## Contents

1. **Introduction**  
   
2. **Measuring Workload**  
   Learning outcomes  
   Introduction to nursing and midwifery workload  
   Approaches to workload measurement  
   Interpreting and applying workload data  
   Work-based learning activities (1-3)  

3. **Workforce Planning and Staff Deployment**  
   Learning outcomes  
   Introduction to workforce planning and staff deployment  
   Skill mix  
   Planning and managing staff resources  
   People management  
   Working in partnership with your HR department  
   Nursing and midwifery budgets/financial management  
   Long-term planning  
   Work-based learning activities (4-10)  

4. **Support materials**  
   Case studies (1-8)  
   Worksheets (1-6)  
   Handouts (1-5)  

5. **References**  

6. **Acknowledgements**
Foreword

Welcome to the second edition of the Nursing and Midwifery Workload and Workforce Planning Learning Toolkit.

The skills and knowledge of Nursing and Midwifery staff continue to be crucial to the delivery of safe, effective and person-centred health services in Scotland, and the relative size of the nursing and midwifery workforce means it has a crucial impact upon healthcare provision (Audit Scotland, 2007).

Effective use of this important human resource is therefore essential, and the first edition of the learning toolkit supported Senior Charge Nurses, to understand workforce planning and to support the robust workload measurement tools in use across NHSScotland.

In addition Releasing Time to Care has been introduced across Boards, further strengthening the impact Senior Charge Nurses (SCN) Senior Charge Midwives (SCM) and Team Leaders (TL) have on the processes to increase direct patient care time within inpatient and community areas.

However, there have been some significant changes within NHSScotland since the first edition of the Learning Toolkit was published; the current economic climate means increased pressure on NHS Boards to improve efficiency; and, alongside this, high profile reports and investigations into concerns about care have meant nursing workforce numbers and models of care provision are under increased scrutiny.

In this challenging context, the Scottish Government has set out the Healthcare Quality Strategy, focussing on safe, effective and person centred care and, in 2012, the Nursing and Midwifery Workload and Workforce Planning tools were mandated as part of the workforce planning process across NHS Scotland. This further highlighted the importance of effective use of the workload tools as part of a triangulated approach to determine nursing and midwifery staffing establishments within all areas of service (CEL 32).

In Leading Better Care – Report of the Senior Charge Nurse Review and Clinical Quality Indicators Project (Scottish Government, 2008), the four dimensions of the SCN role were outlined and Managing and developing team performance (Dimension 3) relates to the use of resources and workforce planning within the practice setting.

SCNs, SCMs and TLs shape the ethos, values and effectiveness of their wards and departments and are instrumental in providing the highest possible care for patients. As leaders on the front line, they are; “the visible embodiment of clinical leadership in NHS settings, co-ordinating patient care, marshalling and inspiring the nursing or midwifery team and advocating on patients’ behalf with members of the multidisciplinary team.” (Scottish Government 2008). That’s why it’s important they can understand and use the tools and are equipped with the skills to lead their teams and manage their resources effectively and efficiently.
The toolkit has previously been used throughout NHS Scotland in a variety of ways; as part of Leading Better Care development and independently as a module used to develop those managing teams of nurses, with several Universities accrediting these at SCQF level 9.

Alongside the focus on developing SCNs, SCMs and TLs, feedback from users highlighted a desire for the resource to be targeted to a wider audience and suggested enhanced chapters on the following: Finance, Working with HR, Skill Mix and Rostering. Therefore, this revised second edition of the Learning Toolkit is designed to be suitable for those managing SCNs, SCMs and TLs as well as those aspiring to reach that goal.

The feedback also suggested that the toolkit worked most effectively when delivered with executive team sponsorship, skilled facilitation from practice development and organisational development and engagement with key staff from within the organisation, such as finance and human resources. Providing information, web links, case studies and exercises from a variety of care settings this toolkit will enable SCNs, SCMs and TLs to embrace the role, ensuring that the resources they are responsible and accountable for are used most effectively.

We see this toolkit as one, of a range of supporting resources for this group of staff, and can be used in conjunction with the *Education and Development Framework for Senior Charge Nurses/Midwives and Team Leaders in All Areas of Practice (Second Edition)* (NES, 2012).

As modes of care provision and settings change, it is imperative we continue to refresh the workload tools to reflect this. The Nursing and Midwifery Workload and Workforce Planning Project team, in conjunction with NHS Education for Scotland, will review and monitor these changes; adapting and enhancing the Learning Toolkit as required, thus ensuring appropriate training and guidance for practitioners. We are confident that professional leaders, equipped with workforce and workload skills, can ensure that they have the right staff at the right place with the right skills at the right time, enabling person centred, safe and effective care.

Finally, we would like to thank colleagues across the NHS, who have contributed to the development and revision of this toolkit and commend it to you.

**Dr Colette Ferguson**
Director of Nursing, Midwifery and Allied Health Professions
NHS Education for Scotland

**Ros Moore**
Chief Nursing Officer
CNO Directorate,
Scottish Government
1. Introduction
The *Nursing and Midwifery Workload and Workforce Planning Toolkit* was published in 2008 as a work-based guide to support the workforce planning issues that are relevant to Senior Charge Nurses (SCNs), Senior Charge Midwives (SCMs), Team Leaders (TLs) and others who contribute to nursing and midwifery workforce planning. The toolkit may also be a useful development resource for aspiring SCNs, SCMs and TLs, and a revision or refresher tool for ‘non-clinical’ managers who manage clinical teams. This second edition has been refreshed to reflect current thinking and policy, including a stronger community emphasis. Throughout the document, comments are included from an evaluation of the toolkit conducted by NHS Education for Scotland (NES), a stakeholder event held in September 2011, and feedback from NHS Boards and users, all of which have helped inform and shape this new edition.

Who is the toolkit for?

This toolkit offers SCNs, SCMs, TLs and their managers the opportunity to develop their understanding of workload and workforce planning and help them use workload measurement tools effectively. It provides background information, learning activities and support materials to assist NHS Boards in planning and delivering programmes of learning for nursing and midwifery staff. Such programmes should be tailored to meet the needs of the specific staff group.

Structure of the toolkit

The toolkit has two main sections covering:

1. Measuring workload
2. Workforce planning and staff deployment

Each section contains learning outcomes, key content and learning activities. Ideas for work-based activities are given at the end of each section. Support materials, including case studies, worksheets and handouts, are given in section 4.

How should the toolkit be used?

It is intended as a flexible resource for those who have responsibility for learning and development within NHS organisations, as well as a course handbook for those participating in programmes of learning. The toolkit could also be used as a self-directed learning resource or revision tool.

“As a facilitator this has heightened my own awareness of the tools involved and through participant engagement has enhanced my knowledge within this clinical field, whilst developing new learning that I will be able to disseminate and share with new groups applying the principles gained.”
It is envisaged however, that attending workshops and networking events will be one of the main benefits of participating in a planned programme of learning, as these will provide time and ‘thinking space’ among like minded people and an opportunity to share ideas, experiences and learning.

The various learning and activities will facilitate application of knowledge to clinical practice, and can be selected to suit different levels of practice. Some activities may be undertaken during a workshop and others have been developed for use in the workplace. These can help professional development through reflection on practice. Worksheet 1 (page 80) which can be used to record learning activities and evidence learning, and can help provide evidence for KSF Development Review, Personal Development Planning and revalidation.

Role of SCNs, SCMs and TLs in workload and workforce planning

SCNs, SCMs and TLs have an important contribution to make to workload and workforce planning. A workforce plan can be prepared on many levels, from the simple to the complex. Examples include the staff roster prepared once a month to ensure that all shifts are covered by staff with the correct skills and competences to ensure that patient services are delivered safely, or it could be the NHS Board’s workforce plan which pulls together the workforce needed to deliver the services at a local level.

It may involve day to day decision making, or determining the longer-term requirements for numbers, skill mix and allocation of staff. Decisions about the size and mix of nursing teams are critical areas for SCNs, SCMs and TLs and it is vital that they are armed with appropriate instruments and data to help them plan and implement efficient and effective nursing teams. They also have important contributions to make in areas such as staff recruitment and retention, managing sickness and absence, and annual leave, or more long-term strategic planning. As a leader, the SCN, SCM or TL has an important role in ensuring that new ways of working are achieved, workforce plans implemented and best practice shared and adopted. Another important contribution is in developing the workforce, understanding what skills and competences will be needed to deliver the service, where these skills and competences will come from, and making provision to develop these skills and competences if they are not already available within the current workforce.

Background and context

NHSScotland workforce policy aims to support the development of modernised, high class services with positive outcomes through:

- improved staffing levels matched to patient demand
- better trained and motivated staff
- effective working practices
- reduction in unreasonable workloads
- adoption of safe working hours
- more responsive community-based provision of long-term care and elective services
Workload and workforce planning is about balancing staff demand with its supply, to ensure that numbers of appropriately trained personnel are available, in the right place and at the right time to match the demand for their services. “Workforce planning plays a key role in enabling the health service to work together with its partners to provide services that are both accessible and meet the needs of patients, and also realise efficiencies and improve productivity. With around 70% of the NHSScotland budget allocated to the workforce, the importance of workforce planning to ensuring sustainable services across Scotland cannot be overestimated” (Scottish Government, 2007a).

Nursing and Midwifery Workload and Workforce Planning Project

The Nursing and Midwifery Workload and Workforce Planning Project (SEHD, 2004) was set up in July 2003 and has been introduced at regional and local levels. It offered a systematic, national approach to measuring nursing and midwifery workload. The three main streams of the programme were:

- assessing the need: identifying nursing and midwifery workload and disseminating workforce planning tools.
- planning to meet the need: devising staff education and training initiatives in workload and workforce planning.
- putting the right workforce in place to meet the need: informing and supporting regional and local workload and workforce planning activities to support recruitment and retention.

The project means that for the first time in Scotland, standardised approaches are used to determine nursing and midwifery staffing levels. Nationally agreed workload and workforce planning tools specifically for nursing and midwifery have been developed and piloted. The project recommended a national standard for predictable absence allowance, and protected management time for nurses and midwives who have overall team leadership responsibility to be built into nurse staffing levels. According to Flynn et al (2010), although the programme does not solve all the problems faced by workforce planners, it can provide evidence that informs decisions, workload and workforce changes. The suite of tools that has been developed, evaluated and introduced will help healthcare staff gather this evidence.

Workforce planning in NHSScotland has been developing over the last few years to build both capacity and capability across the organisation. There is now a network of people for whom workforce planning is their main role, but there are many others, such as SCNs, SCMs and TLs, who undertake elements of workforce planning in their day-to-day working. A UK-wide workforce planning competence framework developed by NHS National Workforce Projects (NWP) and Skills for Health (National Workforce projects, 2005) describes three different levels of activity within workforce planning:

1. Strategic management of workforce planning
2. Specialist workforce planners
3. Contributing to workforce planning

The recommendations of the *Nursing and Midwifery Workload and Workforce Planning Project Report* (SEHD, 2004) laid the foundation for the development of a more systematic and standardised approach to nursing and midwifery workload and workforce planning. The report defines clear accountability for delivery and offers scope for key staff to develop their knowledge and understanding to help them use workforce and workload planning tools effectively.
The NHSScotland Healthcare Quality Strategy (SG, 2010a) aims to put quality at the heart of everything we do and the three Quality Ambitions (SG, 2010b), provide the focus for activity to achieve the aim of delivering the best quality health and social care to the people of Scotland. Nurses and midwives will be able to demonstrate the contribution they make to the quality and experience of care that patients receive under the following three themes by March 2013:

- Safe
- Effective
- Person centred

Leading Better Care and Releasing Time to Care

A national review of the role of the SCN, Leading Better Care, was published in May 2008. The report repositioned the SCN as the ‘visible embodiment of clinical leadership’ (SGHD, 2008) and SCNs, SCMs and TLs as the “arbiters and guarantors of patients’ experiences in clinical areas”. Leading Better Care (LBC) is a long term strategic goal and is seen as key to responding to the challenges that we face in a move to the achievement of consistent and reliable standards of fundamental care and practice. Leading Better Care contributes to all three quality ambitions, has a focus on improving safe and effective care, through powerful leadership from SCNs, SCMs and TLs. The Education and Development Framework for Senior Charge Nurses/Midwives and Team Leaders in All Areas of Practice (Second Edition) (NES, 2012), supports the implementation of LBC and provides guidance for the education and development of SCNs, SCMs and TLs. The framework outlines 13 capabilities linked to the four dimensions of the LBC components. This toolkit will help support learning and development for many of these capabilities, and in particular capability 3.3 outlined below.

**Dimension 3: To manage and develop the performance of the team**

**Capability 3:3 Managing the practice setting**

The SCN, SCM or TL implements and maintains effective workload measurement and workforce planning, ensuring compliance by self and others with professional standards, legislation, national and organisational policies, contributing to the management of the ward/department budget.

Releasing Time to Care (RTC) is another national project sponsored by the Scottish Government and has alignment to LBC. It uses LEAN methodology to enable NHS staff to examine clinical systems and processes, and helps them identify ways of improving them. It empowers staff to increase the quality of patient care in line with the Scottish Government’s three Quality Ambitions. To date, implementation of RTC has had many benefits for patients and staff in all clinical settings. In particular, it has helped to empower SCNs, SCMs and TLs with the structure to meet the leadership capabilities expected of them. RTC has particular relevance to this toolkit because SCNs, SCMs and TLs will be able to work with their teams to increase the direct patient-facing time, in order to better meet the needs of patients now and in the future.

...
2. Measuring Workload
Learning Outcomes

✓ Understands the importance of measuring nursing and midwifery workload
✓ Describes the factors that influence nursing and midwifery workload
✓ Determines the most appropriate workload data to collect
✓ Identifies the evidence base for workload measurement tools
✓ Critically analyses the NHSScotland triangulated approach to workload measurement
✓ Interprets workload data and applies to decision-making in own area of practice
✓ Identifies and debates challenges and opportunities relating to workload measurement
Introduction to nursing and midwifery workload

Key Learning Outcomes

- Understands the importance of measuring nursing and midwifery workload
- Describes the factors that influence nursing and midwifery workload

Workload measurement presents opportunities for SCNs, SCMs and TLs. Understanding and using workload measurement will provide you with reliable and evidence-based data and help inform balanced discussion on your staffing needs. Used alongside other data, it can be used to demonstrate how the relationship between staffing levels and workload can alter the quality and cost of care and how the work environment can facilitate or limit these outcomes. It is a vehicle to communicate what nursing and midwifery care is about, particularly to groups with decision-making power and it’s an opportunity to shape discussion about the nature and outcomes of nursing and midwifery.

Workload data provides information to:
- justify human and financial resource levels
- explain utilisation of resources
- justify allocation of resources
- support trend analysis
- support management decisions regarding changing workloads, rostering and budgeting

Nurses and midwives comprise the largest part of the NHSScotland workforce. It is essential therefore that the work they perform is understood. This requires the development of means to identify their specific contribution to patient outcomes, as well as the resources required to affect those outcomes.

Nursing workload and workforce planning is an area that has attracted significant attention in Government policy statements on health services and in formal research activity. Planning Ward Nursing – Legacy or Design (Audit Scotland, 2002) stated that “little is known nationally about how Trusts plan their nursing workloads”. It concluded that decisions about staffing levels were based on traditional practices, rather than current evidence. A follow-up report (Audit Scotland, 2007), indicated that:

- Although work is underway to improve the information available on the nursing workforce, nursing workload and the quality of nursing care, further work is required before this information can become a routine part of workforce planning
- There was still no national system for gathering nursing workforce information at ward level and this has limited the scope for comparisons of the nursing workforce among NHS Boards
- Most boards have not met national recommendations on building additional time into nurse staffing requirements to cover annual leave, sickness absence, study leave, maternity leave and protected time for senior nursing staff with team leadership responsibilities

SCNs have been empowered to challenge with confidence following appropriate data gathering.

Key Learning Outcomes
Nursing workload can be defined as the daily amount and type (direct and indirect) of nursing resources required to care for an individual patient (O’Brien-Pallas and Giovannetti, 1993). Workload measurement is critical to support workforce planning. It helps provide information about how clinical time is used to deliver patient care. For years nurse and midwife managers have relied on their experience and professional judgement to justify decisions or influence the decisions of others.

The workload of SCNs, SCMs and TLs has changed with the new role framework. Workload is no longer just about the direct care of patients, but incorporates indirect and associated care. For many, this involves forward planning to ensure patient flow is maximised and is appropriate. For example the SCN, SCM and TL will know how many elective cases the ward area will receive.

Many hospitals as part of their unscheduled care agenda have systems in place predicting the number of emergency admissions an area may receive on a daily basis.

Managers need timely and appropriate information to make the link between care inputs and patient outcomes to help determine optimum nurse staffing levels (Ball, 2011). There is a need to capture accurate data to describe the work that nurses and midwives do and the relationship between workload and patient outcomes. Such traditional methods have therefore been replaced with a more systematic approach to workload measurement.

According to Bishop (2011), workforce planning must not be ignored. She highlights the need to provide adequate resources and sufficient workforce for an increasing number of elderly people with complex health needs. She asserts that workforce planning must be high on the Government’s agenda to avert the unbearable consequences to patients, services, and the future of nursing. Effective and efficient decision making requires standardised, accurate and timely operational management information. When good workload data is available, managers can effectively plan, deliver, monitor and evaluate the services they provide. ‘You can’t manage what you can’t measure’!

