Portsmouth Hospitals NHS
NHS Trust

**TRUST BOARD PART I - DECEMBER 2011**

**Agenda Item Number: 196/11**
**Enclosure Number: (4)**

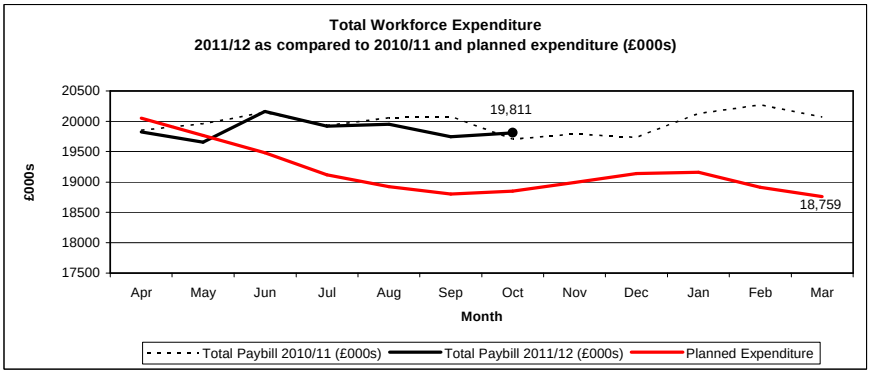
| | |
|---|---|
| **Subject:** | Workforce Performance Report |
| **Prepared by:**<br><br>**Sponsored by:**<br><br>**Presented by:** | Abi Williams, Workforce Planning & Intelligence Manager<br><br>Tim Powell, Director of Workforce and Organisational Development<br><br>Tim Powell, Director of Workforce and Organisational Development |
| **Purpose of paper**<br><br>*Why is this paper going to the Trust Board?* | Regular Reporting |
| **Key points for Trust Board members**<br>*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:<br>▪ Key workforce indicators for Month 7 (October 2011) |
| **Options and decisions required**<br>*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**:<br>*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) increased by £63k to £19.8m in October as detailed in figure 1 below. However the total cumulative paybill is £4m greater than the planned position for October 2011. Further detail is available in appendix 1a and 1b.

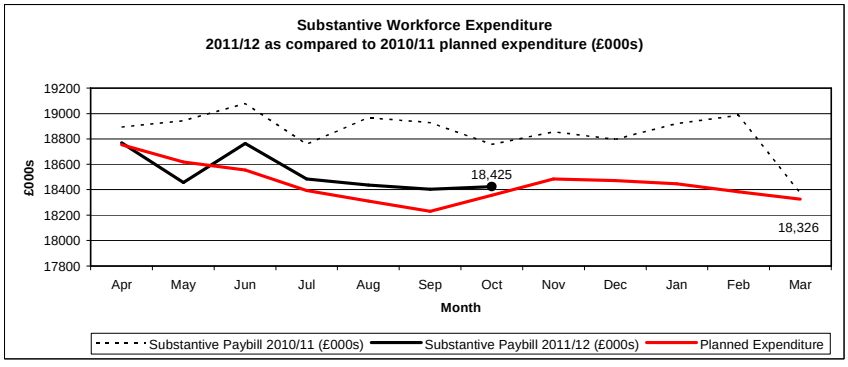
1.2 The planned reductions in workforce expenditure included £5.5m demand management savings, with workforce being the main contributor to these savings, however this has not been fully implemented and therefore associated reductions in workforce costs have not been possible. This is further supported by information from the SHA, indicating that both University Hospital Southampton NHS Trust and Oxford Radcliffe NHS Trust face larger variances from their planned workforce expenditure. Both Southampton and Oxford are approximately 5% over plan, compared to PHT at 3% over planned expenditure. It is also important to note that the value of the additional activity delivered in the first 6 months of the year (£9.5m) has greatly exceeded the additional workforce costs incurred, as detailed further in both the Finance and Operations sections of the report.

