NHS Borders
Local Workforce Plan (Draft)
2016 - 2019

Contents reflecting the 6 Step Workforce Planning Methodology

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Executive Summary

Workforce planning is a statutory requirement as stated in CEL 32 (2011) to support an evidence based approach to planning and developing the workforce. The key aim is to ensure we can deliver the highest quality of care by having the right workforce.

This 2016/19 NHS Borders (NHSB) Workforce Plan has been developed using the NHS Scotland six steps methodology and outlines the anticipated changes in the NHSB workforce in the next three years.

The current NHSB workforce of 3,237 serves a population of approximately 114,030 of which 23% are aged 65 and over. The workforce is predominantly female (80%) and has an average age of 45.5. The plan identifies our intention to seek to enhance our staff engagement, recognising that a positive staff experience will lead to better patient care. This is underpinned by the key values of NHS Borders, and our 5 Staff Governance Standards outlined below;

Values	Staff Governance Standards
Care and Compassion	Well Informed
Quality and Teamwork	Appropriately Trained
Openness, Honesty and Responsibility	Involved in decisions which affect them
Dignity and Respect	Treated fairly and consistently
	Provided with an improved and safe working environment

NHS Borders, in common with all public sector organisations, is currently undergoing significant change in response to both national and local policy. One area being progressed is to further Joint Workforce Planning with the Integrated Joint Board for Scottish Borders Health and Social Care Partnership to improve understanding of workforce planning issues across organisational boundaries.

A number of workforce issues and risks are identified in this Workforce Plan including recruitment and workforce supply, the age profile of the workforce and succession planning. Our future plans include the establishment of a more proactive Recruitment and Retention Strategy, which will for example support staff approaching retirement age to work more flexibly and highlight the promotion of Return to Practice across relevant staff groups.

The Workforce Plan concludes by highlighting further work required to progress the 2020 Workforce Vision and how this will evolve from our flexible and engaged workforce. The Workforce Plan is dynamic and will respond to internal and external opportunities and / or pressures and as a result will be refreshed and updated annually.

NHS Borders - Living our Values

Step 1 – Defining the Plan

1.1 Introduction

Why is a Workforce Plan Required?

Workforce Planning is a statutory requirement that was established in NHS Scotland in 2005 with HDL (2005)52. CEL 32 (2011) refreshes this guidance and provides a nationally recognised framework to develop our Local Workforce Plan.

This workforce plan will support us to achieve our Clinical Strategy (which was published in August 2014), 2020 Vision and organisational Corporate Objectives. The Local Workforce Plan aims to support services to develop structures that deliver the right thing, first time, every time by the right person and will ensure that workforce implications are considered when redesigning services.

We recognise that the majority of Workforce Planning takes place at an operational level and this organisational Workforce Plan provides an overview of the direction for NHS Borders in terms of Workforce Planning.

The profile of the Borders population presents demographic challenges for NHS Borders, and this plan highlights the importance of progressing Workforce Planning locally, regionally and nationally over the coming years. It is forecast that 1 in 4 people born now will live to be over 100 years old.

1.2 Purpose

The purpose of the Local Workforce Plan is to highlight organisational priorities and demonstrate practical examples of how Workforce Planning is being progressed across NHS Borders. It is essential that NHS Borders continue to facilitate a more joined up approach to Workforce Planning ensuring all relevant stakeholders (internally and externally are involved).

Our Local Workforce Plans will support our Clinical Strategy and outline how we can work differently because of these changes. Our Clinical Strategy recognises that NHS Borders benefits from a dedicated workforce which is committed to providing the highest quality services for our patients. However our workforce itself is becoming older and we need to plan now how we will address this demographic challenge by the year 2020.

1.3 Scope

The population of the Scottish Borders in 2014 was 114,030. It is a largely rural area with a sparse population density, with two thirds of the population living outside the main towns in a dispersed network of close-knit small settlements. The biggest towns are Hawick and Galashiels which have a population of over 14,000.

The Local Workforce Plan covers all NHS Borders Health care within Acute, Mental Health, Primary and Community and Learning Disability Services across the Scottish Borders with a Workforce of 3,237 headcount. This includes a District General Hospital and four Community Hospitals.

Population Profile

The 2015 population for Scottish Borders was 114,030 which is an increase of over 10% in the last 20 years

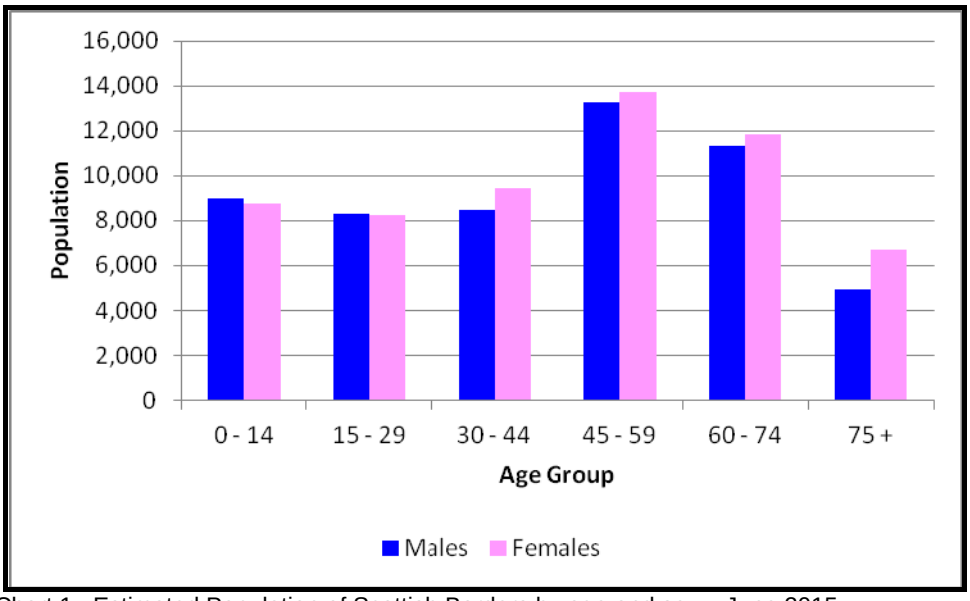


Chart 1: Estimated Population of Scottish Borders by age and sex – June 2015

This population increase is predicted to continue over the coming years which will result in a higher demand for our services particularly from the population aged 65 and over. This will have a significant impact on our services as there will be a rise in people with multiple and complex long term conditions increasing the burden on NHS Borders. Workforce Planning is essential to ensure a proactive approach to delivering care effectively in this changing demographic environment.

The chart below shows the percentage change in population in Scottish Borders and Scotland, 2012-2037 (2012-based projections). This shows that the population under 65 will continue to shrink and the over 65 age group will grow, with the over 75 age group expanding more quickly in the Scottish Borders than in Scotland as a whole.

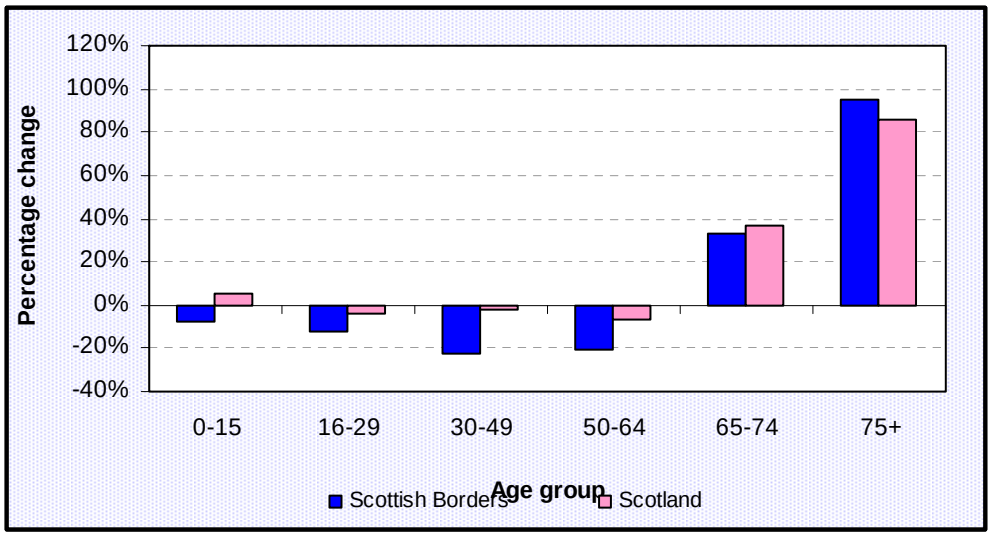


Chart 2: Percentage projected change in population, 2012-2037

The chart below shows the Migration of people into and from the Scottish Borders area averaged over the years 2011 to 2013 and also the net result. This shows a small growth in under 15s, and a reduction in 16 – 29 year olds, increases in 30 – 65 year olds and a balance in over 65s for this period.