**Learning Activity 1:** Approaches to workload measurement (1)

*Identify the possible challenges to workload measurement and discuss your role in overcoming these challenges.*
Approaches to workload measurement

Key Learning Outcomes

✓ Determines the most appropriate workload data to collect
✓ Identifies the evidence base for workload measurement tools
✓ Critically analyses the NHSScotland triangulated approach to workload measurement

SCNs, SCMs and TLSs, are faced with practical and operational decisions about patient care, for example:

- how many staff do I need?
- what skills are needed to provide effective nursing care?
- what staff should be doing what?
- how do I ensure workload is equitably distributed?
- how many admissions do I have?
- how many discharges do I have?

Much time and effort has been invested in developing and refining methods of estimating the ‘right’ number of nurses and midwives. Although there is no single ‘right’ way to do this, it is important that formulas and systems are in place to ensure that nurses and midwives have control over the determination of staffing numbers and skill mix. Workload tools are a valuable aid to decision-making about staffing. There are a number of different tools available to measure nursing and midwifery workload from ‘top-down’ approaches using norms, or recommended standards to plan nurse staffing, ‘bottom-up’ approaches where staffing levels are calculated using factors known to influence nursing workload, to consensus approaches which rely on intuition, consultation and professional judgement.

Whole time equivalent (WTE) is one way of expressing the overall establishment. One member of staff working 37.5 hours a week is one WTE. WTE is calculated by dividing the number of hours worked by 37.5, (e.g. 20 hours divided by 37.5 = 0.53 WTE). Two members of staff working part-time, e.g. one working 20 hours (0.53 WTE) and the other working 17.5 (0.47 WTE) hours a week is also one WTE.

‘Head count’ which expresses the total number of staff employed, is another, way of expressing the establishment. ‘Head count’ consists of both full and part-time staff, who are classified the same.
Managers at different levels require data at different levels of detail. A manager at ward or community level requires detailed data, e.g. nursing hours per patient, staff level and time of day, to inform staff deployment. NHS Boards require aggregate data (Greenhalgh and Co, 1991). For example they may wish to compare:

- nursing and midwifery workload across specialties
- in the same specialties between hospitals
- for the same case mix type between hospitals
- community workload in different localities

If workload data are to be useful, they need to be appropriately detailed and as accurate as possible. The detail required will depend on how the data will be used. Determining what information is required needs to be a structured process. According to the Royal College of Nursing (RCN), the process of estimating and meeting patients’ needs for nursing care is complex. Key factors in any calculations are:

- the direct care workload in a ward or unit;
- indirect care and associated work;
- the appropriate skill mix to meet patients’ needs; and
- the available budget for nurse and midwifery staffing.

In addition, capacity management needs to be considered, as it may add to the workload. Facilitation of timely admission and discharge is vital to ensure quality of care, not only for those patients already in the system, but for those yet to be admitted/referred.

The quality of these management decisions can be judged in terms of:

- outcomes for patients, both clinical and in terms of satisfaction with nursing care;
- staff outcomes in terms of job satisfaction and satisfaction with standards of care; and
- ‘value for money’.

Learning Activity 2: Approaches to workload measurement (2)

Much nursing and midwifery activity can be described in terms of direct and indirect patient contact:

- **direct workload** - that which is directly associated with a specific patient;
- **indirect workload** - where it may be patient related but either not specifically to a named patient, or not directly involving the patient; and
- **associated work** - where workload is not patient related at all.

Think about your own area of practice and identify activities that are direct, indirect and associated work. You may wish to use worksheet 2 on page 81 for this exercise.
Learning Activity 3: Approaches to workload measurement (3)

Think about an activity on which you have spent more time than you would have liked to.

What constituted wasted time?

How could you minimise the wasted time by looking at the activity critically?

What changes would you now make to ensure the time is maximised for patient and staff benefit?

How could you utilise the modules in Releasing Time to Care to help with this?

Short term pain for long term gain might be something to remember here!
Workload measurement systems

The main nursing and midwifery workload measurement systems described in the literature are as follows:

1. ‘Top-down’ approaches

‘Top-down’ planning of the nursing and midwifery workforce may take various forms. It may be done on the basis of the calculated health needs of a population, or on the basis of historic workforce. Such approaches are concerned primarily with the use of norms, or recommended standards, to plan nurse staffing.

Norms and formulae

‘Top-down’ formulae have been used by Government or by Boards to set standards and global budgets for nurse and midwife staffing in the NHS. In the early days, these calculations were made on the basis of such statistical information as bed use and lengths of stay. These factors however, took no account of the impact of the complexity and intensity of patient workload, local differences in workload or of variations in local practices which might affect workforce requirements. The late 1980s saw the development of methods and approaches, such as measures of patient dependency and demand on nursing and midwifery time that attempted to provide a more accurate reflection of nursing and midwifery workload.

Using expert opinion

There is evidence of a renewed interest in this approach with some specialties and professional associations providing guidance about nurse and midwife staffing levels. Such guidelines are developed using the expertise of different professional disciplines, empirical research evidence and the experience of other countries. They recommend the use of systematic approaches to set establishments which take account of patient dependency, nursing activity and skill mix. Such guidelines are used as a starting point for negotiations between employers, clinicians, managers and patient groups.

Population benchmarking database

Benchmarking databases enable comparison between the budgeted staffing establishments and levels of staff employed in similar organisations. Some of the variables (standards) within the benchmarking databases are performance ratings, skill mix, socioeconomic and demographic factors.
2. ‘Bottom-up’ approaches

Nurses per occupied bed

Using average nurses per occupied bed (NPOB) is another commonly used method of determining or evaluating ward staffing. The method can be used to verify professional judgement method. Calculating the desired number of nurses from the actual number of nurses per patient is one way of setting nurse: patient ratios. The NPOB method is useful if your ward bed complement changes and you need to modify the nursing and midwifery establishment accordingly or in long-stay units, community nursing and midwifery settings, where there is little reliable data on the activity of nurses and midwives. While this is a simple and easy approach, it does not however demonstrate the workload related to the occupied bed.

Dependency-activity-quality (Acuity-quality)

This type of method is especially useful in wards where patient numbers and workload fluctuate. The method is sensitive to changes and fluctuations in workload and also includes a quality measure of nursing care standards. These methods are designed to balance the available nursing and midwifery hours with the required nursing or midwifery hours. The purpose is to match nurse and midwife staffing to the peaks and troughs in activity, i.e. to deploy staff when patients’ needs are greatest. Two sets of measurement are involved:

1 Patient dependency: patients, according to their needs and dependence on nursing and midwifery time, are allocated a dependency rating based upon certain criteria

2 Nursing and midwifery activity: dependency ratings are paired with the nursing and midwifery time spent on patient workload in a dependency group, in order to work out the total amount of nursing time required to meet the demands of all patients in a ward. Activity sampling is undertaken to understand the scope and range of nursing workload and how nursing time is split between clinical and non-clinical workload.

This staffing method overcomes most of the weaknesses in the professional judgement and NPOB methods. It is especially useful where patient numbers and mix fluctuate.

Timed-task/activity approaches

This method is based on the belief that the frequency of nursing interventions required by patients is a good predictor of staffing requirements, because it takes account of all the patient variables that impinge on nursing time. Each patient’s direct nursing/midwifery care needs for the day are recorded on a locally developed checklist of nursing interventions, and each intervention is paired with a locally agreed time required for its completion. An allowance for related indirect care and rest time is added.

Regression-based systems

Regression methods predict the required number of nurses for a given level of activity. The predictor is called the independent variable and the outcome or level of staff is known as the dependent variable. Although the statistical analysis is challenging, once completed, all we need to know is the independent variable to predict the number of staff (dependent variable).
3. **Consensus Approaches**

**Intuitive methods**
These are sometimes referred to as descriptive and professional judgement methods. There are many more sophisticated tools and methods available yet the professional judgement method remains the most common approach in use today. Professional judgement is predominantly a consensus method based on intuition. This is in spite of more sophisticated methodologies being available. The strength of this method is that it is simple and quick to apply, and inexpensive.

**Consultative methods**
The most common or better-known consultative method is the Telford method (Telford, 1979) which has been revised and refined through the years. More recently it was updated to run concurrently alongside the workload tools for implementation as part of the Nursing & Midwifery Workload & Workforce Planning Project. The Telford method utilises the professional views of nurses to determine how many nurses are required to staff a clinical area. There are three main elements to this system:

1. **Numerical assessment stage**
2. **Transportation stage**
3. **Summary stage**

The main criticism is that it is a subjective method which results in inconsistent outcomes. Therefore non-clinical personnel are unconvinced as to the reliability of the method. The Brighton Method (Waite & Hirsch, 1986), which is less well known, was developed to build upon the Telford Method and prove the reliability of professional judgement. This method was intended for application in the longer term in order to provide more accurate and realistic judgements.

“As a facilitator this has heightened my own awareness of the tools involved and through participant engagement has enhanced my knowledge within this clinical field, whilst developing new learning that I will be able to disseminate and share with new groups applying the principles gained.”
Workload measurement tools used in NHSScotland

The Nursing and Midwifery Workforce Planning Project report (SEHD, 2004), recommended that systematic approaches should be applied to measuring nursing and midwifery workload across NHSScotland. A number of national sub-groups were set up under the auspices of an expert advisory group to identify tools that could be used for this purpose. Each group carried out an extensive literature review and consulted with experts to identify suitable tools. These tools were then tested, piloted and evaluated prior to their use in Scotland. In some instances there were few or no tools readily available and work had to start from ‘scratch’ to develop these.

Research studies carried out over the years have shown that while workload and workforce planning tools can offer useful assistance to nurse/midwife managers, there is no ‘perfect tool’ that is going to answer all queries and solve all problems. There are nevertheless advantages in using tools to provide evidence to support proposals for staffing changes. In the Nursing and Midwifery Workforce Planning Project report (SEHD, 2004), professional judgement was identified as the foundation for nursing and midwifery workload and workforce planning. While the value of this subjective approach was acknowledged, the importance of using objective approaches and methods to validate the subsequent findings was noted. In other words we should not rely on any single tool as a stand-alone determinant of staffing requirements.

The report went on to state that a combination of tools should be used, with all services using a nationally agreed professional judgement approach as a minimum. It highlighted that as patient dependency measures offered a means of recording changing patient acuity and associated workload, this type of methodology should be used.

Quality was also identified as being a key part of nursing and midwifery workload and workforce planning. It was therefore accepted in principle that NHSScotland, in line with best evidence, would utilise these approaches as a national standard for workload and workforce planning practice. This principle is often referred to as triangulation. The NHSScotland triangulated approach means that you have three main sets of indicators on which to base your judgements (Figure 1). These are obtained from three sources:

1. Outcome of the specialty specific workload measurement tool
2. Outcome of the Professional Judgement Tool
3. Clinical quality indicator evidence or evidence from local quality dashboards or scorecards

Other helpful indicators to be included in the assessment are the funded establishment (as in the staffing establishment you have a budget for) and actual establishment (this includes the use of supplementary staffing i.e. bank and agency). This information, including skill mix and staff turnover should be available from your line manager.

It is also important to be mindful of the local context. There may be a history of integrated workforce planning in your area. For example, there may be a ward housekeeper or the non-registered nurses may have been through competency based training. Different practice models can have an effect on the numbers of staff required and this would also be part of the local context. It is equally important to be aware of turnover/throughput.
NHS Scotland has implemented a core set of clinical quality measures that focus on continuous improvement. The purpose of these indicators is to support individual nursing and midwifery teams to continually monitor and develop practice. To support the triangulation methodology the clinical quality indicators, once embedded in practice, provide a measure of quality. This will be used in conjunction with your local quality dashboard/scorecard. A summary of the tools currently available is provided below. To meet the requirements of a triangulated approach, each specialty specific tool should be used in conjunction with the professional judgement tool and a quality tool. The WTE outcome of each tool should be mapped into the triangulated approach before decisions around staffing levels are reached. NHS Board data will be collated at local, regional and national level. Regional and national data will be available for benchmarking purposes.

**Professional judgement approach**

- suitable for use in all specialties
- based on subjective judgement of lead nurse for their particular area
- takes account of actual workload during specific period of time
- inclusive of all activity, e.g. planned and unplanned workload, ward attenders and ad hoc activity
- calculates WTE numbers
- numbers and skill mix judgements validated when agreement reached between lead nurse and manager
Acuity-quality approach
- in areas where patient numbers and workload fluctuates
- widely used in inpatient settings
- approach available for use in children’s inpatients settings
- similar type approach used in neonatal settings
- tool comprises three measures: patient dependency, activity and quality
- has two components, bed occupancy and actual patient dependency, either of which will automatically calculate staffing WTE

Timed clinical care activities approach (Similar to timed-task/activity approaches)
- similar approach as timed task/activity approaches
- devised by building up the nursing activities particular to a specialty, e.g. mental health, learning disability, community children’s and specialist nursing
- suitable to be developed for most areas
- the quality component is guided by standards and guidelines for best practice specific to that specialty
- includes a calculator that automatically works out staffing needs based upon workload entered into the system
- has potential to be developed into a multi-professional, multi-disciplinary workload tool

Developed in partnership with Care Services Improvement Partnership West Midlands

Benchmarking database
- developed specifically for use in community settings
- includes population/demographic/staffing data for each health board in Scotland
- comprises a set of variables common to all health boards to enable comparison across Scotland
- provides a set of indicators to initiate further investigation where appropriate
- data is available at community health partnership level
Learning Activity 4: How to access workload measurement tools

Have a look at some of the NMWWPP Workload Tools on the SSTS Platform:

Link onto the SSTS website either by using the link from your Local Intranet or by using the address below:

https://workforce.mhs.scot.nhs.uk/eYou/authentication/login.aspx

- **Login**: user name (will be the same if already registered onto SSTS within the Board, if not this will be supplied by the local SSTS System Manager)
- **Tab**: Password (if required a password will be supplied by the local SSTS System Manager. This must be changed when you first logon)
- You will then be presented with a screen which gives you the option to **Select an application** – **Click** on SSTS
- **Click**: My Account on toolbar at top of page, then **Click**: Change Working Location
- You will then see all of the ward and clinical areas that you have access to. **Scroll down**: if necessary to the ward area that you are going to input the data into.
- **Click**: on to the ward then **Click** Select (you will note that the toolbar heading has changed to the ward you are planning to work on, please check that this information is correct? You will also see that the Workload Tools Box is highlighted)
- **Click**: Workload tools. This will give you a drop down menu of all the tools currently available on the SSTS Platform. If a tool is greyed out it is because you do not have access to that particular tool and you need to contact the local SSTS System Manager if you should

Pick a tool relevant to your area
- practise retrieving relevant data (your facilitator will advise), e.g. average bed occupancy, patient dependency level, time rated activity
Interpreting and applying workload data

**Key Learning Outcomes**
- Interprets workload data and applies to decision-making in own area of practice
- Identifies and debates challenges and opportunities relating to workload measurement

"Managers and staff now have same language to use around workforce planning."

In order for workload measurement to be meaningful we need to:
- understand and assess the tools used
- manage the data to guide effective decision-making
- integrate financial data and
- understand the nurse/midwives role in collecting information

Workload measurement tools are primarily quantitative, but may include qualitative elements within their design. They are designed to provide standardised operational management information for decision-making and planning. They are not necessarily designed to measure quality or patient outcomes. For this reason NHSScotland advocates a triangulated approach which uses a workload measurement tool in conjunction with clinical quality indicator evidence and professional judgement.

**Challenges and opportunities relating to workload measurement**

The success of workload measurement tools is related more to the willingness of decision-makers to use this information for staffing decision-making than the comparative merits of the tools themselves.

There are number of potential challenges to workload measurement including:
- inconsistency in the data being reported
- financial resources issues
- human resource issues, e.g. lack of time to collect and document information
- capability issues

However, workload measurement presents opportunities for nurses and midwives and needs to be implemented to give a voice to the practice of nursing and midwifery. It is a vehicle to communicate what nursing care is about, particularly to groups with decision-making power. It is an opportunity to shape discussion about the nature and outcomes of nursing and midwifery work.

SCNs, SCMs and TLs need to provide leadership in this area helping staff understand how information derived from workload measurement can be used to describe their practice more fully and be actively involved in how workload measurement tools are implemented and used.
A useful framework for considering the core components of workload measurement and application of workload data is described in Allied Health Professions – Workload Measurement and Management (SEHD, 2006b) and adapted from A guide to Service Improvement – Measurement, Analysis Techniques and Solutions (SEHD, 2005b).

- **Activity** - the work done, i.e. the throughput of the system
- **Capacity** - all of the resources required to do the work, including staff and equipment
- **Demand** - all demands for nursing and midwifery care
- **Capability** - the skills and competencies required to carry out the activity

**Activity**
Accurate measurement and recording of activity levels, i.e. the total amount of nursing time required to deliver the service, is the starting point for assessing the capacity required to meet demands on resources.

**Capacity**
Determining the capacity of the service and resource available and then matching this to demand is a core feature of workload measurement. An agreed set of parameters by which to measure capacity is needed as well as patterns of the throughput of the service (SEHD, 2005b). Managing capacity is discussed in the Skill mix (page 36) and Planning and managing staff resources (page 43) sections of this toolkit.

