Portsmouth Hospitals NHS
NHS Trust

TRUST BOARD PART I – APRIL 2012

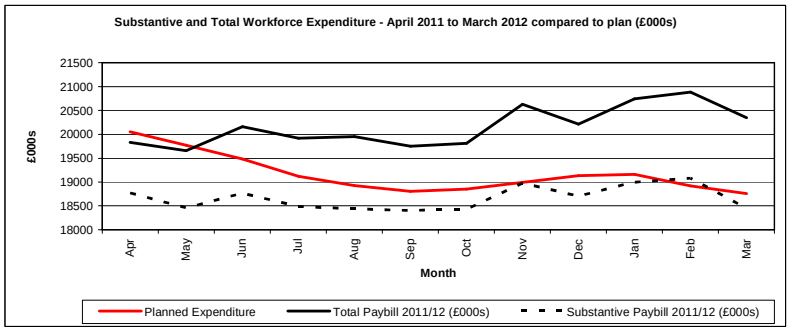
Agenda Item Number: 54/12
Enclosure Number: (4)

Subject:	Workforce Performance Report
Prepared by: **Sponsored by:** **Presented by:**	Abi Williams, Workforce Planning & Intelligence Manager Tim Powell, Director of Workforce and Organisational Development Tim Powell, 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 12 (March 2012) ▪ Summary of annual progress
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 £539k to £20.35m in March as detailed in figure 1 below. This is as a result an increase in temporary workforce expenditure March by £90k to £1.9m relating to continued demand for services above contracted position and backlog clearance, and a decrease in substantive workforce expenditure of £629k to £18.45m, which essentially relates to a standard month without payments for enhancements for the first time this quarter.

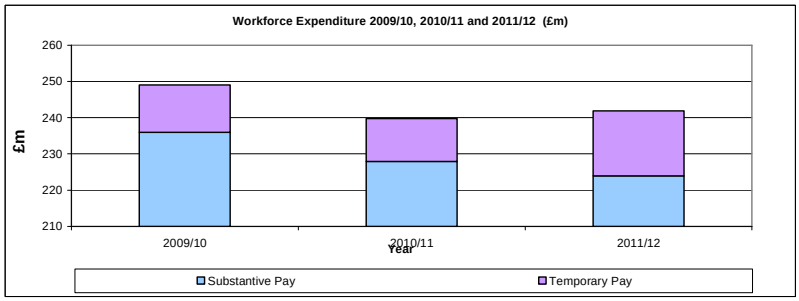
Figure 1



1.2 When considering the financial year in full, an overall saving of £14m was required including £5.5m of demand management. After factoring in inflationary and incremental pressures, this resulted in a required reduction of £9.7m from the previous years expenditure. Savings have been achieved in substantive expenditure, as detailed below, however the true impact of the savings has not been realised due to additional activity over and above contracted levels requiring the use of temporary workforce, some of which has been significantly more costly than substantive staffing would have been.

1.3 The planned cumulative total workforce expenditure for 2011/12 was approx £230m, which would have resulted in a reduction of £9.7m from the March 2011 outturn position, however the cumulative paybill has increased by £2.2m to £241.9m, and is therefore £11.9m greater than the planned position for March 2012 as demonstrated below in figure 2.

Figure 2



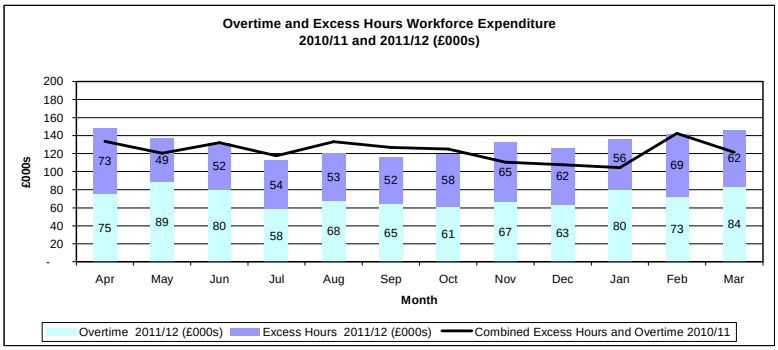
1.4 The adverse variance in the cumulative paybill is mitigated by considerable additional activity delivered throughout 2011/12. The value of activity over performance is approximately £20m over plan (likely associated income of £14m), excluding any additional funds to increase the baseline contract. When the additional funds provided are added to the baseline contract, the value of the activity over performance is approximately £12m (likely associated income of £6m).

1.5 When considering the cumulative substantive workforce expenditure, a reduction of £2.6m has been achieved, against a planned saving of £4.9m, resulting in a variance of £2.3m.

