



NHS Tayside Workforce Plan

2008/09

Final Edition

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Foreword

This document aims to highlight the workforce challenges facing NHS Tayside in the short, medium, and long term. There are a number of factors which influence the design of the healthcare workforce, for example the implementation of national priorities and strategies in particular, Better Health, Better Care (SGHD 2007a) and 18 week referral to treatment (SGHD 2008). The impact of population demographics and the available labour market will have a significant influence in how we shape our workforce to ensure the safe delivery of effective care

In addition the impact of the European Working Time Regulations in 2009 for junior doctors cannot be over estimated. This taken collectively with other workforce changes affected by Modernising Medical Careers will present opportunities as well as challenges in how we meet the current and future healthcare needs of the population.

This document aims to stimulate discussion and debate, to enable a strategic action plan of organisational workforce priorities to be established and delivered. The document was created from face to face discussions across NHS Tayside's clinical groups and departments. This Workforce Plan narrative represents the content of these discussions, each section has been approved by the operational/clinical lead prior to inclusion in the document. Three departments provided their own narrative. The document describes the priority workforce issues identified by the operational units. Key organisational themes have been captured.

Given the percentage of our budget spent on staffing, within a climate of tight financial settlements we need to ensure value for money and productivity. It is essential to ensure there is a strategic understanding of the current and future demands and pressures placed on our workforce. Co-ordinated workforce planning and development is critical to the delivery and sustainability of our services. Understanding internal and external markets will help the organisation to effectively plan services. The future will see increased integration of service, financial and workforce planning, to ensure planning is effective, and affordable. The Workforce Plan 2008 has been signed off and approved by the NHS Tayside Department of Finance.

Workforce planning is a continuous process which is dependent on robust, quality data. Monitoring of the impact of both internal and external drivers and developments on the NHS Tayside will assist in ensuring workforce stability into the future.

Workforce Planning and Development has an increasingly high national profile, the development of robust, auditable approaches to workforce planning will become an increasing focus within public sector organisations. The Workforce Plan 2008 represents a new approach to the annual statutory plan, it aims to provide a corporate overview of our workforce to enable priority planning and the development of an action plan to ensure the NHS Tayside workforce meets current and future healthcare demand.

Professor Tony Wells
Chief Executive

Debbie Donald
Head of Strategic Workforce Development
(Acting Associate Director HR)

1. Executive Summary

The purpose of Workforce Planning & Development is to ensure that we use the talents and experience of our workforce in the best possible way, informed by analysis of healthcare, workforce and population data and trends to ensure appropriate recruitment and retention strategies support future workforce sustainability.

The NHS is a labour intensive organisation with around 70% of the annual costs being allocated to the workforce, in NHS Tayside this equates to approximately £1.1 million a day. The importance of workforce planning and development in ensuring sustainable services is self evident, this is particularly relevant as cash efficiency targets for Boards have been increased from 1% for 2007/08 to 2% for 2008/09.

The submission of the annual Workforce Plan to the Scottish Government in 2008 has a different format to previous years. The Scottish Government now require the template issued to capture workforce projections over 3, 5 and 10 years to be submitted for 30th April 2008. The narrative is to be posted on Board intranet sites at the same time. The narrative is primarily for use by the individual Boards but the Scottish Government Workforce Unit need to be able to access the plans as required.

The Workforce Plan projection template will be signed off by the Director of Finance on 14th April 2008, and Chief Executive on 16th April 2008.

The objective of this Workforce Plan is to provide an overview of the factors affecting the NHS Tayside workforce in the short, medium and long term and highlight areas of demand and pressure. It aims to inform workforce planning and development, to create a robust recruitment and retention strategy and secure a sustainable workforce through the drivers for change. An Action Plan will follow a period of consultation, and presentation to the Board Executive Team, Staff Side Forum and Staff Governance Committee.

There are many challenges which will affect the NHS workforce, these challenges and opportunities arise from demographic changes, national priorities and policy, legislation and regulatory frameworks.

The demographics will affect the workforce in two ways, an ageing workforce, and by an ageing population with multiple long term conditions, presenting with more complex, long term care needs.

Increases in life expectancy, medical, scientific and pharmacological advances will affect the way a range of conditions are treated, together with increasing expectations from the public both in terms of service and access will impact the design of services. It is likely as the population ages, that there will be increases in demand for elective surgery, such as cataract, joint replacement and vascular surgery. Major health problems such as cancer and coronary heart disease are more common in later life, there will also be higher levels of long term conditions such as diabetes which will require a more focused approach towards early intervention, rehabilitation and enablement.

The increasing number of people with long term conditions presents a major challenge for health and social care services and for society. The Scottish Household Survey estimates, in 2005/06, 23.6% of adults aged 16 or over reported some form of long term illness, health problem or disability. By the age of 65 nearly two-thirds of people have

developed at least one long term condition, whilst 27% of people between 75-84 have two or more conditions. (SGHD 2007b)

Someone living in a deprived area is more than twice as likely to have a long term illness compared to someone in an affluent area, and people with a long term condition are likely to be more disadvantaged across a range of social indicators such as employment, educational qualifications, home ownership and income. The impact of deprivation can also be seen in terms of mental health and well being with a recent Scottish survey reporting higher levels of mental wellbeing being associated with those on higher incomes (SGHD 2007b)

In addition to the long term conditions agenda there has been a substantial increase in the number of deaths amongst men and women under the age of 65 from chronic liver disease, and increases in men from this age group from suicides (up 43%), and deaths linked to mental and behavioural disorders due to the use of drugs and alcohol. These increases are far more pronounced amongst people living in deprived areas and are having a major impact overall upon mortality levels, and highlight inequality in mortality between social classes.

In relation to developing a workforce to meet future demand, it is essential to look at the whole person across the health and social care spectrum, and not plan care in compartments, for example elderly care, mental health and long term conditions are likely to affect the same person. This is evidenced in the Audit Scotland Report (2007a) which describes that as the prevalence of long-term conditions increases with age, many older people will also suffer from depression or anxiety, as well as other non-related conditions, these include osteoporosis, hypothyroidism, angina and asthma. Having started to move away from planning the workforce in professional silos, there is a risk we replace these with diagnostic silos.

The changes in our workforce and population demographics provides opportunities to critically examine the profile of our current workforce, and identify the skills and competencies needed for the future, rather than planning along traditional structures. Skills profiling linked to the Knowledge and Skills Framework (DoH 2004) and Career Framework will assist in design of appropriate services

The document aims to stimulate discussion and debate, to enable a strategic action plan of organisational workforce priorities to be established and delivered. It should be noted that whilst not covered in detail in this document, pay and overall reward policy, and pay modernisation and benefits realisation are crucial if organisations are to attract and retain a motivated, loyal and competent workforce. Each section in the document which relates to a specific clinical service has a summary of priorities at the end of each section.

There are clear areas of growth and increased demand, this is due to changing population and healthcare demographics, changing disease profiles, the development of modern treatments, and the delivery of targets and priorities. These predicted areas of growth include both planned and un-planned patient care, some of the areas highlighted are; vascular conditions, cataract surgery, audiology, point of contact testing and diagnostics, dermatology, rheumatic disease, complex maxillo-facial, renal, general medicine, endoscopy, children and young people with long term complex needs and orthopaedics. The delivery of the 18 week referral to treatment target will also present workforce challenges to a number of departments. There will inevitably be training and

development requirements and changes to workforce deployment needed to meet these demands. It is therefore critical, that as an organisation we develop a flexible, adaptable workforce with transferable skills to meet current and future healthcare need. Achieving this will be dependent maximising available learning, and training and development opportunities.

Long Term Condition (LTC) management and elderly care, including dementia and mental health, depression and anxiety disorders, and the affects of loneliness are a core integral part of everyday work, developing the understanding that this is our primary client group is essential to establish the generic care, specialist care, clinical and behavioural skills needed to provide healthcare for this core client group.

There was a clear message from the clinical areas not to plan patient care in diagnostic silos, there was repeated reference that few patients sit in one silo for example long term condition, elderly or mental health. There was a plea to plan services in a way which takes account of the whole patient, across the whole patient journey. Linked to this was the repeated concern across the organisation of the loss of robust generalist skills. The move towards specialisation has left a distinct generic skill gap, work needs undertaken to establish to key skills needed across the workforce ensure the delivery of a quality service into the future which is based on predicted patient need. Associated with the need to enhance generalist skills was the need to balance the fundamentals of caring, including attitudes and behaviours, with technical clinical skills.

Designing the workforce based on the skills and competencies required to deliver care in specific areas, and taking opportunities to review skill mix to match patient need as vacancies arise will assist in meeting future workforce requirements.

The issue of capacity in primary care was also raised across the clinical groups. This was primarily linked to the shift in the balance of care and the prevention of hospital admissions, and of continuity of care across the patient journey.

In relation to legislative change meeting the European Working Time Regulations 48 hour working week by 2009 is a priority to establish the potential risks to service. A working group led by the Medical Director is taking this forward

There was a clear message that the NHS was competing with strong external labour markets from private sector, local authority, and third sector for skilled, quality staff.

Priority workforce areas are as follows:

Pharmacy, Healthcare Science, Senior Charge Nurse and Clinical Team Leader, Dental services, Consultant medical staff, neonatal, specialist paediatrics, mental health nurses, learning disability nurses, OT mental health, stroke and learning disability, and psychologists.

Exploring the potential for integration with other agencies and care providers needs to be a key factor in future workforce planning. As the labour market becomes more competitive, we need to work collaboratively with our partners to secure and retain an appropriate workforce. This includes working collaboratively with Universities and Further Education providers to collectively support workforce development, and the preparation of potential recruits. Education partners have an essential role to play in designing programmes to meet health and social care workforce requirements. Accreditation of learning is essential to enable individuals, regardless of the point of

entry, to progress up the career framework. The Knowledge and Skills Framework is critical to developing full utilisation of our whole workforce, linked to career pathways and the career framework.

Accurate workforce information is a prerequisite to effective planning. Our current data quality does not meet the organisations workforce planning requirements. Implementing the SWISS Recovery plan and progressing the work of the Workforce information Group will allow current gaps and deficits to be rectified. A move to providing regular workforce updates throughout the year would assist in ensuring accurate data capture remains a priority. The use of IT and datasets to understand the geographic profiling of disease and use of healthcare services, will become increasingly important in effectively deploying the future workforce with the correct skill set to meet predicted demand. To respond to our ageing workforce, an essential piece of work is required to compile accurate age profiles across the organisation by sector to establish appropriate skill development and succession planning.

The next stage will be to agree an Action Plan to support the priorities identified in this document, this will be supported by regular workforce updates aiming to ensure workforce priorities are monitored for change in status, and progress of development. Updates will also aim to identify emerging workforce trends.

31 March 2008

2. Introduction

The submission of the annual Workforce Plan to the Scottish Government in 2008 has a different format to previous years. The Scottish Government only require the template issued to capture workforce projections over 3, 5 and 10 years to be submitted for 30th April 2008. The narrative is to be posted on Board intranet sites at the same time. The narrative is primarily for use by the individual Boards but the Scottish Government Workforce Unit require to be able to access the plans as required.

The Workforce Plan projection template, which included projections from the Local Delivery Plan was signed off by the Director of Finance on 14th April 2008, and Chief Executive on 16th April 2008.

Responsibility for NHS Tayside workforce planning transferred to the Head of Workforce Development in late December 2007, chairmanship of the Workforce Planning Group transferred to the same in January 2008.

The development of the narrative has been written in full consultation with senior managers and clinical groups. In January 2008 a multi-disciplinary Workforce Information Group was established to examine the current barriers to the development and access of robust, quality data for workforce planning purposes, this group will agree an Action Plan to improve the quality of data.

The purpose of Workforce Planning & Development is to ensure that we use the talents and experience of our workforce in the best possible way, and that healthcare and population trends are examined to ensure appropriate recruitment and retention strategies support future workforce sustainability.

The NHS is a labour intensive organisation with around 70% of the annual costs being allocated to the workforce, in NHS Tayside this equates to approximately £1.1 million a day. The importance of workforce planning and development in ensuring sustainable services cannot be overestimated, this is particularly relevant as cash efficiency targets for Boards have been increased from 1% for 2007/08 to 2% for 2008/09.

Better Health, Better Care Planning Tomorrow's Workforce Today (SGHD 2007b) sets out the direction of travel for workforce planning, Appendix 1. The document states that workforce planning, service planning and financial planning should be fully integrated, and also emphasises the importance of investment in education and training in delivering appropriate, quality care. This relates to both the existing workforce and new supply flows.

Health improvement, Efficiency and Governance, Access to services and Treatment (HEAT) targets are a core set of Ministerial objectives, targets and measures for the NHS in Scotland. These targets are set for a 3 year period (Appendix 2) and progress towards them is measured through the Local Delivery Plan process. The workforce is the key, essential factor in delivering the HEAT targets.

Better Health, Better Care also identified the need to have access to consistent, quality, accurate information across the whole workforce for planning purposes to ensure more sophisticated and dynamic workforce planning. As we move to providing more integrated services within communities there is a recognised need to improve knowledge and intelligence about our workforce particularly in primary and social care.

The objective of this Workforce Plan is to provide an overview of the factors affecting the NHS Tayside workforce and highlight areas of demand and pressure. It aims to inform workforce planning and development, to create a robust recruitment and retention strategy and secure a sustainable workforce through the drivers for change. An Action Plan will follow a period of consultation, and presentation to the Board Executive Team, Staff Side Forum and Staff Governance Committee.

The themes and recommendations outlined in the Strategic Workforce Development Plan (NHS Tayside 2006) remain consistent with the current priorities and targets outlined in Better Health, Better Care (SGHD 2007a). Many of the issues highlighted in the Strategic Workforce Development Plan are now national priorities and locally, developments from the plan are successfully delivering what was promised.

There are many challenges which will affect the NHS workforce, these challenges and opportunities arise from demographic changes, national priorities and policy, legislation and regulatory frameworks.

It should be noted that whilst not covered in detail in this document, pay and overall reward policy, and pay modernisation and benefits realisation are crucial if organisations are to attract and retain a motivated, loyal and competent workforce.

It is widely known that the demographic changes present some of the most significant influences. The population of Scotland is projected to rise from 5.12 million in 2006 to a high of 5.37 million in 2031 before slowly declining, and falling below 5 million in around 2076. The increase in size of population is because, up until around 2021 natural change and migration both act to increase the size of the population as the number of births exceeds the number of deaths and there is net in-migration to Scotland.

The number of births fell significantly between the early 1960's and 2002, with the number of births dropping below the number of deaths in 1996. However, the last few years have seen an upturn in the number of births and this is projected to continue until 2011.

Scotland has historically been a country of net out-migration, however in the last few years Scotland has experienced record levels of net in-migration. The size of the net inflow is assumed to steadily fall for the first six years of the projection until it reaches 8,500 in 2012-13 when it plateaux's at this level for the remainder of the projection period (this figure represents the net difference between in and out migration).

The number of children aged under 16 is projected to decrease by 7% from 0.92 million in 2006 to 0.86 million in 2031.

The number of people of working age is projected to increase slightly from 3.21 million in 2006 to 3.23 million in 2031 (an increase of 0.4%).

The number of people of pensionable age is projected to rise by around 31% from 0.98 million in 2006 to 1.29 million in 2031. These figures take account of the increases in the state pension age which will rise from 60 – 65 from women between 2010 and 2020, and from 65 to 66 for both men and women between 2024 and 2046. Were it not for these changes the population of pensionable age would increase by 58% by 2031.

The number of people aged 75 and over is projected to increase by around 81% from 0.38 million in 2006 and 0.69 million in 2031

The dependency ratio, the ratio of persons aged under 16 or over pensionable age to those of working age is projected to rise from 59 per 100 in 2006, to 67 per 100 working age population in 2031. All demographic projections are from General Registrar Office Scotland (2007)

The demographics will affect the workforce in two ways, an ageing workforce, and by an ageing population with multiple long term conditions, presenting more complex care needs.

Increases in life expectancy, medical, scientific and pharmacological advances will affect the way a range of conditions are treated, and increasing expectations from the public both in terms of service and access will impact the design of services. It is likely as the population ages, that there will be increases in demand for elective surgery, such as cataract, joint replacement and vascular surgery. Major health problems such as cancer and coronary heart disease are more common in later life, there will also be higher levels of long term conditions such as diabetes which will require a more focused approach towards early intervention, rehabilitation and enablement.

The increasing number of people with long term conditions presents a major challenge for health and social care services and for society. The Scottish Household Survey estimates, in 2005/06, 23.6% of adults aged 16 or over reported some form of long term illness, health problem or disability. By the age of 65 nearly two-thirds of people have developed at least one long term condition, whilst 27% of people between 75-84 have two or more conditions. (SGHD 2007b)

Someone living in a deprived area is more than twice as likely to have a long term illness compared to someone in an affluent area, and people with a long term condition are likely to be more disadvantaged across a range of social indicators such as employment, educational qualifications, home ownership and income. The impact of deprivation can also be seen in terms of mental health and well being with a recent Scottish survey reporting higher levels of mental wellbeing being associated with those on higher incomes (SGHD 2007b)

In addition to the long term conditions agenda there has been a substantial increase in the number of deaths amongst men and women under the age of 65 from chronic liver disease, and increases in men from this age group from suicides (up 43%), and deaths linked to mental and behavioural disorders due to the use of drugs and alcohol. These increases are far more pronounced amongst people living in deprived areas and are having a major impact overall upon mortality levels, and highlights inequality in mortality between social classes.

In relation to developing a workforce to meet future demand, it is essential to look at the whole person across the health and social care spectrum, and not plan care in compartments, for example elderly care, mental health and long term conditions are likely to affect the same person. This is evidenced in the Audit Scotland Report (2007a) which describes that as the prevalence of long-term conditions increases with age, many older people will also suffer from depression or anxiety, as well as other non-related conditions, these include osteoporosis, hypothyroidism, angina and asthma.

Having started to move away from planning the workforce in professional silos, there is a risk we replace these with diagnostic silos.

The changes in our workforce and population demographics provides opportunities to critically examine the profile of our current workforce, and identify the skills and competencies needed for the future, rather than planning along traditional structures. Skills profiling linked to the Knowledge and Skills Framework (DoH 2004) and Career Framework will assist in design of appropriate services. 'Grow your own' strategies and maximising opportunities for skill transfer through rotation will also help to build sustainability into healthcare delivery.

Key themes which will shape the workforce in the short, medium and long term are;

- Shift in the Balance of Care
- Improving access, and anticipatory care
- Medicine for the elderly including dementia care
- Mental health
- Implementation of Visible, Accessible and Integrated Care – The Review of Nursing in the Community
- A focus on rehabilitation and recovery
- Unscheduled care needs
- Designing services to match populations and healthcare trends
- Long term conditions agenda
- Productivity – Local Delivery Plan/HEAT targets (Appendix 2) reflect a rebalancing of previous approaches to performance management, with a greater emphasis on health improvement, mental health, efficiency and anticipatory care with a corresponding reduction in the number of access targets SGHD (2007a).

No development sits in isolation, each element of workforce planning and development will have an impact on the other services either in terms of delivery, or through increasing workforce demand and potentially affecting workforce supply to other services. The workforce is not an add on to service development, it is the core foundation of successful service delivery. Robust workforce planning, including assessment of supply and demand is critical to the sustainability of any development or project. Workforce design should focus on the development of a competent team, maximising the skills and competencies available across the career framework, and should enable each member of staff to work to their level of training and education.

3. Population Forecast for Tayside

The geographic population profile of Tayside is predicted to change. The overall projected population change is a result of a combination of natural change (the difference between the number of births and deaths) and migration. The changes for Council areas are for projected change between 2006 – 2031.

Table 1

GROS Components of projects population change for council areas 2006-2031			
Area	National Change	Net Migrations	Percentage projected population change
Perth & Kinross	-1.3	23.4	22.0
Dundee	-1.2	7.9	-9.6
Angus	-6.2	10.8	4.6

GROS Projected percentage change in population (2006 Based) by age group and council area 2006 - 2031				
Area	All ages	Children 0-15	Working ages	Pensionable
Perth & Kinross	22.	14.1	16.7	42.5
Dundee	-9.2	-14.5	-12.4	5.1
Angus	4.6	-9.8	-3.1	37.2

Source General Registrar Office for Scotland (January 2008)

The above tables set out clear service and workforce challenges for NHS Tayside. Perth and Kinross is a growing council area and will exceed the City of Dundee in population size by 2031. Perth and Kinross will see a growth in their working age population, however, many of this group may commute to the Central Belt so the Council area may not see a net benefit in relation to the available labour market required to support their significant growth in their pensionable age population. Perth and Kinross is the only area have a projected growth in the number of children, Angus and Dundee will see a decline. Angus also shows a significant growth in their population of pensionable age, but a decline in their available labour market.

The age profile of the population acts as a key indicator to the profile of health services that will need to be provided in an area.

The economic profile of the region has an impact on potential recruitment into the NHS. Many of the larger private sector employers have left Tayside, this may mean NHS employees leave the area as their partners seek work elsewhere, this can also work in reverse if an NHS employee is attracted to a post in Tayside but there is no suitable source of employment for their partner in the area.

Action

Monitor relationship between service use across the region and population change. Monitor any changes and internal migration of NHS Tayside workforce. Have Population Monitoring as standing item on Strategic Workforce Information/Planning Group.

4. NHS Tayside Workforce

A number of factors have affected the accuracy of workforce data for 2008. Pay reforms associated to Agenda for Change mean not all staff are assimilated which necessitates two reporting systems being used for staffing numbers this presents difficulty in providing comparisons, there are also issues in relation to the post descriptors used to assimilate staff onto Agenda for Change which affects the accuracy of the reporting. This makes comparing 2007 data with 2008 data difficult. The accuracy of local SWISS (Scottish Workforce Information Standard System) data, and comprehensiveness of the database is also a concern and makes accurate reporting problematic.

The profiles shown have used the most reliable data available. Work is currently being undertaken to improve NHS Tayside workforce planning data, and the communication between departments who hold data. A proposed move to a quarterly reporting system, rather than annual should enable more accurate data to be available for service and financial planning. This is described in greater in the Workforce Information section 22.

Tables are presented at Appendix 3

5. Regional Planning

The National Health Service Reform (Scotland) Act 2004 placed a statutory duty on NHS Boards to co-operate for the benefit of the people of Scotland. HDL (2004) 46 entitled 'Regional Planning' set out a framework for NHS Boards engagement in regional planning of health services, in support of the legislation covering both service and workforce planning.

Regional planning requires effective inter board co-operation in the planning and delivery of services for population groups which span more than one NHS Board area. Regional planning is an important feature of healthcare delivery in Scotland. It is not only about the planning of highly specialised services. There will be a significant number of services where integrated patient care is best determined through collaboration between Boards. Effective Regional Planning is essential to support the delivery of a modern, integrated and sustainable NHS.

NHS Tayside are part of two Regional Planning Groups, North of Scotland Planning Group (NoSPG) and South East and Tayside Regional Planning Group (SEAT).

The current priorities for the North of Scotland Planning Group are;

- The development of a modern integrated approach for the care of forensic patients, including the development of secure accommodation for the North of Scotland (NoS)
- Establish a regional dental service for Oral Health and Dentistry across the NoS

- The NoS Managed Clinical Network for eating disorders will improve patient care in terms of quality, access and appropriateness
- To progress the work of the Cardiac Service network for the NoS and to ensure that regional plans are in place to deliver quality, evidence based services, which meet national waiting time targets
- Set the strategic direction for cancer services for the North, support service improvement and commission regional and national infrastructure improvements
- Lead the implementation of the national Remote and Rural Steering Group Report
- An Integrated Planning Group which combines the Directors of Planning and Finance, and workforce groups will promote and foster a regional approach through the identification of service, workforce and financial planning issues which impact significantly within and across Boards to determine areas where regional working will add value
- To support and progress the work of NoS Public Health Network
- Implement the 20 recommendations of the Nursing and Midwifery Workload report
- Implement the recommendations of the AHP workload project and establish a regional strategic alliance to support the smaller professions across NoS
- Review the role and function of the NoS e-health group
- Performance management of Scottish Neonatal Transport Service
- Ensure the Child and Adolescent inpatient requirements for the NoS are addressed
- Align objectives of NoS Child Health Planning Group with those of Better Health, Better Care and the National Delivery Plan for Children's services to be published in April 2008
- Identify areas where regional working will add value over and above the contribution which can be made by a single NHS Board, in respect of the drivers for change, meeting demand, improving access, improving service quality and maximising efficiency
- Scope the regional approach to neurology

A detailed SEAT Plan is available on request.

6. Employability, Inclusion, Reputation and Branding

Workforce Planning and Development has a responsibility to look for innovative ways of supporting workforce sustainability, and also to develop a workforce in an inclusive way to best reflect the population it serves. The link between poverty and ill health is well recognised, NHS Tayside is actively providing support and opportunities for people from deprived or excluded groups to find employment and careers.

The NHS Tayside Healthcare Academy primary objective is to provide opportunities for people to help them into work. The vision, as Tayside's largest employer was to lead by example by being more socially responsible, acknowledging the greatest determinant of ill health is poverty, and take a new approach to public health and recruitment by providing employment to support health. The Academy aims to help unemployed and excluded groups into employment and long term healthcare careers, but also to provide opportunities across wider population. The Healthcare Academy currently provides three

programmes; 6 week Pre-Employment Programme, 20 week SVQ2 level programme and Modern Apprenticeships. Further detail of Healthcare Academy is in section 21.

Employability and Closing the Opportunity Gap is a Scottish Government priority to tackle health inequalities. The aims of Closing the Opportunity Gap (SEHD 2004a) are;

- To prevent individuals or families from falling into poverty
- To provide routes out of poverty for individuals or families
- To sustain individuals or families in a lifestyle free from poverty

NHS Tayside has committed to working in partnership with Job Centre plus as part of a Local Employment Partnership (LEP) - (Department of Work and Pensions 2007) to help support people with the greatest disadvantage into the labour market. This will include lone parents, disabled people and those with long term conditions, and the lowest qualified.

The NHS Tayside LEP is attached as appendix 4

In addition to Social Inclusion the impact on organisational reputation & branding should also be considered as an integral element of any 'grow your own' strategy. Initiatives such as Modern Apprenticeships and the Healthcare Academy can influence the following;

- Public Perceptions of the NHS as an employer
- Industry perceptions of the extent to which the NHS is responding to the 'employer engagement' agenda that is increasingly demanded in the private sector, notably through the new Local Employment Partnerships (LEP), NHS Tayside signed a LEP agreement in November 2007.
- Public sector perceptions of the NHS as a leader of social inclusion activity
- Employee perceptions of the NHS as an employer

All of these will be critical as the labour market becomes increasingly competitive. NHS Tayside have played a pivotal role in developing the Scottish Government NHS Employer Branding project commencing in January 2008. The concept of developing Employer Branding and Corporate Reputation within NHS Tayside was highlighted in the NHS Tayside Human Resources Strategy 'Managing our People' (2007).

The Healthcare Academy and the Modern Apprenticeships Scheme are examples of Grow your own strategies. Grow your own workforce strategies are characterised by two important features. First, they look to local labour markets as a key source of workforce supply. Second, they encourage organisations to use the skills and talents of their existing unregistered, or not formally qualified workforce more effectively. Developing and extending staff roles, especially to meet new service requirements and expectations, can achieve this. In addition, home grown workforce approaches in the NHS may be more likely to recruit and produce staff with greater commitment and loyalty to their organisation. By offering improved development opportunities, and more interesting and varied roles, the NHS can become the employer of choice locally, which may also reduce staff turnover rates Malhorta (2006).

During 2007 the Scottish Government stated they were interested in developing a National project to research in detail the benefit of developing an NHS Scotland Employer Brand to support Recruitment and Retention Strategies. The aim was to assist in securing the healthcare workforce through the many labour market drivers for change and an increasingly competitive labour market, which potentially puts at risk the sustainability of traditional sources of NHS recruitment.

NHS Tayside has been pivotal in developing the national project outline and will be part of the Scottish Government funded research together with NHS Lothian, NHS Greater Glasgow & Clyde and NHS 24. The Scottish Government has made approximately £90K available for the research. The project will explore a number of aspects which influence peoples decision to work, and stay in the NHS. The research findings will be used to inform future recruitment and retention practice, and the project links with the Staff Survey and NHS Tayside Inclusion Index which was an element of the establishment of the Healthcare Academy,. This research is a natural progression of the inclusion work which is linked to the Healthcare Academy and seeks to explore work place values and culture, and staff engagement. The national project academic lead is Professor Graeme Martin - University of Glasgow Business School. Professor Martin will be undertaking the NHS Tayside element of the work during March 2008.