**Demand**
Demographic changes within Scotland are likely to lead to changes in demand for nursing and midwifery services. “People in Scotland are living longer. While this is something to be celebrated, it also presents challenges to health services” (SEHD, 2006a). These changes and their implications for demand are discussed in more detail in the Long-term planning section (page 66).

**Capability**
“It is essential that the capability of the nursing, midwifery and allied health professions (NMAHP) workforce is considered in relation to delivering on the key policy aims of Delivering for Health. The vision of NMAHP services in multi-disciplinary, multi-agency teams, firmly embedded in traditional values of caring and enablement and practising from an education and research base that promotes safe and effective care, must be central to this endeavour” (SEHD, 2006a).

It is important that staff delivering care have appropriate skills and competencies to do so effectively. “In order to meet public expectations of safe and high-quality patient care, nursing education and regulation must aim to develop practitioners who understand and accept their professional accountability for safe and competent practice” (RCN, 2003a). This needs to be considered as part of workload measurement and planning. Capability is discussed in more detail in the Workforce planning and staff deployment sections.

“As a result of using the toolkit, we have revised our nursing establishments for existing ward areas, supporting service change and new developments.”
Establishment setting

Having adequate staff to match workload has the potential for a positive effect both on the working lives of the staff, their performance and the quality of patient care experience (RCN, 2003a; SEHD, 2004; ICN, 2006). Time management, in particular the apparent lack of time available for staff resources to match the demands of clinical activity, has been highlighted as contributing to increased workplace stress and diminished job satisfaction (Hancock and Campbell, 2006). According to Dean and Kendall-Raynor (2010), three quarters of calls to the RCN whistle blowing hotline are about staffing levels and skill mix at hospitals and they suggest that the problem may worsen due to future cuts in nursing staff throughout the NHS. Workload measurement tools have been developed to determine the staffing requirements for specific patients and provide the baseline for determining appropriate staffing levels.

Nursing and midwifery workload data can be used to answer the question faced by managers and administrators 'how many nurses are needed to provide safe and effective care?' Provided that the data are valid and reliable, they can be used effectively by SCNs, SCMs and TLs to predict staffing needs on a short-term basis. When coupled with data from other related systems, it can help predict staffing needs in the future, based on skill mix, case mix, and expected patient activity. It is also important to consider the responsibility for patients who will require the service/care in the future as well as those currently receiving that care. Knowing predicted demand on a daily basis will help SCNs, SCMs and TLs plan accordingly and help ensure that patients are not delayed whilst waiting for access to the service. This will help facilitate the delivery of safe, effective and patient-centred care.

There is no standard formula for ward nurse staffing levels set nationally or internationally (RCN, 2006a) despite extensive research. According to the RCN (2010a), “to make judgements about numbers of staff needed requires insight into the roles and competences of different staff groups, which may vary considerably locally. As well as taking into account ‘who does what’, staffing levels will also be affected by how things are done, in terms of the efficiency and effectiveness of processes used.” They suggest that given the lack of lack of proven reliability or recommendations about which systems to use, and the many different factors that determine staffing needs, triangulation is essential. The key messages are that staffing reviews need to:

- have board level commitment (with nursing director key)
- involve staff and be transparent (decisions not taken in a vacuum)
- use established approaches and apply them consistently
- triangulate (for example, dependency scoring system to gauge workload, professional judgment and quality)
- evaluate regularly (against patient and staffing outcomes data)
- heed the results and implement consistently (no cherry picking)

The issues around the provision of safe staffing and in particular specific nurse-patient ratios have been explored on an international basis with several large-scale primarily US quantitative studies which directly link low nurse-high patient ratios with adverse patient outcomes. The recommendations include the recognition that investing in increasing nursing staff levels to patient’s ratios does reduce patient mortality and reduce the risk of clinical errors.

Mandatory minimum nurse patient ratios have been suggested as being beneficial to all staff, patients and the healthcare organisations (Needleman et al, 2002; Garretson, 2004). A number of studies (Rafferty et al, 2006; Aiken et al, 2001) have highlighted that hospitals with low patient to nurse ratios in the UK had better clinical outcomes for the patients than hospitals with high patient to nurse ratios. Hospitals with high patient to nurse ratios had increased patient mortality and morbidity with associated nurse job dissatisfaction, elevated burnout levels and reports by nursing staff about low standards of nursing/midwifery care and poor staff retention.
The Nursing and Midwifery Council (NMC) has acknowledged that it has not produced national standards for staffing levels as it believed that this should be performed at local level by nurse management and based on local need and activity (NMC, 2003). Each practitioner has a responsibility to raise concerns on any issue, which may compromise safe standards of practice in keeping with the Code of Conduct (NMC, 2008).

The apparent consensus in the literature on nurse/midwife staffing issues is that it appears to be a very complex area where the professional and organisational focus should not simply be on the numbers of staff required but the leadership, management, ward climate and skill mix of staff needed to match the clinical workload involved in each area. Some of these aspects are covered in the latter sections of this toolkit.

Learning Activity 5: Interpreting and applying workload data

- Discuss the process for calculating and setting staffing establishment and skill mix.
- Use the process as discussed and work out one or all of the following:
  
  **Case study 1**: Based on the information provided, work out the optimum number and grade of staff to deliver the service required.

  **Case study 2**: Based on the information provided, work out the staffing establishment and skill mix required.

  **Case study 3**: Based on the information provided, work out the staffing establishment and skill mix required for each ward in the new hospital. Examine the variances and costs between current staffing and proposed. Generate solutions to overcome any shortfall where possible.

- What other information would have been useful in carrying out this exercise?
Work-based activities

We have used a buddy process and improved communication through work-based assignments.

Work-based activity 1: Gathering workload data
Find out the following information for your ward, department or area of work:
- average number of admissions over the previous year
- present funded establishment by band and how this is derived
- weekly admissions and discharges

Work-based activity 2: Using workload measurement tools
Produce a workload measurement analysis of your own ward, department or area of work using the NHSScotland triangulated approach to workload measurement. (See pages 21 - 24). Produce a comparison of your workload measurement analysis to the current reality of your area of work.

Work-based activity 3: Observation of workload
Identify a colleague who you would like to work with and arrange to observe each other’s ward, department or area of work for one hour. Or carry out this activity in your own area. Use worksheet 3 on page 82 to help you record activities. From the activity sheet:
- identify non-added value work
- use this information to create an action plan which aims to shift the balance of work towards direct patient care by implementing a small change in your own work area under each of the following headings:
  - **Activity** - the work done, i.e. the throughput of the system
  - **Capacity** - all of the resources required to do the work, including staff and equipment
  - **Demand** - all demands for nursing and midwifery care
  - **Capability** - the skills and competencies required to carry out the activity

Handout 1 on page 86 provides some tips on developing an action plan. You may also wish to use the action plan template in worksheet 4 on page 83.
3. Workforce Planning and Staff Deployment
Learning Outcomes

✓ Applies knowledge of workload tools in the development and implementation of workload planning

✓ Describes own role in managing change and empowering staff

✓ Reviews skill mix in own area of practice

✓ Analyses appropriate skill mix using an evidence-based approach, giving consideration to:
  - patient-centred, safe and effective care
  - financial constraints

✓ Applies the principles of rostering

✓ Critically analyses own rostering systems and identifies opportunities for change and/or development

✓ Examines the effects of planned and unplanned time out, and identifies methods to monitor and manage effectively. Identifies factors that affect recruitment and retention of staff and plans measures for improvement

✓ Examines own role in performance management and identifies its link to workforce planning

✓ Describes the role of a HR department and how to access relevant employment legislation and local employment/HR policies

✓ Devises strategies for effective partnership working with colleagues, managers and HR department to ensure the needs and rights of staff are considered and protected

✓ Explains how budgets are set and analyses role in managing the budget including when to take remedial action and what options might be available to do so

✓ Examines the wide variety of issues that need to be considered for long-term workforce planning

✓ Demonstrates knowledge of current Government and NHSScotland policy and how to apply this to own area of work and professional development
Introduction to workforce planning and staff deployment

Key Learning Outcomes

- Applies knowledge of workload tools in the development and implementation of workload planning
- Describes own role in managing change and empowering staff

“...We have used the toolkit to review hospital, community and specialist nursing roles and adjusted the establishment accordingly.”

Workforce planning ensures NHSScotland has the right staff in the right place with the right skills at the right time in order to deliver high quality care and services to the people of Scotland (Scottish Government, 2007). It is a term that can be used to describe a number of related activities (NHS National Workforce Projects (NWP):

- designing the future workforce
- developing the future workforce
- delivering the future workforce

Workforce planning is the process for estimating the required health workforce to meet future health service requirements and the development of strategies to meet those requirements (for a balanced workforce). “The successful delivery of healthcare services in Scotland relies critically on the shape and extent of the nursing and midwifery workforce. There is a need for more effective planning of nursing and midwifery workforce development systems within NHSScotland, in partnership with other professional groups.” (SEHD, 2004)

Nursing and midwifery workforce planning has had a recent high profile within government and professional arenas and is a priority for nurse leaders (SEHD, 2002; SEHD, 2004). The NHS in Scotland completed a literature review and service evaluation of nursing and midwifery workload and workforce planning in 2004. It highlighted that current staffing levels were being calculated on NPOB ratios and professional judgement, rather than evidence-based tools.

There is evidence that where organisational structures have enabled senior nurses to be included in planning strategic direction, better outcomes have been achieved from workforce and staff deployment (Carney, 2006; Hewison, 2006). Nursing staff represent the biggest sector of the NHS Scotland workforce (Audit Scotland 2002; SEHD, 2004). Worldwide, nursing staff costs are rising and often represent the most expensive aspect of healthcare budgets making them a focus for cost containment in times of organisational financial concern (Sullivan and Decker, 2005).

“At its simplest, effective workforce planning ensures you will have a workforce of the right size with the right skills and diversity organised in the right way within the budget that you can afford delivering the services you need to provide the best patient care.” (NWP)
The process of developing the nurse workforce has been described as having three main dimensions, all of which are interdependent (RCN, 2003a):

1. **Planning** - designing patterns of staff mixes and utilisation in line with strategic policy goals
2. **Production** - the supply of nurses and midwives including all aspects of nursing and midwifery education
3. **Management** - covers all matters relating to the employment, use and motivation of nursing and midwifery staff and largely determines the productivity and coverage of different nursing and midwifery services and their capacity to retain staff. The management dimension aims to optimise the use of available workforce

Clinical leaders must acquire the skills to plan and manage the nursing workforce effectively in the interests of good quality care and high staff morale (RCN, 2003a). Workforce planning can:

- identify shortages and surpluses and prevent staffing crises
- define (or redefine) workplace organisation, tasks and roles and encourage teamwork between service providers
- contribute to ensuring patient safety by having the right staff skills in place to deliver effective care
- identify drivers of both demand and supply
- establish workforce education and training needs
- provide knowledge and understanding of the workforce and its activities and ensure there is a process for systematically addressing the factors that are influencing workforce and workplace change
- prepare the ground for decision making
- provide options for decision makers
- improve the quality of decisions
- provide for the orderly implementation of activities or resources
- provide a framework for monitoring and evaluating progress towards defined goals

**Learning Activity 6:** Introduction to workforce planning and staff deployment

“At its simplest, effective workforce planning ensures you will have a workforce of the right size with the right skills and diversity organised in the right way within the budget that you can afford delivering the services you need to provide the best patient care.” (National Workforce Projects).

Discuss your role in workforce planning under the following three headings:

1. **Planning** - designing patterns of staff mixes and utilisation in line with strategic policy goals
2. **Production** - the supply of nurses and midwives including all aspects of nursing and midwifery education
3. **Leadership and management** - covers all matters relating to the employment, use, motivation and retention of nursing and midwifery staff, to ensure the coverage of different services. The aim is to optimise the use of available workforce.

Identify situations where you might apply workload measurement data to workforce plan

What skills and competencies are required for effective workforce planning? Use handout 2 on page 87 as a guide.
Workforce planning requires an investment of your time and energy. This could be at times when you are busy doing all the other things that your job demands. However, whether you are planning at a simple or complex level, preparing a plan will help you manage the services you deliver more effectively by helping you prepare for future changes and assist you in preventing crisis management situations." (NWP) According to the RCN, 2010, in order to plan staffing effectively you need good quality data on:

- patient mix (acuity/dependency) and service demands
- current staffing (establishment, staff in post)
- factors that impinge on daily staffing levels (absence, vacancies, turnover)

Workforce planning is not an end in itself. Staff costs are the single biggest cost to the NHS in Scotland and the availability of the right staff at the right time is critical to service delivery (SEHD, 2006c).

According to Trent Health (1991), there are four different phases to workforce management:

1. **Short term** - this relates to ensuring there is sufficient staff to cope with the expected workload, i.e. rostering
2. **Medium term** - this relates to small adjustments as circumstances dictate. It may be that a member of staff is retiring so you are able to re-evaluate your requirements for that pending vacancy, e.g. skill mix
3. **Long term** - this relates to manpower planning whereby decisions are taken in the longer term regarding staffing for a defined area and may necessitate major strategic change
4. **Operational** - this relates to decisions taken about the deployment of staff that are actually on duty to enable the team to cope with immediate workload requirements. Long-term and strategic planning is discussed further in the Long-term planning section of this toolkit.
Skill mix is a relatively broad term which can refer to the mix of staff in the workforce or the demarcation of roles and activities among different categories of staff. Skill mix is concerned with the knowledge and skills that healthcare teams (which in some cases may be multidisciplinary) employ in their day-to-day work to maximise their efficiency and effectiveness. Skill mix may refer to the mix of registered or unregistered staff or “the proportion of different nursing grades, and levels of qualification, expertise and experience (Ayre et al, 2007) Skill mix has been defined as: “the balance between registered and unregistered, and supervisory and operative staff within a service area as well as between staff groups; optimum skill mix is achieved when the desired standard of service is provided, at the minimum cost, which is consistent with the efficient deployment of trained, qualified and supervisory personnel and the maximisation of contributions from all staff members. It will ensure the best possible use of scarce professional skills to maximise the service to clients” (Nessling, 1990).

Because nursing consumes the majority of workforce resources, it is imperative that managers identify staffing/skill mix decisions that will yield the best patient outcomes (Esparza, 2010). Good skill mix contributes to the quality of patient care, patient satisfaction and clinical outcomes (RCN, 2006b).

The apparent consensus in the literature on nurse/midwife staffing issues is that it appears to be a very complex area where the professional and organisational focus should not simply be on the numbers of staff required but the leadership, management, ward climate and skill mix of staff needed to match the clinical workload involved in each area. It is vital to have the expertise required to provide quality. Skill mix estimation therefore includes the competency of staff matched to the care needs of patients.

Skill mix can be a sensitive issue depending on the ‘interest group’ or level of staff concerned (Greenhalgh and Co, 1991). SCNs, SCMs and TLs, for example, may see a skill mix review as a threat to their budget or to quality of care. There may be concerns that less expensive bands of staff will be imposed regardless of the effect on patient care. However a review of skill mix can also be seen as an opportunity to maximise the effectiveness of the budget and/or enhance the quality of care.

Skill mix should describe the whole range of grades or skills employed or deployed. The differences may be due to learning and development or could simply be differences intrinsic to an individual. There is no such thing as an ‘optimum’ skill mix and it has never been policy in the UK to lay down norms for skill mix at ward level. Instead, it advised that these should be determined ‘systematically’ in relation to the dependency of patients and the objectives or wards or units in each specialty – in other words, a ‘bottom-up’ approach. It is good management practice to undertake periodic reviews of staffing and skill mix. Decisions should be informed by detailed knowledge about a particular ward or department and, once made, should be monitored for their impact on patient and staff outcomes. Local decisions about nursing skill mix should be based upon agreement within the profession, and between the profession and employers, about different nursing roles and levels of practice (RCN, 2003a).
According to Robinson and Griffiths et al (2009), debate continues about the hierarchy of skilled roles in the nursing workforce. For example, should there be grades of qualified nurses other than registered nurses and to what extent should the nursing workforce comprise staff who are not qualified as nurses? Such questions raise critical issues about how different configurations of staff affect patient care outcomes and whether judgments can be made about their cost effectiveness. The projected cuts to the workforce in the next few years are potentially heavily reliant on turnover of staff, with employers seeking opportunities to review posts as staff leave. It is anticipated that reduced natural turnover in the next few years leaves less flexibility to achieve future reductions in posts, and other measures, such as skill mix changes, will now presumably have a more dominant role. The Workforce Plans for 2010/11 from many NHS Boards clearly show plans for a shifting change between registered and non-registered nursing and midwifery staff (RCN, 2010 b).

**Reviewing and determining skill mix**

The following questions are important when considering skill mix for your ward/department:

- what type of work needs to be carried out?
- how many staff do we need?
- what level of skill do we need?
- could another (less skilled) member of staff do this activity?
- should a non-registered member of staff be given responsibility for this activity – would a registered nurse/midwife be more appropriate?
- are staff with such skills available?
- can quality of care be maintained?
- what are the budgetary constraints?

**Learning Activity 7: Skill mix (1)**

Some professional bodies/organisations make specific recommendations about the skill mixes of registered versus non-registered staff.

Discuss the advantages and disadvantages of such recommendations.

Discuss and explore how you would use such recommendations.