Figure 1




1.3 Substantive workforce expenditure (i.e. NHS and Military) increased by £21k, to £18.4m in October, as detailed in figure 2 below. However cumulative substantive paybill is £524k above the planned position for October. This increase is predominantly related to the planned intake of newly qualified nursing staff in almost all CSCs, though is offset against continued voluntary and compulsory redundancy leavers as the redundancy programme nears completion. The final staff will leave in November.

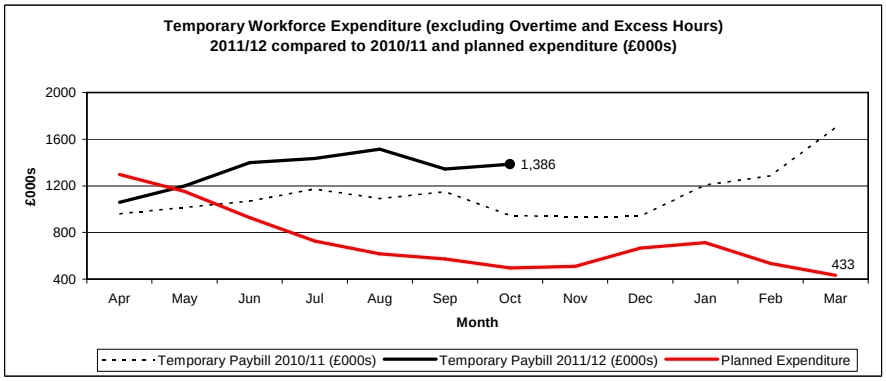
Figure 2




1.4 Temporary workforce expenditure (i.e. combined bank, agency, and all premium payments) increased by £41k to £1.39m in October, as shown below in Figure 3. High levels continue in MOPRS and Emergency as unscheduled care demand continues to be above agreed contracted levels, and as the winter plans start to be activated. The winter pressures ward is now open and temporary nursing staff have been required to backfill staff on this ward. A further review is taking place to ensure that the controls on temporary staff booking are as robust as required.

1.5 Anaesthetics have gaps in their medical staff rotas, as the deanery have not been able to provide 5 posts, and has resulted in Consultants acting down, and other trainees undertaking more hours to compensate. Additional nursing cover has also been required in Musculoskeletal as the backlog of work continues, and additional capacity is being put on to try and resolve this issue.

Figure 3




1.6 Appendix 1c indicates a more detailed breakdown of temporary staffing type, with largest increases observed in October of £46k in Locums and £37k in NHSP.

1.7 Overtime costs have reduced by £3k to £61k in October, and Excess hours payments have increased by £6k to £58k as detailed in Figure 4 and 5 below respectively. Further details are available in Appendix 1d.

Figure 4

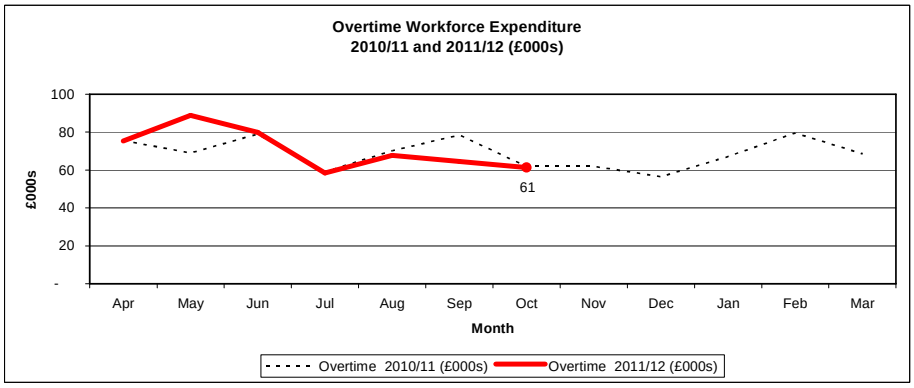
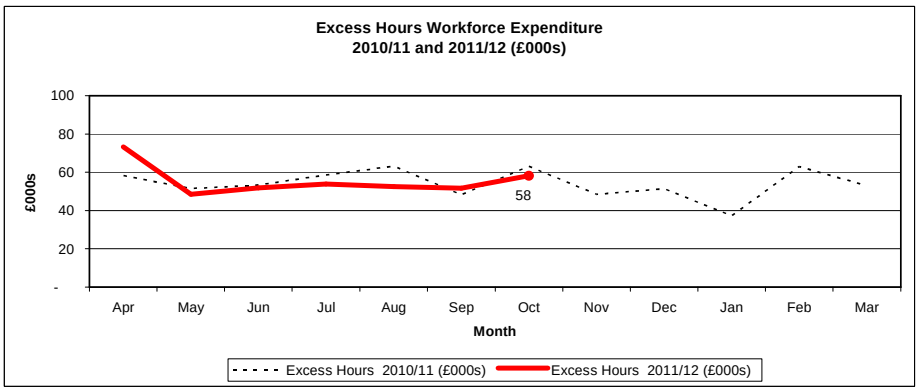