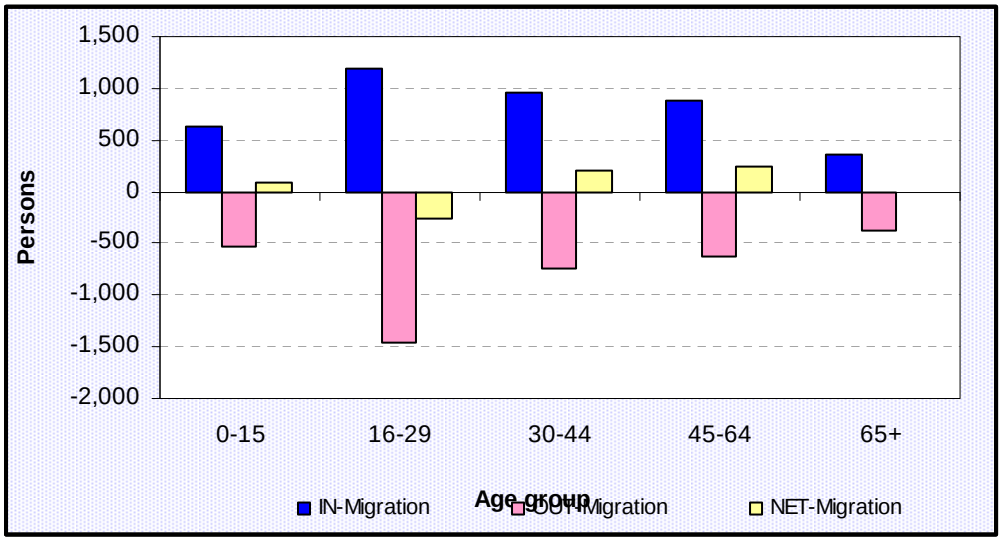


Chart 3: Migration into and from Scottish Borders 2011-2013

2015 saw the re-introduction of the Borders railway which was closed in 1969. It is expected that these new rail links will widen economic and housing opportunities, with the knock-on effect that companies in the local area will also see a boost in their levels of business. As HM Queen Elizabeth said at the opening ceremony, "The Borders railway brings so much promise for sharing and invigorating this most beautiful countryside as a place to work, live and enjoy." A large scale housing development near to the hospital is currently in development as the Borders becomes a more attractive place to live and work, the new railway improving already good access links to Edinburgh whilst still enjoying the benefits of countryside living. The Borders has become a more attractive place to live and work.

1.4 Ownership

Partnership Working and Governance

Our Local Workforce Plan is created in partnership with staff and their representatives. This includes our joint Local Workforce Conference, discussion and agreement at Area Partnership Forum, engagement with services using accepted methodologies for workforce planning and workload measurement ensuring a consistent framework applies for the development of the future workforce. The APF is the working arm of the Staff Governance Committee. Therefore all workforce issues raised through the APF including the development of our Workforce Plan come directly to the Staff Governance Committee. However there are various links between the Staff Governance Committee and other Board Committees such as Clinical Governance and Audit which are reflected through various pieces of work, eg Mandatory & Statutory Training and the Francis Report.

A Partnership Subgroup will review the consultation responses and support the development of the final version, following which a final version will be considered for approval by the Staff Governance Committee.

Step 2 - Mapping Service Change

2.1 Drivers for Change

National Clinical Strategy

The National Clinical Strategy sets out the case for:

- planning and delivering integrated primary care services, like GP practices and community hospitals, around the needs of local communities
- restructuring how our hospitals can best serve the people of Scotland
- making sure the care provided in NHSScotland is the right care for an individual, that it works, and that it is sustainable
- changing the way the NHS works through new technology

NHS Borders Clinical Strategy

The Clinical Strategy sets out a framework to support NHS Borders to continue to provide a high standard of healthcare in a challenging financial environment, when demand for healthcare is increasing. It aims to ensure that NHS Borders services should be patient-centred, safe, high quality and efficient and opportunities to trial innovative models, including moving away from our current traditional bed based system should be embraced.

The 7 Key Principles of the Clinical Strategy are outlined below:

1 Services will be Safe, Effective and High Quality
2 Services will be Person-Centred and Seamless
3 Health Improvement and Prevention will be as important as treatment of illness
4 Services will be delivered as close to home as possible
5 Admission to hospital will only happen when necessary, and will be brief and smooth
6 We are committed to working in Partnership with staff, communities and other organisations to deliver the best outcomes for the people we serve
7 Services will be delivered efficiently, within available means

These principles support the NHS Borders 2020 Vision which was developed in response to the national vision for NHS Scotland.

Everyone Matters: 2020 Workforce Vision

This national framework aims to increase the focus on preventing and detecting health problems and keeping people well in their own homes and in the community. Some of the key changes which will impact our workforce in terms of the way we work, what we do, and the people we work with include;

- ensuring healthcare is available where and when it is needed
- providing wider and more equitable access to healthcare
- working seamlessly with colleagues in NHSScotland and partners who provide care
- making more and better use of technology and facilities to increase access to services and improve efficiency
- strengthening workforce planning to ensure the right people, in the right numbers, are in the right place, at the right time
- putting new and extended roles into practice
- providing a safe environment for innovation and improvement
- using a continuous improvement approach to deliver better ways of working

Scottish Borders Health & Social Care Partnership Strategic Plan 2015-18

The Strategic Commissioning Plan describes how the Scottish Borders Health and Social Care partnership will develop health and social services for adults over the coming three years. It will provide the strategic direction for how health and social care services will be shaped in this area and describes the transformation that will be required to achieve this vision.

For year one, the focus will be on ensuring that business as usual can continue, whilst key strategic change processes are delivered, to enable us to move efficiently to a fully integrated service in the second and subsequent years. Through both the Integrated Care Fund (ICF) and the Social Care Fund (SCF) we will deliver services which will reflect the key priorities of integration, including the introduction of new models of care which will be tested to inform strategic decisions on further investment.

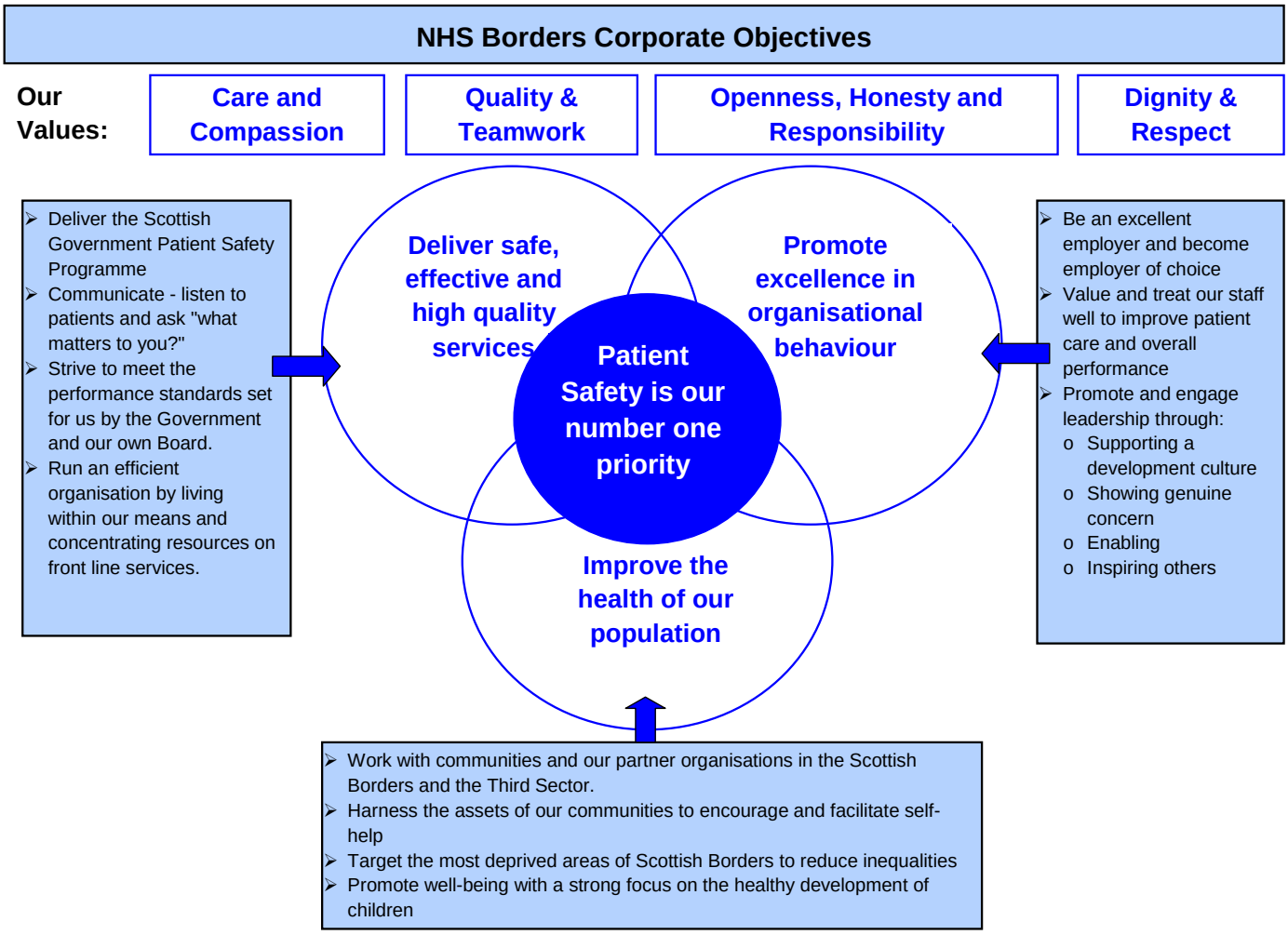
Through 2016-17, the first year of the Integrated Authority, in line with the NHS Borders Local Delivery Plan and the Scottish Borders Council Corporate Plan, we have identified two target areas for us to focus our activities in meeting the local objectives - **supporting people at home** and the **wellbeing of our staff.**

A key focus is on Primary Care, specifically supporting people at home and the following actions are contained within the Health & Social Care Integration Commissioning & Implementation Plan for year one to achieve local objectives.