Skill mix can be planned over four overlapping timeframes:

1. operationally – the mix of staff actually deployed on duty
2. short term – the plan for the mix of skills to be utilised on the roster
3. medium term – the plan to make adjustments to an establishment’s skill mix to reflect changing priorities, changing case mix or changing workload
4. long term – the strategic plan of the numbers of staff and skills required
Buchan and O’May (2000), describe four stages in the skill mix cycle:

1. **Evaluating the Problem**
   Firstly, there is a need to define the current services in terms of activities, staffing configuration etc. In order to be sure of the direction of change, you need to be clear about your starting point. You also need to be able to evaluate the effects of changing skill mix, and this requires baseline indicators. Secondly, the ‘problems’ that may be solved by skill mix changes need to be assessed. Can these problems be solved, and is skill mix the best solution?

2. **Assessing Span of Control**
   An approach to skill mix may be the ideal solution, but it may not be achievable in practice, because of contextual constraints. You must assess your span of control, to identify the best achievable solutions. In assessing your span of control consider the following:
   - what are the financial, resource, legislative and regulatory constraints arising from the context in which your organisation is operating?
   - how do these constraints limit your span of control in implementing skill mix changes and other staffing solutions?
   - which staff groups and work areas do you have responsibility for, and in which of these do you believe there is the potential to implement skill mix changes and/or other solutions?
   - what changes can you actually make, in practice:
     - change mix of posts?
     - change staff deployment across units/areas?
     - change roles of current individual staff or staff groups?
     - change mix by introducing new roles/staff groups?
   - where can you exert most influence; where are the ‘levers’ for change?

3. **What resources do you have available?**
   Before choosing an approach to skill mix, you must assess the resources that you have available to support implementation and evaluation. Different approaches require different levels and types of resources, in terms of staff time, skills and training, information technology, data generation and analysis, technical support, and management resources.

4. **Implementation**
   Selection and implementation of an approach to skill mix will be influenced by the time horizon for change and the desired coverage of the exercise:
   - will it cover one unit, or a whole organisation?
   - will it cover one staff group, or many?
   - what is the likely level of consumer acceptance?
   - what are the power relationships between different stakeholders in the proposed change?

Figure 2 illustrates the four stages in the cycle. A skill mix exercise should not be regarded as a ‘one off’ isolated event; there should be a regular process of evaluation to monitor impact.
Learning Activity 8: Skill mix (2)

What is your span of control in implementing skill mix changes and other staffing solutions?

Consider the data from your use of the professional judgement tool to answer the following questions:

- what can you change?
- what can’t you change?
- who can you influence?
- who does it have an influence on?

Figure 2: The skill mix cycle

- Evaluating the need for change (define the problem)
- Identifying the opportunities for change (span of control)
- Making change happen (identify and implement solution)
- Planning for change (assess resources)
Learning Activity 9: Skill mix (3)

You have just taken over the general management of a hotel. The hotel has not had an overall manager in post for some time and is in need of a review and overhaul. The profit needs to improve, but it is popular with good occupancy rates but needs to rationalise and review the services it offers. Your aim is to maintain or even better enhance the quality of services to your guests, increase income and if possible reduce operating costs. The hotel has 50 rooms, a bar and restaurant. You currently have a range of staff who work a variety of hours, over 7 days per week:

- 4 receptionists (Band 3)
- 2 duty managers (Band 6)
- 2 office/clerical staff (Band 3)
- 2 accounts assistants (Band 4)
- 6 chefs (fully qualified) (Band 4)
- 3 catering assistants (Band 2)
- 8 cleaners (Band 2)
- 6 porters (Band 2)

Other workers are available to you e.g. variety of catering staff, domestic supervisors.

Your salary is a percentage of the profit and you want to increase your income but want to ensure the business operates well in your absence as you want to spend quality time with your family, not to work long unsocial hours. Currently the hotel charge £90 per night for B&B. Your occupancy rate is 70%.

Task 1

In your group brainstorm the key functions and services which you need to offer in your hotel to meet your guest’s needs. Think about the whole experience for your guests from when they first choose to book with you to when they check out at the end of their stay. Consider which functions are essential to running the business and which are optional? Give a rationale for your choice based on your analysis of your customer needs (this is for you to vision in your group).

Task 2

Based on your analysis, plan your workforce needs to deliver the services you feel are essential to meet your guest’s needs but also help to turn over an improved profit in the business. Consider:

- how many staff you will need
- what skills these staff will need and use your knowledge of the AFC bands to map these staff into salary bands how the staff will be deployed e.g. shift patterns etc.
- are your staffing plans affordable, flexible and are the skills you need available?
Task 3
Consider how you would manage change in the team. What would you do and when? What information would you plan to present to the hotel chain’s regional manager to support your business case for change? Summarise your plan as follows:

- which functions and services did you feel were critical and which were optional - what influenced your choice?
- what issues did you consider in your decisions about planning the workforce in the hotel?
- What is your final skill mix in your team?
- how do you plan to manage the change?
- are there any learning points from this activity which you could apply in your own team in the NHS?
- what factors may inhibit your freedom on thinking in the NHS which is not apparent in this abstract exercise?

Adapted from Skills Maximisation Toolkit, available at

www.nes.scot.nhs.uk/media/6326/skills_maximisation_toolkit_facilitators_guide.pdf

New and enhanced roles
Nursing is changing almost as rapidly as the context in which it is practised. As a dynamic profession, nursing is responsive and is adapting to meet the needs of patients and the public. Nurses have taken on new roles, work across boundaries, and are setting up new services to meet patients’ needs. Modernising Nursing Careers (SE, 2006) set the direction for modernising nursing careers across the United Kingdom. By taking on new and enhanced roles and responsibilities, nursing has been instrumental in delivering the improvements in patient care in recent years. Nurses have already played a vital part in reducing waiting times, making services more accessible and improving the quality of care. Currently, the development of roles may take a variety of forms (SEHD, 2004b):

- roles change as professionals expand existing roles. This often means that other staff are required to take on some aspects of a previous role, for example, as registered nurses expand their role, healthcare assistants often take on elements of basic care which were previously part of the registered nurse’s role
- healthcare professionals may develop new roles which are designed to fit within their scope of practice, for example, new clinical nurse specialist roles and emergency nurse practitioner roles. Such roles are an extension of professional practice for an individual group, although in some circumstances another professional group may feel that the role is equally appropriate for them. A partnership approach to developments will be vital in such circumstances
- completely new roles may be developed which do not fit existing professional boundaries, e.g. healthcare support staff who work between nursing, physiotherapy and occupational therapy. These roles can be filled by existing healthcare staff or by staff new to the health service with appropriate training and education

Whatever type of development is utilised, it requires the adoption of a structured approach. “The national strategy for nursing and midwifery, Caring for Scotland (SEHD, 2001a), reflects how nurses and midwives are developing new roles and services to meet patient and public needs. Nurse and midwife consultant, public health practitioner and family health nursing roles (SEHD, 2001b) are examples of the kinds of developments that are extending nursing and midwifery practice and offering new challenges and opportunities for practitioners.” (SEHD, 2004)
The Framework for Developing Nursing Roles Consultation (SEHD, 2004b) states that “The distinction between role development and role expansion should no longer be a key issue for the profession. The critical issue is ensuring the delivery of high quality care and safe practice for patients and communities which reflect health needs. The expansion and development of professional practice and skills should be focused on the needs of the patient and the community based on sound evidence, to enhance clinical credibility and the exercise of professional autonomy.”

Role development for example, assistant practitioner and health care support worker roles, can be valuable within the nursing team, supporting the delivery of quality care outcomes for patients. They also add to career development opportunities and a wider career framework.

**Learning Activity 10: New and enhanced roles**

Think about what registered nurses and midwives currently do and consider:

- what they should do
- what they can do
- what they must do

Choose a new or expanded role that may be introduced in your area of work, or use case study 4, 5 or 6 on page 77, and carry out a SWOT analysis. See handout 3 for information on SWOT analysis. Discuss your role in ensuring ‘buy-in’ and acceptance from other staff and ensuring the new role meets the needs of patients and adds value to your team.
Planning and managing staff resources

**Key Learning Outcomes**

- Applies the principles of rostering
- Critically analyses own rostering systems and identifies opportunities for change and/or development
- Describes own role in managing change and empowering staff
- Examines the effects of planned and unplanned time out, and identifies methods to monitor and manage effectively

---

**Rostering**

A roster for nursing and midwifery staff is a plan showing on and off duty periods for staff within a defined area such as a ward or community locality. Rostering is about matching staff to workload need and the plan should therefore reflect the peaks and troughs of expected workload, ensuring staff are available at the times they are required (Greenhalgh and Co, 1991). Rostering and shift patterns are an extremely significant aspect of managing any team or department (Walker et al, 2006). According to Wells (2007) “managing the ‘off duty’ can be one of the most stressful and time consuming tasks that a ward leader has to do.” It is also one of the most important management functions performed by nurse managers.

Rostering affects:

- patient care
- budgets
- the welfare of staff

Rostering requires critical thinking and good decision-making skills to deliver a roster that effectively balances patient care, and employee and organisational needs. It requires skills in:

- planning
- delegation
- knowledge of patient care
- collaboration

Achieving the right number of staff and skill mix at the right times is vital to the smooth and safe running of a ward or department. It is fundamental to achieving a balance between the supply of nursing and midwifery resources, and service demand.
Principles of rostering

There are a number of different methods of rostering:

- self-rostering
- rotational rostering
- electronic rostering – a number of software packages are currently available and a national approach is being considered

Whatever method is used however, the following principles should apply:

- The SCN, SCM or TL has responsibility for the off duty. This can be and should be delegated to junior staff as a learning opportunity but still remains the responsibility of the SCN, SCM or TL
- the rota should be available to staff at least four weeks in advance and modified to take into account unexpected events
- methods of rostering and shift patterns should be reviewed regularly
- the rota should be kept as a legal document as it shows who was working when
- rota and shift patterns should reflect European Work Time Directives which should be incorporated into hospital policies

Rostering should be supported by clear protocols to guide decision-making. Such protocols should include rules about:

- skill levels
- staffing numbers
- procedures to be followed in the event of unplanned absences
- procedures for the use of supplementary staff
- procedures for making requests
- procedures for planning annual/parental or study leave
- maintenance records
- audit requirements
- length of shifts
- time off in lieu

The requirement of rostering is, according to Greenhalgh and Co (1991), to ensure that you have:

- the right skills,
- in the right place,
- at the right time,
- at the right cost and:
- ensure that nursing care can be provided to an agreed standard.
Learning Activity 11: Rostering methods

Describe how the roster is done in your work area. Identify:

- at least one advantage
- at least one disadvantage
- one element you would like to see change

Compare rostering styles with group members

List the protocols that are available in your area to assist with roster management

Do we need to modernise our rostering practices?

Several national and international authors and researchers have recommended that by improving the shift allocation of nursing staff, this may improve their daily working lives with the potential associated benefits of improved job satisfaction, reduced sickness absence and more effective recruitment and retention of staff (Pryce et al, 2006; RCN, 2006a).

The Office for Health Management (2003) suggests there are a number of reasons why we need to modernise and change rostering practices:

Social Change:
- society demands greater efficiency
- increased patient choice in the healthcare system
- public more informed

Political and Professional Change: Any new policies?
- Nursing and Midwifery Workload and Workforce Planning Project (SEHD, 2004)
- Planning Ward Nursing – Legacy or Design? (Audit Scotland, 2002)
- Delivering Care, Enabling Health (SEHD, 2006a)
- Better Health, Better Care: Planning Tomorrows Workforce Today (Scottish Government, 2007a)
- Better Health, Better Care: Action Plan (Scottish Government, 2007b)
- Visible, Accessible and Integrated Care: Report on the Review of Nursing in the Community in Scotland (SEHD, 2006d)
- Leading Better Care (Scottish Government, 2008)

Workforce change:
- staff want greater flexibility
- improved working conditions
- greater involvement in decisions which affect them
- ‘work/life balance’ is becoming more important
Technological Change:
- IT gives opportunity to modernise;
- development of electronic staff records
- time and attendance systems
- electronic rostering and patient acuity systems

Organisational Change:
- SCN, SCMs and TLs to become more strategic
- drive for greater empowerment of workforce
- need to proceed on a partnership basis

Learning Activity 12: Should we change our rostering practices?
Discuss the need to change/modernise rostering practices using the following points to guide your discussion:
- there are powerful driving forces in society for greater efficiency and patient choice in the provision of healthcare
- professional and political issues have a direct impact on how we allocate staff to patient care responsibilities
- better patient care must be the main driver in modernising staff rostering
- there are changing demands from the workforce for greater flexibility and improved working conditions. The need for ‘work/life balance’ means a matching of the ratio of working time with leisure time and a recognition that working patterns need to vary depending on differing life-stages. Rostering needs to have serious and meaningful input from the staff involved to enhance their control over their working hours in order for them to ‘own’ the system
- with these changing pressures on both managers and staff it is imperative that change is undertaken on a partnership basis
- resistance to such change is likely to be met at all levels – among both staff and management
- development of information technology now offers new opportunities to modernise rostering and to integrate it with computerised time and attendance, payroll and personnel systems

Adapted from Office for Health Management (2003)
Building an effective roster

Flexible working can have positive benefits for staff including addressing individual preferences for shift systems, achieving a more balanced work-life balance, increase job commitment and satisfaction and improve attendance and performance (RCN, 2004a; SEHD, 2004a; RCN, 2006a; RCN, 2006b). By improving the way NHS employees are managed through better rostering, greater value can be released from all resources so that better care is provided to patients. Efficient rostering should aim to deliver increased productivity by helping managers control resources effectively to meet patient demand. The principles of accountability in rostering according to the Office for Health Management (2003) are:

- patient and service needs come first
- involve staff as much as possible
- consider staff competence
- be fair and flexible
- agreeing for one person sets a precedent – think twice
- communicate verbally and in writing
- then communicate again!

The following framework for building an effective roster is adapted from Queensland Health (2003):

1. Matching demand with an appropriate supply of nurses

To roster an appropriate number of staff you will need to be aware of:

- the number of WTEs for your ward/department
- the breakdown of WTEs available in the productive (both direct and indirect and associated work) and non-productive categories for your ward/department. This includes matching daily capacity and demand, including capacity for patients being admitted and discharged, and planned and unscheduled care. Ward establishments should have a minimum predicted absence allowance of 22.5% built into the ward staffing budget for annual leave, sickness absence, other types of leave and training and development (SEHD, 2004a). Leave entitlement can be:
  - planned, e.g. annual leave, parental leave, study leave, special leave
  - unplanned, e.g. sick leave, compassionate leave

2. Allocating a unit’s budgeted WTE

The budgeted productive and non-productive WTEs and knowledge of the peaks and troughs of service demand form the basis for building a roster. The following steps allow you to allocate a ward/department’s budgeted WTE:

**Step 1:** Determine the productive nursing hours (WTEs) required to meet the service demand (direct, indirect and associated work).

**Step 2:** Calculate the non productive nursing hours required (planned and unplanned leave). Planned annual leave can then be allocated and spread evenly throughout the year. Note this may fluctuate according to seasonal demand.

**Step 3:** The remaining portion of the budgeted WTE is now available to manage organisational requirements, unpredictable fluctuations in workload demand (e.g. high dependency patients) and unplanned leave replacements. NB: Be aware of seasonal demand on the capacity of the bank to deliver.
3. Determining and allocating a suitable mix of competency and experience

Matching demand for staffing (defined in terms of nursing and midwifery hours) with an appropriate supply of nurses and midwives is a critical phase of the rostering process. Before determining the skill mix requirements for each period in the day, it is necessary to determine the numbers and skill mix of staff required to meet workload ‘peaks and troughs’. An assessment must be made of the skills of staff required and a demand determined for each skill group for each 24 hour period. This will give you the direct care hours required. The indirect hours as previously described must be factored in. This will give the total productive hours available as the basis of the roster.

Self-rostering

The process of self-rostering involves the preparation of a roster, which has identified within it any pre-planned leave and all vacant shifts. Staff may choose their roster in a spirit of mutual co-operation and negotiation. For self-rostering to be successful, consensus must be reached on ‘ground-rules’ or roster guidelines, and these must be clearly spelt out. It may also be helpful to provide staff with a template to display available shifts. The SCN, SCM or TL should advise staff when this must be completed, and on completion will check to ensure that shift coverage meets all the requirements within the guidelines.

Advantages of self-rostering:
- staff control the process
- staff become more accountable
- maximises flexibility
- good way to build co-operation, negotiation and teamwork

Disadvantages of self-rostering:
- requires SCNs, SCMs AND TLs to delegate and trust staff
- SCNs, SCMs and TLs will still have ultimate accountability
- requires preparation and development of staff

Managing changes in rostering

Managers who compile staff rosters often worry that if they make changes they will find themselves in breach of legal requirements or staff rights. Staff who do not like having their rosters changed will sometimes simply say ‘You can’t do that!’ Managers need to be clear about what they can and cannot do. The first priority must be safe, effective and person-centred care, not simply staff satisfaction. HR issues relating to rostering and other staff management issues are discussed in the Working in partnership with your HR department section of this toolkit.

Change can affect people in different ways but by managing change effectively the stress and anxiety to individuals can be minimised. Staff participation and ownership of the change process is essential in order to overcome resistance, and to foster an organisational culture committed to work practice reforms.