Figure 5

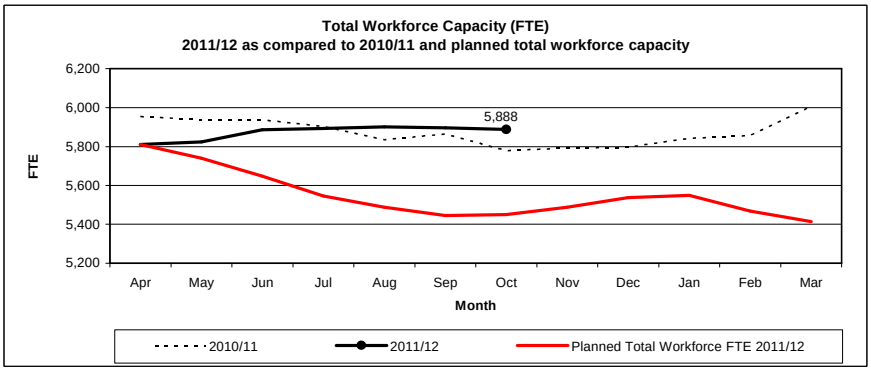



1.8 Unit staff costs are calculated by dividing the total workforce paybill by the Total Workforce FTE, and multiplied by 12 (months) to provide an annual figure which is an indicative gross cost per employee. Unit staff costs have increased by £0.3k in October to £44.2k as the total paybill has increased, whilst FTE has decreased. This relates particularly to medical staff, where locum costs can be significantly higher.

## 2 Workforce Capacity – Full Time Equivalent (FTE) Staff

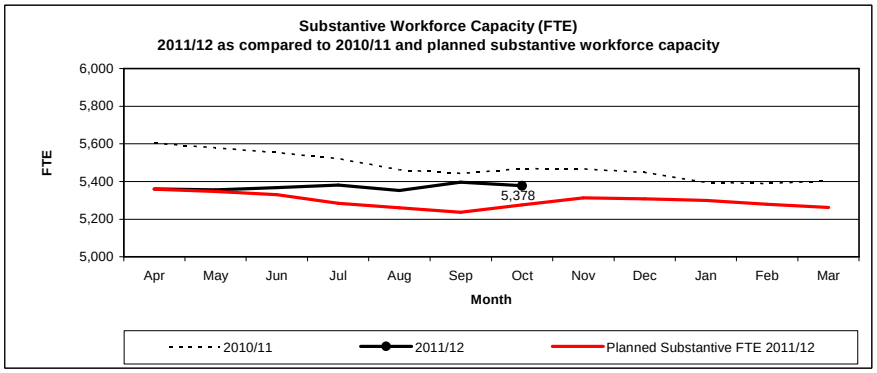
2.1 In October, total workforce capacity (i.e. substantive staff plus temporary capacity) decreased by 8 FTE, to 5,888 FTE as a result of substantive staffing reductions as shown below in Figure 6 and 7. Since March 2011, there has been a 119 FTE reduction; however is 438 FTE above planned position for October. Again this figure relates to the plan submitted to the SHA, and assumes reductions in staffing for demand management, the majority of which was unidentified, and delivery of agreed activity levels. Approx 150 FTE workforce reduction was identified for the whole year through a variety of means.