7. Finance

In November 2007, the Scottish Government published both its Economic Strategy and the Scottish Budget Spending Review 2007. The Budget was subsequently approved by the Scottish Parliament in February 2008.

These key strategic documents state the Scottish Government's overarching purpose as being *"to focus government and public services on creating a more successful country with opportunities for all of Scotland to flourish, through increasing sustainable growth."*

The delivery of the Government's purpose will be supported by five strategic objectives – *to make Scotland wealthier and fairer, smarter, healthier, safer and stronger, and greener.* NHS Scotland, both alone and in conjunction with its partners, has a significant contribution to make to these ambitious objectives. Achievement will be assessed against seven high-level targets and fifteen shared, national outcomes, through a set of forty-five supporting indicators, which will be used to report progress to the people of Scotland over a ten year period. This in turn will be underpinned by a range of performance management systems across the public sector, including NHS Scotland, which will ensure that services and activities are aligned appropriately.

Better Health, Better Care

Improving the health of all the people in Scotland is a top priority for the Government, and it is intended to use the growth in resources available to NHS Scotland to help achieve implementation of the *Better Health, Better Care: Action Plan*, published by the Cabinet Secretary for Health and Wellbeing in December. The Action Plan, which stresses public ownership through a mutual approach, contains a number of proposals that shift ownership of the NHS and accountability to the people of Scotland, and offer them the opportunity to take more control of their health.

Better Health, Better Care is a significant step towards a 'Healthier Scotland' and its three main components of health improvement, tackling health inequality and improving the quality of health care. The Action Plan sets out a programme of comprehensive and targeted action to accelerate progress on each of these components.

The Scottish Budget Spending Review 2007

The Scottish Budget Spending Review 2007, which was approved by the Scottish Parliament in February, sets out the Scottish Government's spending plans for the three year period 2008/09 to 2010/11.

Scottish public services face a period of much lower growth in public spending than in recent years, and in order to ensure that the maximum gain is achieved from available resources, a challenging target of 2% cash-releasing efficiencies across all portfolios has been set for each year covered by the Review.

Funding NHS Tayside's investments plans for the next five years follow a period of unprecedented growth in spending on the NHS, with overall spending in Scotland set to rise to over £10 billion in 2008/09, equating to over £2,000 per head of population. This investment has led to a sustained increase in staff numbers as well as the modernisation of buildings and equipment.

The funding comprises both revenue to meet operating costs, and capital for investments in new assets to modernise services.

NHS Tayside has received a 3.15% increase (£17.3 million) in its Revenue Resource General Allocation for 2008/09. Some Boards have received up to 3.81% of an increase, but this difference is intended to move them closer to their "fair share" of the national funding as determined by the Arbutnott Formula. The Formula is based on population shares, which are then weighted for need relative to national averages in respect of age/sex, morbidity and life circumstances, and remoteness. NHS Tayside has received 8.00% of the General Allocation funding distributed to territorial NHS Boards.

It is forecast that the gross revenue funding available to NHS Tayside will grow from £797.6 million to £885.8 million over the period covered by the Strategic Financial Plan. This means that NHS Tayside will spend an average of £2.2 million per day in 2008/09. Within this sum we will spend c£1.1 million a day on staff pay.

Taking account of these assumptions, citizens should expect that over the next five years, NHS Tayside will invest in their health by spending c£4.2 billion (gross) on operating costs, and c£155 million on the creation of new facilities.

Delivery of greater efficiency through cost improvements is an important element of any Strategic Financial Plan, and NHS Tayside can be proud of its achievements in releasing resources to facilitate improved services in line with national and local priorities. Indeed it has consistently exceeded the Efficient Government targets. Nonetheless, it is fully appreciated that the potential tightening of fiscal constraints underlines the importance of continuing to deliver on this agenda in order to release resources for reinvestment in modernising services. This is challenging but deliverable.

The following is a list of developments which have workforce implications and have been factored into the workforce projections over 3, 5 and 10 years.

Financial Context and Affordability

NHS Tayside developments with workforce implications reflected in the five year financial plan

- Acute Balance of Care
- Adult Mental Health Service Review
- Medical High Dependency Unit
- Third Linear Acceleration
- Learning Disability redesign
- Mentally Disordered Offenders Review – Medium and Low Secure
- Angus and Perth & Kinross Older People with Mental Health Problems
- Palliative Care
- Renal Dialysis

Nationally funded developments with workforce implications

- Smoking Cessation
- Respect and Responsibility – Improving Sexual Health
- Mental Health Care and Treatment Act
- National Oral Health/Dental Programme
- Keep Well Programme
- Local Alcohol Action Plans
- Health Improvement & Health Inequalities
- Access Support

The inclusion of these developments reflects a 3.1% growth in staffing levels over three years, 3.6% over five years and 3.6% over ten years. The staffing increases are spread over differing staff groups as a consequence of particular requirements in respect of certain initiatives e.g. Mental Health Review reflects increases in Medical, Nursing, AHPs and Administration and Clerical.

8. Clinical Groups

The most significant workforce drivers for change across the clinical groups is the demand created ageing population and the impact of deprivation on health, and the delivery of the 18 week referral to treatment waiting time targets.

The groups covered in this section are;

- 5.1 Healthcare Science
- 5.2 Pharmacy
- 5.3 Specialist Services
- 5.4 Women and Child Health
- 5.5 Critical Care
- 5.6 Medicine and Cardiovascular
- 5.7 Surgery and Oncology
- 5.8 Musculoskeletal
- 5.9 Summary of clinical groups

8.1 Healthcare Science

Healthcare scientists form a distinct staff group within NHS Scotland and includes nearly 50 scientific disciplines distributed across three primary streams;

- *Life Sciences* – analysis, testing and interpretation of clinical samples and products, for example, biochemical medicine, pathology, haematology, phlebotomy microbiology and immunology
- *Physiological sciences* – observation and objective measurement of human performance, for example, audiology, renal dialysis, ophthalmic science and respiratory physiology
- *Physical sciences* – using physics and engineering for patient imaging, measurement and treatments, for example, clinical measurement, ultrasound, equipment management and diagnostic radiology

Healthcare scientists represent around 5% of the total workforce in NHS Scotland, yet almost 80% of patient diagnosis will be attributed to their work. Healthcare scientists are making a significant contribution to key policy initiatives which support the delivery of HEAT (Health Improvement, Efficiency, Access, Treatment) targets and reducing waiting times.

Up to 70% of all patient journeys may involve Healthcare Science Staff working in hospital based laboratories.

Healthcare scientists face a number of challenges as NHS services change from a hospital based model of care delivery to one which is firmly embedded in communities. The delivery of services in more rural areas from such a small workforce sector will be particularly challenging, and the focus on preventative and anticipatory care will open up opportunities to force new and innovative roles that will reflect the evolving community-based model of care delivery.

The development of healthcare science support staff and associate practitioners are key to the sustainability of services. In addition, collaboration and integration with other professional groups will assist healthcare scientists to develop their role, *'colleagues from the allied health professions, nursing and medicine have much to contribute in terms of redefining healthcare science roles and exert enormous influence on demand for healthcare science services'* SGHD (2007c)

Role development initiatives should also be taken forward within service redesign projects to ensure they make positive contributions to new services and complement existing and redesigned roles of healthcare professionals.

A National Action for Healthcare Science has been published, *'Safe, effective and Accurate'* (SGHD 2007c) makes recommendations that will position healthcare scientists at the forefront of service delivery. It identifies two immediate gaps in the provision of Scottish healthcare science training;

1. Training for clinical physiologists, who carry out physiological tests related to human performance such as audiology and cardiology measurements for pace maker set-up

2. Training of clinical technologists, this group provide a supporting role across all healthcare sciences.

The clinical group identified the following workforce issues;

As a clinical group they would seek to have greater influence in defining the role of their services, and the referral patterns they are affected by.

There is a recognition that they have a large part to play in the delivery of waiting time and HEAT targets, and need to shape the workforce to undertake more out-patient diagnostics.

There is a need to develop Radiographers to undertake enhanced roles to meet future demand.

Providing Out of Hours (OOH) services can also be challenging, particularly in laboratory services (biochemistry and haematology) and radiology, covering services overnight can deplete service availability during the day which can impact on waiting times.

There is a growth in demand for Nuclear Medicine, but it can be difficult to recruit technical staff to support the service. Within this speciality turnover is low and there are few promotional opportunities, resulting in a flattened career structure. The regional centres have a large pull on this group of specialists creating potential succession planning difficulties.

In terms of succession planning there is a concern about where new junior scientific staff come from, this supports the national concern and should be noted as a potential pressure in terms of future workforce planning and recruitment and retention strategies.

The national drive to focus healthcare on prevention, and to manage long term conditions more effectively has increased the demand for monitoring and screening of at risk groups. This has led to an increase in requests from General Practice, Out Patient Departments and Referral Centres to enhance speedy diagnosis, and to monitor progress and to reduce hospital admissions. There is also an increase in in-patient laboratory testing to improve diagnosis and reduce length of stay by providing more intensive investigation and therapy, to ensure effective treatment of long term and acute conditions. These factors have created an increase of requests received out of hours.

To facilitate more efficient patient care there is a trend for increased use of Point of Care Testing (POCT) in a variety of settings including; acute hospital, community hospital and General Practice. This advance in the provision of care will place increased demands on laboratory services. Laboratory staff are increasingly required to support high throughput clinics where immediate decisions on patient management are supported by immediate access to laboratory data, for example diabetic clinics. The implementation of the Shift in the Balance of Care may involve more POCT in primary care and rural settings, necessitating professional support from centralised services.

Many therapeutic interventions now require monitoring through laboratory testing. This is an increasing feature of innovative treatment and medication, there is also an increase in monitoring due to widespread use of drugs such as statins and new oncology treatment regimes.

The age profile of staff in Biochemical Scientist workforce shows 47.2% over 50 years of age. This profile is largely due to very rapid expansion in the late 1960s/early 1970s leading to a workforce where a significant number of staff are approaching retirement at the same time.

One development which may help succession planning is the first cohort of Biomedical Science undergraduates at Abertay University have been offered the Integrated Degree route whereby they complete their Pre-Registration Health Professions Council portfolio during an 18 week placement within the clinical laboratories and graduate as HPC registered Biomedical Scientists. This should have a positive impact on local availability and recruitment of Biomedical Scientists

As part of Scottish Government strategies to prepare young people for the world of work, Dundee College is engaged in vocational programmes for S3 pupils. For the first time this year they are preparing Laboratory Technicians at VQ3 level. Twelve students attend Dundee Collage one day a week, and will complete their VQ in the summer of 2009.

Priorities

- 80% of patient diagnosis is attributed to this group of staff. Workforce stability and sustainability is critical to the delivery of the HEAT targets
- The Shift in the Balance of Care and the provision of more diagnostic services within communities will present challenges for this relatively small sector of the workforce
- Role development, new roles skill mix and greater collaboration with other professional groups is essential to ensure the service meets modern healthcare demands
- Changing work patterns may be required to enable delivery of improved access to services while continuing to provide core and out of hours services. Drivers for this will include centrally devised policy to extending opening hours of primary care centres later into the evening and at weekends
- The requirements of provision and design of the Out of Hours service needs defined to match service need
- Young people entering Healthcare Scientists education needs to be explored to establish future labour market supply
- High percentage of Bio-chemical workforce approaching retirement

8.2 Pharmacy

The pharmacy workforce in NHS Tayside is approximately 220 headcount (189.8 wte)

The pharmacy workforce consists of the following staff;

Pharmacists work across primary, secondary and tertiary care and cover all areas of NHS Tayside. Pharmacists achieve full qualification by the completion of a 4-year Master of Pharmacy degree followed by a year of pre-registration experience at the end of which there is an examination prior to registration.

There are two schools of pharmacy in Scotland, Aberdeen and Glasgow. The pre-registration programme is developed by NES for local delivery. NES recruits and places graduates in localities throughout Scotland, both within managed service areas and independent settings. Currently NHS Tayside has six pre-registration graduate places filled and there is an annual succession review that determines whether graduates are offered employment in Tayside locations.

As well as deployment within NHS Tayside managed sector there are pharmacists deployed in community pharmacies. These pharmacies are owned and operated by independent contractors as businesses and recruitment and workforce planning for these is not linked to NHS Tayside. These services can act as competitors in the recruitment market.

Pharmacy Technicians are deployed throughout the board's settings. In NHS Tayside student pharmacy technicians undertake a two-year vocational training programme supplied by Telford College. Upon successful completion of this they will obtain an SVQ level 3 qualification consequently they will be eligible to apply to register as a Pharmacy Technician.

Assistant Technical Officers (ATO), Administration and Clerical Officers. There are wide ranges of pharmacy roles carried out by these employees across all NHS settings and in community pharmacy there are staff deployed as healthcare assistants. Many of these community staff have NVQ qualifications.

The drivers for change in pharmacy services are; in recent years the role of the hospital pharmacist has been evolving into a clinical role focusing on the safe use of medicines throughout the patient's time in hospital. Medicines are becoming an increasingly powerful and costly therapeutic intervention and therefore the need to ensure safe and effective delivery of any increased demand. Pharmacists at senior clinical levels carry high levels of responsibility and there is a need to ensure that their roles make best use of the specialist pharmacy qualification. The implementation of near patient medicines management services (MPJIN) in the hospital setting in recent times has had proven benefits to the patient experience and from this the development of teams of pharmacists, pharmacy technicians and ATOs are being developed within Clinical Groups to maximise these benefits.

The introduction of automated dispensing systems will also have a significant effect on skill-mix needs. As well as improving safety by eliminating picking errors, this will introduce efficiencies in stock handling, assembly, labelling and distribution. Experience outside NHS Tayside reflects that an increasing amount of dispensing will be undertaken by ATOs.

Junior pharmacist recruitment can be problematic, particularly in relation to retention in the NHS. In 2007/8 of the 6 pre-registration graduates currently deployed only one is employed in an NHS Tayside post. Of those recruited for the following year none are likely to remain within Tayside. This presents issues for succession planning into clinical pharmacy posts.

In Tayside there are a significant number of pharmacists in primary care who are advanced clinical practitioners. These pharmacists are currently aligned with Medical Practices and these roles will require to evolve to meet priority needs for patients in primary care settings.

The Community Pharmacy Contract, which is currently being implemented on a phased basis, and will require that the role of pharmacists be adapted to focus on clinical outcomes. The impact of this and allied legislative changes, will see the development of support roles, for example, pharmacy technicians are being developed to deliver dispensing checking in addition to other duties which in the past would have been a significant element of the community pharmacist's role. It is increasingly more cost effective and efficient to develop technical roles in this area of the service. NHS workforce planning is not directly integral to this but presents as competition in the labour market.

An assessment of the demand for pharmacy roles shows that in the hospital setting, pharmaceutical services that are ward/Clinical Group based show that team working has improved services. However the workforce has not expanded at a comparative rate and demand increases year by year.

However, much of this could be addressed by the implementation of automated systems. For example the system will operate throughout a longer part of the day in relation to ward order assembly with minimal staff input.

Experience in other locations is that a week of workload could be completed in the equivalent of three hours of operation allowing the release of staff for ward based pharmacy activity.

Accordingly current staff planning will require to take account of the introduction of automated systems in order that efficiencies in staff profiling are achieved post implementation of automation. If NHS Tayside are not successful in securing automated dispensing, planning will require to take account of projected continual workload increases year on year and the need to recruit staff to achieve effective non-automated staff profiles at significant additional cost to the organisation.

In relation to supply there are currently no large recruitment issues in relation to trainee pharmacy technicians.

Recruitment of ATO staff has historically been problematic because of the relatively low salary levels of these roles. Future diversification of these roles in hospital settings may attract enhanced remuneration. In relation to these roles the market competition is largely external to the NHS with large retailers and call centres representing the competition. It is the case however that NHS working conditions such as hours of work, superannuation and employment tenure are seen as comparatively attractive to this workforce and it may be that NHS recruitment processes require to take more account of this.

Currently of the six pharmacist rotation posts for newly qualified personnel in NHS Tayside two are filled. There are a number of reasons for this:

As mentioned previously in section 8.2 there are two schools of pharmacy in Scotland, Strathclyde and RGU, Aberdeen. As a result recruitment to Tayside is difficult.

Starting salaries for new qualified pharmacists in Community Pharmacy (independent sector) range from £35,000 to £42,000, in contrast Band 5 grade for new qualified pharmacists in the NHS has a starting salary of £23,000.

There is a lack of locally domiciled pre-registration graduates. Low levels of local students taking up school of pharmacy places, all the current pre-registration graduates in Tayside are domiciled in Ireland and most are unlikely to remain in Tayside. The outcome of all this is that a recruitment and succession crisis is developing. In Tayside the succession planning to advanced Pharmacist practitioner level has been generated in the past by the pharmacist rotation and training programme. This may require to be reviewed.

Priorities

- Effective planning and forecasting for technical posts will require confirmation of whether an automated dispensing system will be purchased by NHS Tayside within the timeframe. Meantime it is possible to forecast turnover and succession in relation to this and current trainee technician numbers will meet immediate requirements.
- A retention strategy would be beneficial in relation to all pharmacy posts in Tayside. Career development for pharmacy technicians requires to have a focus and consideration needs to be given as to how competency development can be supported for appropriate individuals to equip people for roles out with the technical function.
- The question of rotational pharmacist posts and clinical practitioner succession is more problematic. There may be options to combine posts and to innovate in order to refuel succession for clinical pharmacy. However the benefits of core junior experience are a valuable building stage for the development of advanced practice.
- Work will have to be done at a national level to address the comparative AfC grading which is the root of this problem.
- Promotion of Tayside as an attractive location and pharmacy recruitment visits to Schools of Pharmacy and local schools should also be a feature. Pharmacy staff should be engaged in and participate in any multidisciplinary recruitment organised by NHS Tayside.
- As part of the integration process for pharmacy in Dundee an ideal staffing profile will be constructed against which future recruitment arrangements will be required.

8.3 Specialist Services

It was highlighted that the data quality around workforce information provided by the organisation, the numbers and detail within different systems did not always match up and this created difficulties in drawing up accurate workforce planning projections and business planning. This issue has been identified by a number of areas, an action plan is being drawn up to rectify this to ensure robust workforce data is provided to meet the requirements of the organisation but also the integrated workforce planning agenda of the Scottish Government, which will see integrated planning across service, finance and workforce. This is an issue which affects all the clinical groups see Workforce information section 22.

This clinical group is seeing an increase in referral across the specialities, the waiting time target will have a clear impact on workload and service design. The ageing population is having an impact on the demand for cataract surgery, vascular conditions and audiology. There is also an increased demand on the NHS to provide new technology such as digital hearing aids. There is also an increase in dermatology referrals across all age groups, particularly relating to suspicious skin lesions/skin cancer.

At ward level there are two distinct elements in the provision of care. There is a growth in the number of patients with a very short stay of less than 24 hours, it is anticipated this trend is set to continue, there is also an increase in long term complex care.

One area of growth within this speciality is an increase in oral-maxillofacial surgery. Oral-maxillofacial surgery includes patients with facial and oral cancer, these patients are acutely ill and the clinical group is seeing an increasing number of referrals with this diagnosis. The numbers are small but treatment is often complex with a requirement for long term care. Oral cancer patients frequently present in an advanced stage of illness, this cancer is often associated with deprivation and the client groups who do not access General Practice or Dental services.

Technology is an important driver within this clinical group. Technological advances are enabling changes in the skill set to provide opportunities tailored to the delivery of care across the Career Framework (appendix 5). Technology has enabled registered nurses to advance their skills to match the changing care profile, an example of this is nurses in Out Patients Departments are working autonomously and carrying out investigations such as biopsies.

To balance this advancement support worker /clerical ward outpatient assistant roles are being developed at Level 2 on the Career Framework to assist with the delivery of Out Patient care. The clinical group are also keen to see the development of the Associate Practitioner at Level 4.

The use of technology for e-referral with digital imaging is seeing an increase in IT based work within the clinical group. This advancement is seeing a reduction in the number of people who need to come into Ninewells, but it has an impact on the skill set within primary care to ensure that patients are cared for effectively at home.

This changing skill profile across the Career Framework will have Training and Development implications for the organisation.

All clinical groups are seeing a growth in sub specialisation, which can have an impact on workforce flexibility across the short, medium and long term. To ensure greater skill flexibility, and support succession planning two Neurosciences Band 6 Nurse Development posts have been created to bridge the specialities of Neurology and Neuro-Surgery.

The clinical group felt there was a skill gap at Band 7, Senior Charge Nurse. The development of leadership skills was seen as a key skill associated with this role. There is a perception across the Clinical Groups that the Senior Charge Nurse role was not attractive. It is seen as a challenging role, dealing with a high volume of office based tasks which are perceived as unrewarding.

The role of Clinical Team Manager is also hard to recruit to across the clinical groups. This post is viewed as potentially unattractive amongst staff, predominantly because of the core element of bed management within the role. The age profile of this staff group is mature, this presents a potential future recruitment priority if the role is not corporately evaluated, to make it more attractive as a career enhancing choice.

The Senior Charge Nurse Review will help support the development of people in these roles. This review recognised that the Senior Charge Nurse role should be embedded within a strong clinical leadership model. The approach places the core values of nursing and midwifery at the centre of patient care and focuses on continual service review and quality improvement. The expected outcome is to improve care at the bedside by redesigning the Senior Charge Nurse role around four key functions, to ensure safe and effective practice, to enhance the patients experience, to manage and develop the performance of the team and to ensure the effective contribution to the delivery of organisational objectives and by providing them with the information to continually assess and improve practice. There will be clear Training and Development requirements attached to implementation. The final report is due in Spring 2008.

There have been difficulties recruiting to Administrative & Clerical posts, with the work environments and remuneration not being perceived to be as good as the private sector. Agenda for Change banding has not helped to make the posts attractive.

The opening of the Dental School in Aberdeen presents potential competition by offering new career opportunities for existing Dundee staff. The Dundee Dental Hospital has previously had recruitment difficulties and the establishment of a new facility in an adjacent Board could create recruitment challenges through greater competition. Responding to competition can provide an opportunity to evaluate roles, and create opportunities for development and role expansion.

Priorities

- 18 week HEAT Target, meeting this target within a trend of growing demand will stretch the existing workforce. The ageing population will create a predicted increased demand in elective referrals for cataract surgery, vascular conditions and audiology. There is also an increase demand for dermatology services
- The clinical group has seen a growth in complex oro-maxillofacial surgery, with this group of patients requiring long term complex care and support

- There is a need to develop the skill set in Primary Care to assist this Clinical Group to manage more people in the community. Training & Development, skill and competency issues for both early discharge and complex cases within primary care will require collaboration with primary care.
- To support the changes in care delivery, and the increased use of technology there is a need for role expansion and role development across the career framework. The provision of robust training and development packages to support job redesign is essential for success.
- Recruitment challenges; Senior Charge Nurses and Clinical Team Managers, Administration and Clerical posts, the competition of the new Dental School in Aberdeen, and the impact of Agenda for Change on recruitment and retention if posts have been banded higher in other NHS Scotland Boards.

8.4 Women and Child Health

Better Health, Better Care (SGHD 2007a) highlights the importance of getting healthcare right in the early years and supporting good health choices and behaviours amongst children and young people, to set them on the right path to sustain them through good health throughout their lives.

The Scottish Government has announced its intention to work with local government and other partners to develop a long term early years strategy by Autumn 2008. The aim of this is to develop integrated approaches across agencies to enable the public sector to meet the needs of children and their families.

Getting it Right for Every Child (SEHD 2006a) is about universal services being proactive in assessing and addressing the child's needs. There is a need to ensure that the needs of the most vulnerable children within society are met, these include disabled children, those who are accommodated or looked after, those at risk in situations of domestic abuse and violence, or live with parents with mental health problems. In many instances these risk factors overlap and are associated with poverty and deprivation.

There are a number of specific factors which are currently impacting on the NHS Tayside Women and Child Health Workforce.

The recent consultation from the Nursing and Midwifery Council (NMC) regarding the future of pre-registration programmes would present significant challenges to maintaining services particularly within acute services if a generic programme were to be implemented. This would necessitate the need to undertake some detailed work around the future workforce planning for children's services.

Within Women and Child Health the potential impact of Modernising Clinical Careers in the Neonatal Unit was predicted and Advanced Neonatal Nurse Practitioners (ANNP's) have been trained who now function on a hybrid medical/nursing rota at junior level. Challenges however remain with succession planning for ANNPs. The impact of MMC at middle grade level has yet to be felt. It is anticipated that with run through training consideration will need to be given to skill mix, support and supervision to ensure care needs are met. Potential solutions are increased consultant numbers and use of highly

skilled advanced neonatal nurse practitioners. Neither of these solutions will be easy to implement and are unlikely to be the full solution.

The impact of MMC on other areas of the Group has been less easy to predict and this along with implementation of the European Working Time Directive for junior doctors and the proposed reduction in the numbers of middle grade staff will place significant pressure on clinical services. It is therefore essential that alternative ways of working / staffing models are considered and integrated workforce plans are developed across maternity, gynaecology and children's services. This will entail the need for the development of new profiles and skill sets for Generalist, Specialist and advanced roles.

NHS Tayside is a development site for *Visible, Accessible and Integrated Care – Report of the Review of Nursing in the Community in Scotland (2006b)* which will implement a new model service delivery and new Community Health Nurse role. This will mean changes for how traditional school health and health visiting services are delivered. To meet the needs of modern service delivery there is a perceived skill gap within child health services around the assessment of children and young people, particularly around generic developmental assessment, behaviour, mental health, occupational therapy and speech and language therapy.

Agenda for Change bandings has banded all school health nurses the same which has removed the previous skill mix structure and career progression. Banding of Advanced Neonatal Nurse Practitioners is another potential problem area as provisional banding across the country are not equitable. Nurses are unlikely to be attracted to these highly advanced roles without adequate remuneration.

In addition for many years there has been an identified need for the development of an education framework to provide a core education package for all people seeing children in an unscheduled contact. This is being taken forward through the *Emergency Care Framework (SEHD 2006c)*

Other areas of workforce pressure within Women and Child Health are;

Within neonatal services the role of midwives is currently under debate and it may be that midwives cannot complete their Intention to Practice when only working in this area. This would impact to a small degree in Tayside as this has been anticipated and direct entry midwives have not been employed for a number of years.

Neonatal transport is another area where workforce issues are arising. A review of this service is imminent. Issues continue with maintaining the nursing and medical on-call rota and nurse on-call remuneration.

The provision of Homecare services for children with complex care needs requires an intensive care package. There are a growing number of children who are care for at home with invasive ventilation, the pathway of care is often determined by the tertiary centres but delivered locally with no clear model of care underpinning the service delivery. This is an area of care supported by a high use of agency staff to around £1.1 million per annum. This service is currently under review.

A national group established to review maternity services across Scotland has reported. If endorsed this may have significant impact on both maternity and neonatal services, which would require to be reflected in the workforce plan.

The National audit of children's high dependency care services has concluded and once this has reported there may impact on staffing levels and training requirements.

A Review of Specialist Services is currently being undertaken, there are 26 streams of work which will inform an Action Plan to be published in Spring 2008, the Action Framework from this will inform the design of the specialist Paediatric Workforce.

The delivery of age appropriate care for 14 – 16 year olds is currently being examined. Historically paediatric services provided services up to age 14, the development of adolescent services has evolved to ensure a safe and effective transition of young people with chronic illness and disability from paediatric care to adult health services. To achieve this, three elements must be pursued with vigour. Firstly, a cultural shift in NHS staff attitudes and training is required. Secondly, systems must change to ensure that all paediatric chronic illness and disability services have effective transition programmes in place. Thirdly, young patients need to be trained and empowered to allow them to be an effective partner in their own transition. Improvement of this transition is merely one part of a wider need to improve health care for adolescents.

The Shift in the Balance of Care will require the provision of advanced paediatric skills across the professions. This is a national issue across NHS Scotland, hampered by the difficulty in commissioning a Training and Development package for the Advanced Paediatric Nurse Practitioner. Remuneration for these roles has also presented a barrier to encouraging individuals to taking on additional skills and responsibility.