Learning Activity 13: Managing changes and staff issues

Select one of the scenarios from handout 4 on page 90 for discussion and explore the following:
- if you were in this situation what different actions could you take?
- is there a particular solution that you would favour?
- once you implement the preferred solution what do you think will happen?
- what would be your actions to manage the responses in relation to the situation?
Planned and unplanned time out
Planned time out includes annual leave, study leave, maternity leave and time in lieu. To some extent, and with the absence of maternity leave, planned absences can be estimated with reasonable accuracy but need to be planned evenly throughout the year (1 April to 31 March). Neither supplementary staffing nor overtime should be used to cover planned leave. In contrast, it is difficult to accurately estimate the level of unplanned absence, or absenteeism. It is recommended that ward nurse staffing establishments have a minimum predicted absence allowance of 22.5%. Proportions of this have been defined to support systematic management of maternity leave, sick leave, study leave, parental leave and annual leave.

Unplanned absences through employee sickness disrupt service provision and increases costs of providing services. In addition, patterns of sickness absence may indicate that there are aspects of the working environment that require management attention (Audit Scotland, 2001).

“Successful strategies to reduce sickness rely heavily on the manager’s belief that the problem can be, at least partly, solved. The most common approaches to managing sickness include return to work interviews, setting trigger points and keeping records.” (Wells, 2007).

Learning Activity 14: Planned and unplanned time out
Read case study 7 on page 78.

Choose two wards and work out the target leave using the indicative guide

From your findings give a full account of the potential impact on ward staffing and budgets. Include the impact of predicted and non predicted absence, taking into account the impact of:

- annual leave inconsistency
- sickness rates and management of sickness absence
- maternity leave and if it could be managed differently.

Include your analyses of budgets (both funded and actual) and bank usage implications.

“As a result of using the toolkit, our system for allocating annual leave has been reviewed and redesigned in order to ensure that it is evenly spread throughout the year, thereby reducing stress on our manpower numbers at certain times of the year.”
**Use of supplementary staff**

Audit Scotland produced a comprehensive report on planning ward nursing in 2002. It reviewed all aspects of planning ward staffing and identified the complexity of determining staffing levels in absence of unexplained wide variation of both the costs, skill mix and staffing numbers across NHS Scotland. The need to reduce spending on temporary staff, improve staff information on ward staffing issues and perform more effective nursing workforce planning have been identified as areas which required professional and organisational action to improve the status quo (Audit Scotland, 2002).

The Nationally Co-ordinated Nurse Bank Arrangement: Report and Action Plan (SEHD, 2005c) analysed the pattern of usage of bank nurses in NHSScotland at that time. One of the recommendations of the report was that NHS boards set targets on an annual basis to reduce the proportion of complementary staff utilised from agency as a percentage of the total nurse staff deployment.

The report also recommended that NHS Boards ensure policies and procedures are in place to approve the use of non-contracted agency staff at senior level and ensure ongoing scrutiny is applied, to ensure value for money. While the report found much to be admired in the way supplementary staffing was being handled within the NHS, it also highlighted areas in which a different approach would provide better standards of care for service users and better value for money for the service.

As a result the Scottish Government Nursing and Midwifery Workload and Workforce Planning Project: A Good Practice Guide in the Use of Supplementary Staffing (Scottish Government, 2007c) was developed by nurse bank managers across Scotland for frontline staff and managers. It is a practical guide that will help SCNs, SCMs AND TLs review and improve their role and responsibilities in the management of nurse staffing. It highlights the organisational policies and responsibilities of those who manage the nurse/midwife staffing resource through, for example, staff rostering, use of workload tools, managing sickness and absence and annual leave, providing both the rationale and a means of assessing the ward, care setting or organisational position. It has three main sections:

- the bigger picture
- getting the best from the nurse bank
- getting the best from the bank nurse

**Use of bank staff in non-hospital environments**

The use of supplementary staffing occurs in all areas of healthcare including non-hospital environments: community nursing, school nursing and prison health centres are examples demonstrating the diversity of requirements. Although regularly seen, the appropriate use of bank in these environments presents some unique challenges. Non-hospital environments are more likely to need bank staff with a specific skill set or to complete a specialised local induction process, which reduces the pool of bank staff immediately available to them.

Optimising the use of supplementary staffing in these areas requires local managers to work closely with bank management teams, as well as some additional forward planning. Building strong links with bank managers ensures the bank is fully aware, in advance, of specific skill sets or induction required and of any relevant policies specific to that area. It also creates a mechanism by which the bank can be alerted to any anticipated increases in demand due to forthcoming vacancies or maternity leave, at the earliest opportunity and can maximise the staff resource available in good time. The predicted absence allowance, as described in the previous section, is not always applied to non 24/7 services. As team numbers are often smaller in such areas, managing predicted absences within the existing establishment becomes more difficult. As teams may be more isolated, opportunities to share the staffing resource across a Board may be a less practical option. Therefore, establishing and maintaining a group of skilled individuals available for supplementary work can offer a flexible solution.
Learning Activity 15: Effective rostering and use of supplementary staff

Critically review rosters and the actual/potential patterns of supplementary staff use:

- was the best use made of available resources? If not, what changes would have improved the utilisation?
- was best value for money achieved? If not, what alternative solutions could have been deployed?
People management

SCNs, SCMs and TLs are increasingly being expected to take greater responsibility for the personnel aspects of their work. Audit Scotland (2001) describes five inter-related aspects of good practice in managing people (Figure 3).

**Figure 3: Aspects of good practice in managing people**

1. Developing a partnership culture
2. Assessing staffing needs for service delivery
3. Retraining and recruiting the people we need
4. Managing the performance of our people
5. Improving the performance of our people

Working in partnership is one of the key principles of Delivering for Health (SEHD, 2005a). The Health Plan Our National Health - a plan for action, a plan for change (SEHD, 2000) makes it clear that the NHSScotland is committed to building a modernisation programme to provide high quality patient care and improving the working lives of all NHS staff. The Health Plan builds on the HR strategy Towards a New Way of Working (SEHD, 1998) which seeks to achieve change through substantive partnerships with staff, managers, trade unions, patients and other relevant organisations at national
and local levels. The working in partnership with your HR department and Nursing budgets/financial management sections of this toolkit highlight some important partnerships for the SCNs, SCMs and TLSs.

The previous sections of this toolkit have covered relevant aspects of determining the staff required for service delivery. SCNs, SCMs and TLSs should have a view of the key people issues they are likely to face in the short and longer terms. This might involve the numbers and skills of employees necessary as well as how the organisation will respond to national issues, such as health and safety legislation or requirements.

**Retaining and recruiting the people we need**

**Recruitment**

Effective management of recruitment and the retention of staff are necessary to create stable teams who are committed to best quality of care. Strategic workforce plans must be made to address the potential effects of a nursing and midwifery shortage caused by the increased numbers of nurses approaching retirement which are not being matched by new young recruits (Buchan 2000; Buchan 2002).

The evidence regarding shortages in nursing supply and demand have been reviewed on a national and international basis and common factors identified. These included the difficulty in both identifying the causes and the cyclical nature of perceived nurse shortages and the need for further research on the link between pay, job satisfaction and other working environment issues (Buchan and Aitkin, 2008; RCN, 2003; Janiszewski Goodin, 2003; West and Staniszewska, 2004).

According to the National Workforce Plan (SEHD, 2006c) demand for nurses and midwives in Scotland continues to grow:

- there has been a sharp rise in demand for non-registered staff
- more care will be provided by non-medical staff leading to a greater investment in new roles such as advanced nurse practitioner and assistant practitioner roles
- the numbers of pre-registration nursing and midwifery students in training are at an all time high
- the non-registered workforce shows an ageing workforce
- NHS Boards are beginning to reduce the long term vacancies for nurses and midwives in Scotland

The purpose of the recruitment and selection process is to enable you to choose the person who will contribute the most to your team, both in the present and in the future (Wells, 2007). It is important that you work within your organisations’ policies and your HR team. If you want to attract the best staff you need to consider what your ward or department has to offer. The recruitment and selection of employees contributes to a wider Board strategy which should, in turn, be driven by the organisation’s overall goals. Recruitment should be guided by a strategy which seeks to meet the present and future people needs of the organisation and should be properly integrated with other key aspects of people management including:

- planning the number and type of people needed
- training and development
- competence and skills assessment
- performance review and management reward strategy (Audit Scotland, 2001)
When a vacancy occurs it is good management practice to review the post. Consideration should be given to the following factors.

- do we really need to fill the vacancy?
- do we need to recruit to the same grade or the same number of hours?
- has the job changed or have changing work patterns created a different job?
- is this an opportunity to review the structure of the department?
- are there re-deployment/ill health issues?
- can existing staff be re-deployed to increase their knowledge of the work carried out in the department and their potential?
- are there any other vacancies in other departments which can link with this vacancy?
- are there any anticipated changes which will require different, additional or lesser skills?
- is this post suitable for job sharing or where the duties of a job can be split?
- have the revenue consequences been identified?
- does the post have any training requirements?
- is this a new post?
- has the funding been agreed?
- what kind of person do we need to fill the post?

The basic stages of recruitment are:

- agreeing the vacancy
- preparing a job description
- preparing a person specification
- attracting applicants
- selection
- induction

**Learning Activity 16: Recruitment**

Identify an example of a vacant post and review the post by considering the following questions:

- do you need to recruit to the same band or the same number of hours?
- has the job changed or have changing work patterns created a different job?
- can existing staff be re-deployed to increase their knowledge of the work carried out in the department and their potential?
- are there any anticipated changes which will require different, additional or lesser skills?
- what kind of person do you need to fill the post?
Staff retention

A moderate level of turnover can be beneficial as it can lead to the introduction of different experiences, ideas and approaches to service delivery as new employees join the organisation (Audit Scotland, 2001). In order to examine turnover it will be necessary to use comparative data, e.g. from another department, organisation or Board. Only by using comparative data will you know if a perceived problem at one location is more or less of a problem than somewhere else. If such trends are not currently available you should consider establishing routine data collection and analysis systems. You should consider monitoring trends in turnover by grade/ function. The formula for calculating turnover is:

\[
\frac{\text{number of leavers}}{\text{number of staff working}} = \text{staff turnover rate}
\]

Your HR department should be able to provide you with this information. Where such turnover is felt to be excessive or causing particular problems you should review appropriate actions based on an understanding of the key factors affecting turnover. It is equally important that the impact of any actions is also monitored as part of the performance review process. According to Audit Scotland (2001) the key parts of this process are:

- assessing the situation
- planning what actions to take
- acting upon those plans then checking that the actions have had the desired effect.

Studies into why nurses leave their roles show the reasons to be (Wells, 2007):

- a poor working environment
- low pay
- stress
- understaffing
- high acuity patients
- number of hours worked

Nurses who stay in their jobs give the following reasons:

- job satisfaction
- a positive environment
- recognition
- flexibility

Learning Activity 17: Staff retention

Discuss current issues related to staff retention in your area of work.
Managing performance

A key question for every organisation is ‘How can we get the best from our people?’ In NHS Boards this question is critical because the core business is people delivering services. Armstrong and Baron (2004) define performance management as “a process which contributes to the effective management of individuals and teams in order to achieve high levels of organisational performance. As such, it establishes shared understanding about what is to be achieved and an approach to leading and developing people which will ensure that it is achieved.”

At its best, performance management is a tool to ensure that managers manage effectively and that they ensure the people or teams they manage:

- know and understand what is expected of them
- have the skills and ability to deliver on these expectations
- are supported by the organisation to develop the capacity to meet these expectations
- are given feedback on their performance
- have the opportunity to discuss and contribute to individual and team aims and objectives

(Chartered Institute of Personnel and Development)

Establishing a process for managing people is essential to ensure that people can contribute effectively to the delivery of services and the achievement of the trust’s goals (Audit Scotland, 2001). There will be formal and informal performance management systems operating in your organisation and you need to be familiar with them. The key elements of managing people performance involve:

- setting objectives
- assessing development needs
- making it happen
- review
- doing better

“Performance management is not a ‘quick fix’ which can overcome all the problems of reduced resources. However, by focusing on key aims and improving staff productivity authorities can manage and protect services more effectively.” (Audit Commission, 1997)

Detailed coverage of performance management is outwith the scope of this toolkit. However, an important element of performance management is employee development, a vital part of workforce planning.

Learning Activity 18: Managing performance

Discuss your role in performance management and its relationship to workforce planning.
Discuss the importance of employee development and the role of learning and development in ensuring that you have staff with the right skills and competencies for service delivery.
Improving employee performance

Audit Scotland (2001) suggests that organisations need to have a pro-active attitude to improving the performance of its employees and build appropriate procedures and systems into its management arrangements to identify and achieve such improvements on a continuous basis. This involves:

- gaining commitment from managers and employees. This will ensure that all employees understand the importance of performance improvement in a people context; that employees are properly trained to contribute to the performance improvement process; that effective two-way communications exist to encourage and enable employees to contribute to the improvement process
- creating and using management information systems routinely to monitor employee activity and costs
- taking actions to achieve performance improvement.

Your HR department should be able to provide you with performance information including establishments, trends in staff numbers, turnover, retention data and sickness and absence trends. Such information should be routinely assessed by managers with a view to identifying relevant trends and areas for improvement and acted upon as appropriate (Audit Scotland, 2001).
Working in partnership with your HR department

Key Learning Outcomes

- Describes the role of a HR department and how to access relevant employment legislation and local employment/HR policies
- Devises strategies for effective partnership working with colleagues, managers and HR department to ensure the needs and rights of staff are considered and protected

Staff are central to achieving the aims of NHSScotland and good people management is vital. New staff governance standards published in 2007 apply to all staff employed in the NHS in 2007 “Staff governance focuses on how NHSScotland staff are managed, and feel they are managed, by one of Scotland’s largest employers” (SEHD, 2007).

Staff governance is a system of corporate accountability for the fair and effective management of all staff and is key to the effective and efficient delivery of services. The staff governance standard sets out what each NHSScotland employer must achieve in order to improve continuously in relation to the fair and effective management of staff. Implicit in the standard is that all legal obligations are met, including NHS employers complying with current employment legislation, and that all policies and agreements are implemented (SEHD, 2007).

Staff governance has five key standards which employers will be required to deliver, entitling staff to be:

1. Well informed
2. Appropriately trained
3. Involved in decisions which affect them
4. Treated fairly and consistently
5. Provided with an improved and safe working environment

Partnership for Care (SEHD, 2003) clearly points to single system working and places importance on fairness and consistency of people management and practice, devolved decision-making and partnership working. It is not within the scope of this toolkit to provide information on all relevant legislation, obligations, policies and agreements relevant to your work.
Local policies will be developed within the framework of the Partnership Information Network (PIN) guidelines and will be readily available to you. The PIN guidelines cover:

- dealing with employee concerns
- dignity at work: eliminating bullying and harassment from the workplace
- equal opportunities policies
- facilities arrangements
- management of employee conduct
- personal development planning and review
- fixed term contracts
- management of employee capability
- managing health at work
- redeployment
- secondment
- supporting the work-life balance

Your HR department is a customer service centre for all staff and it is vital that you develop effective partnerships with your HR personnel and ensure that your working practices adhere to local and national policies. They can advise you on a range of staff related issues. The table below outlines the defined components of HR management.

<table>
<thead>
<tr>
<th>Defined components of HR management</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR strategy</td>
</tr>
<tr>
<td>change management</td>
</tr>
<tr>
<td>organisational development</td>
</tr>
<tr>
<td>day to day employee relations</td>
</tr>
<tr>
<td>terms and conditions of employment</td>
</tr>
<tr>
<td>resourcing</td>
</tr>
<tr>
<td>workforce planning</td>
</tr>
<tr>
<td>workforce remodelling</td>
</tr>
<tr>
<td>delivery of employee assistance and welfare</td>
</tr>
<tr>
<td>agency and other contingent labour</td>
</tr>
<tr>
<td>recruitment and selection</td>
</tr>
<tr>
<td>redeployment and transfers</td>
</tr>
<tr>
<td>individual performance management redundancy</td>
</tr>
<tr>
<td>competency and skills planning/frameworks</td>
</tr>
<tr>
<td>performance standards</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>employee appraisal</td>
</tr>
<tr>
<td>secondments</td>
</tr>
<tr>
<td>absence management</td>
</tr>
<tr>
<td>reward and recognition</td>
</tr>
<tr>
<td>pay and reward strategy</td>
</tr>
<tr>
<td>flexible benefits</td>
</tr>
<tr>
<td>pay and benefits administration</td>
</tr>
<tr>
<td>employee recognition schemes</td>
</tr>
<tr>
<td>health &amp; safety policy and procedure development</td>
</tr>
<tr>
<td>incident management</td>
</tr>
<tr>
<td>compliance and inspection regime</td>
</tr>
<tr>
<td>payroll administration</td>
</tr>
<tr>
<td>equality and diversity in the delivery of services</td>
</tr>
<tr>
<td>delivery of occupational health assessment and testing</td>
</tr>
<tr>
<td>job analysis and design</td>
</tr>
</tbody>
</table>
Learning Activity 19: Working in partnership with your HR department

Discuss your role and the role of the HR department in effectively managing the following situations:

- A member of your staff with seven episodes of sickness in the past year
- A member of your staff who has been diagnosed with breast cancer and has been off work for six months
- A member of your staff who has made their second drug error
- A member of your staff who has stolen drugs
- A member of your staff who comes in to work smelling of alcohol
- A member of your staff who has been making adverse comments about a colleague on a social networking site
- A complaint from a patient about the attitude of a member of your staff
Nursing and midwifery budgets/financial management

Key Learning Outcomes

Explain how budgets are set and analyses role in managing the budget including when to take remedial action and what options might be available to do so.