- *We will make services more accessible and develop our communities*
- *We will improve prevention and early intervention*
- *We will reduce avoidable admissions to hospital*
- *We will provide care close to home*
- *We will deliver services within an integrated care model*
- *We will seek to enable people to have more choice and control*
- *We will further optimise efficiency and effectiveness*
- *We will seek to reduce health inequalities*

An extract of this document containing further detail can be found in Appendix 2.

NHS Borders Corporate Objectives are illustrated below, including our Corporate Values.



Local Delivery Plan

The Local Delivery Plan 2016/17 was approved on 23rd June 2016. This highlights the expectations that NHS Borders is to meet during the financial year, including delivery and regular performance management of the LDP Standards.

2.2 Public Health Profile

The Scottish Borders has more people aged 65 and older than Scotland as a whole, having 23% of the population in this bracket, as opposed to 18% in Scotland. It is anticipated that there may be very little change in the overall number of people resident in Scottish Borders between 2012 (113,710) and 2032 (114,881); however, the numbers of people aged 65-74 may increase by almost one third (32%), whilst the numbers aged 75 and over may increase by 75%.

Scottish Borders is a rural area, with nearly half (48%) of the population in 2012 living in rural areas. It has a low population density, having only 24 persons per square kilometre compared to a Scottish average of 69. The largest town is Hawick, with a 2011 Census population of 14,029, followed by Galashiels with 12,604 – although, if neighbouring Tweedbank were included, Galashiels would be the largest town in Scottish Borders with a population of 14,705. The only other towns with a population of over 5,000 people are Peebles, Kelso and Selkirk.

In the Scottish Borders both men and women are expected to have higher life and healthy life expectancy compared to Scotland. There are areas within the Scottish Borders where the male and female life expectancy is lower than for Scotland. Differences in average life expectancy between people living in the least and most deprived areas are mainly due to deaths from coronary heart disease, stroke, cancer and respiratory disease.

By the age of 65, nearly two-thirds of people will have developed a Long Term Condition: 75% of people aged 75-84 have two or more such conditions. At March 2014, the 23 GP practices in Scottish Borders recorded a total of 1,027 patients known to them as having dementia. Cases of dementia are expected to significantly increase in the Borders over the next 5 years and this will have significant implications for families, communities and care providers.

By far the highest rates of emergency admissions to hospital are amongst people aged 75 and over. The increase over the past ten years in emergency admissions amongst the over 75s accounts for approximately half of the overall increase in numbers of emergency admissions across all adult (age 15+) residents in Scottish Borders. The rate of hospital admissions following a fall in the Borders for the over 65s in the period 2010-12 was similar to that for Scotland. However this means there is still nearly 500 emergency admissions each year in Borders persons over 65 years due to falls.

The prevalence of diabetes across Borders is increasing year on year. The excess healthcare costs attributable to diabetes are substantial and pose a significant clinical and public health challenge. This burden is an important consideration for decision-makers, particularly given increasing concern over the sustainability of the healthcare system, aging population structure and increasing prevalence of diabetic risk factors, such as obesity.

The lower income groups have the highest rates of fuel poverty, but fuel poor households are found in all income bands. Around 12% of households in the Scottish Borders are in extreme fuel poverty, compared with a Scottish average of 10%.

Based on results of the Scottish Health Survey and the 2011 Scotland Census the number of people aged 16+ in Scottish Borders who provide unpaid care for someone else may be around 12,500.

2.3 Financial Context

The Local Workforce Plan is closely aligned with our Local Delivery Plan and both consider the financial context when planning for our future Workforce. Future sustainability is key when planning how our services will be delivered and what our Workforce will look like. The proportion of the Board's total budget which is allocated to Workforce has reduced from previous year levels of 60% of total budget to current year levels of around 50% of total budget. The change in the proportion of total budgets between pay and non pay is linked to the agreed % increases to drugs, prescribing and commissioned services being higher in recent years than the 1% pay uplift allocated each year to workforce budgets. In response to the challenging financial environment NHS Borders requires to continue to make significant savings this year, and it is important that we consider more efficient ways of working.

A number of Efficiency Projects are being planned for the current financial year and going forward. These include:

Transforming Outpatients
Supplementary Staffing
Clinical Productivity
Community Services Cost Review
Review of Day Hospital Services
Step Up/Step Down Facilities, Transitional Care
Surgical Flow
ITU/HDU Service Review

The Communication and Engagement Planning Stage is a part of all Efficiency Projects, during which Stakeholders are informed of what changes are planned, why they are happening and how they can contribute to the decision making process. Where Efficiency Projects impact on staff the Board's agreed Organisational Change Policies are applied as appropriate.

Nursing and Midwifery Bank and Agency Spend

Nursing and Midwifery have seen significantly higher spend on Supplementary Staffing than projected over the last 2 years, with a significant increase in recent months, particularly when compared to the same period last year as illustrated in the chart below. Reasons for requests have included Patient Dependency, Vacancies, Sickness Absence, and Maternity Cover. The most significant increase has been over the winter months due to winter surge pressures despite large scale recruitment to Winter Surge beds.

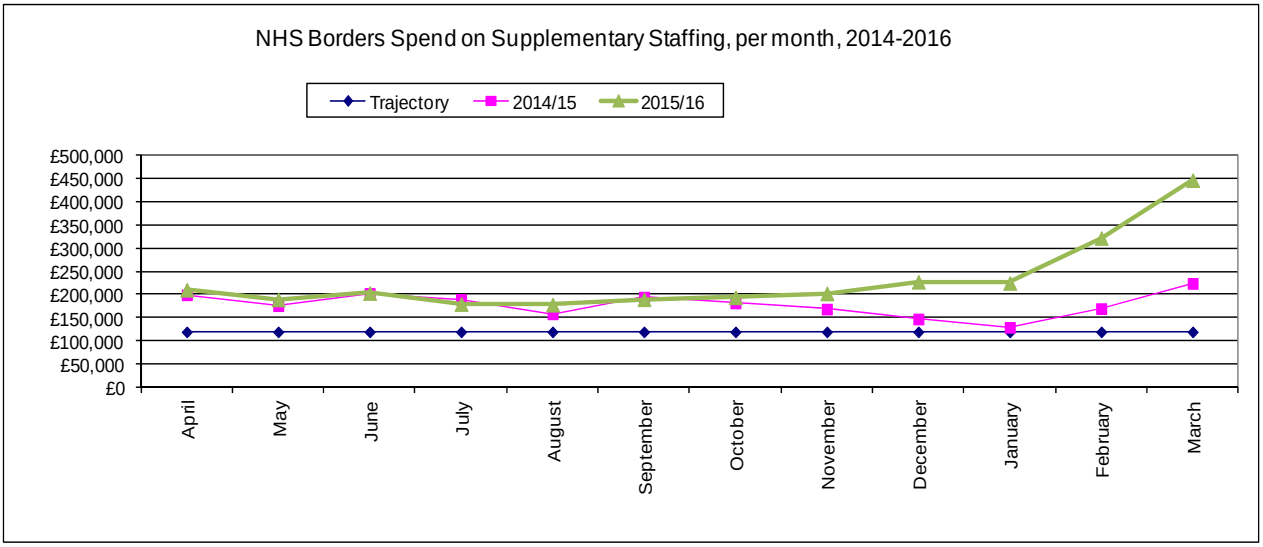


Chart 4: Supplementary Staffing Spend 2014-2016

It should be noted however that a significant number of requests are also for Patient Dependency with a high number of patients requiring 1:1 attention. This has also been highlighted through clinical discussions regarding the results of Nursing and Midwifery Workload Tools where all areas have highlighted that the acuity and complexity of patients has increased over the last few years. The chart below illustrates an increasing trend for supplementary staffing requests for patient dependency throughout the last year, with a significant increase across all clinical boards in the last few months.