This clinical group highlighted the National Workforce & Workload tools have raised questions about accuracy relating to whether workload is being benchmarked against a realistic comparison. This can have implications for Governance and Standards.

The Scottish Government has published a number of important policy initiatives designed to support and improve the mental health of children and young people. Successful implementation requires that, within the workforce, there are skills in promoting mental health, skills in preventing mental health problems and skills in providing appropriate care and treatment for those with emerging and established mental health problems.

Scottish Government policy described in The Mental Health of Young People: A Framework for Promotion, Prevention and Care (FPPC) envisages mental health services with greatly expanded capacity for primary mental health work and early intervention but also for work with children and young people with complex and severe mental health problems.

The workforce for the community-based CAMHS and for inpatients and intensive CAMHS is established at levels well below that necessary to facilitate the kind of improvement in the mental health of children and young people that are anticipated in current policy documents. It will need to expand substantially.

Increasing the capacity to improve the mental health and young people requires a range of activities. In particular it will involve both increasing numbers through new investment in posts and improved retention of current workforce and increased efficiency through training and supervision.

A Maternity Services Strategy is currently being prepared.

Priorities

- Production of a SGHD Long Term Early Years Strategy due Autumn 2008 to develop integrated approaches across agencies to enable the public sector to meet the needs of children and their families.
- Ensure that the needs of vulnerable children and young people are met – many risk factors overlap and are associated with deprivation
- Succession planning for the impact of MMC, in particular middle grade, will require the development of new team profiles and skill sets across generalist, specialist and advanced roles
- Within the community child health services a skill gap in generic paediatric assessment has been identified, this includes; generic developmental assessment, behaviour, mental health, occupational therapy and speech and language therapy
- Sustainability issues around the neonatal transport service on call rotas
- Review the design and provision of the model of homecare services for children with complex needs
- Once published in Spring 2008, take account of the findings of the Review of Specialist Services, and the resultant impact on the design of the specialist paediatric workforce
- Develop transitional services from paediatric to adult care
- Recruitment and retention issues of the predicted expansion of Child and Adolescent Mental Health Services
- There are a number of training and development priorities identified associated with community, transitional services, shift in the balance of care, and child and adolescent mental health services

8.5 Critical Care

Workforce pressures within this clinical group have predominantly been within Renal and Theatres.

The national trend of an increase in the number of people requiring renal dialysis has had a significant impact on workload. The future predictions of increased incidence of long term conditions will see this trend continue.

In addition, many renal patients can be quite challenging to treat this places additional demands on pressured team. The average age of the patient group is 72.75 years, they frequently have complex co-morbidities, including mental health issues, and the department has seen an increase in amputees requiring renal dialysis. A move to a 'hub

and spoke' model of care will see dialysis provided in Perth and Kinross, and Angus. The establishment of these peripheral units will require a change in workforce deployment to provide a community based service which better meets the needs of renal patients in Tayside.

To help meet future needs the renal department has implemented a number of workforce changes. A full-time renal educational co-ordinator has been appointed to help support the training and development needs of the department, this post focuses on helping to get new staff and bank nurses the skills and competencies they need to work with renal patients.

A Senior Renal Nurse has been trained as an independent nurse prescriber, which adds a new dimension and advanced skill to an existing staff members role, but also helps to support and streamline care pathways.

A training programme has been established for Band 3 support staff, which will enable the support worker to expand their competencies and work as a Renal Care Assistant. This provides a career structure and development opportunities for un-registered staff and helps to support staff retention. The advancement of skills is of great benefit to patients, but it is important that the staff themselves receive appropriate remuneration under Agenda for Change for taking on additional responsibility.

Critical care are keen to establish staff rotations across renal and medicine to develop a robust transfer of knowledge and experience, to better support the growing number of patients with complex co-morbidities.

Within theatres a number of initiatives have been introduced to overcome recruitment difficulties.

The changes in population are likely to place increased demand on theatre time, with a predicted increased incidence in elective surgery, for example cataract and joint surgery which is associated with an ageing population. The 18 week waiting time target will also present challenges to the theatre schedules. In addition surgical advances will also place additional pressure on available sessions, like, for example to opportunity to perform onco-breast surgery. This involves therapeutic breast surgery to remove a malignancy, then a plastic surgeon progresses to perform reconstructive surgery, this can take up to 16 hours to perform.

A 6 week 'GO Package' has been introduced for new staff. This provides a higher level of support, and provides on going supervision for 6 months.

The role of the Band 2 support worker is currently being examined to design a role which better meets workload demand. Currently staff are recruited as either Healthcare Assistants or Operating Department Orderlies, it is felt combining the role to develop a Theatre Support Worker would better meet the needs of patients, and provide greater workforce flexibility.

Advanced scrub practitioners who support the surgeon at the operating table demonstrate how hybrid roles can play a vital part in ensuring workforce sustainability. Three existing members of staff are currently being trained in this role through Glasgow Caledonian University.

The role of Anaesthetic and Surgical Assistants are currently being explored nationally by NHS Education Scotland. The potential contribution they could make to the NHS Tayside theatre workforce is being discussed in a variety of forums.

A Planned Care Assessment Programme which will help make the health assessment and psychological preparation of elective patients more holistic and consistent is currently under development. It is also hoped that this will facilitate the creation of more dynamic roles for existing staff, together with improving the patient pathway.

Priorities

- There is an increased number of patients requiring dialysis. This accounts for the future predictions around long term conditions this is a trend which is set to continue. Many renal patients present with complex co-morbidities including mental health issues, requiring staff within this clinical group to have a wide range of flexible skills to meet patient need.
- The future will see renal dialysis provided in a 'hub and spoke' model with peripheral units established in Perth & Kinross and Angus, this will require a re-distribution of skills and potential new recruitment.
- This clinical group are keen to establish staff rotation across medical and renal this will help to establish the flexible skill set needed to manage the complex co-morbidities within the clinical group.
- The 18 week HEAT waiting time target will place additional pressure on theatre sessions and the theatre workforce, in addition changes and advances in surgery are requiring longer theatre time which impacts on the number of available sessions.
- The Clinical group is keen to develop the support workforce at level 1-4 on the Career Framework.
- This clinical group are keen to establish staff rotation to improve the knowledge of older people with complex co-morbidities

8.6 Medicine and Cardiovascular

The growing ageing population will have a marked impact on the predicted workload of medicine and cardiovascular. A key factor is how to bridge acute and primary care, and share skills across the patient journey. An increase in the availability of skills and expertise in primary care matched to the patient profile would provide greater opportunities to explore alternatives to admission. There are a number of examples when patients who could be managed in primary care are admitted because the right skills are not available, examples reported by the clinical group are; catheterisation, and displacement of PEG tube, and because no District Nurse Assessment is available in the evening patients are unnecessarily admitted for assessment and monitoring.

As with other clinical groups there is a move to an increase in sub-specialities. To meet the needs of the predicted future demographic trends there needs to be a debate about how the Medicine and Cardiovascular service model is developed. The Specialist V's

Generalist question is key to future service planning, and in particular the modelling of the service in Ward 15 (Medical Admissions). Should Ward 15 be developed on an A&E triage model? Under this model acute admissions would be assessed by a generalist acute physician, then following assessment patients would be handed over to the appropriate sub-specialist. A cohort of acute physicians would work in Ward 15, meaning sub-specialists would not carry out acute assessments. The issue of how the High Dependency Unit is to be staffed also needs to be defined.

Recruitment to the consultant grade is variable in terms of attracting appropriate candidates. It is predicted that as the clinical group adapts to the changing needs of service the profile of Consultant posts will also change. The impact of this on recruitment is as yet unknown.

Within cardiovascular medicine the development of Primary Angioplasty, to be undertaken within 3-6 hours of a myocardial infarction (MI), will possibly take over from thrombolysis as the primary intervention following MI. This service will need, overtime, to be a 24 hour service, and there are questions to be answered about how we develop and sustain the cardiology workforce across all levels of skill needed to support this service, either locally or as part of a regional service.

The growth in the demand for endoscopy is currently being researched as to whether it is a population trend or a localised phenomena? The increase in cirrhotic liver disease may lead to a greater requirement for interventional endoscopy. The training of Non-Medical/ Nurse Endoscopists in collaboration with NHS Education Scotland is a national agenda, this development will support waiting targets as well as the expansion of existing roles.

The current and future workload within the clinical group will require an increase in generic Medicine for the Elderly skills.. In addition, obesity is on the increase and will put pressure on diabetic and sleep services. The skills and competencies required to provide non-invasive ventilation within the community will also need to be considered in the design of the workforce across the patient journey.

In nursing there is a shift in the balance of experience within the nursing establishment. The ageing workforce means that with increased levels of retirements the balance between experienced and newly qualified nurses is changing. The increased number of newly qualified staff puts pressure on the workload. The alteration in the skill mix, means that there is an increased requirement for mentorship and more time spent supporting staff which ultimately has an impact on the establishment, and time allocated to training and supervision.

There is a growth in the numbers of nurse specialists, linked to the increased incidence of long term conditions, and the change in availability of junior doctors these roles have been developed to fill gaps in roles doctors previously did. The development of nurse specialists enables consultants to see the patients they need to see, however in examining the bigger picture this group of expert nurses need to improve links with primary care to support patients within their own communities.

There is a recognition that skill mix needs to be addressed to better meet the needs of patients. Establishments are continually being examined as vacancies arise. The clinical group is keen to look at expanding the workforce at Levels 3 and 4 on the Career Framework to provide career development for the un-registered workforce, but also to

ensure robust succession planning, and the establishment of a workforce designed around patient need.

Physiologists (carry out physiological tests related to human performance) are in short supply nationally. They can be 'home grown' but then can be lost to other organisations. Agenda for Change bandings has exacerbated this because of the inconsistency in bandings across the territorial boards.

As with other Clinical Groups there is difficulty in recruiting Senior Charge Nurses, it is viewed as an unattractive job with poor remuneration for the increased responsibility. It is also felt that there is not the correct training and development available to prepare nurses to move into this critical role. The Review of the Senior Charge Nurse role may offer a start to changing the profile of this role.

Priorities

- A key issue for this clinical group is finding a way to bridge skills across acute and primary care. An increase in the availability of skills and expertise in primary care matched to the patient profile would provide greater opportunities to explore alternatives to admission. This includes the link specialist nurses have to primary care.
- An increase in sub-specialities, has created some generic skill gaps, there needs to be a debate about the specialist v's generalist balance within the workforce to meet patient need
- The development of primary angioplasty will present workforce issues around the provision of the 24/7 service, and the skills and competencies across the career framework needed to deliver the service
- The increased level of nurse retirement is altering the skill balance in ward establishments, with an increased number of newly qualified staff being employed to fill vacancies.
- The clinical group is keen to develop the support workforce at level 1-4 on the career framework

8.7 Surgery and Oncology

The predicted rise in cancer prevalence (18.9% between 2004 -2015, NHS Tayside 2006) and meeting new waiting time targets will have a significant impact on the workload of this clinical group. There are increased referral rates across all cancer diagnosis, and patient treatments are more complex and lengthy often leading to an increased life expectancy. This affects the whole workforce who contribute to care and treatment including pharmacy (chemotherapy) and radiology. In light of the advances in treatment cancer is now being viewed as a long term condition. The service is also seeing patients who have previously been treated returning with subsequent new primary cancer sites.

There has also been an increase in the number of patients referred to Urology. The increase in referral rates for screening, for example colo-rectal to support early diagnosis

and treatment will also change the profile of the service. In response to this the clinical group are looking to recruit nurse colonoscopists to support the service expansion.

This clinical group reports a growth in workload being managed within a reducing establishment. The clinical group currently has 32 members of staff on maternity leave. The higher incidence of maternity leave may be reflective of, as with other clinical groups, the growth in younger newly qualified staff within the establishments. This may be another factor to consider when examining the wider impact of the changing workforce demography, including the increasing feminisation of the workforce across all professional groups.

The Agenda for Change grading and evaluation system is also affecting the workforce profile, staff are not moving to other posts because they see no incentive. In the past the career advancement from D, to E to F grade was recognised as career progression and the change in grade was viewed as an incentive. Now band 5 covers this staff group and removes the external recognition of progression, therefore staff are remaining in the same posts, rather than being tempted to expand their experience within another area. This may have implications for the wider skill set of the future workforce.

As with other clinical groups there is a keenness to develop roles at Level 3 and 4 on the Career Framework, the section on Associate Practitioner will describe these roles in greater detail.

Again, as with the other clinical groups there is real difficulty in recruiting to Senior Charge Nurse roles.

There have been some challenges in recruiting to some Consultant posts. Posts within Oncology have not been filled, there are three anticipated retirements in Perth Royal Infirmary in the next 4 years. The growth in Urology referrals has led to the creation of an additional Consultant post to meet demand. A shortage in General Surgeons has a working group looking at workforce solutions to meet this skill gap. There is also a difficulty filling Fixed Term Specialist Training Appointments (FTSTA) posts when Senior House Officers leave.

The increase in the number of patients being offered breast reconstruction surgery at the time as therapeutic surgery to remove a malignancy, will not only require longer theatre sessions, it also potentially means longer in-patient stays and more complex post-op support in primary care.

Priorities

- Meeting the HEAT targets within the predicted rise in cancer prevalence will present significant challenges to this clinical group. There is also an increase in patients referred to Urology.
- Treatment pathways for patients are more complex and lengthy, often leading to improved life expectancy and in some cases cure
- Agenda for Change has affected internal movement and progression of particularly the nursing workforce, which is impacting on the development of a flexible skill set and the number of available opportunities for change

- There are challenges in recruiting to Consultant posts, including a shortage of General Surgeons.
- The clinical group has high rates of maternity leave

8.8 Musculoskeletal

The ageing population will affect this clinical group with a potential increase in the numbers of A&E attendances from falls and fractures, increased orthopaedic referrals, and the need for rehabilitation and engineering (orthotics, prosthetics and wheelchair) services.

The patients attending A&E are frequently elderly with complex co-morbidities, this clinical group is seeing an increase in the number of patients with cardio-vascular conditions, myocardial infarction and stroke, and increased numbers with respiratory illness. This reinforces the need to treat the whole patient and not merely by admitting diagnosis, however, the impact of co-morbidities will affect length of stay, recovery and rehabilitation.

An increase in the number of hip fractures and joint replacements, and increase in waiting time targets has a significant impact on the workload of this clinical group.

A change within society with an increase in the number of elderly people living alone is having an impact on discharge planning for patients. Patients frequently suffer a loss of confidence when their mobility is affected, and this impacts on the design and delivery of discharge support. Early supported discharge is available providing combined package of health and social care for up to 4 weeks, increased demand has seen a recent expansion of these services. This service expansion will have an impact on workforce deployment, and to the changing skill and competencies required to deliver care.

Mobility is critical to independence, and inclusion and socialisation within society. The changing demographic profile means there is a greater demand on Tayside Rehabilitation Engineering Services to provide wheelchairs and other devices to help get people mobile.

Increase in demand has not just been confined to older people, there has also been an increase in young people requiring wheelchairs and devices following sports injury.

There is also a change in public expectation around the provision of wheelchair services. A recent National Review of the Wheelchair service has made 40 recommendations for the improvement of wheelchair services (SEHD 2006d). The timeframe for implementation of improvement within wheelchair services has effect from April 2008. Additional Scottish Government resources will be channelled towards the five wheelchair centres across Scotland with £4 million allocated in 2008/09. £6million in 2009/10 and a final £6 million in 2010/11. This money is not 'arbutnotised' but is distributed on a bidding basis linked into improvement outcomes. Locally it is anticipated this will see an extension to some existing roles for some staff, and a combination of Clinical Scientist, technician and AHP recruitment. A rapid improvement event is planned for April 2008 to redesign existing services.

The 18 week whole journey waiting time target from General Practitioner referral to treatment by 2011 is particularly challenging when delivering within tighter financial targets.

The benefits of the Stracathro Netcare initiative currently makes a contribution to the delivery of these targets. If this development did not continue after 2010. To ensure the delivery of the 18 week target is sustained the early preparation of an exit strategy would appear prudent.

A consistent theme across all the clinical groups is a difficulty recruiting to the Senior Charge Nurse role. The role is seen as distant from patients, and increasingly has a focus around the improvement agenda, risk management, complaints handling and root cause analysis. The role needs to be clearly defined and supported to develop a leadership role which is attractive and contributes to the delivery and improvement of patient care.

The need to develop a Housekeeper/administrative role has been identified to meet a skill gap within the existing team, the development of this role would assist in the delivery of the Patient Safety agenda. There have been attempts to introduce this role in NHS Tayside in the past, it may be timely to revisit the work undertaken to date and explore the potential of this role.

There have been recruitment difficulties within rehabilitation services, in prosthetics, orthotists, and clinical scientists. Recruiting Allied Health Professions (AHP) associated with these specialist rehabilitation services has also been challenging. This is viewed as a supply issue due to the narrow field of specialism. One potential solution would be to establish an AHP rotation.

Succession planning of the clinical academics needs to be considered, one orthopaedic surgeon is currently on secondment to the Royal College of Surgeons - Edinburgh, there is also likely to be early retrials within the NHS appointed consultants over the next 2-4 years at a time when demand is increasing due to demographics and the 18 week waiting time target.

The development of new roles needs to be explored, and should be linked to challenges, such as MMC, and workforce demand. The Surgical Assistant, a competency based role, is currently being explored, along with what is the best skill set to undertake the arthroplasty, a co-ordinating practitioner role is being explored.

There is to be further expansion of the emergency nurse practitioner role, this will include discussion with Minor Injury Units where more focus is needed around staff development and the role staff in the units undertake. The role of a trauma nurse co-ordinator/consultant is also being explored.

The development of hospital based and peripheral clinics is key to Shifting the Balance of Care, the role of extended practitioner will help to triage patients more appropriately, and assist in meeting the needs of patients who are reluctant to access health services, thereby tapping into unmet need.

This clinical group is also keen to develop the Level 4 Associate Practitioner role.

Priorities

- Changes associated with the ageing population are creating an increase in the number of A&E attendances with falls and fractures, placing an increased demand on orthopaedic, rehabilitation and rehabilitation engineering services.
- The clinical group is identifying the need to treat the whole patient to ensure optimal recovery, there is an increase in the number of patients with complex co-morbidities, this creates a demand for a flexible skill set to deliver optimal care.
- The delivery of the 18 week HEAT target will challenge the present workforce in terms of demand
- The clinical group have identified the need to develop a number of clinical and non-clinical new roles to support the predicted service demand
- Recruitment pressures; Allied Health Professionals associated with rehabilitation, Orthopaedic surgeons and Senior Charge Nurses.

8.9 Summary of clinical group themes

- A wide variety of areas are seeing a growth in referrals both planned and unplanned, these included; vascular conditions, cataract surgery, audiology, point of contact testing and diagnostics, complex maxillo-facial, renal, general medicine, endoscopy, and orthopaedics.
- A growth in sub specialities across all clinical groups is leading to a loss of competent generalist skills. General assessment skills must be robust across the patient journey. Specialisation is having an impact on career and succession planning, and workforce flexibility.
- The changing and complex presentation co-morbidities was also a common theme – the need for good generalist skills in caring for the growing elderly population across all specialities, these included mental health, dementia and long term conditions was identified, There was a strong message about the need to look at the whole person not just the admitting diagnosis, or specific long term condition. Work needs to be undertaken around skill profiling to develop competency based teams.
- All of the clinical groups raised issues about the introduction of MMC, and the impact this was having on the available skills and competencies to support quality patient care. MMC will be covered in Section 20.
- Several areas saw the development of formalised staff rotations as an answer to developing robust knowledge and experience to manage complex co-morbidities both in acute and primary care. It was also seen as a way of developing capacity in primary care.
- The 18 week Referral to Treatment targets was a primary concern, the configuration of the correct workforce is the key to successful delivery of the targets. Again this points to undertaking an integrated skill profiling exercise

across the professional groups to determine the correct workforce profile for effective delivery.

- There was a strong message that now we are moving away from planning the workforce in professional silos, not to now plan in diagnostic silos. Patients with complex co-morbidities present with a variety of health and social issues which need managed collectively, not under individual diagnostic groupings.
- There were difficulties highlighted across all the clinical groups in recruiting Senior Charge Nurses and Clinical Team Leader's, these roles are critical to the organisation but are not perceived as attractive. This perhaps highlights the need for a focused piece of work on the design and marketing of these roles.
- The development of the support workforce levels 1-4 was seen as a priority for all clinical groups, All were keen to support the development of the Associate Practitioner at level 4.
- Agenda for change, pay discrepancies are affecting all areas and this issue was highlighted by the Area Clinical Forum. The discrepancies are creating recruitment and retention difficulties across a wide variety of departments; Healthcare Science, Pharmacy, Specialist Service and Women and Child Health raised particular concerns for the sustainability of their workforce.
- The skill balance in the workforce is being affected by increased retirements and an increase in newly qualified staff within ward establishments.
- The issue of capacity in primary care to facilitate the shift in the balance of care and prevent hospital admission, and manage complex care was repeatedly highlighted. This included the having correct skill and competency base to provide the services across the 24 hour period
- It was raised that Improvements in leave entitlement resulting from Agenda for Change and HR initiatives such as family friendly policies, maternity leave, carer leave, and parental leave pose significant challenges in maintaining existing levels of service provision with the current staffing levels. Some of these are responses to statutory requirements.
- As predicted the labour market is becoming increasingly competitive, challenges are multi-faceted and come for private companies and private industry, local authority, and the third sector (voluntary sector).
- Areas where sustainability is particularly highlighted are; Pharmacy, Healthcare Science, Senior Charge Nurses, Clinical Team Leader, Dental Services, Neonatal care, renal, theatres, and specialist paediatrics.
- There is a lack of robust workforce information to inform planning
- The Managed Clinical Networks are linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner, unconstrained by existing professional and Health Board boundaries, to ensure equitable provision of high quality clinically effective

services throughout Scotland, the MCN's therefore offer a mechanism to support patient journeys sharing of good practice.

9. Works and Trades

The Works and Trades department has highest age profile within NHS Tayside, with 73.3% currently over 50. This age profile has significant implications for the sustainability of the workforce and the retention of specialist skills to ensure safe and efficient running and maintenance of buildings and plant.

Modern Apprenticeships were re-established in NHS Tayside in 2006, this was after a 22 year gap. The rationale for recommencing the apprenticeship scheme was two fold;

- Within an increasingly competitive labour market failure to develop a robust 'grow your own' strategy could present a significant risk to the sustainability of this sector of the NHS Tayside workforce, and in addition the wealth of expertise and skills our current workforce have of the organisations plant and facilities would be lost unless an opportunity was provided to pass this knowledge onto the next generation.
- NHS Tayside is the largest employer in Tayside, the organisation has social responsibility to provide opportunities to have a workforce which reflects the population it serves. As well as contributing to the Scottish Government's employability targets and to the National Social Inclusion Agenda, initiatives like the Modern Apprenticeship scheme are enhancing the reputation of the NHS as an employer. The NHS as a large employer has the potential to make a significant difference to individuals, families and communities not only through the quality of healthcare, but through employment practices.

As the model of healthcare delivery changes and services are provided closer to people's homes, the supporting workforce and maintenance structures will need to be more flexible, and mobile to match demand and support the new model of care provision. This will include maintenance of community loan equipment which is growing to meet demand, the maintenance of diagnostic and decontamination equipment within primary care to comply new regulations, and increased demand for portable appliance testing within primary care. The development of primary care services will also increase the need for this sector of the workforce to travel to carry out their duties and responsibilities, thereby reducing the available 'hands on' work time within the workforce.

The implementation of new acts and legislation will bring an additional workload, and additional training and development requirements for our existing Works & Trades staff. Together with the maintenance of new, more advanced equipment will bring new challenges and demand for skills, which may be difficult to acquire out with the NHS, therefore workforce development to ensure we have to correct skills to support our healthcare environments is essential.

In addition to the Modern Apprentices, two Management Trainees have been appointed as part of an attempt to ensure continuity as Senior Managers retire. Targeted training and development is also being focused on supervisors to ensure consistent, corporate approach to this crucial role. Having a corporate approach to the supervisor role also helps ensure an understanding of the role across the healthcare workforce.

The news that the Olympic Games would be hosted in London in 2012, and the Commonwealth Games in Glasgow in 2014, was very positive for the UK. However, the demand for skilled works, trades craftsmen to build and develop these sporting venues and event towns cannot be underestimated. Large numbers of skilled workers are already being recruited, at highly competitive salaries, for the development of both sites, as a result securing independent contractors for work is likely to become increasingly difficult, creating significant problems for many organisations across the UK. Growing our own workforce in anticipation of difficulties is prudent.

The comparative salaries available for work and trades staff in the public and private sector show a difference, with the private sector able to offer higher salaries which they can then pass onto the customer. The future sustainability of this skilled workforce requires close monitoring to protect our healthcare environments.

Priorities

- The age profile of this workforce sector can predict high rates of retirement in the next 3 – 5 years, this presents a risk to sustainability and maintenance of skills within this sector.
- There is a need to support 'Grow your own' strategies such as the Modern Apprenticeships to ensure that skills and experience of facilities and plant are passed onto the next generation to ensure workforce sustainability.
- The implementation of new acts and legislation will change the profile of work and levels of demand within this sector
- The recruitment of works and trades staff to support the development of the Olympic and Commonwealth Games sites will affect the availability of external contractors, and increase labour market competition.

10. Public Health

Key national policy guidance for public health

The two key policy drivers are Better Health, Better Care (SGHD 2007a) and the impending 'CEL' around the 'Health Promoting Health Service'. Their significance will impact across both NHS Tayside and our Community Planning Partners. The first 39 pages of Better Health, Better Care focus on the Public Health/Health Improvement agenda. This is underpinned by a strong commitment to tackling health inequalities in Scotland. The priority health topics in Better Health, Better Care, and in particular the early years agenda are reflected in the Public Health Directorate's Priorities for 2008/09 www.taysidepublichealth.com

The role of the public health directorate

The Directorate of Public Health is responsible for leading the Public Health agenda in Tayside. The multidisciplinary nature of the Directorate ensures that multi-faceted approaches can be used to tackle public health challenges. The Directorate works with

partner organisations to focus the public health/health /improvement agenda on tackling health inequalities. In addition the Directorate has a responsibility for minimising the impact of health risks to the population and for assisting NHS Tayside in developing its 'Hierarchy of Care' model so that people receive services within a location appropriate to their needs. To this end the Directorate has aligned a large number of its staff to localities in Angus, Dundee and Perth & Kinross in order to provide direct support to local partner bodies tackling health improvement issues.

Senior staff in the Directorate play a direct role in all key planning structures within Tayside thus ensuring that Public Health and Health Inequalities are integral to the agenda of NHS Tayside and its partners. The services comprise

- Communicable Disease Control and Environmental Health Hazards
- Evidence, Research and Evaluation
- Education and Training
- Resource & Library Service
- The Health Shops
- Health Inequalities
- Healthy Working Lives
- Public Health Nursing

Workforce issues- The Directorate of Public Health

Better Health, Better Care re-emphasises the need for the NHS to promote better health and wellbeing and reduce health inequalities, sometimes through redesign of its own services, but more commonly through joint initiatives and programmes with key partner organisations, particularly our local authorities, and with increasing engagement of the public, patients, community groups and the voluntary sector. While welcome – these are well established public health principles and practices – this inevitably places significant capacity pressures on our specialist department.

An increasing focus on public health activity in a tight financial environment will prove challenging. Whilst increased efficiency and prioritisation of the public health programme will make a contribution, consideration will need to be given to investing in the public health agenda to ensure the board is well placed to meet the policy imperatives in Better Health, Better Care of promoting health and reducing health inequalities.

Skill Mix

The Directorate has a multi-disciplinary workforce of 71.44 wte (87 headcount) comprising medical, dental, nursing, health promotion, pharmacy and support staff.

The workforce is currently stable, the age profile is 15% of the public health staff are aged 55 and over.

Supply of suitably trained Professional Staff

After a period during which NHS Tayside's training recognition in Public Health Medicine was withdrawn, it has in recent years been re-established. Public health now has a SpR/StR training programme which is nationally accredited, with no difficulty recruiting candidates to posts as they become available.

