	91.4%	▲
Medicine	82.9%	77.6%	75.7%	67.3%	67.7%	▲
MOPRS	65.1%	61.6%	60.6%	62.5%	68.2%	▲
MSK	79.0%	79.4%	77.7%	77.6%	79.3%	▲
Renal	85.3%	83.5%	78.6%	71.1%	73.1%	▲
Surgery	76.0%	70.8%	72.0%	72.4%	74.7%	▲
W&C	64.9%	69.2%	76.1%	76.8%	81.3%	▲
Corporate	87.5%	84.5%	83.7%	81.2%	80.9%	▼
Trust	72.2%	72.1%	73.7%	75.3%	78.2%	▲

Key:
>85%
50% to 85%
<50%