Figure 6



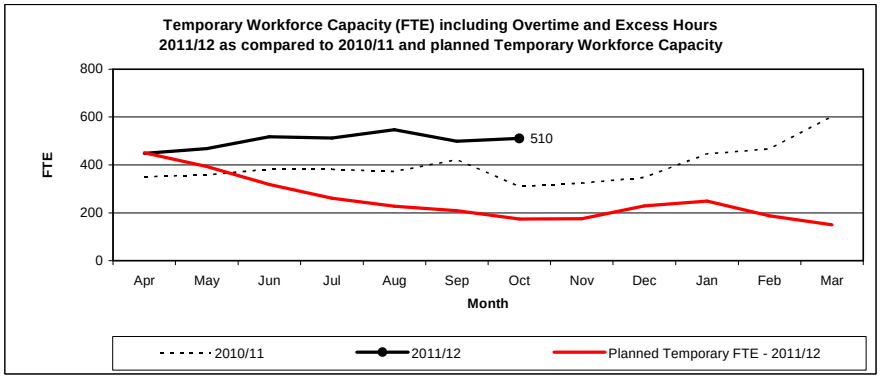

2.2 Substantive workforce capacity decreased by 19 FTE to 5,378 FTE in October. This is a 26 FTE reduction since March 2011, as shown below in Figure 7 however 103 FTE above plan for October. This decrease relates to the leavers through redundancy though also includes a number of voluntary resignations of nursing staff, particularly in MOPS, CHAT and W&C.

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) increased by 11 FTE to 510 FTE in October as shown in Figure 8 below, and is 335 FTE above planned position. Further details are available in appendix 2 and 3. As previously advised, high levels of temporary staffing continue to be used to maintain services where demand is not reducing as planned, to cover critical vacancies, and to resource the winter capacity.

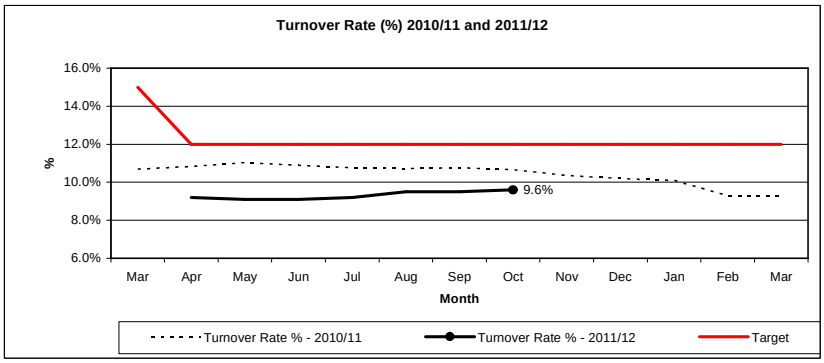
Figure 8



## 3 Workforce Performance

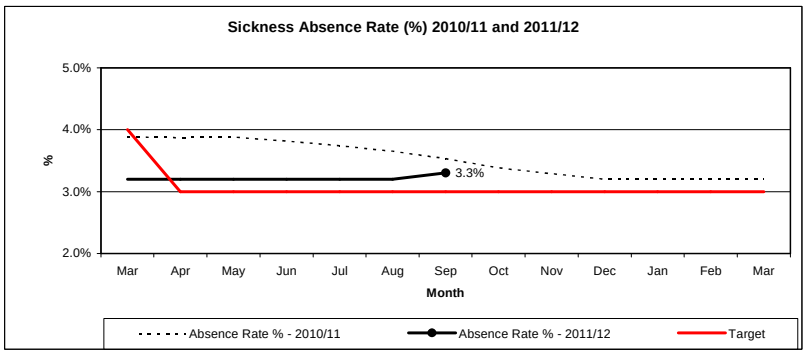
3.1 Turnover has increased in month to 9.6% in October, as shown in Figure 9. Almost all CSC are below the target of 12%, however Cancer CSC, Clinical Support CSC and Head & Neck CSC have all breached this target, mainly within Professional and Technical staff groups. Turnover is measured over a rolling 12 month period.