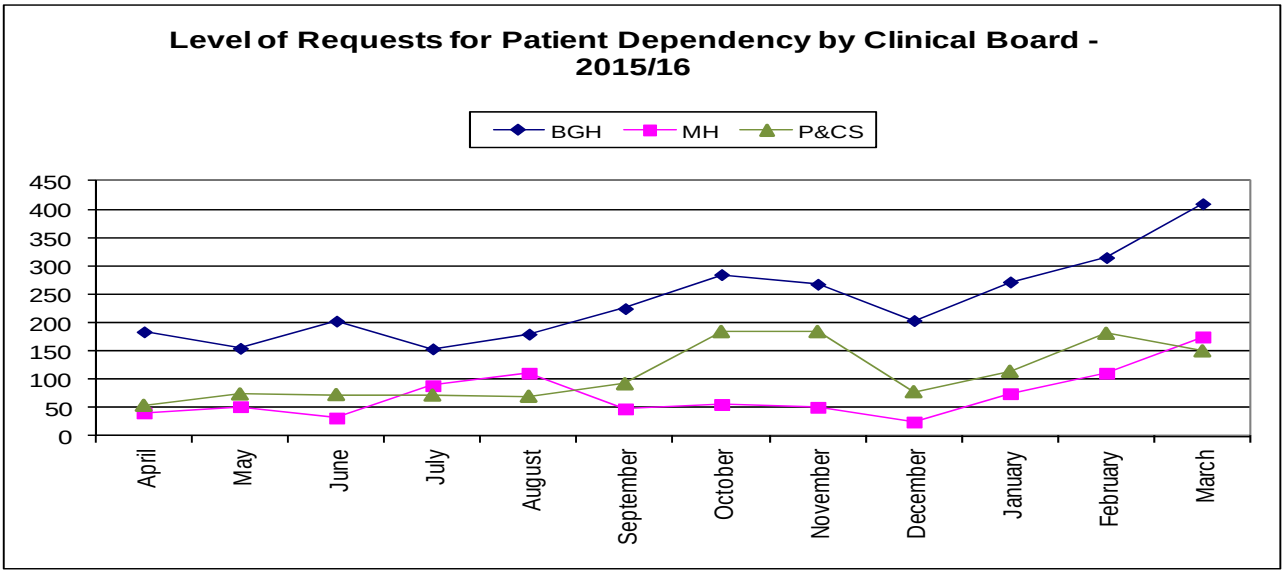


Chart 5: Patient Dependency 2015-2016

To help reduce the requirement for 1:1 intervention and reduce the length of time of the intervention required, the Dementia Nurse Consultant is now involved in assessing all patients where a request for 1:1 support is requested. Staff report that this involvement is beneficial improving their understanding of specific presentations, but there continues to be a high volume of request and therefore alternative methods of management are being explored, for example, use of 'fidget mitts' to provide stimulus and diversion.

Rostering compliance has also been an issue and as a result increased scrutiny is being applied to submitted rosters 6 weeks in advance and a Rostering Master Class has been run for Senor Charge Nurses. A new system of centralising the core rosters and monitoring all changes requested using a Roster Master approach was tested in April 2016 and all wards are being systematically reviewed. All aspects of non compliance to the Rostering Policy are being addressed and ward representatives are

asked to resubmit their rosters following agreed remedial action. Going forward fixed rolling rosters will be established and governance structure put in place via Roster Master. So far 9 wards in Borders General Hospital have been reviewed and monitoring of remedial actions and improved compliance continues on a 4 weekly basis.

The main contributing factors to the increased use of supplementary staff over this period was due to a combination of additional beds being opened particularly a block booking of agency staff to cover these winter beds.

Medical Supplementary Staffing / Agency Locum Doctors Spend

The medical workforce budgets overspent by £1.072 million in 2015 – 2016, this is roughly equivalent to the overspend in the previous year. The overspend is almost exclusively due to the costs of agency locums which have been engaged for (in volume order) vacancies, maternity leave gaps, sickness, waiting times and winter surge pressures. The cost of Agency locums was off-set to some extent by core funding for vacancies and the £400,000 contingency plan in the financial plan (mainly to address maternity leave).

Agency Medical Locum Costs

	2012/2013	2013/2014	2014/2015	2015/2016
Agency Locum Spend	£1.5 Million	£2.17 Million	£2.02 Million	£2.19 Million
% Change (+/-)		+ 45.0%	-6.9%	+7.8%

Table 1: Agency Medical Locum Costs 2012–2016

The reduction in locum spend in Haematology resulted from the phasing out of agency locums for leave cover from April 2015, instead StRs from Lothian provided on-call cover and SHOs from the Medical Rota provided a level of day time support to the remaining consultant. More recently the redesign with a network service with NHS Lothian has progressed with a Nurse Consultant appointed to the team and from 2 April 2016 a shared on-call model with NHS Lothian. We do not anticipate any agency locum costs for Haematology in 2016/2017, whilst in 2014/2015 we spent £18K for single agency locum per week of 24/7 service and on-call cover.

Agency Medical Costs by Service 2015-16

Specialty	Agency Costs	Trend (costs compared to 2014-15)	Background
Unallocated	**£66,000**	↑	Waiting times
Child Health	**£80,000**	↑	Vacancies for ANNP/APNP covered by locums Sickness Cover
Diagnostics	**£34,000**	↓	Final Locums to cover leave in Haematology
Medical / DME	**£717,000**	↑	Vacancy in Respiratory Medicine Maternity Leave in DME Leave cover for cardiology Locums training grade medical cover to secure rotas Locums for Winter pressures
Obs & Gyn	**£3,000**	↓	
Planned Care	**£771,000**	↑	Vacancy in Anaesthetics Sickness / phased return in Orthopaedics Sickness in General Surgery Leave cover in Ophthalmology Vacancy / capacity in Dermatology
Unscheduled Care	**£412,000**	↑	Vacancy cover / safe rotas in BECS Sickness, vacancy & surge cover in Emergency Department Safe cover for night duty GPST required extra locum support

Table 2: Agency Medical Costs by Service 2015–2016

Some of the further measures taken to manage and control agency locum spend include:

- Weekly review by the Medical Oversight Group chaired by the Medical Director of all agency locum requests.
- "Golden Rules" applied to agency locum requests – agency locums engaged for reasons of patient safety and to prioritise the emergency service rather than simply to cover a gap.
- Cross cover on the training grade doctor rotas to fill gaps without agency locum support where possible.
- More effective deployment with the framework agencies – e.g. pre approval and block booking of locums at discounted rates – this has been a partial success in the Emergency Department.
- Avoiding agency locum requirements by better quality NHS appointments – Clinical Development Fellows in Acute and General Medicine is an example of this measure.

Further measures in the planning stage for next year include:

- Investigation of "direct engagement" (model working in NHS Western Isles and NHS Lothian) instead of traditional agency engagement of locums which is more effective for the NHS.
- Setting a voluntary cap on agency hourly rates – avoiding the premium rate agencies.

2.4 Patient and Public Experience

NHS Borders believes that patients and the public have the right to have a say in how health services are best delivered in the Borders. We want our patients and the wider community to play an active part in the decisions that affect them. Consulting with our community is an essential part of our work. We value it because:

- We can make our services more efficient and responsive to local needs
- It helps us to prioritise services and make best use of limited resources
- It highlights our commitment to be open and accountable to the Borders community
- We recognise that we are not always the ones who know best
- It can promote a greater sense of ownership and responsibility within our services
- We support NHS Scotland Participation Standard

NHS Boards have a statutory responsibility to involve patients and members of the public in how health services are designed and delivered. This does not mean that we need to consult the public on every decision we make but rather that we have systems in place that will allow the public to help shape our services. If NHS Borders initiates major service change, we must consult the public. The Scottish Health Council have specific guidelines for major service change and the Public Involvement Team have lead corporate responsibility for ensuring a formal and robust consultation process is undertaken.

Health *in Your Hands: What Matters to You?*

The main purpose of this public engagement exercise was to give the Borders public an opportunity to tell us what was important to them to help NHS Borders shape future services and give consideration to future priorities. The exercise was also aimed at providing the chance for the Board to listen and to give an opportunity for people to give feedback and share their stories on the care that they have received in the past or recommendations for how they would like to receive care in the future should they require it.