The SCN, SCM or TL role includes responsibility for and authority and control over the care environment and delivery of nursing care including the human and budgetary resources they require (RCN, 2006a). With devolved budgetary responsibilities, SCNs, SCMs and TLs require financial education and guidelines to offset the potentially stressful effects of trying to balance ward budgets with limited financial knowledge and awareness (Doherty, 2003). It has been identified that all nurses and midwives must have financial and management knowledge in order to participate in delivering a cost effective service (Krugman et al, 2002; Sullivan and Decker 2005).

What is financial management?

Sound financial management is a fundamental building block of successful, high quality health services. This is because in the NHS, financial management is not just about recording and monitoring expenditure, but about planning to meet new challenges, knowing how money is being spent, whether it is giving good value and how extra investment can best be used to improve services (including redesigning them and providing new ones), and meeting needs most appropriately. Where this is done well, organisations can focus on the quality of and improvements in service delivery; where it is done badly, services are provided in an atmosphere of crisis and retrenchment that undermines day-to-day quality and inhibits change and development. (Audit Commission, 2004).

What is good financial management?

Characteristics of good financial management include:
- effective financial planning
- service, workforce and financial planning are integrated
- expenditure is tracked to services and outputs or outcomes
- spending decisions are underpinned by analysis of service or population need
- various options for achieving the most cost-effective service outcome are considered
- the costs of in-year developments or pressures are accurately forecast and planned for
- new service developments are accurately costed
- the organisation responds to changes in demand and targets resources to areas of need
- financial data and management information supports good strategic decision making and performance management
- medium-term financial plans are produced
- effective forecasting
- ensure resources are targeted at areas of greatest need
- support change and innovation
Budget management overview

Budgets are used to plan, monitor and manage performance as well as for decision making and are set in accordance with the aims and objectives of the organisation.

Budget allocation to nursing and midwifery workload and workforce planning is based on a similar process throughout Scotland but is open to variation. Typically in NHSScotland, nursing and midwifery budgets are agreed within the overall management process. The process is generally the same whether coming from the Board to operating division level, or operating division level to services. In essence, there are two principal budget setting methodologies applied in practice:

1. Incremental budgets
2. Zero-based budgets

Incremental budgets

In setting incremental budgets at the start of each financial year, the baseline from the previous year’s budget is brought forward and is adjusted for a variety of factors, including:

- anticipated salary inflation, including pay awards and incremental drift, e.g. agreed changes to the establishment, measured in WTEs
- non-recurring initiatives, either existing ones ceasing or new ones commencing
- full year effect of recurring items introduced part way through the previous year
- agreed new service pressures identified through the healthcare planning and prioritisation process
- any agreed savings

Zero-based budgets

Alternatively, Zero-based budgets (ZBBs) are sometimes set, particularly where higher unit cost and lower more easily estimated staffing numbers are involved. Rather than referring to the previous year’s budget, the process starts from scratch, building up the budget on an individual post basis. This culminates in a more realistic cost profile, based on up-to-date knowledge and information. A ZBB is not recommended where there are large numbers of staff involved and where staff turnover rates throughout the year are high, as the effort in preparing such budgets is not rewarded in practice.

The incremental approach is normally used for setting non-staffing budgets such as medical supplies and drugs, although ZBB may be applied where a specific drug regime can be identified with a clear estimate of patient numbers and drug types involved in the year ahead.

The Scottish Government Health Directorate may provide funds, usually on a short-term, pump-priming basis, for specific initiatives such as the creation of nurse and midwife consultant posts or specialist nursing and midwifery initiatives (SEHD, 2004b).

Components of a budget

The components of individual ward/team budgets depend on the level and extent of devolved responsibility delegated to the budget manager. For example, the SCN or team leader may be held responsible for nursing staff, domestic staff and porters, and may also be asked to manage medical supplies, drugs and facilities such as heat and power, property rates and laundry. In other words, they may have responsibility for a smaller version of the organisation as a whole. A more common profile, however, is likely to focus on what are termed direct costs, i.e. costs over which the SCN has direct control or influence.
An effective budget will hold statistical and financial information for staff on an individual band basis, to allow a comparison between skill mix planned and deployed in practice throughout the financial year. This might include:

- Clinical and non-clinical staff WTE and costs
- Drugs costs, possibly by grouping, e.g. cancer, or by individual drug, where the cost is likely to be significant and measurable
- Medical supplies, either by grouping, e.g. disposables, or by individual product, e.g. needles

The budget may stop there or may extend to other ‘controllable costs’, e.g. postage and stationery, communications costs, minor equipment purchases etc.

**Interpreting a budget**

Different organisations may choose to report performance against budget in a variety of ways to suit their own circumstances and preferred ways of working. A fairly standard approach is to report against each cost heading as follows:

- Annual budget – a guide to the total estimated cost for the year
- Year-to-date budget – how much of the total budget should have been spent so far?
- Year-to-date actual – how much of the budget has been spent to date?
- Year-to-date variance – the difference between the budget and the actual. A favourable variance would generally mean that spend is lower than budget, while an ‘adverse variance’ would signify that more has been spent to date than has been allowed for in the budget.

Reports may go on to report not only the year to date performance, but also the latest individual accounting period (normally 12 in each financial year). That would also show budget, actual and variance. Some organisations may choose to report only the year-to-date position, being of the view that monthly reports may be misleading as they may include adjustments from prior periods.

Finally, budget reports may incorporate a ‘full year forecast’ which would reflect the latest estimate of how much is likely to be spent by the end of the financial year. This is then compared against the annual budget to assess where financial risks and opportunities may arise.

However the budget performance reports are set out, the next stage is to interpret the outcome and consider what remedial action, if any, is required to ensure that financial balance is assured while simultaneously achieving all the other objectives faced by the ward management and staff. A key interpretation method is ‘variance analysis’ where budget variances are reviewed to determine whether they are significant, temporary or perhaps the start of a trend of some sort. Some questions to be asked in reviewing variances include:

- Has the budget been ‘phased’ correctly? In other words, if expenditure normally follows a seasonal pattern, e.g. winter pressures, has the budget been phased appropriately or simply divided into 12 or 13 equal parts? The variance may simply reflect a timing difference that will disappear over time.
- Are the actual costs recorded accurate or is some information missing or have costs been allocated to the incorrect cost centre? This needs to be raised by the budget holder for investigation by finance colleagues.
- Is a favourable variance (under spend) really a ‘good thing’ or does it reflect the fact that staff recruitment is proving difficult and staff on the ground are under undue pressure of work as a result?
- Is an adverse variance (over spend) the start of a trend that requires remedial action to fix or is it due to a one-off, unexpected charge that will not repeat in the year? The solution may be to seek special budget allowance or indeed plan ways of making savings to compensate. If it is the start of a trend, that may well be much more serious and require a team approach to agreeing on a remedy.
Pay budgets reflect the full cost of employment including Employers National Insurance and Employers Superannuation Contributions. An example of the cost elements included in a budget for a Band 5 nurse is detailed below.

**Figure 4: How to read budgets**

<table>
<thead>
<tr>
<th>Band 5 Pay Budget - Cost of 1 WTE</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Salary</td>
<td>24,554</td>
</tr>
<tr>
<td>Enhancements</td>
<td>4,001</td>
</tr>
<tr>
<td>Employers National Insurance</td>
<td>2,104</td>
</tr>
<tr>
<td>Employers Superannuation</td>
<td>3,855</td>
</tr>
<tr>
<td><strong>Total cost to organisation</strong></td>
<td><strong>34,514</strong></td>
</tr>
</tbody>
</table>

This is the amount that will be allowed for in the budget, although the overall budget may be adjusted for vacancy factor or efficiency saving targets.

**Forecasting financial performance**

One of the most difficult financial exercises for everyone is forecasting what financial performance against budget will look like at the end of the financial year. Forecasts will change from month to month due to many factors such as:

- staff turnover
- unexpected activity
- new drugs
- a complex patient requiring a range of services, care and treatment may have an impact on costs for future financial planning
- unavoidable employment of agency staff

Forecasts should become more reliable as the year progresses. There are some things to consider while trying to make forecasts as accurate as possible:

- incremental movement
- can the year-to-date position help to forecast a trend?
- does the year-to-date position include any ‘one-off’ items that should be discounted in forecasting future months’ performance?
- what intelligence do we have about unusual forthcoming events that will have a financial impact?
- are we being realistic about staff recruitment estimates or are we reflecting our hopes which may not be realised?
- are our staff turnover assumptions realistic or have we assumed that all of our staff will remain in post for the rest of the year, again in hope rather than reflecting likely reality?
- in terms of non-staff costs, have we simply used the annual budget as a forecast and ignored the year to date position on the assumption that ‘things will be OK’ by the end of the year?
- can we look at last year’s actual financial performance to give us a guide to the current year? Where were we at this point last year?
The forecast, once completed, may indicate an overspend, under-spend or ‘break even’ situation where actual spend for the year is estimated to closely match budget. Depending on the organisation, a projected under spend may be available for use by the ward, probably on a non-recurring basis in the year. It may, however, be required elsewhere in the organisation to compensate for budget overspends. It is likely that a forecast overspend will be more of a problem. Solutions may include:

- seeking additional budget to allow for overspends that will be considered beyond the control of the budget holder
- planning to reduce expenditure in the coming months by doing things differently or doing less of something, or by delaying expenditure into the following year where that is possible, e.g. change of skill mix or making better use of supplies
- agreeing a temporary budget transfer with another budget holder where he or she is facing an under spend this year to be ‘made good’ in the following year. This needs to be thought through very carefully however to avoid simply building up problems for the future

**Responsibilities of budget managers**

All budget managers should recognise and understand their role in committing resources and how good use of resources will contribute to better service provision. Budget managers should be familiar with the financing arrangements for their service and understand the basics of budgetary management. The following are the responsibilities of the budget manager

- to review budgetary information on a regular basis and undertake any corrective action that may be required to bring it in line with the plan
- review how your ward/department is running from a financial perspective and measuring financial management as a key performance indicator
- to contain expenditure within budget – if this is not possible, to notify your line manager as soon as you become aware of any likely overspending
- to ensure that all expenditure charged to your budget has been requisitioned and authorised by an appropriate designated officer of the budget holder using official documentation/procedures.
- co-ordinate and monitor the use of financial resources in the ward/department
- make efficiencies and achieve value for money
- liaise with the finance department to assist with service and financial planning.
- to ensure recurring expenditure is not set against non recurring funding.
- to conform with standing orders, standing financial instructions, scheme of delegation, financial operating procedures (available on intranet)

You, the budget manager are responsible for managing your budget and ensuring you stay within resources.

**Learning Activity 20: Nursing and midwifery budgets**

Look at Fitandwell Ward’s Nursing budget in case study 8 (page 79)

The budget is overspent by £15,254 at the end of September 2012 (6 months).

1. What factors could have caused this overspend?
2. How would you go about forecasting the likely out-turn at year end?
Long-term planning

The Scottish Government’s strategy for a healthier Scotland, Better Health, Better Care Action Plan (SG, 2007b), made a series of commitments to improve the health of everyone in Scotland and to improve the quality of health care and the health care experience. It described the NHS in Scotland as an organisation that ‘helps people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care.’

A national workforce framework, A Force for Improvement (SG, 2009) is the workforce response to Better Health Better Care. It sets out a vision for the NHS in Scotland, describing the challenges the workforce will face within a UK wide context as well as globally, and identifying strategic actions to deliver the vision. The key ambitions contained within A Force for Improvement are;

- All staff will be ambassadors for health improvement, safety and quality, using every interaction with individuals, communities and populations, and every patient care episode to maximise their public health and education role
- NHSScotland will develop and implement multi-disciplinary and multi-agency models of care which are more responsive, more accessible and more joined up to meet the needs of local communities and ensure efficient utilisation of skills and resources
- NHSScotland will be an “employer of choice” which acquires the best talent, motivates employees to improve their performance, keeps them satisfied and loyal, and provides opportunities for them to develop and contribute more
- All staff in NHSScotland will work together to promote the benefits of preventative action and measures of self care for patients and the public across a range of health issues, supporting them in ensuring that they have the knowledge and understanding to undertake this and where appropriate to seek expert advice and treatment
- We will work together with Universities, Further Education and the wider education sector to encourage and maximise flexible access to education and training, for people already working in NHSScotland and those with aspirations to join, that is reflective of the changing demography and increasing diversity of Scotland

Changes in demography present some of the most significant challenges for workforce planning. In 2006, it was estimated that Scotland’s population stood at 5,116,9001, an increase of 22,100 on the previous year. The age structure of the population is also changing towards an older profile. The latest
projections predict that the population of Scotland will continue to rise over the next 12 years to 5.13 million, before falling to around 5.07 million by 2031 (Scottish Government, 2007a). Health workforce planning is subject to complex and multidimensional factors such as the broad array of stakeholders, the range of health policy and planning initiatives, and the broad determinants of health and health needs. These should be addressed as part of the planning process.

Health systems and health workforces are dynamic, therefore the impact of changes to health policy, funding, service delivery, technology should be considered. Planning requires monitoring, updating and refining. Successful workforce planning requires appropriately resourced organisational structure to conduct planning, stakeholder participation, clear principles, objectives, methodologies and processes, and accurate, timely, reliable data.

**NHSScotland workforce**

The NHS in Scotland is a large employer with a workforce which comprises those directly involved in clinical care and staff who provide infrastructural support. Nurses and midwives form the largest of all staff groups within NHSScotland, representing just under 43% of the workforce. In Scotland in 2005, the average age of a nurse was 42 years, a trend which has been increasing steadily over past years, and contributing to the evidence base of the nursing profession's ageing profile (RCN, 2005).

The total demand for all registered staff shows an 8.8% increase on the current baseline figure. The five year projected increase collected as part of previous student nurse intake planning (SNIP) exercises was 8.5% in 2004 and 9% in 2005.

“Models for employment for nurses and midwives in NHSScotland which support efforts to increase recruitment and retention and reflect the need to develop flexibility in employment practices, in addition to changes in nursing and midwifery roles, have significant implications for workload and workforce development.” (SEHD, 2004a). Specific issues in relation to the nursing and midwifery workforce include protected time which SCNs, SCMs and TLs spend away from clinical activity in fulfilling management responsibilities, e.g. performing staff appraisals, rostering and undertaking clinical governance activities.

**Patient care characteristics**

Patient experiences of services have changed considerably over the last decade or so. Inpatient stays tend to be shorter, with quicker discharge to community services. The advent of day-care services, minimally invasive surgery and an increased range of services accessible from GP services have transformed healthcare, and have had considerable effects on nursing workload. Patients' needs and expectations are also strong drivers of services and consequently have implications for nursing and midwifery workload and workforce planning (SEHD, 2004a). They want:

- choice about services
- more care available outside hospital and closer to home
- to take personal responsibility for their own wellbeing and to be supported in caring for themselves better care for those with long-term conditions (SEHD, 2006e)

NHSScotland has an established history of being committed to the delivery of person-centred care which is respectful, compassionate, and responsive to individual needs, values and preferences. In the Better Health, Better Care Action Plan, the Scottish Government (SG, 2007b) committed to delivering an NHS based on a mutual ethos where staff and service users are co-owners of the NHS and have a greater say in the way services are delivered.
The new NHSScotland Healthcare Quality Strategy (SG, 2010a) aims to put quality at the heart of everything we do. It is built around the criteria which the people of Scotland identified as their key priorities:

- Caring and compassionate staff and services
- Clear communication and explanation about conditions and treatment
- Effective collaboration between staff, patients and others;
- A clean and safe environment
- Continuity of care, and
- Clinical excellence

Three Quality Ambitions (SG 2010b), provide the focus of activity to achieve the aim of delivering the best quality health and social care to the people of Scotland.

<table>
<thead>
<tr>
<th>Key Drivers:</th>
<th>Quality ambitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person-centred</td>
<td>Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making</td>
</tr>
<tr>
<td>Safe</td>
<td>There will be no avoidable injury or harm to people from healthcare, advice or support they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times</td>
</tr>
<tr>
<td>Effective</td>
<td>The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated</td>
</tr>
</tbody>
</table>

The Releasing Time to Care (RTC) initiative forms part of the quality strategy. It focuses on better organisation of wards so staff have more time to spend on direct patient care. In pilot areas it also resulted in shorter stays in hospital, better hand washing and reduced staff sickness.

**Changes in healthcare in Scotland**

Healthcare in Scotland is in the early stages of the most significant changes in the way services are provided since the inception of the NHS. The status quo is not an option: the nursing profession in Scotland can lead some of this change and has a key role to play in working with others to ensure that new sustainable models of healthcare are designed around the needs of patients. The drivers for change include:

- demographic changes - a declining working population supporting an increasingly elderly population
- increased burden of multiple long-term conditions within an aging community
- the need to promote public health and tackle health inequalities
- the formation and development of community health partnerships (CHPs) to improve the health of their population by tackling health inequalities
- increases in demand for elective surgery, i.e. non-emergency demand such as cataract and hip replacement surgery
- medical advances that widen the range of conditions that can be treated
- advances in diagnostics and new technologies including telemedicine and eHealth
- the need to work in partnership with people and communities
increased pressure to centralise acute services because of workforce constraints
integrated assessment framework joint future working
patient safety considerations and improving clinical standards
the need for sustainable, affordable services
educational requirements and competency based frameworks for professional staff
pay modernisation, e.g. Agenda for Change
recruitment and retention challenges within a competitive global labour market
the demands of regulation
national targets
integrated working
new nursing roles
focus on multidisciplinary team working
long-term condition management and rehabilitation
health and social care integration

Health workforce planning should therefore, be integrated with education planning, service planning and financing, and HR management functions. This approach to workforce planning can be summarised as being:
- built around health service needs, which are in turn based on population health needs
- integrated with health workforce production, management and financial planning
- holistic in approach, looking across occupational groups and care settings and
- responsive to change.