Figure 9




3.2 Sickness absence rate in September increased fractionally to 3.3% as detailed in Figure 10 below. This is above the Trust target of 3%; however does compare favourably at a regional and national level against other acute hospitals. Sickness Absence data is one month in arrears and is calculated as a rolling 12 month average.

Figure 10




3.3 MSK continues to be the CSC with the highest levels of sickness absence at 4.7%, however this is now being proactively managed, with a 5 point action plan, and it has become apparent that some sickness absences are not being closed off by managers in ESR, therefore the process has been reiterated to managers and is now being rectified. Work continues in all CSCs to decrease absence levels to well below this new target.

3.4 Appraisal Compliance has increased further in October by a further 1% to 83.9% as demonstrated in figure 11. Significant improvements have been observed in most areas over the last few months however some areas who had reached the target have slipped back slightly. One area where this is particularly apparent is in Clinical Support, and it is suggested that some of the internal reorganisations have resulted in delays by managers to pick up their new staff members appraisal requirements. This has been addressed with all managers concerned.

Figure 11

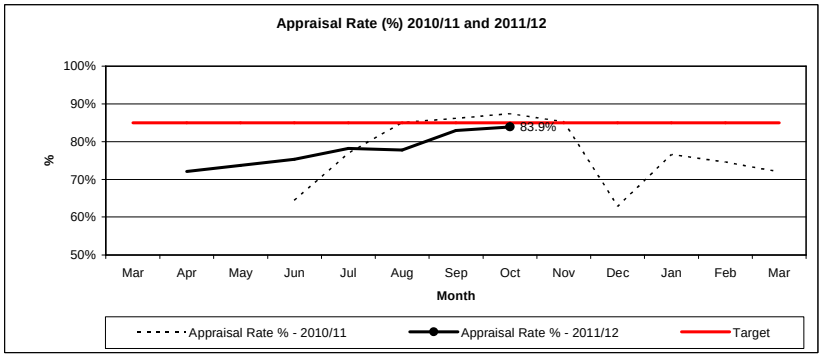
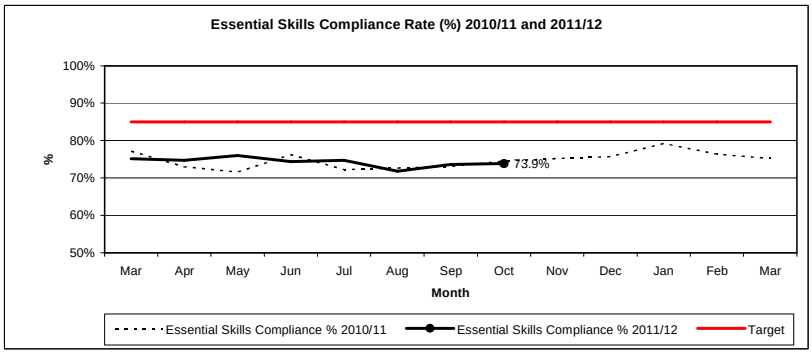