Scottish universities (Robert Gordons University and Queen Margaret University) produce post graduates in health improvement at a level to meet organisational requirements. The use of 'equivalent experience' in Agenda for Change job profiles has allowed the department to use incoming core transferable skills and with further training and coaching to meet post requirements.

The department has identified the need for investment in the dietetic profession to manage malnutrition and obesity in the population.

Recruitment

A number of posts are fixed term as they are funded from ring-fenced monies. It is difficult to retain these staff when the post has been running for around 2 years as the employee understandably seeks a more permanent position or a longer contract within other organisations.

The commitment to CPD, a varied work remit, the implementation of NHS Tayside's family friendly policies, a generous annual leave allocation, the provision of sick, special and carers' leave and the final salary pension help retain staff.

Our wider PH workforce

The vast majority of the public health/health promotion programmes require the participation and cooperation of all disciplines of community nurses. These nurses provide services, for example, immunisation, smoking cessation, breastfeeding support and a range of other services which help people to sustain and improve their health.

The proposed new model of the community health nurse is generating concerns particularly as the current job descriptions demonstrate no clear pathways for work with children or the public health function of the new community nurse, whilst in reality this may be no different to other clinical priorities, for example care of the elderly. In view of the range of actions set out in Better Health, Better Care to tackle health inequalities, given these concerns the transition period is likely to be particularly challenging for those in the public health directorate accountable for the efficient delivery of health promotion programmes, innovative solutions will need to be developed.

The department has a continuing commitment to align senior directorate staff to the three CHPs. This has been very successful model with added-value being experienced both by the CHPs and the wider community planning partnerships.

Priorities

- Planning and leading the Public Health/Health Improvement agenda outlined in Better Health, Better Care (2007a)
- Increased demands being placed on Public Health Directorate with a static substantive workforce resource
- Difficulty retaining staff on fixed term/ ring fenced contracts

- Public Health relies on the substantive NHS Tayside core workforce for the delivery of the majority of its strategies. This can be amidst conflicting high priority agendas.

11. Allied Health Professions

The single most significant driver for the AHP workforce of Tayside over the next few years is the planned shift in the balance of care. Local priorities and policy drivers will change the location and models of rehabilitation, in particular community rehabilitation, this will lead to the requirement for much greater coordination across all sectors and agencies. Rehabilitation is defined as '*a process aiming to restore personal autonomy to those aspects of daily life considered most relevant by patients or services users and their families*' (SEHD 2007). This affords the opportunity to focus on enabling people to be 'the best they can be' and for us to look at innovative use of our workforce through integrated health and social teams.

Models of care

Within this context of change NHS Tayside is currently looking at the potential models for therapy services across the whole patient pathway, and in particular the configuration of community services. It is important to recognise the additional impact of Visible, Accessible and Integrated Care - the Review of Nursing in the Community (SEHD 2006b), with a particular need to focus on the skill and competences needed to provide appropriate, quality community services.

There is further potential to develop integrated teams and roles to focus on promoting independence, and for the workforce to be sufficiently proactive to prevent further admission to hospital, and to actively prepare patients within secondary care towards the appropriate level of support and intervention on discharge. The emerging community models are based on a hub and spoke principle, affording the opportunity to build a clear line of clinical leadership and practice development.

Demand continues to rise for all AHP professions with shorted guarantee times and an increase in complexity of referrals. The increased requirement for timely diagnostics impacts on radiography and reduction in cancer times impacts significantly on therapeutic radiography. The roll out of Hall 4 - Health for all Children Hall & Elliman (2003) increases demand on therapy service in particular Speech and Language therapy and orthoptics. Several areas have reviewed the efficiency of their service by applying LEAN methodologies.

Currently the overall turnover rate of the therapy professions is 1.1%. The challenges in recruitment remain largely at senior level, particularly in occupational therapy although within physiotherapy the development of a physiotherapy bank to aid placement of unemployed new graduates probably disguised the true impact. Over 2007 the bank recruited in the region of 47 newly graduated physiotherapists and has provided substantive appointment for 9/47, 16/47 are waiting for HPC registrations. New schemes and new models of care are evolving with the development of vocational rehabilitation and OSHAS Xtra.

Information systems continue to develop with an improvement in the processes for reporting measurement of capacity, activity and waiting times. This is, however not without its challenges and will require further refinement as the national workstreams for

AHP mature. (AHP Workload Measurement and Management, SEHD, 2006e) Although available on the intranet there is a caveat that this needs to be significantly refined.

Priorities

- Develop skills and competencies to support the shift in the balance of care, in particular rehabilitation.
- Develop a hub and spoke model of provision to assist in the preparation for discharge of patients in secondary care, and prevent admissions
- Recruitment hotspots include; radiology, therapeutic radiology, speech and language therapy, orthotics and Senior Occupational Therapists. Other areas of recruitment difficulty have been highlighted in the various clinical sections of the paper.

12. Nursing Services – Single Delivery Unit

The workforce issues affecting nursing services are varied across the region, many are described within the individual clinical groups and CHP's, but some areas in particular are highlighted. Visible, Accessible and Integrated Care (SEHD 2006a) is covered separately in Section 18.

Better Health, Better Care (SEHD 2007a) and Delivering care, Enabling health (SEHD 2006f) are key strategic documents which offer the opportunity to approach workforce planning and development from the perspectives of the patient journey, to take account of the changing levels of complexity across this journey, from self-care to acute hospital care and building the workforce around that.

The need to establish a suite of core, flexible, transferable skills within the workforce was identified. This includes the need for a generic skill set in to care of older people and patients with long term conditions, for example communication skills, core caring skills which were transferable across specialities. The need to see the whole patient and not a single diagnosis, is a consistent theme throughout this paper, and strengthens further the need for robust transferable skills within the workforce. This includes the ability to identify, assess and protect vulnerable adults and children across all care environments and specialities.

Skills associated with the older peoples agenda, for example dementia care, mental health, and cancer care are seen as a priority for all care environments, with a need for consistency across acute and primary care. If a range of core skills can be agreed, dialogue with the Higher Education Institutions would be helpful in ensuring newly qualified staff are better prepared for practice, and will assist in the design of training packages for existing staff.

The growth in specialisation and sub-specialisation has presented some difficulties particularly during periods of leave, when in some areas of practice there is only one specialist. Specialist roles have enabled significant advances in patient care, to assist in maximising the benefit of these roles, it would perhaps be helpful to define the generalist skills needed to enable cross cover across the specialities. This highlights a need to understand more about the sustainability of certain specialities, and the unique skills

required to provide the service. Nursing and Midwifery Advanced Practitioners offer the opportunity to enhance the delivery of safe and effective care, and improve the patient experience. There is a variance in the training requirements, and the time it takes to train Advanced Practitioners from different specialities, this is not an issue unique to NHS Tayside, but potentially identifies work which could be undertaken locally to better understand what is unique and what is generic within Advanced Nurse Practitioner roles.

In looking towards ensuring future workforce sustainability there is a need to learn more about the structure of clinical teams, and the skills and competencies needed to deliver each area of service, the Knowledge and Skills Framework (KSF) will assist with this, the KSF is described in detail in section 27. This work would include all professional groups, including medical staff and primary care to outline the role of the different agencies in the provision of care. What is key is to plan the workforce to deliver patient centred services.

There is an increase in the need for the management of Long Term Conditions in Children and Young People. An examination of the skills and competencies required to sustain this service and provide long term packages of care across the lifespan is required, to ensure that we are managing complex long term care effectively across the patient journey. This has been identified as a National Issue by NHS Quality Improvement Scotland (NHS QIS).

Within the context of the ageing population many learning disability patients who are cared for at home, their own carers are getting older. Supporting this client group will require a multi-agency care package, but a great deal of support will need to be available to support patients through a period of transition should they no longer be able to be cared for within their home environment. Concerns about the sustainability of the Learning Disabilities workforce are described in section 14.

The need to understand the interface and impact of the different developments across clinical groups and CHP's has been identified. The ripple effect of individual developments across service provision is important to acknowledge, even small changes can alter care pathways, internal recruitment markets, or training and development needs.

The current quality of the available workforce data is not adequate to inform planning decisions, this is covered in greater detail in the Workforce information Systems section 22.

Hard to recruit areas have been described within the clinical groups and CHP's, but particular hotspots are described as Critical Care, theatres and renal.

Preparation for work is key to all levels of staff. This can take different forms for example, the Healthcare Academy 6 week Pre-Employment Programme, and induction. There are also opportunities to enhance the final year of nurse training to better prepare nurses for registration. One potential way to do this is to make better use of the available resources at the clinical skills centre, but there is also an opportunity to explore ways to improve the level of understanding of the responsibility and accountability that comes with registration. Taking advantage of inter-professional learning opportunities can help to share experience but, also to break down professional barriers and develop standards across clinical groups.

The development of support structures is key to the provision of services, and the implementation of the Senior Charge Nurse Review. One example of this is the possible introduction of the Housekeeper role as a way of releasing qualified registered staff time to care directly for patients. Initial work has been done in NHS Tayside to establish this role, it is perhaps worth revisiting this and moving the agenda forward. Work examining different roles to support the Senior Charge Nurse Review is already being undertaken.

The following offers a summary of key initiatives impacting on Nursing and Midwifery services:

- *The Senior Charge Nurse/Ward Sister Review*
- *The role of the Senior Charge Nurse in workload and workforce planning*
- *The Development of Clinical Quality Indicators*
- *Nursing and Midwifery Workforce and Workload Planning Project*

The Senior Charge Nurse/Ward Sister Review

The aim of the Senior Charge Nurse/Ward Sister Review is to create a modern role that will enable front line clinical leaders to maximise their contribution to delivering safe and effective care and develop clinical leadership capacity and capability. The purpose is to enhance the contribution of the nursing and midwifery workforce to implementing the policy vision of the Scottish Government.

The Senior Charge Nurse/Ward Sister role is to be developed around four key functions; to ensure safe and effective practice, to enhance the patients experience, to manage and develop the performance of the team and to ensure effective contribution to the delivery of the organisational objectives and by providing them with the information to continually assess and improve practice.

There is recognition that the Senior Charge Nurse (SCN) role should be embedded within a strong clinical leadership model. This approach places the core values of nursing and midwifery at the centre of patient care and focuses on continual service review and quality improvement. The SCN review has therefore been closely linked with the development of quality clinical indicators. Together they will empower the SCN to directly influence the care they and their teams provide and provide a direct link between the SCN role and the wider governance agenda of NHS organisations, enabling individual SCN's to understand the impact their role has in assisting with the delivery of both policy and the organisations strategic objectives.

The SCN Review currently focuses on the role in the acute sector.

The role of the Senior Charge Nurse in workload and workforce planning

SCN's 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 all shifts are covered by staff with the correct skills and competencies to ensure that patient services.

The SCN's role 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 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 absence, and annual leave, or more long

term strategic planning. As a leader, the SCN 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 competencies will come from, and making provision to develop these skills and competencies available if they are not already available within the current workforce.

The Development of Clinical Quality Indicators

NHS Boards are responsible for delivering patient-focused care that is high in quality, safe and effective with patient safety an increasing priority across NHS Scotland. It calls for a commitment from all levels of service to develop an organisational patient-safety culture based on risk assessment and risk management built on strong leadership, organisational commitment, clinical data management systems, openness to learning and engagement with clinicians. Clinical Quality Indicators or measures derived from routine data sets that relate to both the process and outcomes of clinical care can contribute to the achievement of this aim.

Audit Scotland published *Planning Ward Nursing – Legacy or Design?* In December 2002 (Audit Scotland, 2002), it highlighted that despite the high numbers of nursing and midwifery staff there was limited information available to compare nursing numbers, costs and their impact on quality. The report recommended that:

- NHS Scotland should develop and agree clinical quality measures that focus on continuous improvement
- NHS Boards should review the quality indicators regularly and take action when problems arise.

Audit Scotland recently published a follow up report to *Planning Ward Nursing – Legacy or Design?* (Audit Scotland 2007) and although recognising the progress made by the pilot study to investigate the feasibility of developing clinical indicators for nursing and midwifery (NHS QIS 2005), it noted that “Boards are still measuring quality in a variety of ways but challenges remain in working towards a national system of quality indicators.”

Nursing and Midwifery Workforce and Workload Planning Project

The Nursing and Midwifery Workload and Workforce Planning Project (SEHD 2004) was set up in July 2004, under the auspices of *Facing the Future* (SEHD 2002) in response to Audit Scotland’s report *Planning Ward Nursing – Legacy or Design* (2002). It made 20 recommendations for action at national, regional and local level, to enable consistency in nursing and midwifery workload and workforce planning across Scotland. The report had suggested a need for greater scrutiny of current practice in nursing and midwifery workload and workforce planning. The recommendations, outline what NHS Boards and others should implement in the short and medium term, are set out under five broad headings;

1. Principles to govern nursing and midwifery workload and workforce planning
2. Education and development
3. Nursing and midwifery workload and workforce planning systems
4. Allowances (protected time for SCN’s and a national standard for predictable absence allowance)
5. Areas for further research.

There are 5 tools; adult, paediatrics, maternity, mental health and community. In advance of the roll out of each tool, and as each of the tools has different methodologies, a series of training and briefing events are being held for targeted groups of staff across Scotland.

The consultation for this Workforce Plan 2008 raised to main issues relating to the nursing & midwifery workforce. These were; for nurses now that Agenda for Change Band 5 incorporated Whitley D, E, and F, career progression was viewed as limited, and the single band was believed to be stagnating movement because nurses felt there was no benefit in moving if the financial reward was to be the same. It was felt that work needed to be undertaken to define the development opportunities available for this staff group. Band 6 Midwives felt the same restrictions applied to them.

The need to implement the Senior Charge Nurse Review within Community Hospitals was also highlighted.

13. Community Health Partnerships (CHP's)

Common themes which will impact across the CHPs are - Shift in the Balance of Care, development of community hospitals, management of long term conditions and development of integrated care delivery with social care and the third sector.

Building workforce skill and competency capacity to meet the requirements of shifting the balance of care, and providing 24/7 care requires further examination. The clinical groups have raised specific issues for primary care around rehabilitation, and primary care capacity to manage complex co-morbidities and prevent admission.

The implementation of Visible, Accessible and Integrated Care is also the main focus of the redesign of community nursing services.

13.1 Angus

Angus CHP is keen to become a teaching CHP by develop a teaching partnership with the Council, local Further Education Colleges, NHS Education Scotland and Universities. This would provide increased training and development opportunities, to promote and develop new models of care, and the management of increased patient acuity. Developed in partnership with social care this would enable to development of a rural community medicine and care teaching model. Fife CHP are working with NHS Education Scotland on a prototype model which lessons can be learnt from.

The development of teaching CHP's in Scotland is based on creating sustainable capacity in the community setting, it is intended that the teaching framework will act as a vehicle for integrated roles across historical boundaries both between primary and secondary care, and also health and social care. The development would create a working environment which enhances; teaching, learning and research and development.

Learning partnerships are also being explored with Angus College to establish a joint health and social campus facilities in Arbroath, a project group is currently looking at the accommodation issues.

Angus Community Planning Partnership have established their own workforce planning group led by the CHP General Manager to develop a Community Care and Health workforce plan which addresses their own workforce needs.

There is a need to increase the skill capacity for meeting the needs of Children and Young people within Education, Social Work and Health. One change which will help to support this is the move to have Angus school nurses on annualised contracts to enable them to cover the 52 week year, this move is reported to have been well received.

The health improvement and primary prevention agenda will place additional demands on the workforce, ways of managing this key agenda and building capacity are being explored.

The Angus labour market is reported to be coming increasingly competitive, with the NHS, social work and voluntary sector all competing for the same labour market.

Within Angus there are very positive workforce developments like the establishment of joint posts with health and social care, these posts improve both partnership working and workforce capacity. There are also new developments like the Orthopaedic support service which provides a full fracture service at the Minor Injury Units, and is an example of a nurse led assisting in shifting the balance of care.

Recruitment hotspots within Angus CHP include;

Allied Health Professions; Occupational Therapy (Mental Health and Stroke Care), Speech and Language Therapy (Adults), and variable recruitment in Podiatry.

Mental Health; Substance misuse and learning difficulties have variable recruitment challenges. In Learning Disabilities across NHS Tayside there is considerable competition from the local authority and third sector this is further described in Section 14, Mental Health and Learning Disabilities.

Diagnostics; issue of sustainability of radiographers

Pharmacy; private sector is more attractive, increased salary and reduced responsibility, agenda for change bandings have exacerbated this problem

Project managers; there is a concern about the availability of experienced project managers, this group of staff can attract more competitive packages within the private sector.

13.2 Perth and Kinross

Perth and Kinross is a growing population, with an expected population growth of 22% by 2031, and a 42.5% growth in residents of pensionable age within the same period. There is currently a high ratio of retired residents in Perth and Kinross, with the town of

Comrie having the highest concentration of elderly residents per head of population anywhere in the UK.

There is a planned expansion of up to 2000 new homes in the Carse of Gowrie and Bridge of Earn. This expansion will potentially attract residents from Dundee, and commuters for the central belt. This significant growth will have an inevitable impact on the design and use of healthcare services.

In recent years Perth and Kinross has seen inward migration from Eastern Europe, this population group are helping to fill low wage jobs particularly within the tourist trade. Many are settling in rural areas, and look for accommodation to be attached to their place of employment. It is difficult to assess how long this group of migrants will choose to remain in Scotland, but in the short to medium term they will have an impact on demand for health services.

The issue of the availability of affordable housing does affect recruitment of healthcare staff in Perth and Kinross, the areas of Crieff and North Perthshire are particularly problematic. A recent Social Research Study (Jamieson and Groves 2008) identified that the lack of affordable housing was identified as an important driver of out-migration by young people. It was noted that the limited housing options available for young people in rural Scotland contrasts with urban areas where the rental market is cheaper and more plentiful, and can come with the option of sharing with a peer group.

Perth College hope to be granted University status the near future, this will potentially affect the number of students in Perth City and will have an impact on accommodation needs, in the short term the increase in demand may have an affect on prices both to buy and let.

Whilst Perth and Kinross is a relatively affluent local authority area, it does have pockets of deprivation, these are 5 recognised areas of regeneration;

- Muirton
- Fairfield
- Rattray
- Letham and Hillyland

The Scottish Indices of Multiple Deprivation (SIMD 2006) confirm that 3 areas in Perth & Kinross are within the 15% most deprived data zones in Scotland. These areas are Muirton and Fairfield, both in North Perth and Rattray in Eastern Perthshire.

In addition to this, it is recognised that in the Letham/Hillyland area of North Perth, many of the indicators of deprivation apparent in Muirton, Fairfield and Rattray also exist and, although Letham/Hillyland is just outside the most deprived 15% of data zones, this area has also been identified as a priority with the aim of preventing a further slide into deprivation.

Five key themes run throughout the Perth and Kinross Regeneration Outcome Agreement:

- Building strong, safe and attractive communities
- Helping people back to work
- Improving health
- Raising educational attainment
- Engaging young people.

The key challenge for Perth and Kinross CHP is to maintain and sustain care to a substantial ageing population. Long Term Condition Management will represent a high proportion of the healthcare demand. The management of this agenda is being developed in partnership with social care, using an integrated team model, with case management as the preferred model of care delivery. Six localities across Perth and Kinross have been identified for the provision of community nursing and rehabilitation, and a team leader has been appointed to each.

To meet the needs of an ageing population with complex co-morbidities there is a need to integrate the Allied Health Professions (AHP) rehabilitation teams with nursing teams to provide a comprehensive service to sustain people in their own homes. The rehabilitation teams are currently a small resource, but have an increasing workload, consideration needs to be given to finding the best way for the AHP teams to integrate with the nursing localities.

The CHP stress the importance of assessing and providing care to the 'whole' person, not just the presenting illness or dominant diagnosis. This was also a consistent theme from the clinical groups who were concerned about patients being placed in diagnostic silos, this includes mental health. Dementia care is now a national priority, but there are a whole spectrum of mental health conditions which need considered when caring for an ageing population including, anxiety disorders and depression, and the potential impact of loneliness and social isolation, all of which will affect recovery and maintenance of wellbeing. Psychiatry of old age, psychological therapies for older people, and dementia care are predicted to be dominant features in future service need.

In terms of workload providing care for an ageing population presents a workforce challenge on two fronts: there is the need to establish a workforce which can respond quickly to need, but also to have in place models of care which will allow the service to work with people over a long period of time.

The CHP is seeing a growth in the number of patients with rheumatic disease, respiratory and dermatology problems. There is also an increase in the number of children and young people with long term complex needs in Perth and Kinross.

The implementation of Visible, Accessible and Integrated Care, Report of the Review of Nursing in the Community in Scotland (SEHD 2006b), and Co-ordinated, integrated and fit for purpose; A Delivery Framework for Adult Rehabilitation in Scotland will both be a focus for redevelopment of community services.

Podiatry services are also seeing a development of their services, new technology has enabled improvements to be made in the assessment and mapping of progress to improve clinical care, and develop more robust goal setting around treatment pathways.

Within the context of remodelling, there needs to be consideration of the medical workforce, and co-ordinating work towards the delivery of core objectives and targets.

Establishing the benefits realisation from nGMS is an important part of having a clear vision for the whole service. Ensuring job satisfaction within General Practice is part of this, as well as defining General Practitioner job plans.

Community Hospitals in Perth and Kinross are implementing a new model of care, the hospitals will move to providing care in 4 zones: Perth City, Strathearn, Strathmore, North Perthshire. Within this new model the roles of the medical workforce will be more clearly defined, with a view to building capacity around geriatric and palliative care skills. As with other clinical groups there is a need to balance the available skill set with specialist skills defined by need and robust generalist skills.

The provision of dental services also needs to be reviewed to best meet the needs of the population, with a mixed economy of salaried and GDS dentists being the preferred model. A new integrated community dental facility is to be opened in Perth to assist in meeting identified population need (NHS Tayside April 2007). This is a response to an increasing trend for dentists in the area to transfer to private practice and reduce practice lists and to predicted retirements, leaving a growing number of people unable to access NHS Dental treatment or indeed to register with a dentist at all. The centre will have 20 dental surgeries for GDS, CDS, will provide vocational training and outreach training, a decontamination area, dental laboratory, and teaching/training facilities. The facility is scheduled for completion in 2009.

In terms of recruitment, the availability of affordable housing acts as a barrier to employment, this was predicted in the NHS Tayside Strategic Workforce Development Plan (2006).

Other areas of recruitment to be highlighted are:

Three surgical consultants expected to retire from Perth Royal Infirmary in the next 3 – 5 years, the succession planning around the sustainability of the services they provide needs to be explored.

A high number of nursing homes in the Crieff and Comrie area, reflects the demographics of the area, but the cost of housing and lack of an available labour market affects recruitment, and the availability of care.

There have been problems with recruitment and retention of pharmacists, particularly in Perth Royal Infirmary (PRI) and Murray Royal. For example in PRI there is a staffing establishment of 12 wte, but there are actually 6 in post. The issues of competition were described in the pharmacy section 8.2, and pharmacists in Perth and Kinross are attracted to the central belt, independent sector and industry for better salaries and working conditions.

There have also been some difficulties recruiting mental health nurses within Perth and Kinross, again because of labour market competition.

13.3 Dundee

The most significant issue facing the Dundee CHP is the redesign of its community nursing service. The current deployment is historical and does not match the modern treatment pathways, and projected demand based on population and healthcare demographics. The CHP also currently have a rich skill mix ratio 90:10 trained:untrained.

Dundee faces considerable operational challenges, not least in response to Shifting the Balance of Care. The increasing clinical activity in the community, the need to progress

the implementation of a Long Term Conditions management model and the inability of the present model to realise the benefits from closer working with partner agencies makes the current position unsustainable.

Visible, Accessible and Integrated Care; Report of the Review of Nursing in the Community (VAIC) (SEHD 2006b) offers opportunities to redesign the community nursing workforce to meet modern healthcare requirement. See VAIC section 18 for more detail.

A model of deployment is being suggested which in addition to providing General Practitioner practice based support, a locality based model of deployment which matches Local Authority Community Planning Partnerships, will increase opportunities for better engagement with local communities, provide a better environment to explore new health improvement approaches and enable community nurses to better meet the needs of the population, particularly those living in deprived communities.

Dundee CHP faces considerable operational challenges in Community Nursing in delivering against the key drivers for change. These are:

1. Community Nursing-Adult Services -District Nursing (DN)

- Managing the significant increase in workload resulting from the shift the balance of care to the community
- Accelerating the challenge to unsustainable traditional working practices
- Modernising current shift patterns to provide patient care across the 24-hour period
- Accelerating team reconfiguration to address the variance in patterns of nursing activity which currently exist across the city
- Addressing historic DN activity wholly focused upon delivery of a full range of care to GP populations across the breadth of the city, to that of a community model based upon local need, and best use of skill mix
- Developing Health Care Assistant (HCA) roles i.e. administration of medication
- Developing Staff Nurse roles to release Senior nursing capacity to deliver complex care
- Identifying and training Senior Nurses as Case Managers

2. Community Nursing - Children, Young People & Health Improvement Service -Health Visiting & School Nursing

- Managing the service response to *increasing* levels of child protection & welfare needs
- Responding to high numbers of identified vulnerable families in Dundee
- Progressing the integration of children's services at locality level with LA
- Managing competing priorities between family, and health improvement work.
- Advancing the safe implementation of skill mix in teams
- Targeting staff resources to need whilst maintaining a universal service
- Ensuring the Universal Hall 4 screening programme is delivered to *all* of Dundee's children
- Address 40 % staffing shortfall in School Nursing Service

- Supporting the continued integration of children's service in Dundee as outlined in A Plan for Dundee's Children (2005-2008).

Community Nursing Teams have, until recently, been actively encouraged by policy to integrate with GP teams. As a result, many teams' workload patterns are shaped by GP priorities and systems. The strengths of the current configuration lie in the close working relationships existing between both parties with particular emphasis placed upon the day to day communication and trust required in the management of end of life care, and in managing risks associated with the health needs of chaotic families where child protection issues are identified. District nurses also play a major role in supporting delivery of aspects of the GMS contract, in particular in the management of LTC of housebound patients.

Within this model communication with other public sector partners is challenging in that they are orientated around geographical 'neighbourhoods' which do not match GP practice patient lists or physical location of practice premises. It is also recognised that following the national publication of Visible, Accessible and Integrated Care, the changing role of the Community Nursing workforce necessitates a whole systems review of the configuration of this workforce to maximise the benefits of the new evolving roles and better respond to the needs of the Dundee population. At the same time care must be taken to capture and sustain the positive partnerships and high quality services that currently serve the patient population well.

To maximise the available resource within Community Nursing Services in order that it is in the best possible position to deliver key objectives contained within:

- Better Health Better Care (SGHD 2007)
- Visible, Accessible and Integrated Care Report of the Review of Nursing in the Community (SEHD 2006)
- Health for all Children 4th Edition (SEHD 2003) - 'Hall 4
- NHS Tayside Shifting the Balance of Care (2007)
- NHS Tayside Long Term Conditions Management (2007)
- Dundee Partnership-Health Improvement Plan
- NHS Tayside Local Delivery Plan – HEAT targets
- 18 weeks Referral to Treatment (SGHD 2008)

In addition there is a need to explore better integration of skills and competencies across the patient journey from primary to secondary care, this will assist the community workforce to build sustainable capacity to ensure success.

To facilitate the change a number of stakeholder events have been held, and from this two workstreams have emerged;

1. Workforce Development
2. Improving the Health of Dundee

Within the CHP Pharmacy recruitment is very problematic given the competition with the independent sector and industry, who offer higher salaries for, what is perceived as a less stressful job. The issues relating to the sustainability of the pharmacy workforce are further described in the pharmacy section 8.2.

The CHP also report that the AHP service has a bias towards the hospital sector, when the focus should be shaped towards rehabilitation and recovery to support individuals within their own homes and communities. There will also need to be an alignment of AHP services with the new model of community nursing to maximise the skill and competency base within the available workforce.