Keeping up to date with current government and NHSScotland policy will help you contribute to long-term planning and influence service delivery. A list of publications to consider in long-term planning are given in handout 5 on page 91.

**Learning Activity 21: Long-term planning**

Discuss some of the changes that have taken place in the NHS over the past 10 years:
- what impact have they had/might they have on nursing and midwifery?
- what affect have they had/might they have on your working practices?

Discuss the implications for nursing and midwifery of an ageing population
Work-based activities

**Work-based activity 4: Skill mix**

Look at the skill and grade mix in your ward, department or area of work. Identify:
- your present funded establishment
- the ratio of registered versus non-registered staff
- one change you might make to your skill mix

Plan how you might change your skill mix to improve efficiency and effectiveness.

**Work-based activity 5: Rostering**

Implement a change in your rostering system and assess the impact on relevant areas of your work such as:
- skill mix
- staff satisfaction
- planned and unplanned leave
- use of bank and agency staff
- clinical quality indicators
- patient care

**Work-based activity 6: Staff turnover**

Calculate the turnover in your ward, department or area of work. The formula for calculating turnover is:

\[
\text{staff turnover rate} = \frac{\text{number of leavers}}{\text{number of staff working}}
\]

Compare your data with another department.
- how does your staff turnover compare?
- what actions could you take to reduce turnover?
Work-based activity 7: Planned and unplanned time out

Examine your rosters and record for the past year and look for staff shortages and surpluses. Identify ways to achieve a more even occurrence of planned time out throughout the year. Use worksheet 5 to record predicted absence.

Work-based activity 8: Working with your HR department

Make an appointment with someone from your HR department. Use the list of HR components on pages 56 and 57 as a guide to identify areas for discussion if you haven’t already done so in learning activity 21.

Work-based activity 9: Budgets

Make an appointment with management accountant. Discuss:
- how the budgets are set/allocated
- the components of a ward/department budget
- how to interpret a ward/department budget
- how to forecast and manage overspend and underspend

Work-based activity 10: Long-term planning

Choose one of the publications from handout 5 on page 91 or your own local delivery plan. Read the document and prepare a summary for presentation to include:
- purpose
- main points
- relevance to workload and workforce planning
- what you have learnt
4. Support Materials
Case study 1

In 2009 the public health teams in Morayshire undertook the SAW process. The initiative called Safe Affordable Workforce is an organisation wide review of staff numbers, grades and skills. It is so called because patient safety and clinical care remain a top priority. It aims to deliver a safe, affordable and sustainable workforce at the same time as achieving cost reductions in each sector and directorate, and is one of the ways we are seeking to achieve financial balance in the organisation. One of the teams, which covers two GP practices with a combined practice population of approximately 16,000, went through this process.

Their caseload varies from approx 720-750 with the dependency levels varying between

- 516 – 526 requiring Core input
- 189 – 213 requiring Additional input
- 12 – 20 requiring Intensive input

What is the team /function/ department required to deliver?

Public Health Team – work in the community with children, young people and families (pre-conception – transfer to adult services)

Areas of priority include:
- Identification of core/additional/intensive case management
- Child Protection
- Domestic Abuse
- Hall 4
- Antenatal care
- The vulnerable and complex needs of children and young people
- First visits to new families
- Parenting
- Substance Misuse (including tobacco)
- Oral Health
- Healthy Weight
- Mental Health & Well-being
- Sexual Health

What are we doing now that does not contribute to this requirement?

1. Immunisation programmes – requirement of GP practices, delivered on their behalf without reimbursement. Compromise by continuing to deliver immunisations where HV contact with child for developmental review as impact on time required not significant. However, difficulty arises where not enough time in a busy immunisation clinic for the HV to include the developmental review.
2. Minor illness consultations for GP practices
3. Older people screening visits and clinics
4. Well-person clinics Minor illness/accident management in schools
5. Pastor care in schools
6. Administration of routine medication/ medical procedures for school children

With approximately 250 been deemed an acceptable caseload (50 per WTE per day) workout the skill mix ratio. The staffing was initially as follows:

<table>
<thead>
<tr>
<th>Band</th>
<th>Contracted Hours</th>
<th>Proposed Band</th>
<th>Proposed Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>37.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>37.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>37.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>37.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>18.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total hours</td>
<td>277.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total WTE</td>
<td>7.4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Case study 2

A SCN working in an operating theatre suite in a district general hospital set out to examine the staffing establishment and skill mix and discovered that it was out of synchronisation with other health boards with similar theatres and staff ratios. The RCN recommend a skill mix ratio of 65% registered practitioners to 35% trained health care assistants (HCAs) as a benchmark and the Association for Perioperative Practitioners (AfPP 2008) guidelines state that the perioperative workforce ratio should consist of two registered practitioners to every non registered practitioner.

Current staffing grades were:

- Band 7 Senior Charge Nurse – 1 WTE
- Band 6 Senior Theatre Practitioners - 5.8 WTE
- Band 6 Theatre Practitioners – 14.33 WTE
- Band 5 Theatre Practitioners – 13.85 WTE
- Band 2 Health Care Assistants - 1.39 WTE

This only gives the perspective of whole time equivalent (WTE) staff. In reality, if you break down the actual number of staff employed full and part time it equates to:

- Band 7 Senior Charge Nurse – 1
- Band 6 Senior Theatre Practitioners - 7 staff
- Band 6 Theatre Practitioners – 17 staff
- Band 5 Theatre Practitioners – 13 staff
- Band 2 Health Care Assistants - 2 staff

Having a total of 24 bands 6’s was an anomaly which came about because of agenda for change (AfC). There were also three theatre registered AHP practitioners who are not nurses but allied health professionals (AHP) who were an integral part of the team.

A skill mix review utilising the RCN and AFPP guidelines and our own clinical judgement, suggested they would have to recruit a minimum of six HCAs. However, they decided to initially employ only four HCAs full time. The rationale behind this decision was there had to be a period of integration and learning and four HCA could be accommodated and supported within the theatre; this would not compromise patient care.

After ten months the HCAs were fully integrated, although some concerns about accountability and clinical ability were raised on a number of occasions. Endeavouring to change stereotypical views on what is a nursing role was not without difficulty and this will always be a challenge when undertaking a skill mix review, but reality is there are many roles with in theatre that do not require a registered practitioner to undertake.

<table>
<thead>
<tr>
<th>Staff band</th>
<th>WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 8</td>
<td></td>
</tr>
<tr>
<td>Band 7</td>
<td></td>
</tr>
<tr>
<td>Band 6</td>
<td></td>
</tr>
<tr>
<td>Band 5</td>
<td></td>
</tr>
<tr>
<td>Band 4</td>
<td></td>
</tr>
<tr>
<td>Band 3</td>
<td></td>
</tr>
<tr>
<td>Band 2</td>
<td></td>
</tr>
</tbody>
</table>

Work out the skill mix ratio expressed as a percentage of registered to non-registered staff. This should equate to the figures.
Case study 3

**Staffing levels in a new hospital**

<table>
<thead>
<tr>
<th>Ward</th>
<th>Actual staffing total registered</th>
<th>Actual staffing total non-registered</th>
<th>Actual staffing total</th>
<th>Workload tool outcome</th>
<th>Professional Judgement tool outcome</th>
<th>Beds now</th>
<th>Future beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Rehabilitation</td>
<td>12.6</td>
<td>13.59</td>
<td>26.192</td>
<td>26.16</td>
<td></td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>2 Elderly</td>
<td>5.9</td>
<td>5.85</td>
<td>11.75</td>
<td>12.35</td>
<td></td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>3 Elderly</td>
<td>8.23</td>
<td>12.58</td>
<td>20.81</td>
<td>23.98</td>
<td></td>
<td>22</td>
<td>26</td>
</tr>
<tr>
<td>4 Rehabilitation</td>
<td>13.8</td>
<td>18.63</td>
<td>32.43</td>
<td>33.90</td>
<td></td>
<td>30</td>
<td>26</td>
</tr>
<tr>
<td>5 Elderly</td>
<td>9.16</td>
<td>14.75</td>
<td>23.91</td>
<td>26.16</td>
<td></td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>6 Rehabilitation</td>
<td>8.8</td>
<td>14.0</td>
<td>23.7</td>
<td>26.16</td>
<td></td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>7 Rehabilitation</td>
<td>10.6</td>
<td>16.89</td>
<td>27.49</td>
<td>27.75</td>
<td></td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>8 Rehabilitation</td>
<td>12.71</td>
<td>12.8</td>
<td>25.51</td>
<td>27.12</td>
<td></td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>9 Elderly</td>
<td>11.8</td>
<td>14.16</td>
<td>25.36</td>
<td>27.12</td>
<td></td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>93.6</strong></td>
<td><strong>124.15</strong></td>
<td><strong>217.15</strong></td>
<td><strong>230.7</strong></td>
<td></td>
<td><strong>207</strong></td>
<td><strong>213</strong></td>
</tr>
</tbody>
</table>

Using the tools to inform your outcomes, identify any differences in WTE

This new model requires staffing to be 60% registered to 40% unregistered: identify changes that may be required within the skill mix.
Case study 4

Examination of roles and responsibilities of staff in ward 23 saw the creation of a housekeeper/ward assistant role being created from auxiliary nurse money.

This role involved:
- assisting with meals,
- completion of menus
- ordering and monitoring of stores and supplies
- admission documentation
- patient admission computer system.

This ensured:
- fluid and nutrition standards being adhered to
- accurate store ordering and as a result achieving a more acceptable financial
- balance registered and unregistered staff free to deliver patient care when they previously
- carried out these duties cover for receptionist when on leave which had traditionally been done by nursing staff

Case study 5

Staff Nurse White and Staff Nurse Brown have just completed their University of Central Scotland degree courses in Cognitive Behavioural Therapy. In addition to their named nurse role and responsibilities, their Service Manager wants them to:
- carry out a training needs analysis in the adult admission wards
- develop a group programme for patients
- support colleagues in the delivery of social and therapeutic activities
- identify appropriate clinical supervision provider(s)
- provide clinical supervision when appropriate

Case study 6

In 2009, a public health team in Morayshire had the opportunity to have a trainee healthcare support worker placed in their team, through funding from Health and Wellbeing in Schools Project. Healthcare support workers are sponsored to do their training through the Robert Gordon University. As the project came to an end, so did the funding for these now acknowledged, invaluable posts.

One of the Band 7 public health nurses informed us that, as she was approaching retirement, she would like to reduce her hours by 7.5. This allowed the team to employ a Band 3 healthcare support worker for 15 hours per week, in a role that would support the school nurses and health visitors. The loss of 7.5 hours health visitor time has been absorbed by the 15 hours healthcare support worker role.
### Case Study 7

#### Work out the target leave using the indicative guide for predicted absence allowance below:

- Annual leave: 14.5%
- Study leave: 2%
- Maternity leave: 1%
- Sickness absence: 4%
- Annual leave: 14.5%

<table>
<thead>
<tr>
<th>Ward</th>
<th>Annual Leave</th>
<th>Study Leave</th>
<th>Maternity Leave</th>
<th>Sickness Leave</th>
<th>Other Paid Leave</th>
<th>Total Leave</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 1</td>
<td>0.08</td>
<td>0.05</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.23</td>
</tr>
<tr>
<td>Ward 2</td>
<td>0.12</td>
<td>0.01</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.14</td>
</tr>
<tr>
<td>Ward 3</td>
<td>0.15</td>
<td>0.02</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.19</td>
</tr>
<tr>
<td>Ward 4</td>
<td>0.17</td>
<td>0.01</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.20</td>
</tr>
</tbody>
</table>

#### Budget and Actual Hours

<table>
<thead>
<tr>
<th>Ward</th>
<th>Budget Hours</th>
<th>Actual Hours</th>
<th>Bank WTE</th>
<th>Bank Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 1</td>
<td>26.5</td>
<td>30.41</td>
<td>0.04</td>
<td>25.96</td>
</tr>
<tr>
<td>Ward 2</td>
<td>20.3</td>
<td>17.57</td>
<td>0.05</td>
<td>20.3</td>
</tr>
<tr>
<td>Ward 3</td>
<td>18.3</td>
<td>17.69</td>
<td>0.03</td>
<td>18.3</td>
</tr>
<tr>
<td>Ward 4</td>
<td>16.6</td>
<td>17.57</td>
<td>0.02</td>
<td>16.6</td>
</tr>
</tbody>
</table>
### Case Study 8

**Surgeon and Midwifery Workload and Workforce Planning**

**Learning Toolkit**

**N03031 Fitandwell Ward**

#### Surgical General Surgery

**Period:** 06 September 2011/2012

<table>
<thead>
<tr>
<th>PERMANENT NURSING</th>
<th>Annual Budget</th>
<th>YTD Budget</th>
<th>YTD Actuals</th>
<th>YTD Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>71A2 GENERAL ACUTE NURSING</td>
<td>127,891</td>
<td>63,869</td>
<td>43,934</td>
<td>19,962</td>
</tr>
<tr>
<td>71A3 GENERAL ACUTE NURSING</td>
<td>30,104</td>
<td>14,996</td>
<td>9,153</td>
<td>5,843</td>
</tr>
<tr>
<td>71A5 GENERAL ACUTE NURSING</td>
<td>567,786</td>
<td>283,144</td>
<td>255,042</td>
<td>28,102</td>
</tr>
<tr>
<td>71A6 GENERAL ACUTE NURSING</td>
<td>39,917</td>
<td>19,922</td>
<td>21,469</td>
<td>(1,547)</td>
</tr>
<tr>
<td>71A7 GENERAL ACUTE NURSING</td>
<td>52,953</td>
<td>26,501</td>
<td>26,097</td>
<td>404</td>
</tr>
<tr>
<td><strong>Total PERMANENT NURSING</strong></td>
<td><strong>818,651</strong></td>
<td><strong>408,459</strong></td>
<td><strong>355,695</strong></td>
<td><strong>52,764</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BANK NURSING</th>
<th>Period Budget</th>
<th>Period Actuals</th>
<th>Period Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>71T2 BANK NURSING SERVICES</td>
<td>0</td>
<td>0</td>
<td>18,565 (18,565)</td>
</tr>
<tr>
<td>71T5 BANK NURSING SERVICES</td>
<td>0</td>
<td>0</td>
<td>41,271 (41,271)</td>
</tr>
<tr>
<td>72T2 BANK NURSING SERVICES</td>
<td>0</td>
<td>0</td>
<td>2,324 (2,324)</td>
</tr>
<tr>
<td>72T5 BANK NURSING SERVICES</td>
<td>0</td>
<td>0</td>
<td>6,129 (6,129)</td>
</tr>
<tr>
<td><strong>Total BANK NURSING</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>68,288 (68,288)</strong></td>
</tr>
</tbody>
</table>

**N03031 TOTAL FITANDWELL**

- Annual Budget: 818,651
- YTD Budget: 408,459
- YTD Actuals: 423,983
- YTD Variance: (15,524)
- Monthly Period Budget: 67,960
- Monthly Period Actuals: 69,690
- Monthly Period Variance: (1,730)
- Period Estab: 24.70
- Period Avg: 24.43
- Period WTE: 24.37
## Worksheet 1: Recording Learning and Development

This form can be used to record learning activities and to evidence your learning.

<table>
<thead>
<tr>
<th>Learning/work-based activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Description of learning activity</td>
<td></td>
</tr>
<tr>
<td>Key learning points</td>
<td></td>
</tr>
<tr>
<td>Impact on practice</td>
<td></td>
</tr>
<tr>
<td>Are there any other actions you need to take as result of this learning?</td>
<td></td>
</tr>
</tbody>
</table>
Worksheet 2: Nursing/midwifery activity checklist

<table>
<thead>
<tr>
<th>Nursing activity</th>
<th>Direct</th>
<th>Indirect</th>
<th>Associated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Worksheet 3: Observation checklist

**Department:**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>By whom</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Worksheet 4: Action plan

<table>
<thead>
<tr>
<th>Topic/activity</th>
<th>Success criteria</th>
<th>Actions</th>
<th>Resources</th>
<th>By/when</th>
<th>Progress &amp; evaluation</th>
</tr>
</thead>
</table>

**Aim:**
### Worksheet 5: Workload measurement checklist

<table>
<thead>
<tr>
<th>Agenda for Change</th>
<th>Workforce Planning</th>
<th>Allocated budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical grading</td>
<td></td>
<td>Average number of admissions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other leave per band (HOURS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Study leave per band (HOURS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maternity leave per band (HOURS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sickness/subsence per band (HOURS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Annual leave per band (HOURS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Current overtime usage (HOURS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Current extra hours usage (HOURS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Current agency usage (HOURS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Current bank usage (HOURS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Current vacancies per band (WTE)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Current establishment in post (WTE)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Current funded establishment (WTE)</td>
</tr>
<tr>
<td></td>
<td>AGENDA:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>BANDS:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>8B</td>
<td>8A</td>
</tr>
<tr>
<td>Subject</td>
<td>What is the development need/interest?</td>
<td>What will I do to develop myself? How will I know I have done this?</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Handouts

Handout 1: Developing an action plan

1. Clarify your goal. Can you get a visual picture of the expected outcome? How can you see if you have reached your destination? What does make your goal measurable? What constraints do you have, like the limits on time, money, or other resources?