A wide range of responses were received from over 700 conversations, including members of the public, patients, carers, family, visitors, staff and stakeholders. The chart below outlines the split of these responses:

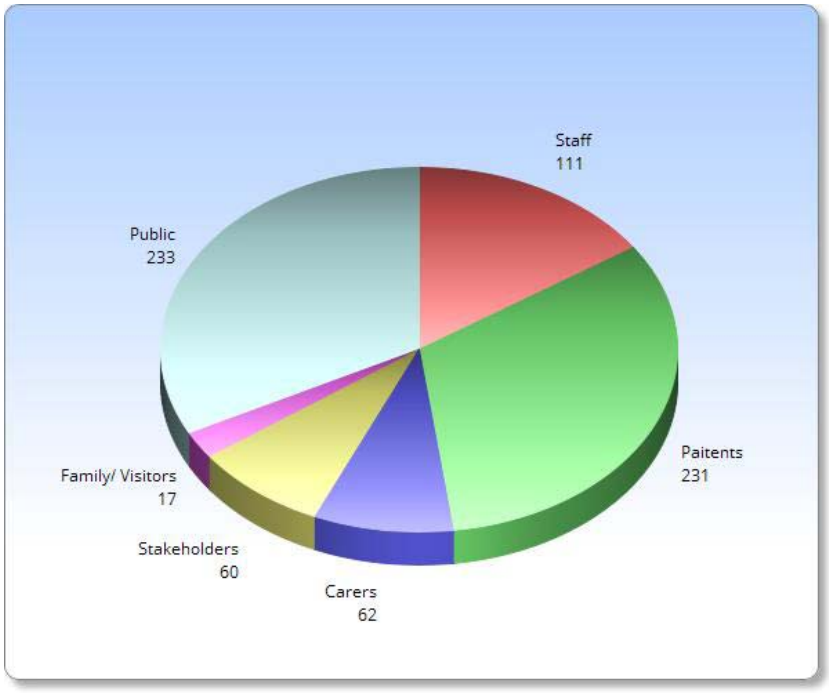


Chart 6: Sources of responses to public engagement exercise

NHS Borders has a responsibility to ensure that we provide services that match the needs of our local population and in a way that is accessible to all. In order to achieve this NHS Borders must be committed to involving our public and communities in designing, planning and developing our services.

Borders General Hospital Participation Group

The BGH Participation Group consists of 12 members of the public from across the Borders area supported by BGH staff and managers and meets monthly.

The group gives a public perspective and support to staff at Borders General Hospital on ways to improve services. The Group was set up four years ago and has worked with BGH staff on many projects. These have included:

- Noise of TVs on wards and noise at night
- Knowing who is in charge of the ward
- Information for patients on danger signs to watch for after discharge
- Nurses and doctors washing their hands before attending to patients
- Mobile phone policy
- Dining Room opening times
- Telephone switchboard etiquette

As well as attending meetings, some members have been involved in ward walkrounds and one member sits on the Endoscopy Group and gives updates at regular times. At the December 2015 meeting public members and staff looked at what projects to take forward in 2016. These have been taken from the most recent National In-patient Survey results for BGH and include:

- Patient knew which nurse is in charge of their care
- Visiting times on wards – flexibility within the times
- Information for patients on discharge

The Group welcomes members of staff who come along to tell of the different services provided by BGH. This helps them to learn about services, how they are delivered and to increase their knowledge of the hospital as a whole. It also gives staff the opportunity to bring forward ideas of how the group can help to improve things.

2 Minutes of Your Time

NHS Borders has introduced a proactive patient feedback system ‘2 minutes of your time’. Feedback boxes are located within our acute hospital, community hospital and mental health units. In addition patient feedback volunteers have been recruited and gather feedback from patients, carers and their relatives within clinical and public areas throughout the hospital. This enables us to look at changing the way in which we do things and ensuring our work has a more person centred approach.

The feedback collected is reported to our clinical and public areas in a timely manner. Within our clinical areas this is displayed on their quality and safety information boards and in public areas this is visible in a ‘You said, We did’ report. This enables the public and staff to see what changes have been made as a result of feedback. This feedback is reported across the organisation and to the Board. In addition to this proactive approach patient opinion is another way in which NHS Borders can receive feedback. Public involvement and feedback is actively sought through our wide range of public involvement groups. There is a growing network of volunteers providing a range of roles to enhance patient experience across the organisation.

Volunteering

NHS Borders is committed to involving volunteers in enhancing patient experience and values the different skills and experience each of them bring to their roles. We now have a Volunteer Co-ordinator post and the number of volunteers has increased by 100% in the 2 years since this role began.

There are approximately 222 people volunteering with us or going through the process to become a volunteer. In addition to 30 specific volunteering roles there is a network of 43 volunteers who support our Public Partnership Forum, Public Reference Group and our BGH Participation Group. Examples of volunteer roles include, patient feedback volunteers, chaplaincy ward visitors, pamper sessions volunteer and Macmillan Centre volunteers. As well as recruiting our own volunteers we also engage with Third Sector organisations such as Royal Voluntary Service, Red Cross and Pets as Therapy, to provide support to patients and carers in many ways. NHS Borders is also committed to ensuring there is an effective infrastructure in place to support volunteering and strives to make sure that people who give up their free time to volunteer with NHS Borders have a positive experience.

2.5 Statutory and Mandatory Training

In September 2015, a deep dive into Statutory and Mandatory training took place at the NHS Borders Staff Governance Committee and an internal audit took place in October 2015. A significant amount of work has been undertaken by the Training Leads alongside representatives from the service and Staff Governance champions to address the specific recommendations and areas of risk.

The initial focus has been on significantly reducing the bureaucracy that was in place around Mandatory and Statutory training, streamlining the underpinning processes and removing “blocks” to service managers and staff. Training providers have benchmarked Mandatory and Statutory training with colleagues in NHS Scotland. This has resulted in a rationalised core list of Statutory and Mandatory training for all members of staff, which is e-learning, with an approximate completion time of 5 hours. In addition to the core list, a revised training matrix identifying the Statutory and Mandatory training required for each staff group, with revised refresher periods and modes of delivery, has been compiled.

Efforts are now focused on redesigning the way the required training is delivered to be responsive to service requirements.2 day Clinical and Non-Clinical Statutory and Mandatory training updates are being developed to introduce a phased approach to address organisational statutory and mandatory training needs. In the meantime, training providers have worked closely with the Associate Directors of Nursing to identify and address the statutory and mandatory training hot spots of clinical staff.

A training management system to ensure robust, dynamic organisational reporting and monitoring of training compliance is being piloted with full implementation by September 2016, linked to learnPro, given the national delay in the implementation of eESS. The learnPro platform is familiar to staff and managers, having been widely used in NHS Borders to deliver, assess and report upon e-Learning since 2007 and there are plans to interface with eESS longer term.

2.6 eESS

A significant workforce planning activity in the forthcoming years is the continuing implementation of the new national electronic Employee Support System (eESS). There have been a number of national delays that have impacted on our ability to deliver to date, and ongoing discussions around timescales to roll out fully.

The aim of eESS once it's fully functional is to provide a single national HR system which includes:

- manager and staff self service (e.g. a benefit is that existing employees will access their own personal details and enable direct electronic updating of changes of address, next of kin etc, reducing paperwork and bureaucracy)
- e-payroll interface (reducing the need for paper based payroll instructions)
- online recruitment
- training administration
- workforce reporting

Our staff data has already been migrated from our previous HR system to eESS and the system is "live" in the HR & Training Departments. All managers attended an initial training course in preparation for full roll out of eESS, with update sessions planned once timescales are clarified. The system will be an important tool for effective people management (e.g. absence and leave management) once the SSTS and Payroll interfaces have been fully implemented.

2.7 Local Workforce Conference

The key theme of our Local Workforce Conference on the 11th March 2016 was "Living our Values – working in partnership with staff to support positive values in NHS Borders." The conference was aimed at frontline staff and included powerful presentations around living our values from our Chief Executive, and staff engagement from our Employee Director. Interactive Workshops further explored these values and included specific sessions on Implementing Values, Care and Compassion – Dementia Interaction and Dignity and Respect – Social Media. Positive evaluation has lead to agreement to re-run the Workforce Conference on 1st November 2016 to enable more frontline staff to hear the core messages and engage in the workshops. Outcomes/Actions from the Local Workforce Conference will feed into our 3 year Local Workforce Plan for 2016-19.