14. Mental Health & Learning Disabilities

There are a number of key drivers for changes to the provision of Mental Health Services

- The Same as You: a review of services for people with learning disabilities (Scottish Executive Health Department 2000)
- Framework for Mental Health Service in Scotland (Scottish Executive Health Department 1997)
- Building a Better Scotland (Scottish Executive Health Department 2002)
- NHS Scotland PFPI Framework (Scottish Executive Health Department 2001)
- Mental Health (Care and Treatment)(Scotland) Act 2003
- Future of Adult Mental Health Services in Tayside May 2004
- Building a Health Service Fit for the Future (Scottish Executive Health Department May 2005)
- Delivering for Health (Scottish Executive Health Department November 2005)
- The Scottish Recovery Network and the Recovery Programme 2005
- Delivering for Mental Health (Scottish Executive Health Department 2005)
- "Rights, Relationships and Recovery": The Report of the National Review of Mental Health Nursing in Scotland (Scottish Executive Health Department 2006)
- Better Health Better Care Action Plan (Scottish Government Health Department 2007)
- Promoting Health, Supporting Inclusion: The National Review of the Contribution of all Nurses and Midwives to the Care and Support of People with learning Disabilities (Scottish Executive Health Department 2002)

The main themes for the provision of Mental Health Services are

Improve patient and carer experience of mental health services

Implementation of the hierarchy of care model which transcends all services including inpatient, community and services and pursuits provided within the wider community. With the objective of providing a service which offers choice, opportunity, equality, social inclusion and recovery. The shift in the balance of care should move towards our target of 65/45 workforce provision in favour of community services.

Responding to depression, anxiety and stress

Individuals presenting with depression are formally assessed against a standardised assessment tool and a matched therapy appropriate to their level of need. There is an evidence based stepped psychological therapies service in place across NHS Tayside.

Better management of long term conditions

Integrated Care Pathways (ICPs) for mental health are being developed in line with the ICP Standards issued by NHS Quality Improvement Scotland in December 2007. These should be in place by the end of 2008. A Mental Health Collaborative has been

established throughout Scotland with regional and local Project Managers being appointed to take forward the National, Agenda with respect to Mental Health, Long Term Conditions and the 18 weeks Referral to Treatment Standard. We anticipate that the Tayside Long Term Conditions Collaborative will work closely with the Mental Health Collaborative. In Tayside links between both have already been established to ensure those with co-morbidity of mental and physical conditions are treated equally.

Early detection and intervention in self harm and suicide prevention

Suicide assessment tools and suicide prevention training programmes are being rolled out across the services including general acute care and we have a plan in place to train professionals with a target of 50% staff trained by 2010.

Manage better admission to, and discharge from, hospital

A multi-agency/multidisciplinary Acute Inpatient Forum has been set up to offer guidance on what services and standards are expected to be achieved across Tayside. This work includes a baseline audit, standards expected and a walkabout programme to ensure compliance.

Training and education and workforce planning

A robust workforce plan has been developed and is constantly being reviewed to ensure that staff have the skills and competencies to meet identified need.

The workforce plan for each locality reflects the most appropriate skill mix.

Training and development plans are also in place to support this.

Benchmarking and information

We are involved in a National Benchmarking Exercise where data has been collected and scrutinised. A Mental Health IT System is under development and the collection of specific information relative to the HEAT targets for mental health will also be supported by a Mental Health Collaborative Information Manager once appointed.

Performance management

A benefits realisation plan has been developed and measures are in place to collect outcome data on the benefits to service users and carers achieved through our business changes.

Services will be underpinned by the concept of Recovery and values based practice and therefore will take account of the need to ensure that hope and self-determination are integral to the culture of the organisation.

The needs of this care group will be met predominantly within the community. The aim is to ensure that choice and opportunity for service users and carers is increased locally. This will be supported by more robust, inclusive community services that can support people in their own homes and ensure that their personal safety is maintained at all times. Hospital admission will be to highly specialised services as close to the user's natural community as possible and will occur only when there is an active safety and/or security risk to themselves or others.

The service changes described above will require an overall increase in staff numbers within the specialty presenting challenges in relation to recruitment within a very tight general market place. There will also be pressure on specific recruitment pools due to concurrent demands from different areas of development within the overall mental health specialty.

New ways of working will require new competencies thus increasing the need for different learning and development opportunities both within service and via formal training. The service will be developed using skill profiling, to develop teams based on the skills and competencies required to deliver care.

Organisational change places demands on staff both emotionally and practically. These will need to be managed in a sensitive and positive manner to ensure morale is maintained and staff members are happy to remain within the service whilst working in new places and in new ways.

Recruitment and retention strategy and issues

A short life working group has been established to consider how recruitment and retention to underpin robust succession planning should be managed. The group are considering a management model for recruitment and retention for all mental health services and aim to produce a report with recommendations by June 2008.

Hot spots

There are difficulties with the recruitment of Occupational Therapists's and Psychologists nationally and at times we need to recruit other grades and professions in the interim.

There will be issue in the coming years in respect of the numbers required to be recruited in 2009/10 at the same time as the Secure Care Clinic and measures are being put in place to develop proactive recruitment and retention plans particularly for in patients at that time.

Student nurse recruitment may not deliver the required numbers of mental health professionals and this applies across Scotland, particularly in light of the reduction in allocated training places for 2008. Measures are being discussed at Scottish Government level to address this.

Predicted change

Once the community and psychological therapies staff are recruited in full as agreed the situation within the community should settle down and the predicted growth will remain constant for two years until 2009/10 when the above then applies.

- Community Mental Health Services are operational with the model being tested out across Tayside. Some appointments have not been made due to changes in service delivery and skill mix requirements.
- Psychological Therapies waiting times reduced significantly in Dundee with no waiting times in Perth and Angus.
- Psychotherapies services well established within Adult Mental Health Services and being developed across all age groups.
- Rehabilitation and Resettlement of those requiring longer term care progressing well with a marked shift from inpatient to community based services such as accommodation with support by health staff where required.
- Unplanned Care model has progressed significantly to ensure a service response is available over a 24 hour period with Mental Health practitioners already in place out of hours within the Hub at Wallacetown.
- IT System specification for Adult Mental Health agreed and signed off for Phase Two development and construction.

- Stepped psychological care including self help materials to promote Mental Health and Wellbeing is now in place and being tested out within the localities.
- A culture change strategy has been developed and is being consulted on for implementation 2008/9.

Learning Disabilities

The Learning Disability service is undergoing a service redesign to support the shift in the balance of care from hospital focused care to one that is community based. The redesign will ensure there are robust services in the community with the back up of specialised inpatient services. Currently occupancy levels of assessment and forensic beds are maintained at 100%, which presents real challenges when the service is requested to accept referrals from the courts or admit patients with acute mental health needs. The new model of developing specialist community services will allow more individuals to be cared for at home thereby building capacity for inpatient services to manage shorter-term admissions. It provides opportunities to continue developing relationships with local authority partners, is flexible to meet the diverse needs of this very vulnerable client group and promotes service objectives as detailed in the Strategic Framework for Learning Disability Services for Adults in Tayside (2004).

Learning Disability services are provided through developing local community services managed within the three CHP's in partnership with local authorities, and supported by specialist area wide provision based at Strathmartine and Carseview Centres in Dundee.

There are 10 independent re-settlement projects within Tayside, all of whom require experienced of Learning Disability staff. NHS Tayside is supporting these projects through secondments, but this is not sustainable. There is extensive competition for skilled Learning Disabilities staff, from non-NHS providers, the third sector and prison service.

The lack of availability of pre-registration training places has been highlighted as one contributory factor. Within the service there are many experienced healthcare assistants who would be interested in undertaking pre-registration training, but could not do so within Tayside. This issue is not unique to Tayside, and early discussions are taking place with Stirling University to offer a training with distance learning packages and local placements within territorial Boards.

Registered Learning Disability nurse are needed to support the care of individuals detained under the Mental Health Act, and the Criminal Justice Act.

Learning Disabilities are keen to be a pilot for the development of the Associate Practitioner at level 4 on the Career Framework.

There are issues relating to inconsistencies in Agenda for Change banding for Psychologists, within Learning Disabilities Psychologists were banded 6, elsewhere they received a 7.

There have been consistent difficulties in recruiting Occupational Therapists for Learning Disabilities, one solution following unsuccessful recruitment campaigns is to establish staff rotation through all OT specialities.

There are also shortages and recruitment issues around Learning Disability Dietetic services. Due to the lack of staff the focus for service is the provision of essential nutrition, for example supporting P.E.G feeding in the community. The impact of this means a reduction of health improvement work being undertaken with other Learning Disability Groups.

Forensic Services

The North of Scotland Secure Care Project proposes a newly built, co-located facility on the Murray Royal Hospital site in Perth, combining the NHS Tayside low secure service re-provision with a regional medium secure service that will operate in conjunction with other forensic services in the region.

In order to provide the required standards of service and security effectively, it has been identified that the recruitment, training and development of the correct level and quality of staff is of the utmost importance. Perhaps the biggest risk to completion of the project will be securing the required workforce with the necessary skills and experience to deliver the appropriate level of service.

The Workforce Planning Group have conducted a number of assessments and benchmarkings to ascertain the optimum staffing requirement for the 35 bed, low secure and 32 bed, medium secure facility.

The commissioning plan for the Clinic identifies a two to three-year phased programme before the clinic will be fully commissioned. As has been noted above the biggest risk to this project is the availability of suitable staff. A phasing plan for the recruitment of staff is therefore also proposed, commencing a full 12 months prior to opening and continuing throughout the commissioning programme. This is necessary to ensure that staff have the appropriate training and to ensure that the clinical team develop appropriately to have the capacity to cope with the challenging patient/client group to be cared for in, particularly the medium secure unit.

The Workforce Planning Group for the project have initiated a strategy to address recruitment and retention and staff development. Proposed actions include:-

- Early Recruitment – attracting senior staff to posts within the new secure care clinic at least one year prior to the opening of the facility
- Establishing development opportunities including secondments to other secure care facilities
- Extending established Staff Nurse Development Programmes including guaranteed posts for one year at the end of the programme
- Participation in the development of the new Tayside Healthcare Academy to ensure health care support workers are prepared for work within the field of mental health
- Links with local universities in relation to pre and post registration training needs within mental health are already strong and productive
- Participation in a range of recruitment drives and career fairs both nationally and locally to raise the profile of careers in mental health

- The opportunity to increase the attractiveness of the area is already being discussed with local authority partners
- Phased opening – The commissioning plan for the medium secure service identifies a 2/3 year phased opening programme.

Full details of the proposals can be obtained from the Project Team.

Forensic services anticipate difficulties from the reduced number of Pre-registration places available for nurse training in 2008. A national group is being drawn together to review the process of planning pre – registration nurse education. The competitiveness within the labour market for skilled mental health nurses can create retention difficulties, one solution is to increase staff rotation amongst the existing workforce to develop flexible, transferable skills across the mental health disciplines.

15. 18 weeks – The Referral to Treatment Standard (SGHD 2008)

The impact of achieving the 18 week target by 2011 on the workforce was raised by each clinical group.

From December 2007, all patients are being seen in a clinic within 18 weeks of being referred by their GP, and if an operation is needed, all in patients and day cases are being treated within 18 weeks of being placed on a hospital waiting list.

From 2011, 18 weeks will become the maximum wait from referral to treatment for non-urgent patients. The 18 week standard requires NHS Scotland to measure the total period waited by each patient up to treatment and to manage each patients journey in a timely and efficient manner, the aim of this is to create one standard that is well understood by patients and the clinical teams delivering healthcare.

Almost all patient pathways begin (and end) through interaction with primary and community health services. In the past, waiting times reduction strategies have focused on hospital services. The 18 week Programme will seek to further develop the potential for primary and community care services to work with secondary care in ensuring where possible, diagnosis and treatment can take place locally and without the need for unnecessary hospital visits.

The need for an examination of the skill and competencies, and capacity with primary care to assist secondary care to manage the patient journey was raised in discussions with the clinical groups.

The work in ensuring the correct services are provided does not end with the achievement of the 18 week target. The continuing care of patients following hospital treatment is a vital element in the patient journey. Improved discharge and continuing care will augment the ability of hospitals to provide better and faster access. This will require coherent planning and joint working between community health partnerships and local acute hospital services.

The Delivery Strategy describes how the key elements in each of the four strategic work areas will be delivered as part of the 18 weeks Referral to Treatment Standard (RTT), and is available at www.18weeks.scot.nhs.uk.

1. Service Redesign and Transformation Strategy
2. Planning Strategy
3. Information Strategy
4. Performance Management Strategy

Clearly, the achievement of this strategy is dependent on robust workforce planning and development. The design of the workforce based around a competent team model, which identifies the skills and competencies required rather than planning the workforce around more traditional roles will be pivotal to success.

Staffing implications will be identified within the bids for submission to the Access Support Team of the Scottish Government.

16. Local Delivery Plan 2008/11 – Workforce Implications

For the first time in 2008 the workforce requirements to enable the delivery of the Local Plan were described as part of the process. This reflects the Scottish Governments vision for integration of workforce, service and financial planning. The description of workforce implications were brief headlines, and did not reflect any detail of costed, or evidenced workforce planning.

The areas identified were as follows;

To achieve the Health Improvement target of reducing mortality from heart disease among under 75's in deprived areas, the LDP states there is a need to increase staff capacity, particularly dieticians, and staff skilled in behaviour change techniques.

The opening of the new dental facilities at Perth and Kings Cross, Dundee will see an increase in salaried dentists. Both of these initiatives are jointly funded by the Scottish Government and NHS Tayside.

The achieve agreed completion rates for child healthy weight intervention programme 2010/11, Tayside does not currently have a specialist weight management service for children and young people, the LDP describes the need to appoint an appropriate staff complement to achieve the target.

Supporting the reduction in suicide rate between 2002 and 2013 by 20%, supported by 50% of key frontline staff in mental health and substance misuse services primary care, and accident and emergency being educated and trained in suicide assessment tools/suicide prevention training programmes by 2010. Requires information to be collated on numbers, locations and existing skill base of staff included in the target group has required a significant amount of work and remains incomplete. Releasing large numbers of frontline staff will require careful management and co-ordination.

A business case is being prepared for the appointment of an additional anaesthetist to support the improved efficiencies for first OPD attendance DNA, non-routine inpatient average length of stay, and review new outpatient attendance ratio and day case rate by

March 2011. A review of clinical and non-clinical staffing also needs undertaken to establish any recruitment or capacity issues, this includes the impact of MMC and EWTR.

The achievement of the maximum wait of 2 months for urgent referral to treatment for all cancers. The growth in sub specialty expertise creates difficulties when individuals are on periods of leave, this then leaves a perceived skill gap. Skill mix reviews and role development needs to be undertaken to increase capacity dependent on need.

The staffing requirements for the 18 week referral to treatment target 2011, require to be identified.

Recruitment and retention of staff within the NHS 24 hub, is critical to the achievement of the reduction in attendance at A&E. The development of the Pathfinder service model in Angus, will see paramedics and nurses teaming up to deliver a roving response to category B & C ambulance calls, and will have training and development implications for staff working in the service and call handlers allocating calls.

The target to reduce the proportion of older people (aged 65+) who are admitted as an emergency inpatient two or more times in a single year by 20%, by 2008/09, and reduce by 10% emergency inpatient bed days for people aged 65 and over by 2008, is dependent on the shift in the balance of care. It has been identified that this will require significant training and development of current nursing, community and medical staff, to take on new roles, especially in areas of step-down into community hospitals, and in supporting and enabling patients with long term conditions to self care and be maintained in their own homes.

17. Pre-registration Nurse Education

There have been some local difficulties in recruiting to pre-registration nurse education. Low numbers of applicants resulted in the January 2007 intake being cancelled, since then there has been a concentrated piece of work to market and recruit to nurse education. Nursing currently accounts for 43.6% of NHS Tayside staff headcount

Attrition from Pre-Registration nurse education is also a concern, but is improving. Across the University sector, the published average attrition rate is 27%. The most recent published data for all categories of nursing and midwifery the attrition rate has ranged from 23.4% for the 1999/2000 cohort of students to 28.9% for the 2002/03 cohort. The attrition rate at Dundee University is significantly higher than the national average. The national target is 15% (SGHD 2007d). In other health related education programmes, the attrition rate also varies. Although the data is not published information from Universities about 2006 Allied Health Professional courses suggests that for example the average attrition rate for physiotherapy is 3.5% and for dietetics 3.2%.

Analysis from the national 'Facing the Future' Recruitment and Retention Working Group suggests that mass recruitment and less competition for places has drawn into the system students who are less likely to progress/complete. It is also believed that this high number of students in the system is causing pressure on both the Higher Education Institution's and clinical placements which may, in turn, have a detrimental effect on students' overall learning experience and consequently impact on retention. While the reasons that students leave programmes are often multi-factorial, a number of key areas

have been highlighted as impacting on student retention including; effective marketing, recruitment and retention selection process, factors linked to academic and clinical skills failure and those which impact on effective student support in education. (SGHD 2007e). A national group is to be formed to specifically promote pre-registration nurse student recruitment & retention.

Due to demographic changes and the development of strategies to reduce attrition, there is likely to be an 8 – 10% year on year reduction in Pre-Registration training places offered by Universities.

The level of academic attainment required for registered nurse training should also be considered a factor. The national target for registered nursing to be an all graduate profession may be having an impact on recruitment, and closing off opportunities to sectors of the labour market.

Encouraging people to enter the health professions will become increasingly competitive, in comparing salary scales alone the NHS falls behind other professional groups in terms of financial reward, see table below.

Table 2

Profession	Salary Scale (Newly Qualified)
Entry level NHS professional Incl. Nurse AHP	£19 730 - £24803
Teacher	£19879 - £31707 (incl. 13 weeks annual leave)
Social Worker	£28000 - £35000
Police (after initial 6 week training)	£23450 - £32895
Solicitor	£25000 - £30000 (depending on practice size)
Doctor FY1	£32,087
Doctor FY2	£39,789
Dentist	£32000 - £50754

**Information Careers Scotland
www.careers-scotland.org.uk

The Nursing and Midwifery Council (NMC) is currently undertaking a consultation on 'The future of pre-registration nursing education' The NMC is the UK regulator for nursing and midwifery, the primary purpose of the NMC is protection of the public.

The purpose of the Review of pre-registration nursing education is to ensure that all those who qualify as new registrants are fit for purpose. The consultation is about the future shape of pre-registration nursing education in the UK and relates to the possibility of introducing new arrangements, the context for the consultation has been set out in *Nursing: towards 2015* (Longley et al 2007), the full document is available at www.nmc-uk.org

Currently pre-registration training has four branches; adult, children's, mental health or learning disability. Any new pre-registration nursing education framework must be aligned with the changing nature and structure of healthcare delivery and future career structures across the four countries of the UK. Looking further afield there are changes taking place in Europe which may influence the way in which nursing programmes will be delivered in future. There are proposals to better align higher education qualifications and nursing across Europe, through the Bologna Process and the TUNING project. The Bologna Process intends to lead to more accessible and comparable degrees across Europe as well as greater mobility, co-operation and competition, and incorporates a European Credit Transfer System. In addition the TUNING project intends to lead to greater harmonisation of nursing within Europe.

Part of the consultation is considering the future of the Branch programmes, some argue that instead of branches there should be generalist programmes that could draw on a range of knowledge, skills and best practice from the existing branches. Others believe that such preparation would develop insufficient skills to meet current expectations of client groups particularly in children's, mental health and learning disability nursing.

The results of this national consultation will be independently audited, and published later in 2008, with any changes unlikely before 2014.

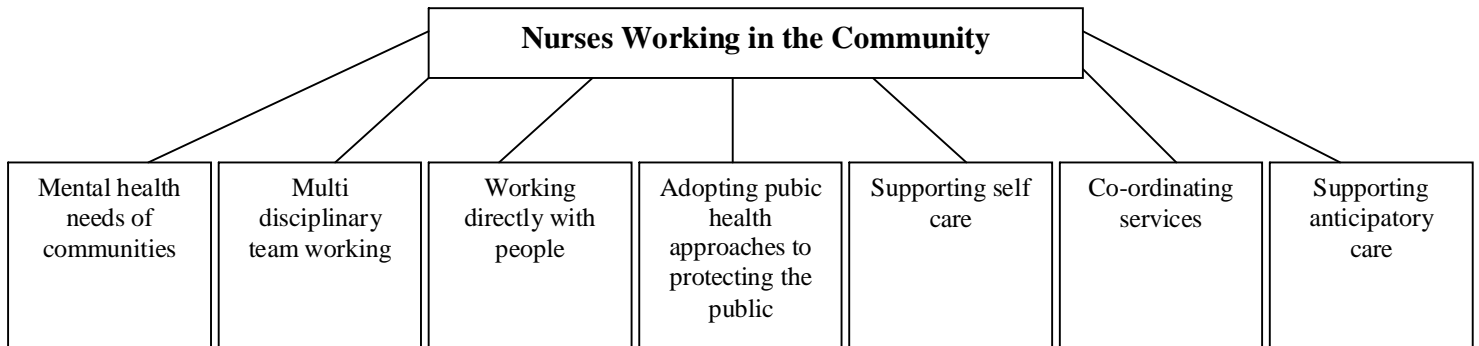
Concerns have been raised across a number of clinical groups about the Fitness to Practice of nurses upon qualifying. Many newly qualified staff demonstrate a lack of knowledge of core tasks, and aspects of care which make the transition to qualified practitioner more challenging. This is a significant issue for the service as it is within the practice placement that students learn clinical skills.

18. Visible, Accessible and Integrated Care – the Review of Nursing in the Community

Delivering for Health (SEHD 2005) signalled a change in the NHS from a service, which is focused on providing care in hospitals to one where care is planned, delivered and evaluated close to people's homes, Better Health, Better Care (2007a) further augments this work and focuses on the provision of services closer to peoples homes. To support the shift of health care provision, a review of nursing in the community was commissioned, to identify how nurses in the community can contribute effectively to the new health agenda.

The Report of the Review of Nursing in the Community in Scotland: Visible, Accessible and Integrated Care (2006b) places nurses at the heart of services in the community, working in partnership with individuals, carers, communities and working as part of a multi-disciplinary, multi-agency teams. The new service model (Appendix 5) and the seven core elements of practice, illustrated below enable nurses to provide proactive, modern and safe services which are embedded in communities. The report recommends

that the disciplines of District Nursing, Public Health Nursing (Health Visiting and School Nursing) and Family Health Nursing be absorbed into a generic Community Health Nurse discipline.



The Community Health Nurse will be the visible access point for people to the nursing services, providing care through a team of Community Staff Nurses backed by Health Care Support Workers and administrative support. Where appropriate, particularly for people with complex care needs, the Community Health Nurse will refer on to Clinical Team Leaders/Advanced Practitioners. Professional leadership will be provided through the introduction of Community Nurse Consultant posts thus creating the development of an enhanced career structure within the community nursing workforce.

'Shifting the Balance of Care' has been highlighted as a corporate priority for NHS Tayside. NHS Tayside is one of four development sites for a two year project to develop and test the new service model. This creates the opportunity to design a workforce which provides high quality services which are safe, effective and near people's homes.

During the life span of the project, staff and stakeholders, including patient/public representatives will have the opportunity to explore and influence how the service model will be operationalised within each of the 3 Tayside Community Health Partnerships. Following consultation and acquisition of any additional training/education the model will be introduced in a phased approach from Spring 2008. This phased approach will ensure that the model is introduced safely with existing services continuing for patients and communities as well as offering the opportunity and flexibility to test and develop local services which are responsive to individual and community needs.

To facilitate this process each Community Health Partnership has identified a local implementation group/work-stream groups which consists of nursing staff, managers and stakeholders. They will identify local population profiles, review workforce and workload capacity and ensure that nursing teams are configured around patient and communities needs.

An independent evaluation will be undertaken which will measure nurse's contribution to meeting the aims of Delivering for Health as well as both outcomes and experiences of individuals, families, communities, professional colleagues and nurses.

In parts of NHS Tayside recruitment difficulties are reported in community nursing;

Across this service there are high predicted rates of retirement, a loss of nurses to other sectors. The evening service often has high turnover – there is also a question about how attractive evening service posts are, and if the workforce capacity matches the increasing demand.

19. Associate Practitioner

Associate Practitioners are at Level 4 on Career Framework (appendix 5)

The current NHS Scotland workforce profile identifies the lack of current opportunities at level 4, and a significant gap that exists in the workforce between support staff and registered professionals, this is demonstrated in Appendix 7. It also highlights an over reliance on registered practitioners (level 5). The profile also highlights the opportunities for expansion at level 3, Senior Support Worker, this will enable staged progression from level 2.

Associate Practitioners will enable the development of robust career progression along the Career Framework. Currently many support staff will hit a 'glass ceiling' at level 2 because there is no defined career pathway, the current workforce profile can therefore prevent people reaching their potential.

Associate Practitioners will be a valuable addition to teams, relieving some of the pressures on professional staff, enabling professional staff to take on extended roles. Associate Practitioners will be key to helping improve the care for patients across a variety of care settings and professional groups.

An Associate Practitioner can be a specialist or generic role that either works to, or crosses, professional boundaries and is at a higher level than traditional support roles. Associate Practitioners can have multiple skills (nursing, therapy, social care, technical and therapeutic), determined by patient needs in the area that they work. Associate Practitioners will not always be aligned to specific professional groups.

A working definition:

'A worker that delivers care to patients under the direct supervision of a registered practitioner, with a level of knowledge and skill beyond that of the traditional support worker, releasing the registered professional to undertake more advanced roles, and may work across many of the traditional professional boundaries. This role fits between that of a senior support worker and a qualified professional.'

(Essex Workforce Development Confederation (2004))

The delivery of modern healthcare requires the workforce to diversify. The development of the Associate Practitioner does not sit in isolation, it needs to be examined and developed in a fluid way with other workforce developments across the Career Framework, for example there are clear links with the Healthcare Academy, and the development and advancement of the Registered Practitioner role. A mixed model of delivery is more likely to lead to sustainable growth and will be more dynamic in responding to future workforce needs and in theory lead to more innovation. This development also enables further implementation of a 'Grow your own' workforce strategy.

Potential candidates to fill Associate Practitioner level posts;

- Existing employees who can progress through Bands 1 – 4
- Students leaving FE Colleges with Health & Social Care, and Scientific qualifications
- Students leaving Pre-Registration programmes prior to completion/registration

NHS Education Scotland (NES) have expressed an interest in NHS Tayside being a 'case study' for the development of Associate Practitioners, linked to the work of the Healthcare Academy to demonstrate a clear career pathway for support staff.

20. Modernising Medical Careers (MMC) and the Medical Workforce

MMC sought to reform postgraduate medical education and training to speed up the production of competent specialists. Reform comprised: a two year foundation programme (FY1 & 2); centralised selection into 'run-through' specialist training; the creation of fixed term specialist training appointments (FTSTA's); revisions in the non-consultant career grade.

The clinical groups describe a number of issues which MMC presents to them:

- There is a perceived reduction in experience of FY1 & 2, they are able to carry out fewer tasks, and generally have lower competency levels, they therefore have a reduced work output and a need for higher levels of supervision.
- The increasing trend towards early specialisation is causing concern, with there being a loss of general medical and surgical skills, this concern has been reflected across all clinical groups. The loss of generalist skills early in medical careers will affect the generalist skills of middle grade doctors.
- The gap in generalist skills and the lack of robust core skills and competencies is affecting the delivery of service. Consultants will have to be in the hospital more to provide supervision and cover, increased presence will need to be incorporated into future job plans.
- The trend for specialisation is increasing with an extension of specialities to sub-specialities.
- There is a perceived gap in training of organisational/political awareness, priorities and targets

MMC is one of a number of factors which will influence medical workforce issues in the coming years which will need to be addressed.

Modernising Medical Careers

The introduction of Modernising Medical Careers (MMC) will lead to a less skilled junior medical workforce being available to support service delivery.

Medical students leave university and embark on a 2 year Foundation program. This is a generic, competency based training program which equips Junior Doctors with a generic set of skills.

Following completion of Foundation Training, Junior Doctors apply to enter Speciality Training. This can take, on average, between 5 and 7 years for hospital based specialities and 3 year for General Practice.

Doctors in training enter Speciality Training at an earlier stage in their career, so they will not have developed as wide a range of skills as they would have in the past, when they may have spent 3 or more years at the SHO grade, before moving into Speciality Training.

This shortening of training creates two main problems. The first is that junior doctors will not be as skilled as they were in the past, and so cannot deliver the same level of service. The other main issue is that they require more supervision. This in turn reduces the productivity of supervising consultants.