2. Write a list of actions. Write down all actions you may need to take to achieve your goal. At this step focus on generating and writing as many different options and ideas as possible. Take a sheet of paper and write more and more ideas, just as they come to your mind. While you are doing this, try not to judge or analyse.

3. Analyse, prioritise, and prune. Look at your list of actions. What are the absolutely necessary and effective steps to achieve your goal? Mark them somehow. After that, what action items can be dropped from in the plan without significant consequences for the outcome? Cross them out.

4. Organise your list into a plan. Decide on the order of your action steps. Start from looking at your marked key actions. For each action, what other steps should be completed before that action? Re-arrange your actions and ideas into a sequence of ordered action steps. Finally, look at your plan once again. Are there any ways to simplify it even more?

5. Monitor the execution of your plan and review the plan regularly. How much have you progressed towards your goal by now? What new information you have got? Use this information to further adjust and optimise your plan.
Handout 2: Contributing to workforce planning competencies

A UK-wide workforce planning competence framework has been developed by NHS National Workforce Projects (NWP) and Skills for Health, designed to support everyone involved in workforce planning throughout the UK. It describes three different levels of activity within workforce planning:

1. strategic management of workforce planning
2. specialist workforce planners
3. contributing to workforce planning

Many of the competencies listed would be of interest to individuals who are contributing to workforce planning, but are not specialists in the field. The full competency directory can be downloaded for the NMP website www.healthcareworkforce.nhs.uk/projects/completed_projects/uk-wide_workforce_planning_competence_framework.html

1.3 Contribute to preparing for workforce planning based on service needs
2.3 Contribute to assessing workforce demand and supply
6.1 Explore and assess the potential for collaborative working, and initiate and develop collaborative working relationships
6.2 Sustain collaborative working relationship arrangements, and review and evaluate collaborative working
6.3 Develop and sustain effective working relationships with staff in other organisations
7.3 Develop your own knowledge and practice
7.5 Develop productive working relationships with colleagues and stakeholders
8.1 Ensure your own actions support the equality, diversity, rights and responsibilities of individuals
8.2 Promote equality of opportunity and diversity in your area of responsibility
9.3 Ensure your own actions reduce risks to health and safety
Handout 3: SWOT analysis

SWOT Analysis is a powerful technique for identifying Strengths and Weaknesses, and for examining the Opportunities and Threats you face. The SWOT matrix is a useful tool for strategic planning and achieving your goals both individually or within a team. What makes SWOT particularly powerful is that with a little thought, it can help you uncover opportunities that you are well placed to take advantage of. And by understanding your weaknesses, you can manage and eliminate threats that would otherwise catch you unawares. You use each of the four quadrants in turn to analyse where you are now, where you want to be, and then make an action plan to get there.

The SWOT Matrix

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is good now?</td>
<td>What is bad now?</td>
</tr>
<tr>
<td>(maintain, build)</td>
<td>(remedy/stop)</td>
</tr>
<tr>
<td>Opportunities</td>
<td>Threats</td>
</tr>
<tr>
<td>What might be good for the future?</td>
<td>What might be bad for the future?</td>
</tr>
<tr>
<td>(prioritise, optimise)</td>
<td>(minimise, counter)</td>
</tr>
</tbody>
</table>

Regardless of whether you or your team are future planning for specific products, work, personal or any other area, the SWOT analysis process is the same.

Step 1 – In the here and now…
List all strengths that exist now. Then in turn, list all weaknesses that exist now. Be realistic but avoid modesty!

Step 2 – What might be…
List all opportunities that exist in the future. Opportunities are potential future strengths. Then in turn, list all threats that exist in the future. Threats are potential future weaknesses.

Step 3 – Plan of action…
Review your SWOT matrix with a view to creating an action plan to address each of the four areas.

In summary:
- Strengths need to be maintained, built upon or leveraged
- Weaknesses need to be remedied or stopped
- Opportunities need to be prioritised and optimised
- Threats need to be countered or minimised
### SWOT analysis

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunities</td>
<td>Threats</td>
</tr>
</tbody>
</table>

### Action plan

- **Strengths**
- **Weaknesses**
- **Opportunities**
- **Threats**
Handout 4: Scenarios

Scenario 1

On a day when you have only just managed to staff the shifts, a member of staff comes to you and asks you for time off. Staffing is really tight but you feel if you say no she may go off sick anyway.

Scenario 2

Your normal service requires three nurses per day to cover each day. Your normal day is seven hours, but due to service pressures you have been asked to staff the service for twelve hours per day.

Scenario 3

Recruiting to the service is difficult at the current time. You have a number of vacancies: there are 19 posts available and 3.5 of these are vacant. One proposal is replacing registered nurses with non-registered staff, suggesting you could have more for the money.

Scenario 4

You have certain members of staff who work just nights. This is a historical situation. Night duty is being covered more frequently with less senior staff. Concerns have been raised regarding the practice of one member of the team and it is suggested that closer supervision is required. Due to the dilution of skill mix on nights this is not possible.
Handout 5: List of publications to consider in long-term planning

For up to date policy and strategy resources visit the NES Effective Practitioner website.
http://www.effectivepractitioner.nes.scot.nhs.uk/resources/policies-and-strategies-resources.aspx

Scotland’s National Dementia Strategy (2010). This strategy intends to transform dementia standards by developing common standards of care; by producing a framework to ensure that all staff who provide care and support are skilled and knowledgeable about dementia; by significantly improving care pathways; and by strengthening the integration of health and social care services.

Rights, Relationships and Recovery (2006). The Report of the National Review of Mental Health Nursing in Scotland. The purpose of the review was to enhance and develop mental health nursing so that service users, their families and carers gain continual improvements in their experiences and outcomes of care. It outlines the foundations for actions to develop mental health nursing in Scotland; how these actions will be supported; and the next stages in delivering and implementing the actions.

Reshaping Care for Older People. This programme of work is in early stages and is required as current services are not sustainable in the face of demographic change and financial pressures.

Refreshed Framework for Maternity Care in Scotland (2011) This framework outlines the principles which govern maternity services in Scotland from pre-conception through pregnancy, childbirth, postnatal care and into parenthood.

Midwifery 2020: Delivering Expectations (2010) sets out an informed vision of the contribution midwives will make to achieving quality, cost-effective maternity services for women, babies and families across the UK.

Living and Dying Well (2008). The action plan aims to ensure that good palliative and end-of-life care are available to all patients and family who need it, in a consistent, comprehensive, appropriate and equitable manner in all care settings in Scotland.

Getting it Right for Every Child (2011). Information, tools and resources aimed at practitioners and professionals who are implementing the Getting it right for every child approach.

Gaun Yoursell is a self-management strategy for long-term-conditions in Scotland. It is informed by the lived experiences of people with long-term-conditions. The strategy outlines how people with long-term-conditions can be better supported and how better working partnerships can be set up between the NHS, voluntary sector.
http://www.scotland.gov.uk/Publications/2008/10/GaunYersel

The Healthcare Quality Strategy for Scotland (2010) reflects the shared ambitions of everyone in Scotland to create a high quality, person-centered, clinically effective and safe healthcare service.
http://www.scotland.gov.uk/Publications/2010/05/10102307/8
Delivery Framework for Rehabilitation Document (2007) is a joint document for health and social work. It gives strategic direction and support to all health and social care services and practitioners who deliver rehabilitation or enablement services to individuals and communities.  
http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/adultrehabilitation

Nursing and Midwifery Workload and Workforce Planning Project: A Good Practice Guide in the Use of Supplementary Staffing (2007). This guide helps nurse bank managers review and improve their role and responsibilities in the management of supplementary staff setting out the qualities substantive staff can expect to see in bank nurses.  
http://www.scotland.gov.uk/Publications/2007/12/20141732/0

Better Health, Better Care: Action Plan (2007). This action plan sets out the Government’s programme to deliver a healthier Scotland by helping people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to healthcare. The report is informed by the response to the consultation on Better Health, Better Care: A Discussion Document (August 2007).  
http://www.scotland.gov.uk/Publications/2007/12/11103453/0

Better Health, Better Care: Planning Tomorrows Workforce Today (2007). On 16 August 2007, the Cabinet Secretary for Health and Wellbeing launched a national discussion on the future of health and healthcare in Scotland. This document sets out the strategic direction for workforce planning in NHSScotland.  
http://www.scotland.gov.uk/Publications/2007/12/13102832/0

Delivering Care, Enabling Health (2006) - Harnessing the nursing, midwifery and allied health professions’ contribution to implementing Delivering for Health in Scotland builds on the vision described in Caring for Scotland, the strategy for nursing and midwifery published in 2001, to set out new actions that will drive the delivery of high-quality, patient-centred services to the people of Scotland and support the policy agenda for the NHS.  
http://www.scotland.gov.uk/Publications/2006/10/23103937/0

Building a Health Service: Fit for the Future (2005) identified the challenges to health and wellbeing from an ageing population, persistent health inequalities and a growth in long term conditions. These factors are increasing demand for health and care services and changing the pattern of that demand, with a rise in emergency admissions and an increase in age related conditions such as dementia.  
http://www.scotland.gov.uk/Publications/2005/05/23141307/13104

Delivering for Health (2005) sets out a programme of action for NHSScotland, based on an understanding of Scotland’s changing health needs. It sets out the plans for responding to the challenges of an ageing population, the growth on long-term conditions, and the trend of rising emergency admissions.  

Nursing and Midwifery Planning Project (2004) commissioned via the Facing the Future group offers recommendations on managing workload and workforce planning for all staff including nurses and midwives.  
http://www.scotland.gov.uk/Publications/2004/04/19299/36370

Partnership for Care: Scotland’s Health White Paper (2003) sets out a clear pathway for NHSScotland to improve services as well as a new approach to improve the health of the nation. It includes measures that encourage service redesign as well as placing a greater emphasis on better integration and partnership arrangements. Partnership in Care sets out a framework for a modernised NHSScotland.  
http://www.scotland.gov.uk/Publications/2003/02/16476/18730
Report of the Expert Group on Acute Maternity Services – EGAMS (2002) acknowledged the challenging workforce pressures faced within maternity services in Scotland. It concluded that the current configuration of acute maternity services was no longer viable. It confirmed a need to review critically how resources could be made more efficient and effective, advocating flexible, collaborative and innovative models of working as a way forward.

http://www.scotland.gov.uk/Publications/2003/01/16018/15750

Planning Together (2002) built upon the initiatives first identified in Our National Health. This identified the need to take an integrated approach to workforce planning. It also set clear recommendations for creating a dynamic and effective workforce planning function at national, regional and local levels.

http://www.scotland.gov.uk/Publications/2002/02/10660/File-1


Working for Health: The Workforce Development Action Plan for NHSScotland (2002) identifies that workforce development has a key role to play in order to bring about reform and improvement of the health service in Scotland. It sets a vision for workforce development and identifies the role workforce development will play now and in the future, putting workforce development in a wider context of developing a workforce in Scotland that is fit for purpose.

http://www.scotland.gov.uk/Publications/2002/08/15189/9502

Caring for Scotland: The Strategy for Nursing and Midwifery in Scotland (2001) outlines how the capabilities of nurses and midwives will be enhanced in order to provide the flexible, responsive, needs-driven services demanded by the public. It acknowledges the challenges that individuals face in becoming a nurse or midwife, but at the same time demonstrates the educational and career opportunities available in these fields.

http://www.scotland.gov.uk/Publications/2001/03/8437/File-1

A Refreshed Framework for Maternity Services in Scotland (2001) sets out a clear vision for how maternity services should be offered across Scotland. It recognises the need for a shift in emphasis in how the services are delivered. It challenges the NHS to provide more community based midwifery managed services, while retaining appropriate links to specialists services.


Facing the Future: Report of the Convention on Recruitment and Retention in Nursing and Midwifery (2001) is the banner under which a number of initiatives were launched to ultimately build capacity in the nursing and midwifery workforce, by improving upon recruitment, retention and development of nurses and midwives across Scotland.


Our National Health: A Plan for Action, A Plan for Change (2000) provides a vision for the modernisation of health services in Scotland. It aims to improve patient involvement in the design and delivery of services, to encourage team working among NHS staff and to ensure services are provided across Scotland as a national service.

http://www.scotland.gov.uk/Publications/2000/12/7770/File-1
5. References


Leading Better Care Website. [www.evidenceintopractice.scot.nhs.uk/leading-better-care.aspx](http://www.evidenceintopractice.scot.nhs.uk/leading-better-care.aspx)


National Workforce Projects. *Introduction to workforce planning*. [www.healthcareworkforce.nhs.uk](http://www.healthcareworkforce.nhs.uk)


Royal College of Nursing (2003a) Setting safe nurse staffing levels. An exploration of the issues. London: RCN.


Royal College of Nursing (2006a) Setting Appropriate Ward Nurse Staffing Levels, London: RCN.

Royal College of Nursing (2006b) RCN Response to the Health Select Committee Inquiry into Workforce needs and planning for the Health Service, London: RCN.

Royal College of Nursing (2010a) Guidance on safe nurse staffing levels in the UK, London: RCN.

Royal College of Nursing (2010b) Taking the pulse of NHSScotland: A report from the Royal College of Nursing on the finance and workforce pressures facing NHS Boards. Edinburgh: RCN.


Scottish Executive Health Department (2001a) Caring for Scotland. Edinburgh: SEHD.


Scottish Executive Health Department (2004a) Partnership for Care. Edinburgh: SEHD.

Scottish Executive Health Department (2004a) Nursing and Midwifery Workload & Workforce Planning Project. Edinburgh: SEHD.


Scottish Executive Health Department (2006a) *Delivering Care, Enabling Health*. Edinburgh: SEHD.

Scottish Executive Health Department (2006b) *Scottish Workforce Plan*. Edinburgh: SEHD.

Scottish Executive Health Department (2006b) *Allied Health Professions: Workload Measurement and Management*. Edinburgh: SEHD.

Scottish Executive Health Department (2006c) *National Workforce Plan*. Edinburgh: SEHD.


6. Acknowledgements
Editorial Group

Dorothy Armstrong  
Programme Director, NHS Education for Scotland

May Grafen  
Programme Advisor, Nursing and Midwifery Workload Workforce Planning Programme

Mairi Kellagher  
Programme Advisor, Nursing and Midwifery Workload Workforce Planning Programme

Sheonagh Lawlor  
Nursing Workforce Planner, NHS Forth Valley

Fiona C Mackenzie  
Programme Manager, Nursing and Midwifery Workload and Workforce Planning Programme

Julie Main  
Project Lead, NHS Education for Scotland

Mary Richardson  
Consultant, MER Consulting

Contributions from:

Sandra Blades  
Nurse Co-ordinator (Projects), NHS Greater Glasgow & Clyde

Fiona Cook  
National Programme Leader - Releasing Time to Care

Betty Flynn  
Programme Advisor, NMWWPP

Fiona Ireland  
Senior Staff Bank Manager, NHS Lothian

Joan Main  
Nurse Bank Manager, NHS Fife

Clark Paterson  
Senior Finance Manager, NHS Grampian

Claire Smith  
Chief Nurse, Theatres, Anaesthetics and Critical Care, NHS Lothian

Vicky Thomson  
National Programme Leader - Leading Better Care

Fiona Towe  
Staff Bank Manager, NHS Lothian

Margaret Wickham  
LBC Facilitator, NHS Grampian

Finance Department  
NHS Forth Valley

Expert Readers

Anne Marie Cavanagh  
Head of Nursing, Surgical Services Division, Golden Jubilee National Hospital

Jane Omerod  
Head of Professional and Practice Development, NHS Grampian

Julia Scott  
Director of Learning, Teaching and Quality Enhancement, University of Stirling

Dr Annie K Ingram  
Director of Workforce NHS Grampian
Contributions to the first edition were made by:

**Jim Cannon**  
Regional AHP Workload and Workforce Planning Co-ordinator

**Amanda Croft**  
NHS Grampian

**Alan Gall**  
NHS Grampian

**Eileen McKenna**  
Project Manager (Secondment), Chief Nursing Officer Directorate, Scottish Government

**Brian Paterson**  
NHS State Hospital

**Alicia Young**  
NHS Greater Glasgow & Clyde

The Nursing and Midwifery Workload and Workforce Planning Programme Education, Training and Research Sub-group

- Shona Chaib
- Mairi Kellagher
- Betty Flynn
- Dorothy Armstrong
- Irene Barkby
- Marilyn Barrett
- Sandra Blades
- Jim Cannon
- Peter Cartwright
- Carol Christie
- Rhona Sturrock
- Jane Ewan
- Sheonagh Lawlor
- Eleanor Lang
- Patricia Leiser

- Gordon Mackay
- Sue Mackie
- Mary McElligott
- Joan Main
- Eileen McKenna
- Avril Milne
- Alex Mowat
- Careen Mullen
- Jane Ormerod
- Brian Paterson
- Maggie Quayle
- Gloria Short
- Claire Smith
- Heather Weir