Figure 12

| All staff groups | Mar-11 | Apr-11 | May-11 | Jun-11 | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Movement |
|---|---|---|---|---|---|---|---|---|---|
| Cancer | 84.5% | 82.1% | 80.2% | 80.2% | 66.1% | 53.8% | 55.1% | 56.8% | ↑ |
| CHAT | 69.1% | 69.8% | 69.5% | 69.7% | 80.0% | 81.2% | 92.4% | 92.0% | ↓ |
| Clinical Support | 64.8% | 68.3% | 74.1% | 86.7% | 87.8% | 84.8% | 85.9% | 85.0% | ↓ |
| Emergency | 58.5% | 60.6% | 55.8% | 58.2% | 64.7% | 68.0% | 70.9% | 76.5% | ↑ |
| H&N | 70.9% | 71.8% | 83.1% | 86.9% | 91.4% | 90.4% | 89.2% | 87.1% | ↓ |
| Medicine | 82.9% | 77.6% | 75.7% | 67.3% | 67.7% | 65.9% | 70.9% | 74.3% | ↑ |
| MOPRS | 65.1% | 61.6% | 60.6% | 62.5% | 68.2% | 67.6% | 78.3% | 81.0% | ↑ |
| MSK | 79.0% | 79.4% | 77.7% | 77.6% | 79.3% | 83.7% | 92.5% | 93.2% | ↑ |
| Renal | 85.3% | 83.5% | 78.6% | 71.1% | 73.1% | 64.0% | 72.2% | 70.1% | ↓ |
| Surgery | 76.0% | 70.8% | 72.0% | 72.4% | 74.7% | 78.2% | 86.6% | 90.5% | ↑ |
| W&CS | 64.9% | 69.2% | 76.1% | 76.8% | 81.3% | 82.8% | 86.3% | 86.2% | ↓ |
| Corporate | 87.5% | 84.5% | 83.7% | 81.2% | 80.9% | 82.6% | 86.6% | 88.2% | ↑ |
| TOTAL | 72.2% | 72.1% | 73.7% | 75.3% | 78.2% | 77.8% | 82.9% | 83.9% | ↑ |

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

3.5 Emphasis continues to be placed on Essential Skills compliance, and levels have increased slightly, but not to a satisfactory level. Further work is in progress to ensure that all staff have the appropriate essential skills training, and this includes a review of what essential skills are necessary by post, and action plans for each CSC to implement. Trajectories for CSC's to reach a compliant state are in development and performance monitoring will continue via the monthly Performance Review Process.




| All staff groups | Mar-11 | Apr-11 | May-11 | Jun-11 | Jul-11 | Aug-11 | Sep-11 | Oct-11 | Movement |
|---|---|---|---|---|---|---|---|---|---|
| Cancer | 72.1% | 71.0% | 72.0% | 68.0% | 70.7% | 65.8% | 67.9% | 69.9% | ↑ |
| CHAT | 75.9% | 75.7% | 76.9% | 76.7% | 76.3% | 75.1% | 78.6% | 78.2% | ↓ |
| Clinical Support | 79.1% | 79.4% | 81.6% | 79.1% | 80.2% | 77.3% | 78.1% | 78.7% | ↑ |
| Emergency | 62.9% | 63.2% | 66.0% | 65.8% | 64.2% | 61.5% | 63.2% | 63.9% | ↑ |
| H&N | 77.1% | 76.1% | 77.5% | 75.1% | 75.3% | 73.8% | 75.8% | 76.9% | ↑ |
| Medicine | 73.7% | 74.0% | 75.5% | 70.8% | 70.6% | 65.8% | 67.2% | 67.4% | ↑ |
| MOPRS | 75.2% | 74.9% | 75.0% | 73.5% | 74.0% | 68.9% | 70.6% | 72.3% | ↑ |
| MSK | 75.4% | 76.5% | 77.9% | 77.3% | 77.8% | 74.0% | 75.7% | 75.6% | ↓ |
| Renal | 75.3% | 73.7% | 75.9% | 74.1% | 74.5% | 71.2% | 73.2% | 73.9% | ↑ |
| Surgery | 75.9% | 73.7% | 74.5% | 74.0% | 75.1% | 73.0% | 71.5% | 75.4% | ↑ |
| W&CS | 75.5% | 74.1% | 74.4% | 73.3% | 74.4% | 72.2% | 76.1% | 75.0% | ↓ |
| Corporate | 78.3% | 77.5% | 79.9% | 77.7% | 77.6% | 76.6% | 77.1% | 72.5% | ↓ |
| TOTAL | 75.2% | 74.7% | 76.0% | 74.4% | 74.7% | 71.8% | 73.7% | 73.9% | ↑ |

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

3.6 Further information relating to sections 1, 2 and 3 is available in Appendix 4.