Speciality Training will be based on the achievement of competencies, rather than being time sensitive. It has not yet become apparent what effect this will have on training, as well as Service delivery, as the competency based curricula are still in the process of being developed.

It has been raised by the clinical groups that from the introduction of Foundation, more time is required to assess trainees' competence, which in turn reduces consultant productivity. The introduction of competency based training was expected to speed up the period of time it takes to train specialists and doctors and lead to a reduction of errors and mistakes, which in turn should improve productivity. This remains to be tested.

European Working Time Directive

To comply with European Working Time Directives, all junior doctor rotas must be reduced to less than 48 hours by August 2009. Currently 40% of Junior Doctor rotas are EWTB compliant. In order to reduce the remaining rotas to 48 hours, NHS Tayside will have a gap of 3000 hours which require to be filled.

NHS Tayside have established a Steering Group which will co-ordinate a Board-wide implementation plan to ensure we meet the target. The Steering Group will be supported by Operational Groups, at Directorate or Speciality level, to develop local implementation plans. These groups will redesign the delivery of services in a way which will take into account the changes they are facing regarding workforce numbers, increasing referrals to the service and staff training and development issues.

Feminisation of the Workforce

There are an increasing number of female students graduating from the University of Dundee, which in turn is likely to lead to more female doctors in FY1 & 2 training.

In order to meet Equality & Diversity targets, PMETB and NES are setting targets to offer 20% of doctors in training the opportunity to train *Less Than Full Time*.

Whilst this is a laudable aspiration, it can and does create real operational difficulties for NHS Boards who have to try to deliver services with a reduced workforce.

If a Trainee opts to train at 80% of Full Time, we are unable to attract Trainees to cover the remaining 20% of the workload. Services then have to run at staffing levels below their establishment. It is possible to offer 2 posts to Trainees who wish to train at 50% of Full Time, but this is only possible when 2 individuals are looking to train in the same speciality at the same time. In the past Deaneries were able to manage their budgets so that *Less Than Full Time* Trainees were regarded as supernumerary, however, the introduction of MMC has changed this and *Less Than Full Time* Trainees now have to be considered to be part of a Speciality's establishment.

The following table highlights the number of women who will graduate from the University of Dundee over the next 5 years. Currently around 70% of doctors entering Foundation Training in NHS Tayside graduate from Dundee University.

Table 3

Year of Graduation	No of Male Students	No of Female Students
2008	66	98
2009	51	112
2010	66	81
2011	67	97
2012	67	107

In relation to feminisation of the medical workforce, there would be benefit in doing a trend analysis of which specialities are most likely to be affected by part-time working, for example Paediatrics, GP, Psychology and Public Health.

Increasing Consultant Recruitment

NHS Tayside has worked towards increasing consultant capacity by appointing a number of consultants across various specialities. This is a planned approach to developing capacity which will ensure we continue to meet national Waiting Time Targets. It also means that we are building increased capacity for the future, which in turn will allow us to develop new services and cope with increases in demand, which result in changes to the demographics of the local population.

Changing Roles for Staff

NHS Tayside introduced the concept of Hospital at Night in August 2005 on the Perth Royal Infirmary site and then on the Ninewells site in August 2006. The intention is to further develop these models to meet increased pressures as a result of the introduction of MMC and in order to meet pressures as a result of working towards meeting European Working Time Directive (EWTd) compliance.

Additional Medical staffing concerns

There is concern about how high quality medical cover is going to be provided over the 24 hour period. This problem becomes increasingly difficult with the degree of specialisation and reduction in generic skills which has been raised throughout this paper. A robust assessment of the skills and competencies required to provide cover

needs to be established, and the layers and composition of medical/professional staff who will provide it defined.

The need for an increase in knowledge and skills generic medicine for the elderly across all specialities including primary care is of particular concern. The predicted need for these skills to match the patient population can not be overestimated, agreed action to establish solutions to a recognised problem should be agreed.

The skills of the primary care workforce should be appropriate for the population and should be consistent with organisational priorities and targets. This will assist in managing people in their own homes, or local communities without the need to travel to large secondary care centres. It would also assist in the delivery of the Local Delivery Plan and HEAT targets.

A broad view of how best to develop and sustain the medical workforce, as part of an integrated workforce planning process would be helpful.

Work needs to be undertaken to examine the workload Out of Hours (OOH), this is often a reflection of what is not being provided effectively during the day. The provision of care should be examined as a whole system approach, and the OOH service not viewed and developed separately.

21. NHS Tayside Healthcare Academy

The NHS Tayside Healthcare Academy is part of a modern, innovative Human Resources and Workforce Development Strategy, which aims to ensure a sustainable quality workforce, which is responsive to local population need. It offers 3 programmes, a 6 week Pre-Employment Programme, Modern Apprenticeships and a 20 week SVQ 2 level programme.

The vision for the Academy was, as the largest employer in Tayside to lead by example by being more socially responsible, acknowledging the greatest determinant of ill health is poverty, and take a new approach to public health and recruitment by providing employment to support health. The Academy aims to help unemployed and excluded groups into employment and long term healthcare careers.

The Academy received start up non-recurring funding from the Scottish Executive Health Department, and opened in August 2006. The initiative is an example of true partnership working between Job Centre Plus, Scottish Enterprise, Careers Scotland, local Further Education Colleges and the NHS. It is now a substantive part of NHS Tayside, run by a team of three consisting a Development Officer, Development Practitioner, and an Administrative Co-ordinator.

The development of the NHS Tayside Healthcare Academy was a recommendation within the NHS Tayside Strategic Workforce Development Plan, and is a key part of the Inclusion and Diversity Agenda. Its objectives are to provide employment opportunities for a wide variety of people who are, presently unemployed, or from excluded groups, and through clear partnership based workforce development and planning, address and positively influence the health agenda.

Key Objectives;

- To reflect the Social Inclusion and the Equality and Diversity policy agenda
- To contribute to the overall long term health of the region through the creation of employment and development opportunities
- Create innovative workforce recruitment and retention solutions to support and sustain quality healthcare
- Provide quality services with a focus on essential support services

The Academy runs as a Health and Social Care Academy in Perth & Kinross and Angus. Students for the 6 week pre-employment programme are recruited through Job Centre Plus, they are invited to an information day where candidates are given the opportunity to speak to NHS and College staff, we also now have ex-students supporting the information days. Candidates then put themselves forward for interview. All partner agencies contribute to the interview process, an Occupational Health questionnaire and Advanced Disclosure is completed by candidates with NHS HR Staff.

All successful applicants are offered a voluntary week with Worknet, an organisation with promotes self esteem, and literacy and numeracy skills. Over 80% of students take up this opportunity, prior to commencing the programme.

The programme itself consists of 126 hours of college tuition and 3 placements of 4 days, each in a different area of the health service. Placements are very varied, the philosophy around this is to allow students to understand all the contributions directly, and indirectly to patient care. This is to help build a culture which values all contributions equally, and understands it takes everyone to make the patient journey a success.

The programme provides all statutory and mandatory training, for example Manual Handling, Infection Control, Food Hygiene and First Aid. The programme also focuses attention on customer care, and soft skills. All students are guaranteed an interview on completion, and can apply for internal vacancies. This programme is targeted at entry level posts at Band 2. On exiting the programme students are prepared for employment, Managers have reported that Healthcare Academy employees are ready for work, and understand the responsibilities of working in a healthcare environment. However, perhaps the greatest improvement is in the candidates themselves, many candidates enter the Academy with low self esteem, and no self worth, they come from a variety of social circumstances, for example – a lifetime within the care system, homelessness, abusive environments, third generation unemployed, carers, and those with physical and mental health issues. At the end of the six week programme the transformation is inspiring and emotional, candidates have grown and developed in every aspect of their lives, in particular their confidence and aspiration. Each cohort has established a social group and meet regularly for peer support. The Healthcare Academy maintains regular contact with ex-students.

The Modern Apprenticeship Scheme commenced September 2006. This was the first time NHS Tayside had offered apprenticeships for 22 years, there were 6 vacancies, 2 Electricians, 2 Mechanical Fitters, and 2 Plumbers, over 200 people applied for these opportunities. In 2007 NHS Tayside advertised for a Joiner, an Electrician, a Painter, a Plumber and 2 Mechanical Fitters, and received 589 applications, whilst this represents a positive recruitment policy for NHS Tayside, we underestimated what we had exposed in the lack of opportunities for Young People, and understood that we would leave a

large number of people disappointed. The Works and Estates department were delighted to have apprentices back within the workplace, and from an organisational perspective this scheme is about growing our own talent, and relying less on costly external contracts.

The Academy also offers an annual 20 week SVQ 2 level programme in Dundee from August 2007. This programme is aimed at a variety of people, but could capture young people who are leaving school with few opportunities or qualifications. The programme will be run from Dundee College, and on completion students will have completed 50% of an SVQ 2 qualification, NHS Tayside will develop ways to support the completion of this qualification. By broadening the entry gate, we were reducing the potential of stigma and labelling of those individuals who entered NHS Tayside through the Academy route.

The pastoral care aspect of the group cannot be underestimated, and a great deal of social support is required to assist the transition to work, and often for many months after. This is a life changing experience for the students, which impacts on all aspects of their lives, the Academy team offer support in a variety of ways, but often it is enough that someone is there to listen.

The team maintain contact with current and ex-students through a dedicated mobile hot-phone, it was recognised that students often didn't have the money for a phone call, but could afford a text, the Academy team would then call them back, the hot phone is on from 8am – 6pm. There is also a dedicated email address and landline number. Students and Ex students are also contacted by mail, and a postcard system is to be established to allow the organisation to track the progress of the students as their careers develop. We are keen to ensure that future development needs of this group are met, linking with the Knowledge and Skills Framework and Appraisal we will ensure that Academy employees are encouraged to progress to reach their potential.

NHS Tayside took part in a Work Foundation audit of Pre-employment programmes (Work Foundation 2007), the audit explored the individual and organisational benefits of pre-employment programmes. Respondents reported improvements to health since the start of pre-employment training and the time of interview, this included weight loss in those who were overweight, decreased daily cigarette consumption and fewer units of alcohol consumed, eating more fruit and vegetables and taking more exercise, and a reduction in depressive symptoms.

The NHS Tayside Healthcare Academy 6 week course is presently funded through programmes facilitated by Job Centre Plus and Scottish Enterprise. The funding bodies require that entry into jobs occur within a specific time frame. For students funded through the New Deal initiative, entry into work must be within 6 weeks of course completion, for Training for Work funded students employment must be achieved within 26 weeks.

Linked to the work of the Healthcare Academy, and the importance of valuing all contributions to healthcare, is the NHS Education Scotland work around Developing and Education Framework for Administrative & Clerical and Support Services Staff (NES 2007). This work ensures a national commitment to ensuring that the NHS in Scotland improves the training and development opportunities made available to administrative services, and estates and environment staff. Workforce Development and the Healthcare Academy have played an active role in the development of this framework.

To meet healthcare workforce demand the future will see diversification and expansion of the Healthcare Academy. Work is currently being undertaken to expand the SVQ opportunities and explore how existing NHS staff can take advantage of the opportunities the Academy offers.

22. Workforce Information systems

Local data gathered by the ISD Census in September each year (linked to SWISS – Scottish Workforce Information Standard System) and the workforce projections contained in NHS Board workforce plans informs national decision making around the training of healthcare professions and national workforce planning, the quality of the data input is therefore critical.

SWISS is a national HR workforce system, which represents a core part of the work of HR Employment Services, all aspects of IT management and maintenance are controlled nationally. Significant gaps in the implementation, management and maintenance of SWISS within NHS Tayside have been identified. NHS Tayside is currently behind the target dates for implementation, Data which is in the SWISS database has not been maintained, and is therefore cannot be viewed as accurate. The lack of reliability of our SWISS data is now affecting our local workforce planning and national staff reports. The SWISS database contains mandatory and non-mandatory fields, both provide essential information for planning purposes.

The impact of inaccurate reporting to the Scottish Government cannot be overestimated. This year the Scottish Government have reinforced that national workforce planning is dependent upon robust local data input which is used by ISD for national decision making. An SWISS Action Plan has been written with key target dates to ensure compliance with mandatory fields by August 2008.

The accuracy of post descriptors for Agenda for Change are also critical, for example if a community mental health nurse, is categorised as community nursing, the headcount/wte for mental health is affected. Discrepancies have been identified in the post descriptors, a cleansing exercise should be undertaken to ensure that these errors are not replicated year on year.

A recent Audit Scotland Report examining NHS Priorities and Risks (2007b) identifies that *'workforce information is not sufficiently robust or accurate to enable the construction of credible evidence-based decisions to support workforce management, including planning and development. This includes work in the development of team working, delivery of care, skill mix and career development. Boards should be able to demonstrate;*

- *Data on workforce is sufficiently detailed and accurate to meet the requirements of workforce planning, SWISS, and staff governance standard; and*
- *Contingency plans are in place to address any workforce deficiency in workforce data'*

A Workforce Information Group was established in January 2008 to in response to the identified issues relating to the quality of NHS Tayside's workforce information. Annually, a short life Workforce Planning Group is convened to prepare the Workforce Plan.

The Scottish Government has also identified the need to translate the impact of new working environments and or types of roles into clear workforce plans. The 6 Step Plan, approved by the Board Executive Team in February 2008 will help NHS Tayside to better understand the workforce implications of new developments. The 6 Step Plan (Appendix 8) is used widely throughout the UK, and is being put forward by a national working group as the model NHS Scotland should use. The 6 Steps would give continuity across a range of workforce issues that organisations need to address. The value of the 6 step guide is that it has been developed in an e-learning format that can be used to gain a broad overview or specific detail. It is essential to have a central point within the organisation where information from individual projects, developments and plans are collated. This will ensure the impact of change, large and small, is reflected in any workforce reports, it also allows for an accurate picture of internal and external labour markets.

Currently under nGMS General Practice, as independent contractors, are not required to provide workforce data to NHS Boards or ISD Scotland for planning purposes. This presents a significant gap in data for planning across the patient journey.

Robust information about future projections of workforce need are required to ensure a robust link between service, financial and workforce planning, but also to plan and implement the Shift in the Balance of Care. Information systems in the NHS have traditionally focused on the hospital sector with community information still needing further development. Systems such as the Quality and Outcomes Framework (QOF) and Practice Team Information (PTI) are still relatively new, and comprehensive information about community activity in the NHS is therefore not yet available. Activity information about social care services for people with long-term conditions is not available as social care data are not collected about individual diseases. Audit Scotland (2007a)

In order to provide more community services for people with long-term conditions NHS Boards, through CHP's need to redesign services and transfer resources from acute to primary care. However, decisions on the best use of resources are currently being made on limited evidence, there is little information at a national or local level about the activity, cost and effectiveness of services for people with long term conditions, which account for approximately 80% of all GP consultations and 60% of hospital bed days. Audit Scotland (2007a)

The development of the work around the Highland Cost Cube, and the HR Knowledge Transfer Partnership research project examining patient dependency and workforce planning will assist in providing NHS Tayside with more robust information for audit and planning.

Using e-KSF for Workforce Information

The e-KSF tool was commissioned to support organisations implement the NHS Knowledge and Skills Framework (KSF) (DoH 2004). Although the focus at the moment is on fulfilling the requirements of creating KSF post outlines and tracking development reviews, there is an increasing realisation that the KSF, and hence e-KSF, is a very tool for workforce development and change.

The e-KSF tool enables organisations to track KSF dimension 'demand' (KSF post outlines) and KSF 'supply' (outcomes of development reviews which record where individuals are against their KSF post outlines). E-KSF also stores organisational data,

pay and staff group data. Once the post descriptor and staff group are checked for accuracy, these key pieces of data can be used to inform a wide range of service design, workforce analysis and workforce development initiatives. For example KSF data can be interrogated to answer like;

Does the spread of KSF dimensions reflect the current and future priorities of the organisation?

Is the organisation too reliant on one staff group, or pay band for certain knowledge and skills, i.e. are we building inflexibility?

Is there clear progression? Are our staff being developed for the future to ensure sustainability?

Are there any trends in the use of KSF dimensions, or development of people in certain dimensions which may need to be reflected in the organisations recruitment or education needs?

Knowledge Transfer Partnership Research Project – Patient Dependency

Following the approval of the Strategic Workforce Development Plan (NHS Tayside 2006) a successful bid was made to the Dti Knowledge Transfer Partnership scheme to fund research into assessing the skills and competencies needed to deliver modern healthcare. The project will draw on existing CHI data, population data, and utilise the Knowledge and Skills Framework. It will also involve extensive research into existing methods of assessing and predicting patient need.

Priorities

- SWISS Recovery Plan: Implementation monitoring via Taystat – Project Board, chair to be appointed.
- Establish a lines of accountability and responsibility within HR for the implementation and maintenance of SWISS
- Undertake a programme of training and development within HR to ensure staff understand the importance of data collection, and the processes involved in managing and maintaining SWISS
- Undertake a cleansing exercise of Agenda for Change Post Descriptors
- Workforce Information Group was established in January 2008 with the aim of pulling together all sources of data including HR, Finance, SSTS, Payroll, Agenda for Change, E-KSF and Training and Development, these departments also depend on accurate workforce data. The group will produce an action plan, with the aim of ensure improved quality of workforce data which meets the needs of the organisation, the group is chaired by the Head of Strategic Workforce Development
- Review the annual short-life Workforce Planning Group which prepares the Workforce Plan. Consider the ongoing requirements of NHS Tayside in providing a real – time corporate profile of workforce planning and development.

- Implementation of 6 Step Plan within NHS Tayside
- Propose quarterly meetings with Workforce Planning/Development, HR Workforce Information and individual Clinical Group Managers, followed by quarterly organisational report
- Identify ways of improving the quality and accuracy of information from Primary Care

23. Workforce Regulation

Professional Regulation must create a framework that maintains the justified confidence of patients in those who care for them as the bedrock of safe and effective clinical practice and the foundation for effective relationships between patients and health professionals (Crown Copyright 2007).

Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century (Crown Copyright 2007) is the UK White Paper which sets out a programme of reform to the United Kingdom's system of regulation of health professionals. It is complemented by the recommendations of the Fifth Report of the Shipman Inquiry and to the recommendations of the Ayling, Neale, and Kerr/Haslam Inquiries, *Safeguarding Patients*, which sets out a range of measures to improve and enhance clinical governance in the NHS.

Key Principles are identified which should underpin statutory professional regulation;

1. Its overriding interest should be the safety and quality of the care that patients receive from health professionals
2. Professional regulation needs to sustain the confidence of both the public and the professions through demonstrable impartiality.
3. Professional regulation should be as much about sustaining, improving and assuring the professional standards of the overwhelming majority of health professionals as it is about addressing poor practice and bad behaviour
4. Professional regulation should not create unnecessary burdens, but be proportionate to the risk it addresses and the benefit it brings.

Within an NHS organisations there is the need to have robust methods of collecting details of healthcare professionals who require registration to practice. Once established, constant maintenance of the system is essential to ensure good governance and avoidance of risk.

SWISS (Scottish Workforce Information Standard System) will provide the database to record the members of staff across all professional groups who need to be registered to practice. The recording of registrations is a mandatory field in SWISS (Phase 1 & 2). This field is not established within NHS Tayside. It is worth noting that from 1st January 2006 there was a change to the Registration of Nurses and Midwives, in the past this

group re-registered every 3 years at a cost of round £70, now registration is annual for a fee of £76.

Within the Healthcare Scientist workforce compliance with appropriate regulatory requirements places very significant demands on existing staffing levels. Examples are Clinical Pathology Accreditation (UK) Ltd [CPA] and Health Professions Council registration and retention requirements.

Healthcare support workers are one of a number of NHS Staff groups that are not regulated by statute. In 2006 the Scottish Government commenced a project to develop standards and a model to test out the arrangements for the regulation of Healthcare Support Workers

Core competencies for healthcare support workers who provide support to healthcare support professionals were negotiated on a national basis in Scotland in 2001, these can be found at

www.healthworkerstandards.scot.nhs.uk/Documents/HCSuppWorkcompetencies.pdf.

Further information on occupational standards and competencies for this group can be found on the Skills for Health website www.skillsforhealth.org.uk

There are three documents which detail the required standards relating to healthcare support workers. These were launched by Scottish Ministers and comprise:

1. Induction Standards for healthcare support workers. November 2006 (Edinburgh Scottish Executive)
2. Code of Conduct for healthcare support workers. November 2006 (Edinburgh Scottish Executive)
3. Code of practice for employers of healthcare support workers. November 2006 (Edinburgh Scottish Executive)

The Scottish pilot project on the regulation of healthcare support workers will report on 2008. The work represents the first step towards helping both employers and employees in NHS Scotland fulfil their obligations to patient safety and public protection as part of a future regulatory framework for healthcare support workers.

24. E-Health

NHS Tayside recognises the development and innovation in eHealth and health informatics as a key to delivering quality healthcare in the 21st century. The availability of dynamic, real-time clinical information management has the potential to put NHS Tayside at the forefront of efforts to enhance patient care and safety. NHS Tayside already has a significant track record in relation to eHealth developments including; 100% use of the Community Health Number (CHI) and widespread use an electronic patient record (NHS Tayside 2008).

This paper relates to the impact of developments on the workforce and there will inevitably training and development requirements for all staff as IT becomes an increasing part of their working day. There are 19 commitments within the eHealth

Strategy, it is generally agreed that the processes and procedures are in place through the Health Informatics Implementation and Training Team to meet staff requirements when systems are being implemented. Four areas have been identified as requiring additional attention;

1. Out of Hours cover for the Health Informatics Technical Team
2. Implementation and roll out of bed management system Summer 2008 (Patient Management System PMS)
3. Implementation of Scottish Standard Time System (SSTS)
4. Implementation of Picture Archiving and Communication Systems (PACS)

Developing the eHealth workforce is a essential to success. The NHS Tayside Health Informatics staff will have a critical role to play, both in implementing the national programme and in ensuring the continuity of existing services. The department are committed to the development of a modern, efficient and professional eHealth workforce. All staff have their skills assessed to ensure they are adequately trained in the products that they will use in their everyday working environment.

25. Senior Managers

The age profile of the NHS Tayside senior manager and executive cohort presents some potential sustainability issues in relation to future predicted retirement. The age profile of this sector is 16.1% are over 55 years, and 27.6% are over 50 years (equals 43.7% over 50 years).

Work needs to be undertaken to establish a broad overview of the skills and experience which might potentially be lost from the organisation in the next 10 years, this will include a number of components including leadership development, and Local and National HR strategies. Work relating to Leadership and Management Development aspect is already underway. This will enable the organisation to establish if there are groups or departments more significantly affected than others. From this a opportunities for development of existing staff can be explored, and a profile of the potential skill gaps which may be created by retirement.

The NHS Tayside Finance Function has already started to examine methods of sustainability and is working through the learning and development agenda under the umbrella of the Finance Training & Support Unit (FTSU), a body recently established by NHS Education for Scotland to take forward the national Finance Training & Development Strategy.

FTSU objectives for 2007/08 are as follows:-

- Develop the network of Area Development Managers (ADM) to provide a knowledge base from which the national strategy can be implemented.
- Establish a framework for coaching and mentoring.
- Scope, implement and manage a national strategy for professional finance training.
- Gain CCAB accreditation for training policies and continuing professional development frameworks.
- Establish a secondment network.
- Promote uptake of training and development opportunities across the NHS finance community.

- Review existing staff networks, establishing any gaps in networking opportunities for middle and senior managers.
- Publish a summary of learning needs from information gathered locally to inform the wider strategy.
- Develop a best practice guide for staff induction.

NHS Tayside has appointed an Area Development Manager, who is tasked with taking forward the above issues through implementation of a comprehensive local Learning and Development Plan.

26. Voluntary Sector

The Third Sector makes a direct impact on the growth of Scotland's economy, the wellbeing of its citizens and the improvement of its public services.

Voluntary and community groups are in close touch with marginalised groups and are well placed to identify and respond to changing needs. The Third Sector has income of approximately £2.08 billion, employs 107,000 and accounts for four per cent of GDP.

Twenty four per cent of Scots volunteer on a regular basis contributing £4 billion to the economy. The Third Sector is crucial for its input to policy development and service delivery and plays a key role in responding to and meeting local needs.

The Third Sector is made up of a rich diversity of organisations with different legal forms and structures including unincorporated community and voluntary groups, registered charities, friendly societies like credit unions and the growing number of social enterprises.

The voluntary sector and volunteers make a significant contribution to health improvement and the delivery of health care. Their involvement complements the work of employed professionals and provides an opportunity to augment NHS skills and resources at a time when these are becoming increasingly scarce. An active voluntary sector and volunteering also has the effect of building social capital in communities, which has a positive impact of health inequalities as well as enhancing individual mental health and wellbeing of the people involved.

A National Volunteer Strategy was approved in December 2007 which will act as a model for NHS Boards to follow.

27. Training and Development

Better Health, Better Care Planning Tomorrow's Workforce Today (SGHD 2007) highlights the importance of investment in education and staff development in delivering appropriate quality services.

The success of any organisation depends on the people who work in it. It is essential that they are equipped to perform their duties to deliver an improved and efficient service.

The Learning & Development function within the organisation has a key role to play within this context.

The importance of having an informed and flexible workforce that has the capacity to learn and acquire appropriate knowledge, skills and behaviours is fundamental to us being able to meet the 21st century healthcare needs of our population.

There are clearly common learning & development themes emerging from the wide consultation that has taken place during the development phase of NHS Tayside's Strategic Workforce Development Plan.

Close working relationships with universities and Further Education colleges across the country is fundamental to progressing the careers of a diverse workforce.

Working closely with NES will facilitate educational solutions for workforce development and by supporting the following 4 strategic areas will provide a framework to drive forward the educational agenda:

- Building workforce capacity for service improvement
- Delivering educational support for national clinical priorities
- Developing educational infrastructure
- Strengthening partnership working

Service Improvement are also delivering service improvement skills programmes to frontline staff throughout Scotland, NHS Tayside is a partner Board for this work.

NHS Tayside currently supports a variety of vocational programmes in partnership with various F.E. colleges from across Scotland and is committed to progressing future developments across the wide spectrum of vocational qualifications that are available. The provision of a high standard of work placements for students across the organisation is crucial to the success of this method of learning and the Learning & Development team are active in this area.

Supporting staff in meeting their learning and development needs in relation to the long term conditions agenda is being addressed.

The educational needs of practitioners working with children in an unscheduled care context requires to be addressed via the "emergency care framework"

The need for a training and development package to support the Advanced Paediatric Nurse Practitioner has to be pursued.

Training and development priorities have been highlighted to enhance and extend the clinical skills of staff working within the community/primary care setting, this will not only reduce the need for unnecessary admission to hospital for patients, it will also facilitate community staff's clinical skills development.

Learning from patient experiences and sharing patient journeys, provides a rich source of valuable learning and is an area which we continue to develop to ensure staff have a high standard of interpersonal and communication skills.

The ongoing implementation of new legislation, policies and professional standards brings with it many learning and development needs for all staff groups whether it be to meet Health & Safety legislation, Diversity & Equality legislation, Quality Improvement Scotland standards for Schizophrenia or Healthcare Acquired Infection. The resource implications to meet the many diverse learning & development agendas cannot be underestimated.

Investment in management development is crucial for ensuring our current and future line managers have the knowledge and skills required of them.

The “Best Value Review” on learning & development resources within NHS Tayside will provide a position statement on the current situation and make recommendations for future planning.

There are a number of key learning and development agendas associated with the public health priorities, e.g. Health inequalities, Domestic Abuse, Healthy Working Lives.

The majority of these learning and development programmes are being taken forward in partnership with colleagues from other public sector and voluntary organisations as this model of delivery enhances the joint working of colleagues to the benefit of our service users.

Through working with our partner agencies and partners in education to support the modernisation of services and shifting the balance of care we will ensure our workforce have the opportunity to maximise and enhance their skills. The enhancement of e-learning, knowledge management and tele-education offers flexible learning opportunities for ongoing continuous professional development and the I.T training team in NHS Tayside has a number of priority work streams it is taking forward.

The introduction of the Knowledge Skills Framework which applies to all employees covered by the Agenda for Change agreement will encourage everyone in the organisation to take an active responsibility in developing their own competence through the use of the NHS Knowledge and Skills Framework (KSF) tool together with the Performance and Development Planning and Review (PDPR) process. It will encourage people to generate new ideas and to develop flexibility through learning relevant new skills thereby improving their contribution to the delivery of service.