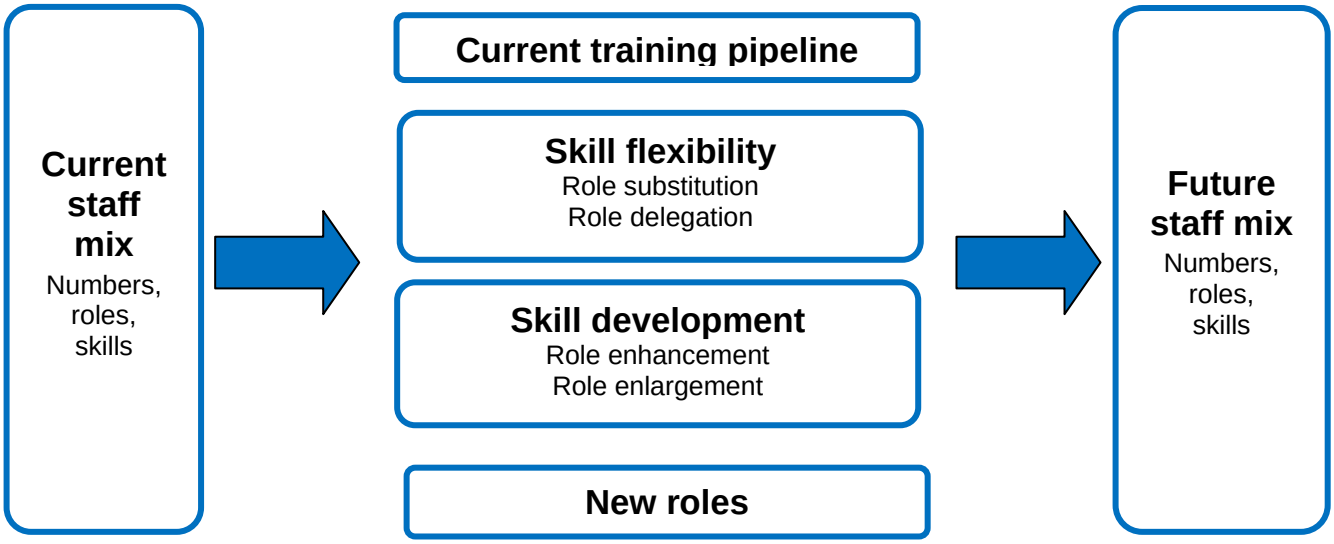
Step 3 – Defining the required Workforce

3.1 Changing Workforce

NHS Borders Workforce is changing and revised and new roles are being explored to meet predicted service need. Our commitment to role development, new and advanced roles and life-long learning of our staff is key as we can no longer rely on increasing staff numbers and traditional roles.

In a rapidly moving healthcare environment the workforce is facing major challenges around changing demographics, higher expectations of health, advancements in technology, improving quality and new ways of delivering care. Meeting these challenges will require new approaches to multi-professional learning and workforce planning. Health and Social care professions are dependent on each other and there is evidence of a shift towards more collaborative working.

Change is not easy. It takes skill, resources and persistence, and local leaders can expect local professional resistance. However, with careful attention to role design, teamworking and effective change management, the potential benefits are significant. Reshaping the NHS workforce can deliver benefits for patients through more patient-focused care and improved health outcomes. It can deliver benefits for staff through more rewarding roles and enhanced career pathways. It can deliver benefits for NHS organisations through greater efficiencies and helping to address potential workforce gaps.



3.2 Integration

Within Scottish Borders, the Strategic Plan for 2016-19 was formally agreed by the Integrated Joint Board at the end of March 2016. This Plan sets out how the Partnership is planning to improve health and well-being in the Borders through integrating health and social care services.

The Learning Disabilities Service is already a fully integrated service, as is Health Improvement, and the Mental Health Service will follow, being partially integrated at present. The AHP Service is beginning to be integrated, and our Associate AHP Director has responsibility for AHPs in both NHS Borders and Scottish Borders Council. Scottish Borders Community Planning Partnership has launched the Integrated Children and Young People's Plan 2015-18 which sets out the strategic priorities for integrated Children and Young People's Services across partner agencies in the Scottish Borders.

Scottish Borders Council and NHS Borders have recently recruited three Locality Co-ordinators who will spend the next 18 months planning, supporting and contributing to the delivery of Health and Social Care Integration in the Scottish Borders.

They will focus on:

- Developing locality plans;
- Redesigning locality based health and social care services;
- Improving co-ordination and access to services for service users and their families

Joint Workforce Planning Framework

NHS Borders and Scottish Borders Council presented a paper to the Integration Joint Board in March 2016 highlighting how workforce planning is undertaken within both organisations and outlining how we are/will integrate in future to support the integrated services. It is evident that NHS Borders and SBC share a joint understanding regarding the principles of Workforce Planning and a similar approach to how local workforce/people plans are developed. The Six Step Methodology matches very closely to the facilitated sessions described by Scottish Borders Council and the workforce information reviewed as part of the process is very similar across both organisations. It was highlighted that the integrated services means all health and social care services contained within the Scheme of Integration. There will be no changes to existing terms and conditions of staff or any transfer from one employer to another. The focus is on working more effectively together in joined up teams. While there may be co-locating and changes to the make-up and management of teams, including potential changes of duties and roles, there is no intention or requirement to transfer staff into a “new” joint organisation.

Workforce Planning leads from across NHS Borders and SBC committed to working together to ensure future workforce planning across these services becomes more aligned during 2016/17 and into future years. Initial actions to progress Joint Workforce Planning will be contained within our Action Plan.

3.3 Local Quality Improvement Initiatives relating to Workforce

Work is underway to look at innovative ways of working across services to develop a resilient workforce model including appropriate generalists and specialist skills:

- Increased use of multidisciplinary roles in the Borders Emergency Care Service including Advanced Nursing roles and Paramedic Practitioners

- The use of Advanced Nurse Practitioners in Paediatrics covering Junior Doctors’ rotas

- Testing of a Rapid Assessment & Discharge Team in Emergency Department, made up of Physiotherapists and Occupational Therapists

- Development of a Virtual Frailty Team coordinating care for older people between Geriatricians, Older Persons Liaison Nursing, Physiotherapists and Occupational Therapists

- Development of link nursing or champions’ roles in inpatient wards with enhanced skills and knowledge in Falls; Tissue Viability; Food Fluid and Nutrition; The Deteriorating Patient and Dementia.

- A new Alzheimer's Consultant Nurse post has been permanently funded to provide support for staff, patients and families in the care of patients with dementia, in addition permanent funding has now been secured for an Older Peoples Specialist Nursing Service.

- Specialist advice and support is being sought through virtual clinics with specialist tissue viability services hosted in larger NHS Boards.

- A model of recognition of deterioration is being rolled out in the community initially with the introduction of the National Early Warning Scoring System (NEWS) in community hospitals and structured treatment and escalation tools. Testing is also underway with community nursing teams and care homes.

3.4 Professional Revalidation

NMC (Nursing & Midwifery Council)

As from 1 April 2016 all nursing and midwifery staff are required by NMC to revalidate every 3 years. Revalidation is the process that allows nurses and midwives to maintain their registration with the NMC. It builds on existing arrangements for the renewal of that registration.

As part of this process, all nurses and midwives need to meet a range of requirements designed to show that they are keeping up to date and actively maintaining their ability to practise safely and effectively. Nurses and midwives need to collect evidence and maintain records to demonstrate to a confirmer that they have met the revalidation requirements.

Every three years all nurses and midwives will be asked to apply for revalidation using the NMC Online system as a means of renewing their registration. Completing the revalidation process is the responsibility of nurses and midwives and they are the owners of their own revalidation process. The purpose of revalidation is to improve public protection by making sure that nurses and midwives demonstrate their continued ability to practise safely and effectively throughout their career.

One of the main strengths of revalidation is that it encourages nurses and midwives to use the Code in their day-to-day practice and personal development. It is important for employers to be aware of the Code and the standards expected of registered nurses and midwives in their professional practice.

Any staff failing to submit their revalidation application before the end of the three year renewal period, will have their registration lapse (automatically expire). To come back on to the register, they will need to apply for readmission. During this period they will no longer be a registered nurse or midwife and will be unable to work as one.

Whilst recognising that revalidation is the responsibility of the individual nurses and midwives, NHS Borders have provided much publicity and advice in the lead up including numerous Road Shows and Drop-in Sessions throughout the NHS Borders area, and are continuing to provide support with a number of aspects of the process during the early stages. It is hoped that through time it will become embedded as a normal part of the appraisal process. Further information about NMC revalidation can be found at: https://www.nmc.org.uk

GMC (General Medical Council)

GMC Revalidation is the process by which all licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise in their chosen field and able to provide a good level of care. This means that holding a licence to practise is an indicator that the doctor continues to meet the professional standards set by the GMC and the specialists standard set by the medical Royal Colleges and Faculties. Licensed doctors have to revalidate usually every five years.

The responsible officer, normally the Medical or Clinical Director, will make a recommendation to the GMC, based on the doctor's appraisals over the preceding 5 years and other information drawn from their organisation's clinical governance systems. GMC will then carry out a series of checks to ensure there are no other concerns about that doctor. If there aren't any such concerns, the doctor will be revalidated. This will mean that the doctor can continue to hold their licence to practise.
Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the GMC. Further information about GMC revalidation can be found at: http://www.gmc-uk.org

HCPC (Health and Care Professions Council)

In 2006 the HPC (now HCPC) launched the Standards of Continuing Professional Development (CPD). These standards are designed to ensure that each registered professional is committed to continually maintaining and developing skills in line with the changing needs of the profession to ensure safe and effective practice.

The Standards for CPD say that a registrant must:

1. Maintain a continuous, up-to-date and accurate record of their CPD activities;

2. Demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice (NB these should be structured to your individual learning needs therefore may include learning requirements for a current or future role);

3. Seek to ensure that their CPD has contributed to the quality of their practice and service delivery;

4. Seek to ensure that their CPD benefits the service user;

5. Upon request, present a written profile (which must be their own work and supported by evidence) explaining how they have met the standards for CPD.