1.6 Temporary workforce expenditure (i.e. combined bank, agency, and all premium payments) has increased by £4.5m against a planned saving of £4.8m, resulting in an adverse variance of £(9.3)m. This has been predominantly related to higher than anticipated unscheduled care levels and scheduled backlog. The CSCs predominantly affected have been Emergency, Medicine, Clinical Support, Head & Neck and MOPRS, particularly within nursing and medical staff.

1.7 Overtime costs have increased by £11k to £84k in March, and Excess Hours payments have decreased by £6k to £62k. The combined overtime and excess hours costs are approx £90k higher during 2011/12 than 2010/11 as detailed in Figure 3 below.

Figure 3

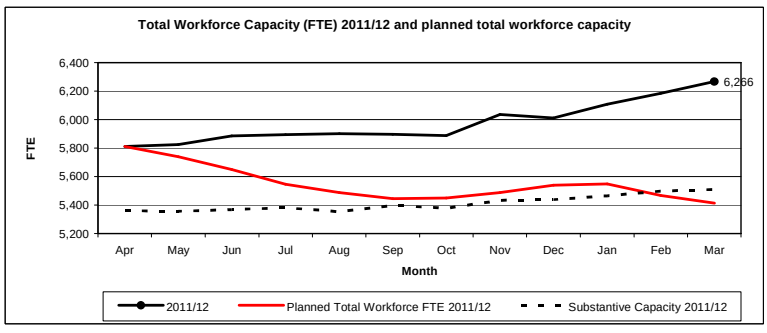


1.8 Unit staff costs are calculated by dividing the total workforce paybill by the Total Workforce FTE, and multiplied by 12 (months) to provide an annual figure which is an indicative gross cost per employee. Unit staff costs have reduced by £1.2k to £44.3k in March, and overall for the full year have reduced by £0.3k.

2 Workforce Capacity – Full Time Equivalent (FTE) Staff

2.1 In March, total workforce capacity (i.e. substantive staff plus temporary capacity) increased by 81 FTE, to 6,266 FTE, as a result of increases in both substantive and temporary workforce, as shown below in Figure 4. This is 852 FTE above planned position for March, however as previously described in section 1.2, this position relates to the plan submitted to the SHA, and assumes reductions in staffing for demand management of £5.5m, the majority of which was unidentified, and delivery of agreed activity levels.

Figure 4



2.2 Substantive workforce capacity increased by 11 FTE to 5,508 FTE in March, and is 245 FTE above plan for March, whilst Temporary workforce capacity (i.e. total expenditure on temporary capacity, including bank, agency, locums and overtime, converted to an indicative FTE) increased by 70 FTE to 758 FTE in March, and is 607 FTE above planned position. 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 and backlog of cases.

2.3 When considering the year end position, compared to 2010/11, Total Workforce Capacity has increased by 237 FTE since March 2011.This is as a result of an increase in Substantive staffing of 104 FTE over the year, predominantly in Medicine and Clinical Support, both of which were carrying large numbers of vacancies in 2010/11. The main areas of substantive staffing reductions have been as the result of TUPE transfers of MOPRS and GU Medicine Staff. In addition, the Redundancy and Redeployment process implemented this year has prevented a larger increase.

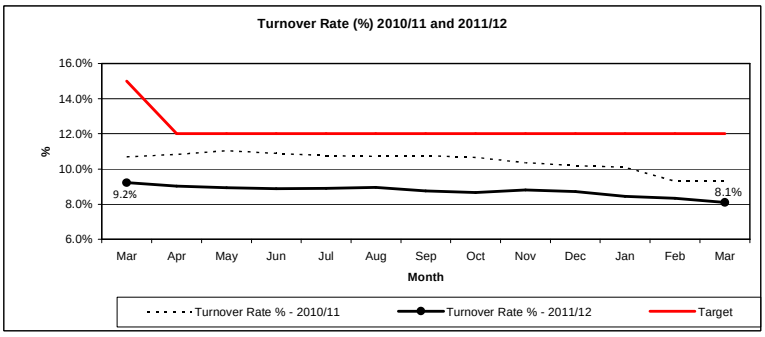
2.4 In addition there has been an increase of 133 FTE in Temporary workforce since March 2011. Main areas of increase have been Clinical Support, mainly in relation to Pathology and Infection Control, and MOPRS medical and nursing staff, supporting the winter ward and covering vacancies.

2.5 Staffing levels have not reduced in line with planned levels, as demand has been significantly higher than anticipated, with increases in emergency attendances and elective and non-elective admissions, and assumptions regarding demand management based on activity commissioned not coming to fruition.