Implementation of the Career Framework is a key aspect of workforce development and raising awareness of this will facilitate the review process to support workforce planning in relation to the development of new roles and services, workforce implications of service redesign and succession planning.

As the career framework is aligned to the Knowledge Skills Framework (KSF) staff will be supported to develop their KSF outlines into relevant personal development plans for existing and potential future roles using the “Skills for Health” competencies. The benefits of this approach will allow staff to develop in different ways and aspire to new workforce roles in the future.

28. General Practice

This section has been written in consultation with representatives of General Practice, this final entry was approved by a General Practitioner representative and the NHS Tayside Director of Primary Care.

General Practice (GP) workforce data from independent contractors is not readily available to NHS Tayside, under nGMS General Practice is under no obligation to provide data. We estimate we have a headcount of around 350 General Practitioners currently working in Tayside.

Due to changing labour markets the General Practice workforce face the same issues around workforce stability as the rest of the health service. There are concerns that traditional General Practice may be becoming less attractive to young, newly qualified doctors, the impact of external NHS service development is also having an impact on job satisfaction amongst existing GP's, this includes the recent drive towards extended hours for current practitioners. Feminisation of the GP workforce and an increase in numbers seeking to work part-time are all affecting future sustainability.

Nationally, there is also the debate about whether the future service should be salaried or remain independent. There are a number of issues affecting the desirability of a salaried model, including cost, productivity and the current investment in premises by many GPs. The nature of the future general practice contract is clearly a national issue, though this does not preclude local discussion about salaried option.

General Practice does not stand in isolation, but works alongside a number of other NHS professions to provide the appropriate package of care for patients. The design, available skill set and provision of services around General Practice impacts on the composition workload and demand for their services. The shift in the balance of care, development of community hospitals and the resultant change in patient acuity will all affect the future GP role.

To explore the impact of future demographics and NHS service design a small group of General Practitioners and NHS Tayside Senior Managers met to discuss the future vision for General Practice in Tayside. There was unanimous agreement that additional work will be need to be undertaken to examine career and role development to make the General Practice more attractive and dynamic, for both the current and future General Practice workforce. The relationship and integration of work with secondary care colleagues, and discussion about the future design of General Practice were also highlighted as areas requiring further exploration. Agreement has been reached on the initial stages of this process.

The question about whether the future service should be salaried was viewed as a debate which had to be had both at local and national level. It was also recognised that their needed to be a greater emphasis on quality of care rather than volume of patient throughput.

A Strategic paper is being produced on the provision of the Out of Hours Service. Currently out of hours care is provided by a combination of full time salaried OOH doctors, part time salaried OOH doctors who are often also independent contractors, and sessional GPs. Currently there are potential vulnerabilities relating to extended periods of cover such as previous four day Christmas and New Year weekends, and the rotation

of salaried GP's over the 24 hour period on a shift based system was put forward as a future option

Concern about the loss of robust generalist skills through the implementation of MMC is also a concern for general practice. The need to identify the core skills and experience primary care doctors should be exposed to in the first 5 – 7 years of their careers in primary care was viewed as a priority. The need to establish core skills in the management of undifferentiated illness was seen as critical to the sustainability of the service.

The development of robust generalist skills and experience was also seen as essential to take account of the whole patient and not plan a workforce around a single diagnostic silo. General Practice were concerned that specialisation and channelling patients down single diagnostic routes frequently leads to patients seeing a variety of specialists which impacts on continuity of care and effective patient management.

29. Summary of key themes

It is clear from this narrative which supports the Workforce Plan 2008 template, that robust workforce planning & development are essential to the delivery of safe, quality healthcare to meet the needs of today's and tomorrow's population. The NHS is a labour intensive organisation with the workforce accounting for up to 70% of base costs. Effective workforce planning and development needs to become a core factor in everyday decision making, backed up by accurate, real time data on the deployment of the current workforce, and data to inform decision making about the future workforce. To ensure efficiency and sustainability it is essential to have an NHS Tayside corporate workforce overview of the impact of clinical change, internal and external labour markets, recruitment hotspots and areas of workforce development.

There are clear areas of growth and increased demand, this is due to changing population and healthcare demographics, changing disease profiles, the development of modern treatments, and the delivery of targets and priorities. These predicted areas of growth include both planned and un-planned patient care, some of the areas highlighted are; vascular conditions, cataract surgery, audiology, point of contact testing and diagnostics, complex maxilo-facial, renal, general medicine, endoscopy, and orthopaedics. The delivery of the 18 week referral to treatment target will also present workforce challenges to a number of departments. There will inevitably be training and development requirements and changes to workforce deployment needed to meet these demands. It is therefore critical, that as an organisation we develop a flexible, adaptable workforce with transferable skills to meet current and future healthcare need. Achieving this will be dependent maximising available learning, and training and development opportunities.

Exploring the potential for integration with other agencies and care providers needs to be a key factor in future workforce planning. As the labour market continues to become more competitive, we need to work collaboratively with our partners to secure and retain an appropriate workforce. This includes working with Universities and Further Education providers to collectively support workforce development, and the preparation of potential recruits. Education partners have an essential role to play in designing programmes to meet health and social care workforce requirements. Accreditation of learning will enable individuals, regardless of the point of entry, to progress up the career framework.

Marketing health careers at all levels in schools is a vital part of meeting future workforce need. NHS Tayside is aligned to WHAN (Working in Health Access Network). It provides an opportunity to market health careers at all levels to school pupils, enabling us to target careers and talents we need to meet future demand.

Accurate workforce information is a prerequisite to effective planning. Our current data quality does not meet the organisations workforce planning requirements. Implementing the SWISS Recovery Plan and progressing the work of the Workforce Information Group will allow current gaps and deficits to be rectified. A move to providing regular workforce updates throughout the year would assist in ensuring accurate data capture remains a priority. The use of IT and datasets to understand the geographic profiling of disease and use of healthcare services, will become increasingly important in effectively deploying the future workforce with the correct skill set to meet predicted demand. Taking account of our ageing workforce, it is important to be able to compile accurate age profiles across the organisation by sector is an essential piece of work required to establish appropriate skill development and succession planning.

Long Term Condition (LTC) management and elderly care, including dementia and mental health, depression and anxiety disorders, and the affects of loneliness are a core integral part of everyday work, developing the understanding that this is our primary client group is essential to establish the generic care, clinical and behavioural skills needed to provide care for this core client group.

There was a clear message from the clinical areas not to plan patient care in diagnostic silos, there was repeated reference that few patients sit in one silo for example long term condition, elderly or mental health. A debate needs to be had about how this fits with the Collaborative Commissioning Model. There was a plea to plan services in a way which takes account of the whole patient, across the whole patient journey. Linked to this was the repeated concern across the organisation of the loss of robust generalist skills. The move to greater specialisation has left a distinct generic skill gap, work needs undertaken to establish to key skills needed across the workforce to ensure the delivery of a quality service into the future. Associated with the need to enhance generalist skills was the need to balance the fundamentals of caring, including attitudes and behaviours, with technical clinical skills.

Designing the workforce based on the skills and competencies required to deliver care in specific areas, and taking opportunities to review skill mix to match patient need as vacancies arise will assist in meeting future workforce requirements.

The issue of capacity in primary care was also raised across the clinical groups. This was primarily linked to the shift in the balance of care and the prevention of hospital admissions, and of continuity of care across the patient journey.

In relation to legislative change meeting the European Working Time Regulations 48 hour working week by 2009 is a priority to establish the potential risks to service. A working group led by the Medical Director is taking this forward. The feminisation of the workforce will need to be monitored across the organisation to review its approach to work-life balance issues as part of service redesign.

There was a clear message that the NHS was competing with strong external labour markets, private, local authority, industry, third sector for skilled, quality staff. Employer

branding and effective marketing will become of greater importance in securing our future workforce.

Priority workforce areas are as follows:

Pharmacy, Healthcare Science, Senior Charge Nurse and Clinical Team Leader, Dental services, Consultant medical staff, neonatal, specialist paediatrics, mental health nurses, learning disability nurses, OT mental health, stroke and learning disability, and psychologists.

Staff rotation, which was raised as part of the Strategic Workforce Development Plan 2006 is becoming increasingly important to the organisation to ensure consistent skill transfer across the patient journey, and to provide stability in hard to recruit areas, and to reduce reliance on agency staff and overtime payments.

Consideration needs to be given as to how all parts of the organisation are contributing to the organisational objectives and priorities, and the skills and competencies required to deliver on these priorities. The Knowledge and Skills Framework will act as one of the main tools for determining workforce training need. The Knowledge and Skills Framework is critical to developing full utilisation of our whole workforce, linked to career pathways and the career framework.

Many of the areas highlighted in this narrative formed part of the recommendations of the Strategic Workforce Development Plan April 2006. The next stage will be to agree an Action Plan to support the priorities identified in this document, this will be supported by regular workforce updates aiming to ensure workforce priorities are monitored for change in status, and progress of development. Updates will also aim to identify emerging workforce trends in preparation for the design of the 2009/10 NHS Tayside Workforce Plan.

31st March 2008

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Groups attended
Senior Management Group (SDU)
Clinical Group Managers meeting
Joint Negotiating Committee
Area Partnership Forum (Staff Side Forum)

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Appendix 1

Better Health, Better Care: Planning Tomorrow's Workforce Today (Scottish Government, 2007a) sets out the direction for workforce planning to ensure NHSScotland has the right staff in the right place with the right skills at the right time. The report outlines the challenges in supporting delivery of the *Better Health, Better Care: Action Plan* (Scottish Government, 2007b) and emphasises the importance of investment in education and training, both in relation to the existing workforce and new supply flows.

Amongst the report's recommendations for delivering the NHSScotland vision for workforce planning are:

- ensuring the workforce supports affordable and sustainable delivery which places people at the heart of services;
- working with partners across and outwith NHSScotland to ensure workforce planning delivers accessible services across organisational and professional group boundaries;
- developing new roles, redesign services and review models of delivery to enable a shift in the balance of care towards more local, community focused care;
- ensuring education and training of the workforce enables quality standards to be met across services;
- attracting and retaining the best talent in a shrinking labour market to ensure today's workforce is well placed to meet tomorrow's requirements; and
- working with educational partners, such as NHS Education for Scotland (NES) and
Higher Education Institutes (HEIs) to ensure education and training supports a confident, competent, flexible and adaptive workforce.

Local Delivery Plan - Key Targets and Performance Measures

Health Improvement

H1 : Reduce mortality from Coronary Heart Disease among the under 75s in deprived areas.

REPLACES: *Reduce health inequalities by increasing the rate of improvement for the most deprived communities by 15% across a range of indicators including; CHD, cancer, adult smoking, smoking during pregnancy, teenage pregnancy and suicides in young people: target date 2008.*

MEASURE ⇒ European Age-Standardised CHD Mortality Rate per 100,000 population for people aged under 75 years, in the 15% most deprived datazone areas in Scotland, defined by Scottish Index of Multiple Deprivation 2006. This measure does not have a target end point. Boards are asked to propose improvement trajectories taking account of local ambitions and circumstances.

H2 : 80% of all three to five year old children to be registered with an NHS dentist by 2010/11.

REPLACES: *60% of 5 year old children (primary 1) will have no signs of dental disease by 2010.*

MEASURE ⇒ Percentage of 3-5 year olds registered with an NHS General Dentist.

H3 : Achieve agreed completion rates for child healthy weight intervention programme by 2010/11.

REPLACES: *50% of all adults (aged 16+) accumulating a minimum of 30 minutes per day of physical activity on 5 or more days per week.*

MEASURE ⇒ The performance measure is the number of children aged 7-13 years completing Scottish Government approved healthy weight intervention programmes.
NHS Scotland will be expected to deliver interventions to 15% (19,638) of children aged 7-13 years defined as overweight (includes obese) cumulatively over the period 2008/9 – 2010/11. All interventions completed from April 2008 will contribute to the cumulative total. This is a developmental measure. Target to be reviewed after year one.

H4 : Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines by 2010/11.

REPLACES: *Reduce incidence of exceeding the weekly alcohol limit of 21 units to 29% for men, and of 14 units to 11% of women: target date 2010.*

MEASURE ⇒ NHS Scotland will be expected to deliver 149,449 alcohol brief interventions cumulatively over the period 2008/9 – 2010/11, in line with SIGN 74 guideline.
The longer-term aim is for SIGN 74 to become part of the routine offer of the NHS.

H5 : Reduce suicide rate between 2002 and 2013 by 20%, supported by 50% of key frontline staff in mental health and substance misuse services, primary care, and accident and emergency being educated and trained in using suicide assessment tools/ suicide prevention training programmes by 2010.

REPLACES: *Reduce suicide rate between 2002 and 2013 by 20%.*

MEASURE ⇒ 50% of key staff trained in suicide prevention relative to the established baseline and learning levels.

H6 : Through smoking cessation services, support 8% of your Board's smoking population in successfully quitting (at one month post quit) over the period 2008/9 – 2010/11.

REPLACES: *Reduce adult (16+) smoking rates from 26.5% (2004) to 22.0% (2010).*

MEASURE ⇒ NHS Scotland will be expected to deliver 83,978 successful quit attempts (at 1 month post quit) over the period 2008/09 – 2010/11.

H7 : Increase the proportion of new-born children exclusively breastfed at 6-8 weeks from 26.6% in 2006/07 to 33.3% in 2010/11.

NEW *target for 2008/09.*

MEASURE ⇒ Number of babies recorded as being exclusively breastfed at their 6-8 week review as a percentage of all babies receiving a 6-8 week review.

Efficiency and Governance

E1 : Universal utilisation of CHI.

NO CHANGE *to target.*

MEASURE ⇒ Laboratory requests that include a CHI number, expressed as a percentage of all laboratory requests made.

E2 : NHS Boards to achieve a sickness absence rate of 4% from 31 March 2009.

REPLACES: *NHS Boards to achieve time-releasing savings including an increase in consultant productivity by 1% pa over the next 3 years and a sickness absence rate of 4% by 31 March 2008.*

MEASURE ⇒ Hours lost due to sickness absence expressed as a percentage of total hours available.

E3: NHS Boards to ensure that all employees covered by Agenda for Change have an agreed KSF Personal Development Plan by March 2009.

NEW *target for 2008/09.*

MEASURE ⇒ Percentage of staff covered by Agenda for Change who have an agreed KSF personal development plan.

E4: NHS Boards to deliver agreed improved efficiencies for 1st outpatient attendance DNA, non-routine inpatient average length of stay, review to new outpatient attendance ratio and day case rate by March 2011.

REPLACES: *NHS Boards to achieve time-releasing savings including an increase in consultant productivity by 1% pa over the next 3 years and a sickness absence rate of 4% by 31 March 2008.*

MEASURE ⇒ The number of the BADS surgical procedures performed in a day case or outpatient setting (same day care) expressed as a percentage of the total number of BADS procedures including inpatients. The dataset used is based on the 2006 Directory of procedures (Blue Book) and is aligned with the BADS information system produced by the Planned Care Improvement Programme. Day case rate measure relates to 2007/08, 2008/09 and 2009/10.

- MEASURE** ⇒ Reduce the average length of stay in hospital for acute inpatients discharged following an urgent, emergency or other non-routine, unplanned admission. This includes emergency transfers.
- MEASURE** ⇒ Reduce the ratio of return to new outpatient attendances. All specialties.
- MEASURE** ⇒ A 10% reduction in all Boards in the 1st outpatient appointment DNA rate between year ending March 2007 and March 2010. Based on the percentage of first outpatient appointments where a patient did not attend (DNA); All specialties.

E5 : NHS Boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement.

REPLACES: *NHS Boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement ; meet their cash efficiency target.*

- MEASURE** ⇒ Deficit or surplus for 'End financial year' against total revenue resource limit.

E6 : NHS Boards to meet their cash efficiency target.

REPLACES: *NHS Boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement ; meet their cash efficiency target.*

- MEASURE** ⇒ Cumulative recurring savings.

End year target information for the Cash Efficiencies measure is not available at time of issue. The Scottish Government Health Directorates will issue this data and the LDP trajectory template to Boards separately, as soon as it is available.

E7 : To increase the percentage of new GP outpatient referrals into consultant led secondary care services that are triaged online for clinical priority and appropriate recipient service to 90% from December 2010.

NEW target for 2008/09.

- MEASURE** ⇒ Percentage of new GP outpatient referrals into consultant led secondary care services that are triaged online for clinical priority and appropriate recipient service. Boards are expected to achieve a minimum of 10% by March 2009.

Access to Services

A1 : Ensure that anyone contacting their GP surgery has guaranteed access to a GP, nurse or other health care professional within 48 hours.

REPLACES: *Ensure that anyone contacting their GP surgery has guaranteed access to a GP, nurse or other health care professional within 48 hours from April 2004.*

MEASURE ⇒ The measure is percentage of practices, in a Health Board area, claiming to meet the requirements for the DES payment.

A2 : The maximum wait from urgent referral to treatment for all cancers is two months.

REPLACES: *The maximum wait from urgent referral to treatment for all cancers is two months ; women who have breast cancer and need urgent treatment will get it within one month where appropriate.*

MEASURE ⇒ Percentage of patients treated within 62 days of urgent referral.

A3 : To respond to 75% of Category A calls within 8 minutes from April 2009 onwards across mainland Scotland.

REPLACES: *To respond to 75% of Category A calls within 8 minutes in Quarter 4 of 2007/08. (mainland Health Boards only).*

MEASURE ⇒ To respond to 75% of Category A calls within 8 minutes from April 2009 onwards across mainland Scotland.

A4 : As a milestone in achieving 18 weeks referral to treatment, no patient will wait longer than 15 weeks from GP referral to a first outpatient appointment from 31 March 2009.

REPLACES: *By the end of 2005, no patient will wait longer than 6 months from GP referral to an out-patient appointment, reducing to 18 weeks from 31 December 2007.*

MEASURE ⇒ Number of outpatients waiting over 15 weeks at month end census, GP/GDP referrals only.

A5 : As a milestone in achieving 18 weeks referral to treatment, no patient will wait longer than 15 weeks for inpatient or day case treatment from 31 March 2009.

REPLACES: *No patient with a guarantee should wait longer than 6 months for inpatient or day case treatment from 31 December 2005, reducing to 18 weeks from 31 December 2007.*

MEASURE ⇒ Number of inpatients/day cases waiting over 15 weeks at month end census.

A6 : As a milestone in achieving 18 weeks referral to treatment, no patient will wait longer than 6 weeks for one of the 8 key diagnostic tests from 31 March 2009.

REPLACES: *By the end of 2007 patients will wait no more than nine weeks for any MRI or CT scans and other key diagnostic tests.*

MEASURE ⇒ Number of patients waiting over 6 weeks for : MRI scan/CT scan/barium studies/ultrasound non-obstetric/gastroscopy/sigmoidoscopy/ colonoscopy/ cystoscopy.

A7 : NHS Boards will achieve agreed reductions in the rates of attendance at A&E, from 2006/7 to 2010/11; and from end 2007 no patient will wait more than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment.

REPLACES: *By end 2007 no patient will wait more than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment.*

MEASURE ⇒ Number of A&E attendances, per 100,000 population.

MEASURE ⇒ The percentage of patients seen waiting no more than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment.

Treatment

T1 : By 2008-09, we will reduce the proportion of older people (aged 65+) who are admitted as an emergency inpatient 2 or more times in a single year by 20% compared with 2004/05 and reduce, by 10%, emergency inpatient bed days for people aged 65 and over by 2008.

NO CHANGE *to target.*

MEASURE ⇒ The number of patients (65+), admitted, for any reason, two or more times in one calendar year, as an emergency to acute specialties defined as a rate per 1,000 population.

MEASURE ⇒ The rate per 1,000 of population of occupied emergency bed days, in acute specialties, for patients aged 65+.

T2 : QIS clinical governance and risk management standards improving.

NO CHANGE *to target.*

MEASURE ⇒ NHS Boards demonstrate improvement against NHS QIS clinical governance and risk management standards from the baseline published in the NHS QIS National Overview published October 2007. Level of achievement in 2009/10 against NHS QIS Clinical Governance and Risk Management Standards from baseline. Qualitative performance assessment reports and achievement against a four point assessment scale which gives a single score.

T3 : Reduce the annual rate of increase of defined daily dose per capita of anti-depressants to zero by 2009/10, and put in place the required support framework to achieve a 10% reduction in future years.

REPLACES: *Reduce the annual rate of increase of defined daily dose per capita of anti-depressants to zero by 2009/10.*

MEASURE ⇒ Number of anti-depressant DDDs per capita in year ending March 2010 is less than or equal to the number of anti-depressant DDDs per capita in year ending December 2009. Includes prescriptions dispensed in the community, i.e. through a community pharmacist or dispensing doctor. Figures are shown by the NHS Board where the prescription was written. Antidepressants are defined as drugs in section 4.3 of the British National Formulary (BNF).

T4 : Reduce the number of readmissions (within one year for those that have had a psychiatric hospital admission of over 7 days by 10% by the end of December 2009).

NO CHANGE *to target.*

MEASURE ⇒ Reduce the number of readmissions (within one year) for those that have had a hospital admission of over 7 days (in a Scottish psychiatric hospital) by 10% by the end of December 2009.

The baseline year is year ending December 2004. Analysis based on Health Board of Residence. Includes all psychiatric specialties except learning disabilities; admissions can be elective/emergency but not an inter-hospital transfer. For example, patients discharged in January 2004 would be 'tracked' until January 2005 to determine whether they were readmitted; similarly patients discharged in February 2004 would be tracked until February 2005.

T5 : To reduce all staphylococcus aureus bacteraemia (including MRSA) by 30% by 2010.

NO CHANGE *to target.*

MEASURE ⇒ Number of identifications of *Staphylococcus aureus* bacteraemias (including MRSA and MSSA) as detailed in Health Protection Scotland SSHAIP surveillance protocols.
Base year is 2005/06.

T6 : To achieve agreed reductions in the rates of hospital admissions and bed days of patients with primary diagnosis of COPD, Asthma, Diabetes or CHD, from 2006/7 to 2010/11.

NEW *target for 2008/09.*

MEASURE ⇒ Numbers of hospital episodes for specified long term conditions, per 100,000 population. This measure does not have a target end point. Boards are asked to propose improvement trajectories taking account of local ambitions and circumstances.

T7 : Improvement in the quality of healthcare experience.

NEW *target.* No trajectories required to be submitted. Work required to identify NHS specific target for future.

MEASURE ⇒ To be confirmed.

T8 : Increase the level of older people with complex care needs receiving care at home.

NEW target. No trajectories required to be submitted.

MEASURE ⇒ Increase the percentage of people aged 65 and over with high levels of care needs who are cared for at home, as part of shifting the balance of care.

Proportion of older people with complex care needs receiving support or care who get that support or care in their own home as opposed to in an institutional setting.

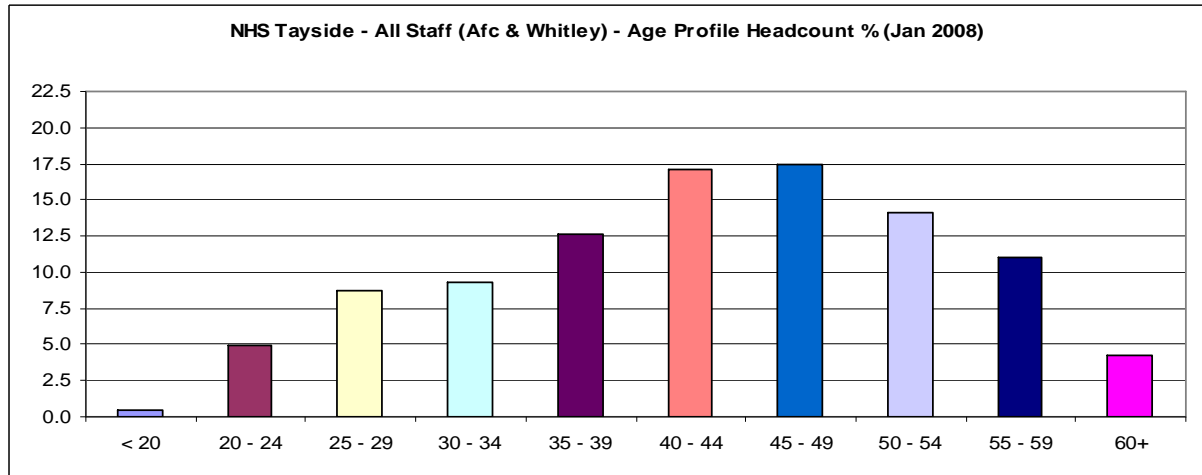
T9 : Each NHS Board will achieve agreed improvements in the early diagnosis and management of patients with a dementia by March 2011.

NEW target for 2008/09.

MEASURE ⇒ Number of people with a diagnosis of a dementia on the QOF dementia register.

Boards are expected to achieve a 33% increase on the baseline by March 2011. This will be reviewed after year one.