2.5% of registrants are selected annually for HCPC CPD audit per profession, with the only exclusion being those who have been on the register for less than 2 years (e.g. newly qualified practitioners.)

The profile required should contain a 500 word summary of work/current role; and a second section of 1500 words, focussing on between 3 and 5 different learning activities that have been undertaken over the last 2 years.

HCPC have a positive assessment process therefore it is not the intention to have people removed from the register but in fact to ensure that each registered professional is committed to CPD. The assessment is undertaken by 2 assessors (one from your own profession). The registration process continues as normal whilst the profiles are assessed against the standards. The outcome of the assessment will be either:

- profile meets standards
- additional information is required (e.g. incomplete submission received)
- standards partially met (an extension would then be provided)
- failure to meet standards (no profile submitted, no evidence of commitment to CPD)

Only in the latter circumstance will a registrant be removed from the register. This is not the same as being struck off and the HCPC have an appeals process. http://www.hpc-uk.org/

(GPhC) General Pharmaceutical Council

GPhC currently ask pharmacists and pharmacy technicians to provide an assurance that they are meeting standards for safe and effective practice through a declaration as part of annual renewal. They expect a pharmacist or pharmacy technician who has made this declaration to make sound judgements which place the public's interests before their own. Unless there is reason to believe that the declaration is false or an allegation is received about a registrant, this declaration is accepted on the basis of trust. Pharmacy professionals are also currently required to maintain and develop professional knowledge and skills by undertaking and recording continuing professional development (CPD) activities. CPD records are audited to make sure this happens.

GPhC have been working on the introduction of new arrangements for further assuring standards for safe and effective pharmacy practice for some time, and initially this was called 'revalidation', but this term is no longer used because it was not well understood.

New ways are being developed to further assure the public that pharmacists and pharmacy technicians meet standards for safe and effective practice throughout their careers. The activities proposed to provide that assurance are:

- Annual renewal (which already occurs)
- Undertaking and recording continuing professional development (CPD) (which already occurs but changes in this are being considered)
- A peer discussion (which is being explored for impact and feasibility)
- A case study on a change to practice for the benefit of patients or service users (which is being explored for impact and feasibility).

These proposed activities are currently being piloted with 1000 volunteers and what is learned through the pilot will help shape any future requirements. This is currently being piloted and evaluated and, following consultation, implementation is scheduled for 2018.

3.5 Staff Experience including Health and Well-being

Work & Well-Being

The link between staff health & well-being and improved clinical outcomes is well recognised and reflected in the Workforce 2020 Vision. In support of this NHS Borders has developed a person centred Work and Well-Being Framework covering 2015-2020 which sets out how we will support staff to keep them healthy, motivated and engaged. This framework demonstrates the ethos of the Board and its determination to support our staff in the workplace. It includes a variety of proactive initiatives to support staff health and well-being and our work life balance policies.

NHS Borders was awarded the Gold Award for Healthy Working Lives in June 2015, with the Assessor concluding: "*This was a strong assessment, characterised by a clear strategic drive for health and wellbeing, sincere senior management backing, excellent participation from employees across a highly geographically distributed organisation. All facilitated by a dedicated and highly effective HWL Group*."

One of our Staff Side representatives chairs the Work & Well-Being group which works to ensure we implement the framework and maintain the gold award.

In April 2016 NHS Borders launched a specific project to focus on Promoting Attendance and Improving Staff Well-being designed to identify initiatives designed to improve employee well-being and promote attendance at work.

Staff Experience

Recognising that a positive staff experience will lead to better patient care the staff experience employee engagement tool, iMatter, will complete its roll-out across all of NHS Borders by the end of 2016.

With a focus on improving staff engagement through listening to staff and action planning in teams, iMatter has the potential to improve efficiency and effectiveness as engaged staff feel more valued at work and are more productive. Agreed organisational actions from the overall NHS Borders iMatter report are being taken forward through the Staff Governance action planning process.

We see the big message of 2020 Workforce Vision compared to previous workforce plans is to emphasise and embed our shared values in NHS Borders, these are:

- care and compassion
- dignity and respect
- openness, honesty and responsibility
- quality and teamwork.

In addition, all staff have the opportunity to complete a NHS Scotland Staff Survey anonymously annually. The survey gathers information on all staff views which will feed into policy-making for the NHS at both a national and local level. Importantly, it is a means of finding out how staff feel about working in NHS Borders, how well they feel they are being managed and to what extent the NHS Scotland Staff Governance Standards are being met.

The most recent Survey was completed in August/September 2015 and the results were published in December 2015. 49% of NHS Borders staff completed this and of those who completed the survey, they said that: they are happy to go the extra mile, have confidence and trust in line-managers and get help and support needed from colleagues. The Survey results are reflected in the Staff Governance Action Plan which includes corporate actions and has been taken through the Area Partnership Forum to support its delivery.

Carer Positive

Carer Positive is a Scottish Government funded initiative which has been developed with the support of a strong partnership of private and public and voluntary sector organisations in Scotland. It aims to encourage employers to create a supportive working environment for carers in the workplace. Further details can be viewed at www.carerpositive.org/

NHS Borders has been recognised as a Carer Positive employer at the Engaged level. We were the first mainland Scottish NHS Board to receive this recognition. To achieve this NHS Borders required to demonstrate:

1. The organisation has awareness of carers within the workforce and has made a commitment to support carers through workplace policies/working practices
2. There is some evidence that systems and processes have been developed to support this
3. Carers are supported to identify themselves as carers and can access support within the organisation to help them manage their work and caring responsibilities.

Working Longer

In the 2015 scheme, Normal Pension Age (NPA) is set equal to State Pension Age (SPA). This means that up to 70 per cent of 2015 scheme members will have a pension age of between 65 and 68.

It was acknowledged that this may have changed some members' retirement plans and members of the 1995 section of the NHS Pension Scheme who joined the 2015 scheme on or after 1 April 2015, were offered the opportunity to move their existing membership into the 2008 section in a time limited exercise known as 'Choice 2'. The deadline for Choice 2 decisions was 16 March 2015.

The majority of current 1995 section members who moved to the 2015 scheme will have a NPA of at least age 67. Moving their 1995 section membership to the 2008 section via the Choice 2 exercise may have benefitted some members who intend to retire on or closer to their new NPA.

With a greater number of staff working into their later 60s, we will need to consider what steps can be taken to ensure motivation, engagement and productivity of the whole workforce. Individuals age differently, and capacity to work in particular roles will vary greatly. It follows that decisions on capability, and their consequences for individual employment and role, should be based on individual assessment, not chronological age (which is, in any event, unlawful). One possible direction would be to make flexible working practice a normal option. Many workers would be better able to stay longer if they could move to roles which are less stressful or physically challenging or with reduced hours. Changing cultural attitudes, to make flexible working part of normal career development, might help to support the retention of experienced staff.

NHS Borders is in the process of formalising a Retirement Policy in line with the Supporting Work-Life Balance PIN Policy. In addition a series of Pre-retirement Workshops have been arranged, with a Retirement Specialist from Affinity Connect. These are available to all staff who may be considering retirement within the next 2 years.

3.6 Staff Development

NHS Borders recognises the importance of management and leadership capacity and capability in ensuring the delivery of safe, effective and high quality services for the people of the Scottish Borders and to support the 2020 vision. Promoting excellence in organisational leadership is embedded into the Staff Governance Action Plan.

Using the Engaging Leadership Framework (Beverley Alimo-Metcalfe) NHS Borders is committed to promoting and engaging leadership through:

- Supporting a developmental culture
- Showing genuine concern
- Enabling
- Inspiring others

By building this into local programmes as well as appraisal processes we will ensure that managers and leaders are clear about their role and responsibilities and enable performance to be managed appropriately. In addition the link between engaging leadership and employee engagement will be strengthened through the support of iMatter.

Candidates from NHSB are put forward through National Leadership Programmes, which are run by NHS Education for Scotland. A maximum of 6 go through Leading for the Future, which is aimed at people in middle to senior level leadership roles, across all professional groups, and aims to provide a

challenging development experience for those in middle-senior leadership positions, building their leadership and management skills and behaviours to enable them to deliver service objectives. A further 2 through Delivering the Future, which is a programme that develops strategic healthcare leaders from across the clinical professions and from general manager positions, for future roles at NHS Board regional and national levels. The programme is delivered over an 18 month period with up to 24 participants from across the NHS Board areas in Scotland. The programme focuses on succession planning for high-level strategic healthcare leadership roles, ensuring that there is the right cadre of leaders to recruit from in the future. Assessment Centres are run locally to choose the candidates for these programmes.

Development of further work streams will support the six priority actions identified in the 2020 2015-16 implementation plan, in particular the adoption of value driven approaches, addressing the challenges around middle management and the development of more robust succession and talent management plans.

NHS Borders Training & Development Department are working towards creating a Talent Management Programme. They work particularly in 'hot spots' – areas with issues around succession planning etc – to develop both professional and leadership talent in these specific departments for the future.