3 Workforce Performance

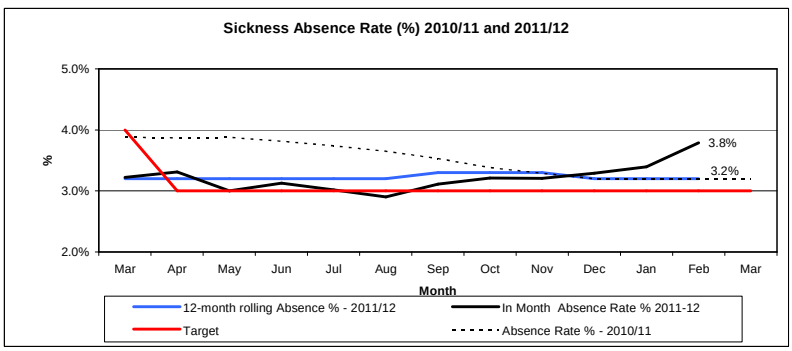
3.1 Turnover has steadily decreased throughout the year from 9.2% in March 2011 to the current level of 8.1%, as shown in Figure 5 below. All CSCs are below the Trust target of 12%, with MOPRS (11.6%), Head & Neck (10.9%) and Cancer (10.9%) over 10%, and the remainder under 10%. Head and Neck is particularly high within administrative staff, and Cancer continues to have higher turnover in Nursing and Radiographers.

Figure 5



3.2 The 12 month rolling average sickness absence rate as reported to the SHA in February has remained unchanged at 3.2% and has been consistent over the year as shown below in figure 6. 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.

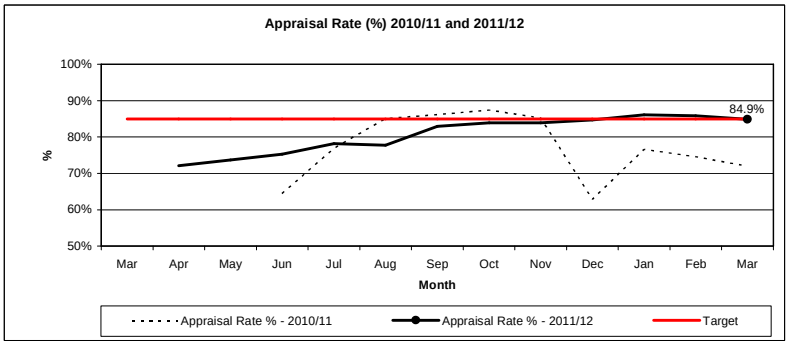
Figure 6



3.3 However for insight into the month on month position, figure 6 above also demonstrates the In-month sickness absence rate for the Trust, which is currently 3.8%. Considering the full year, sickness absence reduced to its lowest point of 2.8% in August, however has now increased to 3.8%. An element of seasonality is to be expected due to higher prevalence of winter viruses over the winter period, however significant increases have been observed in MOPRS (6.8%), Renal (6.7%), MSK (5.8% and Cancer (5.4%). A dedicated team from the Workforce directorate are targeting these areas specifically to reduce absence.

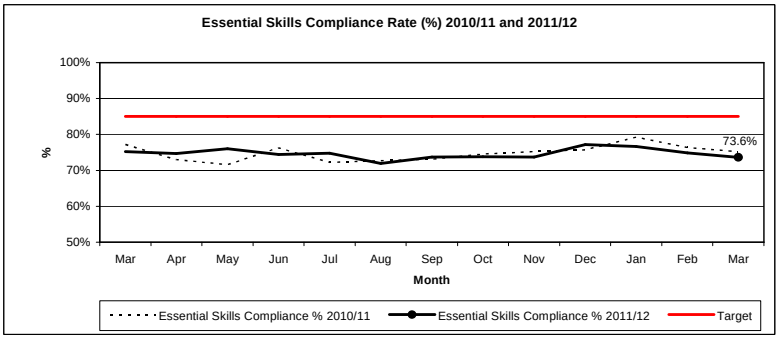
3.4 Appraisal Compliance has decreased in March by 0.9% to 84.9%, and is fractionally below target of 85% as demonstrated in figure 7 below. Over the year an improvement of 13% has been observed as a result of significant efforts and implementation of a comprehensive action plan. 7 of the CSCs exceed the target level, CHAT (92.4%), Medicine (90.3%), Surgery (89.1%), MSK (88.9%), Head & Neck (87.9%), Renal (87.7%) and MOPRS (85.8%).

Figure 7



3.5 Several of the CSCs have increased their Essential Skills compliance rates this year, in particular CHAT (84.2%), MSK (81.2%), Renal (80.6%), Surgery (79.6%), Head & Neck (78.7%) and Emergency (67.2%). All CSCs are required to improve further to ensure they achieve the target of 85% compliance as detailed in Figure 8. Specific targeted work continues to ensure all staff are compliant.

Figure 8



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