Table 4



Age Band	< 20	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+
%	0.5	4.9	8.7	9.3	12.6	17.1	17.4	14.1	11.1	4.3
HC	69	664	1172	1251	1693	2298	2340	1893	1486	578

Table 5

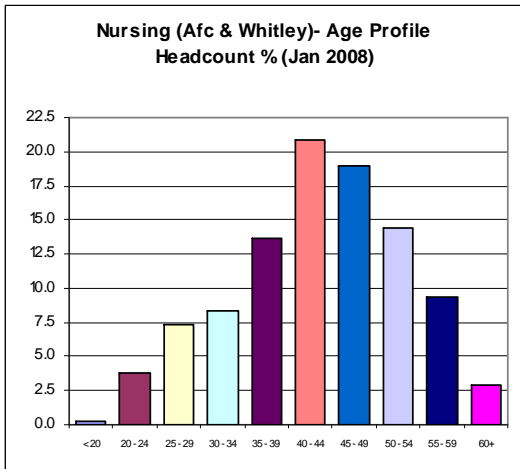


Table 6

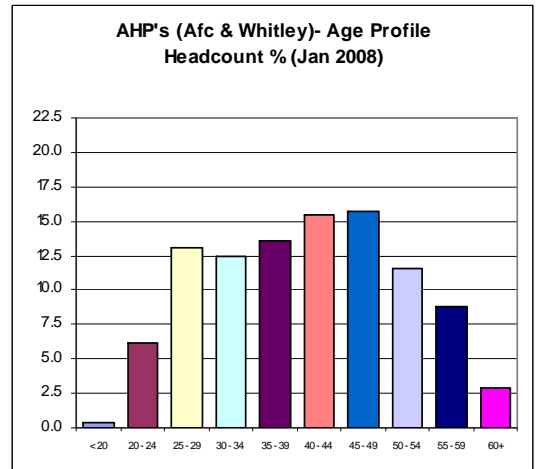


Table 7

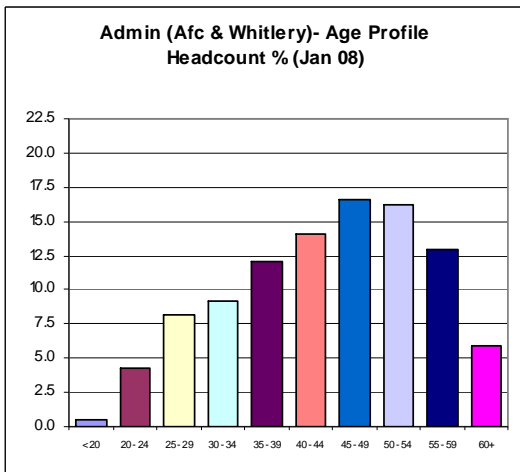


Table 8

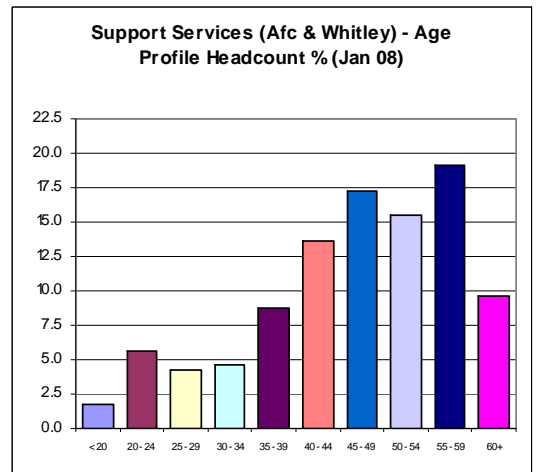


Table 9

New Starts, October 2006 - September 2007

Job Family	Staff In Post as at 30 Sept 07	% Starts
All staff	13444	13.76%
Administrative Services	1862	12.41%
Allied Health Profession	873	9.97%
Health Science Services	476	10.50%
Medical And Dental	1195	30.21%
Medical And Dental Support	157	15.29%
Nursing/Midwifery	5511	9.96%
Other Therapeutic Service	292	17.47%
Personal And Social Care	36	2.78%
Senior Management	139	2.88%
Support Services	1842	17.37%
Not Assimilated (various)	1061	16.21%

Notes:

1. Source SWISS WIR/ Business Objects 30th September 2007
2. Bank Staff and GP's Excluded

Table 10**Whole Time/Part Time Working Headcount as at 30 September 2007**

Job Family	Total		Male		Female	
	Whole Time	Part Time	Whole Time	Part Time	Whole Time	Part Time
All staff	7945	5499	2419	361	5526	5138
Administrative Services	1117	745	208	25	909	720
Allied Health Profession	483	390	93	16	390	374
Health Science Services	339	137	164	10	175	127
Medical And Dental	909	286	540	96	369	190
Medical And Dental Support	106	51	26	1	80	50
Nursing/Midwifery	3067	2444	492	50	2575	2394
Other Therapeutic Service	212	80	66	12	146	68
Personal And Social Care	25	11	5		20	11
Senior Management	132	7	58		74	7
Support Services	871	971	620	139	251	832
Not Assimilated (various)	684	377	147	12	537	365

Table 11**Whole Time/Part Time Working as at 30 September 2007**

Job Family	Total		Male		Female	
	Whole Time	Part Time	Whole Time	Part Time	Whole Time	Part Time
All staff	59.10%	40.90%	17.99%	2.69%	41.10%	38.22%
Administrative Services	59.99%	40.01%	11.17%	1.34%	48.82%	38.67%
Allied Health Profession	55.33%	44.67%	10.65%	1.83%	44.67%	42.84%
Health Science Services	71.22%	28.78%	34.45%	2.10%	36.76%	26.68%
Medical And Dental	76.07%	23.93%	45.19%	8.03%	30.88%	15.90%
Medical And Dental Support	67.52%	32.48%	16.56%	0.64%	50.96%	31.85%
Nursing/Midwifery	55.65%	44.35%	8.93%	0.91%	46.72%	43.44%
Other Therapeutic Service	72.60%	27.40%	22.60%	4.11%	50.00%	23.29%
Personal And Social Care	69.44%	30.56%	13.89%	0.00%	55.56%	30.56%
Senior Management	94.96%	5.04%	41.73%	0.00%	53.24%	5.04%
Support Services	47.29%	52.71%	33.66%	7.55%	13.63%	45.17%
Not Assimilated (various)	64.47%	35.53%	13.85%	1.13%	50.61%	34.40%

Notes:

1. Source SWISS WIR 30th September 2007
2. Bank Staff and GP's Excluded

Table 12**Staff Turnover, October 2006 - September 2007**

Job Family	Staff In Post as at 30 Sept 07	Turnover (%)
All staff	13444	11.89%
Administrative Services	1862	6.28%
Allied Health Profession	873	6.99%
Health Science Services	476	2.73%
Medical And Dental	1195	24.35%
Medical And Dental Support	157	6.37%
Nursing/Midwifery	5511	6.48%
Other Therapeutic Service	292	9.59%
Personal And Social Care	36	16.67%
Senior Management	139	4.32%
Support Services	1842	16.29%
Not Assimilated (various)	1061	38.55%

Notes:

1. Source SWISS WIR/ Business Objects 30th September 2007
2. Bank Staff and GP's Excluded

Table 13**Sickness Absence, October 2006 - September 2007**

Staff Groups	Total Lost Hours	Total Contracted Hours	Sickness Absence Rate
All Staff	1116075	21947916	5.09%
A&C	157364	3915994	4.02%
AHP	123596	3000986	4.12%
Ancillary	171299	2442497	7.01%
Estates	23499	455825	5.16%
Medical	21648	2049715	1.06%
Nursing Registered	416999	7265488	5.74%
Nursing Unregistered	191058	2514480	7.60%
Phar/Misc	10611	302931	3.50%

Notes:

1. Source - NHS Tayside monthly published reports
2. Excludes GP's
3. Sickness absence rate is hours lost divided by total contracted hours
4. Total contracted hours is calculated as weekly contracted hours multiplied by 52.179

Table 14
Ethnic Origin

Job Family	White Scottish	White British	White Irish	Other White	Any mixed background	Indian	Pakistani	Bangladeshi
	18	6	-	<5	-	<5	-	-
Administrative Services	1680	154	10	20	6	6	<5	-
Allied Health Profession	655	124	19	22	<5	<5	<5	-
Emergency Services	<5	-	-	-	-	-	-	-
Health Science Services	376	63	6	22	<5	<5	6	-
Medical And Dental (Excl. GPs)	452	254	41	85	15	101	24	<5
Medical And Dental Support	119	<5	-	<5	-	-	<5	-
Not Known	<5	-	-	-	-	-	-	-
Nursing/Midwifery	4302	416	59	77	15	10	8	<5
Other Therapeutic Service	170	37	7	6	<5	<5	-	-
Personal And Social Care	20	7	<5	<5	<5	-	-	-
Senior Management	98	17	<5	<5	-	<5	-	-
Support Services	1060	58	5	14	<5	9	5	<5
	7	-	<5	<5	<5	-	-	-
TOTAL	8,957	1,136	147	246	36	126	43	0

Table 15

Job Family	Chinese	Other Asian	Caribbean	African	Other Black	Other Ethnic Background	Declined	Not Known
	-	-	-	-	-	-	<5	<5
Administrative Services	<5	<5	-	-	<5	<5	25	362
Allied Health Profession	<5	-	-	-	-	<5	14	191
Emergency Services	-	-	-	-	-	-	-	-
Health Science Services	<5	<5	-	<5	-	<5	6	158
Medical And Dental (Excl. GPs)	27	13	<5	9	-	18	66	282
Medical And Dental Support	-	-	-	-	-	-	<5	26
Not Known	-	-	-	-	-	-	-	-
Nursing/Midwifery	6	23	<5	45	8	<5	385	1393
Other Therapeutic Service	-	<5	-	-	-	<5	<5	49
Personal And Social Care	-	-	-	-	-	-	-	5
Senior Management	-	-	-	-	-	-	<5	20
Support Services	<5	5	-	6	<5	-	45	704
	-	-	-	-	-	-	<5	<5
TOTAL	33	41	0	60	8	18	541	3,190

Notes:

1. Source - SWISS Workforce Information Repository as at 15/12/07

2. Information presented in this table is based on self-reporting by staff in NHS Scotland. Data are collected via staff engagement forms when people join, or change organisations within, NHS Scotland, or via the "e:you" questionnaire exercise undertaken for all staff in post during 2005. Completion of the questionnaire exercise was optional and response rates varied across the country. Those staff who did not return their questionnaires are counted under "Not Know".

Table 16
Disability

Job Family	Yes	%	No	%	Declined	%
	-	-	34	100	-	-
Administrative Services	14	0.62	2254	99.16	5	0.22
Allied Health Profession	6	0.58	1024	99.13	<5	*
Emergency Services	-	-	<5	*	-	-
Health Science Services	<5	*	646	99.23	<5	*
Medical And Dental (Excl. GPs)	<5	*	1387	99.64	<5	*
Medical And Dental Support	-	-	154	99.35	<5	*
Not Known	-	-	<5	*	-	-
Nursing/Midwifery	20	0.3	6724	99.53	12	0.18
Other Therapeutic Service	<5	*	274	98.92	<5	*
Personal And Social Care	-	-	37	100	-	-
Senior Management	<5	*	138	97.87	<5	*
Support Services	5	0.26	1914	99.53	<5	*
	-	-	14	100	-	-
TOTAL	45		14600		17	

Notes:

1. Source - SWISS Workforce Information Repository as at 15/12/07

Table 17

All NHS Tayside as at 31/01/2008

Job Family	WTE
Administrative Services	1576.8
AHP – Other Therapeutic	260.3
AHP – Therapeutic Services	714.5
Health Science Services	420.6
Medical & Dental	1019.8
Medical & Dental Support	139.9
NOT ASSIMILATED	905.8
Nursing & Midwifery	4723.4
Personal And Social Care	30.4
Senior Management	136.6
Support Services	1494.2
Grand Total	11422.3

Table 18

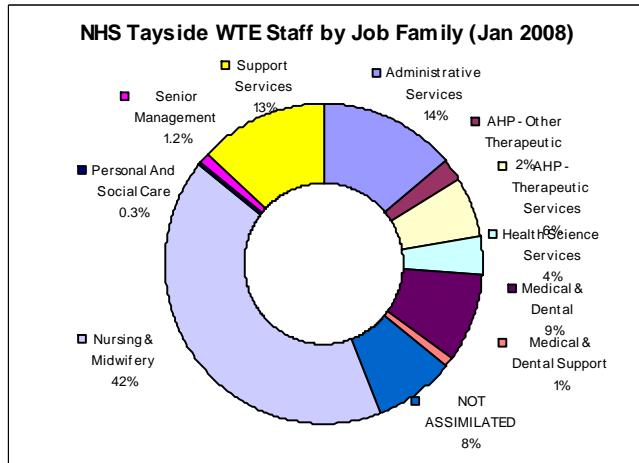
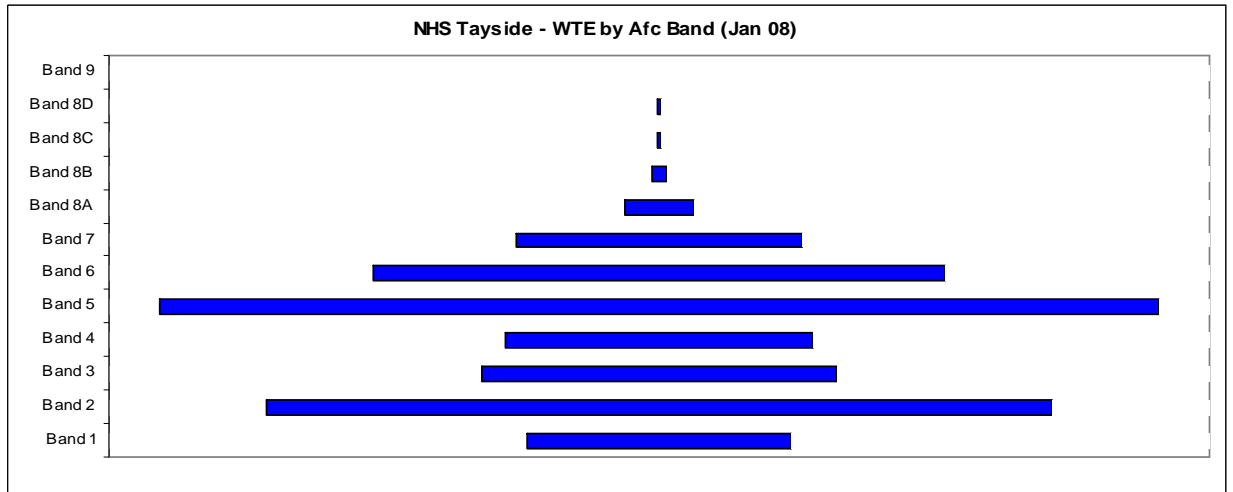


Table 19



Afc Band	1	2	3	4	5	6	7	8A	8B	8C	8D	9	Total
WTE	673	2009	905	787	2554	1462	730	173	41	14	10	3	9360

Table 20

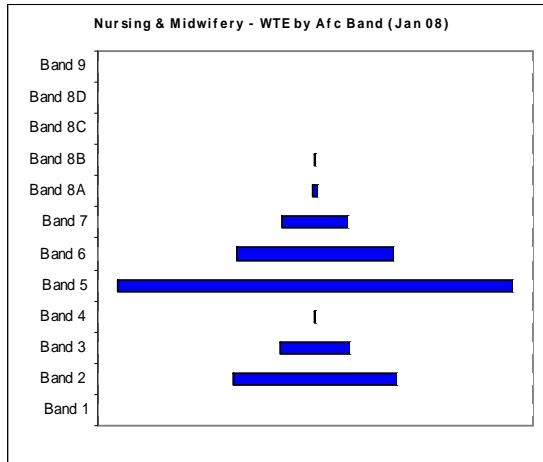


Table 21

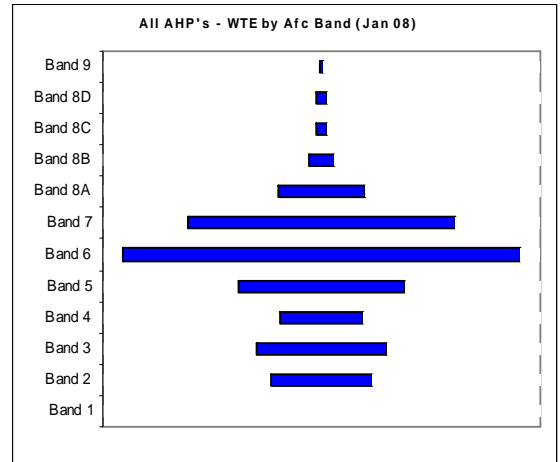


Table 22

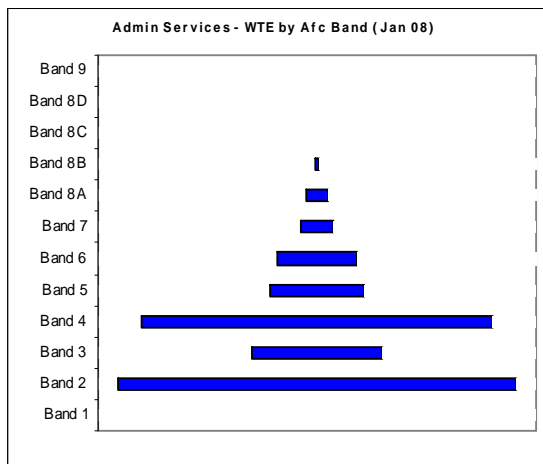
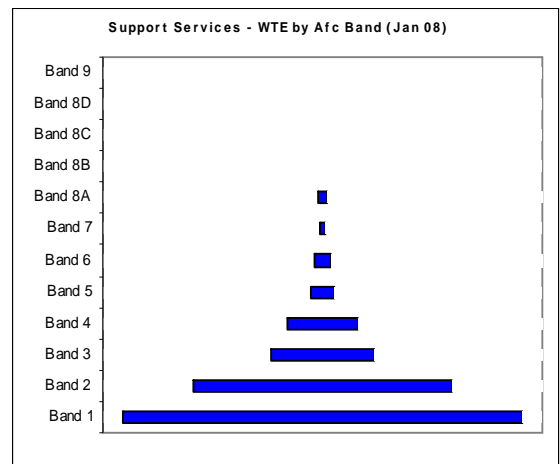


Table 23



LOCAL EMPLOYMENT PARTNERSHIP AGREEMENT

NHS Tayside is wholeheartedly committed to working with JobCentre Plus in Tayside to help long-term benefit claimants back into employment building on the longstanding activities they have to benefit the communities they serve and make them better places to live and work.

To demonstrate this commitment NHS Tayside agree to encourage their managers to enter into Local Employment Partnerships with JobCentre Plus to support their efforts in getting benefit claimants into work.

Measures to help support benefit claimants into work could include:

- Offering 3 week work placements to local benefit claimants;
- Working with JobCentre Plus on the design of pre-employment training to ensure that it is relevant to NHS Tayside and agree to guarantee interviews to local benefit claimants who complete the training consistent with the Healthcare Academy;
- Encourage employees to volunteer to provide one-to-one mentoring for long-term benefit claimants to help prepare them for work;
- Ensure the assessment and selection process is based only on the requirements of the job;
- Hold annual Job Fair supported by JobCentre Plus for benefit claimants.

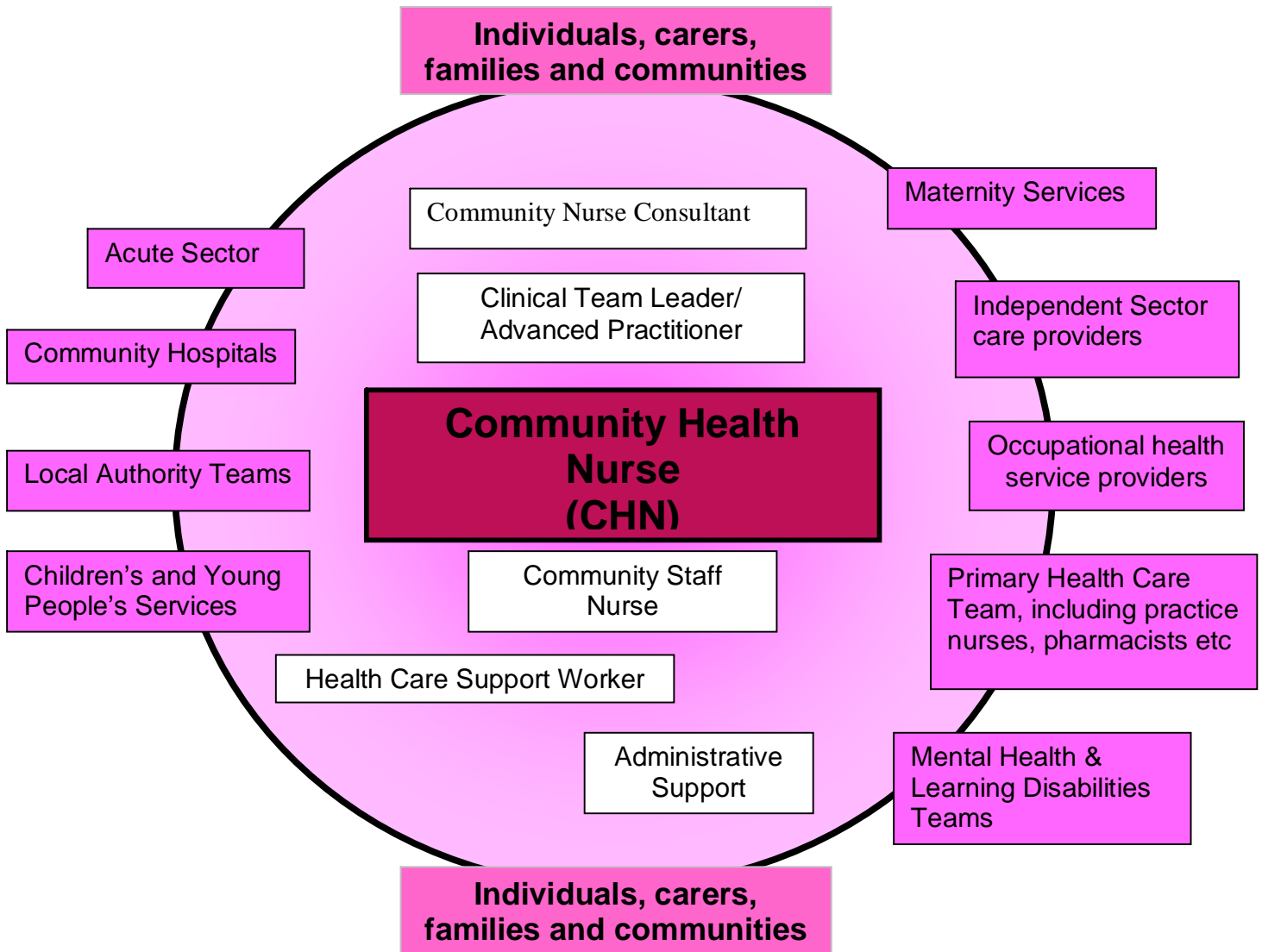
JobCentre Plus will establish a single point of contact to lead on the Local Employment Partnership. The JobCentre Plus lead will work with NHS Tayside to establish which measures might be most appropriate across areas and departments. They will also identify sources of funding for pre-employment training that are considered necessary for meeting the needs of both NHS Tayside and JobCentre Plus.

Alan Boyter
Director of Strategic HR & Workforce Development

5 October 2007

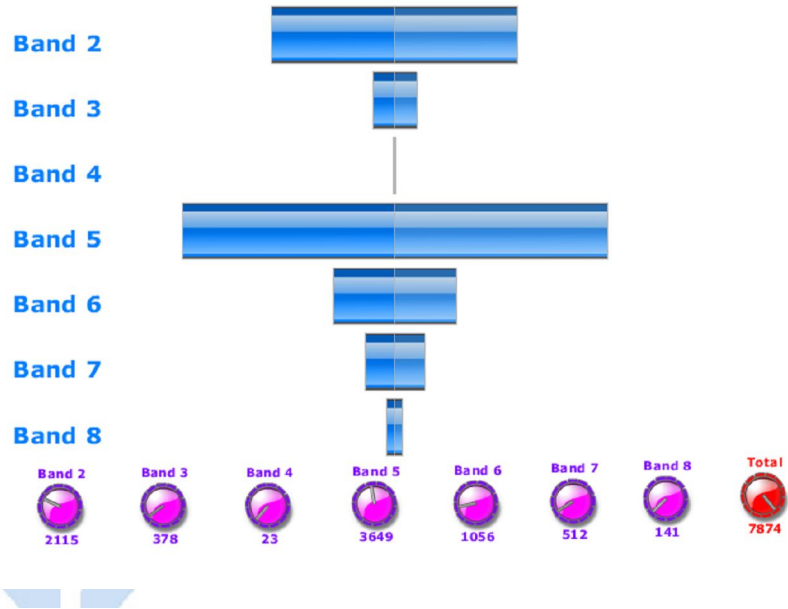
Key Elements of the NHS Career Framework

9	<p>More Senior Staff - Level 9 Staff with the ultimate responsibility for clinical caseload decision making and full on-call accountability.</p>
8	<p>Consultant Practitioners- Level 8 Staff working at a very high level of clinical expertise and/or have responsibility for planning of services.</p>
7	<p>Advanced Practitioners - Level 7 Experienced clinical professionals who have developed their skills and theoretical knowledge to a very high standard. They are empowered to make high-level clinical decisions and will often have their own caseload. Non-clinical staff at Level 7 will typically be managing a number of service areas.</p>
6	<p>Senior Practitioners/Specialist Practitioners - Level 6 Staff who would have a higher degree of autonomy and responsibility than 'Practitioners' in the clinical environment, or who would be managing one or more service areas in the non-clinical environment.</p>
5	<p>Practitioners - Level 5 Most frequently registered practitioners in their first and second post-registration/professional qualification jobs.</p>
4	<p>Assistant Practitioners/Associate Practitioners - Level 4 Probably studying for foundation degree, BTEC higher or HND. Some of their remit will involve them in delivering protocol-based clinical care that had previously been in the remit of registered professionals, under the direction and supervision of a state registered practitioner.</p>
3	<p>Senior Healthcare Assistants/Technicians - Level 3 Have a higher level of responsibility than support worker, probably studying for, or have attained NVQ level 3, or Assessment of Prior Experiential Learning (APEL).</p>
2	<p>Support Workers - Level 2 Frequently with the job title of 'Healthcare Assistant' or 'Healthcare Technician' - probably studying for or has attained NVQ Level 2.</p>
1	<p>Initial Entry Level Jobs - Level 1 Such as 'Domestics' or 'Cadets' requiring very little formal education or previous knowledge, skills or experience in delivering, or supporting the delivery of healthcare.</p>



NHS Tayside Nursing

Nursing NHS Tayside



Workforce Development – 6 Steps

The aim of this paper is to provide guidance and a checklist for CHP's and Clinical Groups in Secondary Care to support programme and project leads with the creation of workforce development plans as part of the integrated planning process.

There will inevitably be Workforce and Training and Development needs attached to all new projects and developments, and many will impact on the same or competing workforce sectors. Human Resources Workforce Development, Workforce Planning, and Training and Development will act as enabling strands to support and advise agreed projects within NHS Tayside. Having one agreed organisational template will be helpful to ensure a consistent approach to workforce planning and development and will help to identify project overlap, focus resource, identify hotspots, and avoid duplication of work and/or data collection.

The vision would be to have an agreed standardised NHS Tayside template, to be completed as part of every project or development proposal. This would then be returned to the Department of HR and Workforce Development. This could assist in preventing the creation of internal workforce markets, but would also allow proactive prediction of potential skills shortages and recruitment hotspots, it will also allow better forecasting of training and development needs within the organisation.

This development will also assist in raising awareness of the impact of a service or policy change in one area, will have an impact elsewhere in the system, and it is hoped will see full integration between workforce, service and financial planning.

Workforce Development would therefore consist of the following 6 stages;

- 1. Defining the Plan**
- 2. Forces for Change**
- 3. Assessing Demands**
- 4. Assessing Supply**
- 5. Developing an Action Plan**
- 6. Implementation and Review**

Workforce Development would therefore consist of the following 6 stages;

1. Defining the Plan

- The rationale, why is the Plan being prepared, for example what outcomes is the development/redesign intended to achieve?
- The function, what decisions will the plan support, for example when do decisions need to be made?
- Scope, what does the plan cover, for example what client groups does it cover?
- What stakeholders need to be involved, and included in the development and consultation?
- What types of staff are covered by the plan?
- What geographic area does it cover?
- What services and organisations are covered by the plan?
- What is the timescale for the plan?

2. Forces for Change - the need for change

- Agree workforce policy drivers and constraints, what are the reasons for change, eg demographics, retirements, population healthcare need?
- Clarify base cost of current workforce, measure the baseline before changes are made, this is critical for effective evaluation
- Agree vision of future workforce and ways of working
- Agree expectations eg. increased productivity, skills base, reduction or increase in workforce costs
- Agree success criteria and measurement

3. Assessing Demand – the numbers and types of people, and skills needed to achieve the planned service activities

- What services are required to meet the patient/client need?
- Use the Knowledge and Skills Framework to identify the clinical and non-clinical skills required by the team at each stage of the care pathway
- Agree skill and competency profile for the teams - it is important not to specify profession or staff group at this stage – skill and competency requirements should lead the team design. Outline workforce numbers aligned to each skill level.
- What are the hours of service, patterns of working?
- What resources will the team need access to, for example equipment, IT?
- Identify, where possible, barriers to achieving workforce objectives
- Utilise existing workforce/workload tools to assist in this level of planning as appropriate. Many tools are profession specific, and may help part of the planning process. Developing a competent team model should be the focus (clinical and non-clinical).

4. Assessing Supply – analysis of current workforce and labour market.

This is the number and type of people and skills that are available to be deployed in the delivery of services, both now and including an assessment of future supply.

- Provide a baseline assessment of what skills are available within the current workforce
- What is the profile of the current workforce, age, wte and headcount, contracted hours, sickness/absence and turnover?
- What are the current staffing costs?
- What time is spent on non-value added tasks or tasks which could be done by others? Examine the current roles and responsibilities in the team?
- What is the potential impact of the development, for example is there availability and capacity for ongoing training, learning and development, impact of other developments on supply, and the impact on other existing services?
- What is your current main recruitment pool, and what is the availability, are there untapped labour markets?
- What students are currently in training across the professions?
- Is this suitable as an Employability project?
- Is there legislation which could impact on supply, eg EWT 2009?

5. Developing and Action Plan

- What is the gap between the demand and the supply, establish this both in terms of skills and availability? Use the Agenda for Change Christmas Tree Generator if available to clearly depict the differences.
- Can any skill shortages be predicted, for example specialist skills?
- Are there areas where individuals are only using their specialist skills part of the time?
- What are the areas where generalist skills can be carried out by a range of different individuals?
- Under any redesign will there be any excess staff following implementation
- What new skills need to be developed? What are the predicted training and development needs?
- What are the IT implications, review of systems?
- What retention strategies are in place for existing staff?
- Agree the profile of new team structure, including profile of new and enhanced roles
- Write a recruitments plan
- Write a retention strategy
- Make the National Career Framework, PDP and KSF integral to development
- Financial plan for the new staff profile, compare with existing workforce
- Assess any potential risk in terms of workforce provision

- Assess any impact on Diversity & Equality in relation to the workforce

6. Process implementation and review

- Review process
- Measure and evaluate benefits and impact
- Budget realisation and time realisation
- Cost reduction and productivity gains

D. Donald
October 2007