In addition NHSB participates in the NHS Scotland Management Trainee Scheme, which has been very successful and includes hosting a trainee for a period of 3 years.

A Scottish Public Sector Leadership Exchange Programme allows staff to swap into other Public Sector organisations, pairing up leaders across sectors to provide insight into different cultures, constraints and opportunities within the public service.

Coaching & Mentoring

In conjunction with Scottish Borders Council, coaching and mentoring is available through training courses "Coaching for Success" and "Mentoring for Managers". Coaching is built in to the First Line Manager Training Programme. Through the Scottish Coaching Collaborative, there is access to coaches across the entire public sector in Scotland on a collaborative basis. This allows for the best match of both coach and kind of coaching and is free of charge, as NHSB coaches also take part in the scheme. Executive coaching is available through the National Leadership Unit at NSS.
"To help and support people to manage their own learning in order to maximise their potential, develop their skills, improve their performance and become the person they want to be."
"Coaching is unlocking a person's potential to maximize their own performance. It is helping them to learn, rather than teaching them."

Newly Qualified Practitioner Programme

The Newly Qualified Practitioner Programme provides a great opportunity for us to support and value newly qualified staff nurses within NHS Borders. The programme consists of 5 study days spread over 5 months; followed by 6 months where the NQPs will be supported to complete a small scale improvement project. The development that takes place within the Programme acts as evidence for the participants Flying Start professional development portfolios. The first cohort which began last November has completed the first 5 study days and a 2nd cohort started on the 24th May 2016.

The aim of the NQP Programme is to develop confident reflective professional nurse practitioners with a commitment to life-long learning who are able to deliver high quality person centred, safe and effective care.

At the end of the programme NQPs will have demonstrated within their clinical roles development of confidence and application of

- the principles of person-centred practice
- values-based care
- evidence-based practice
- clinical decision making processes
- effective leadership appropriate to their role

Learning outcomes will be evidenced by the NQPs' Flying Start Portfolio entries and a presentation of a small scale improvement project at the end of the NQP Programme.

There have been very positive and encouraging evaluations being returned. The main themes that emerge are:

- Appreciation of time to constructively reflect on practice
- Feeling supported by sharing experience with peers in an otherwise overwhelming experience of being newly qualified.
- Support and guidance with portfolio development
- Learning from experts in practice

Return to Practice

We have actively supported the Return to Practice Programme for many years. We ran a successful joint programme with Lothian in the early 2000s & more recently have been taking students from Stirling, Cumbria and currently have an SLA with Glasgow Caledonian University (GCU). NHS Borders are offering placement to 2 nurses in September 2016 from GCU and will be advised whether 450 hours = 12 weeks or 300 hours = 8 weeks practice hours are required. The Scottish Ongoing Achievement Record is utilised.

Over the past 5 years there have been 5 Physiotherapists who have successfully returned to practice, and in addition 1 further with an EU Registration who is currently being supported through the process of fulfilling the requirements to register with the HCPC, allowing her to take up a post as a Physiotherapist.

Careers Fair

A Careers Fair was held at Galashiels Academy in Spring 2016 and an NHS Borders Practice Education Facilitator attended on behalf of 'Healthcare Careers', promoting NHS Borders as a prospective employer for those wishing to pursue a career in healthcare. Recruitment colleagues from the 3 local Universities were invited and both QMU and University of Edinburgh attended, with NHSB Practice Education Facilitator representing Edinburgh Napier University on this occasion. The primary focus was on Healthcare and Allied Healthcare. The overall impression of the event was a very positive one. Moving forward we plan to access all 9 Borders High Schools and also highlight career opportunities in medicine in a bid to improve the numbers and quality of applications for careers in healthcare.

3.7 Clinical Academic Strategy

A clinical academic strategy for Nursing, Midwifery and Allied Healthcare Professionals (NMAHP) was developed between Edinburgh Napier University (ENU) and NHS Borders in 2013 to strengthen clinical academic links and engagement between the two organisations. The main objectives were to establish clinical academic career pathways and to build Nursing and Midwifery capacity and capability in research. In addition curriculum design, development and practice learning was reviewed to ensure compassionate person-centred and quality improvement approaches to care.

More recently a clinical academic strategy has been established between Queen Margaret University (QMU) and NHS Borders. Deliverables include dedicated academic time for the new Nurse Consultant in Dementia to undertake Masters level education towards PhD and research. In addition development of a Clinical Academy for QMU Lecturers to update their practice within clinical settings and establishment of collaborative educational research links in clinical skills and simulation.

Links have also been recently established with the Nurses, Midwives, and Allied Health Care Professionals (NMAHP) Research Unit (RU) at Stirling University, which will highlight opportunities for our NMAHPS to develop their research skills whilst retaining their clinical practice.

Clinical academic links have been established to ensure our registered nurses and midwives are involved in the current review of the undergraduate nursing and midwifery programme. This will ensure education reflects contemporary evidence base and current practice.

A research activity scoping exercise was undertaken across NHS Borders to establish:

- How many staff have academic research qualifications
- How many are interested in developing research skills
- Current research activities and potential research interests

The key messages from this multidisciplinary survey is helping to inform future research plans and research skills development for NMAHPs and the wider workforce. A register for staff with an interest in research has also been established.

The Chief Nursing Officer's Review of Nursing and Midwifery Education, Setting the Direction for Nursing & Midwifery Education in Scotland (2013) aims to strengthen clinical academic collaboration to ensure that NMAHP research and evidence underpin and drive improvements in quality.

An example of such a collaborative approach is the latest research project between Edinburgh Napier University and NHS Borders. This research will explore the presentation, experiences and patterns of decision making that influence self management following attendance at an unscheduled care consultation. This will hopefully inform the development and testing of interventions which may influence a more proactive and managed approach to illness, and the encouragement and engagement of patients to plan for acute exacerbation of chronic conditions/future symptoms.

The Head of Training and Professional Development is co-principle investigator collaborating with ENU and the clinical unscheduled care team and the longer term plan is to seek larger grants from external research funding providers which will include intervention studies linking with other unscheduled care centres/units.

NHS Borders is also actively collaborating with NHS Lothian, ENU, QMU and Edinburgh University to develop a refreshed NHS Lothian and NHS Borders NMAHP Research Framework which, aims to increase the volume and quality of applied research that will lead to improvements in patient/client health, well-being and service delivery.

Moving forward a more stream-lined approach to clinical academic collaboration will be taken utilising a single delivery plan approach for all our partner education institutions. This will simplify and help achieve our deliverables in a timelier manner. The Clinical Academic Academy is progressing with four Lecturers identified from Queen Margaret University who will work in collaboration with key clinicians in the Borders to identify key themes in the context of care assurance such as wound care and managing the critically ill patient. We will develop an integrated practice and research model, which is innovative in terms of clinical academic careers and will help get research into practice through teaching and action research projects. In addition 6 clinical nurse specialists will be undertaking associate lecturer roles participating in the QMU pre-registration undergraduate nursing curriculum.

3.8 Values Based Recruitment

Over the past year NHS Borders has introduced Values Based Recruitment (VBR). VBR is an approach to help attract and select students, trainees and employees, whose personal values and behaviours align with an organisation's values.

The values that are shared across Scotland's Health Service are:

- care and compassion
- dignity and respect
- openness, honesty and responsibility
- quality and teamwork.

These were developed as part of 2020 Workforce Vision which aims to ensure our health service has the workforce needed for the future. This Vision has been produced with the help of around 10,000 staff (many of whom work within NHS Borders) and sets out what the workforce needs to look like by 2020, the things that need to change and the support that staff will be given. We know from evidence that staff who are valued and treated well improve patient care and overall performance. The 2020 Workforce Vision sets out a commitment to valuing the workforce and treating people well.

NHS Borders adopted those values when we developed our Corporate Objectives but, whilst we can all agree the values are probably the core values of the majority of our staff, we have never really embedded those values explicitly.

Since April 2015 the Behavioural Framework has been developed. Existing frameworks were adapted and tested to allow this to be more specifically linked to NHS Borders values. Testing of the framework continues but managers and members of staff have consistently reported that they find this a useful and user-friendly tool. All individuals asked to attend for interview now receive the framework in advance. An exercise to allow evidencing individuals' abilities to implement the behaviours linked to our values was introduced successfully in the nurse recruitment event in September 2015. Both interviewers and interviewees reported that this was extremely useful.

To ensure that we attract the right people, the values of NHS Borders have been added to the recruitment bulletin and advertisements. Values based adverts have been tested with good effect. The Behavioural Framework is now sent to all candidates to allow recruiting managers to be more assured about the "fit" of candidates. Values based short listing criteria have been developed and tested (scoring against competencies and values).

A values/competency based questions repository is now available within HR. Values based questions have been tested within recruitment since September 2015. Individual scoring matrix linked to values and weighted for competencies have been developed and tested. Managers report positively on their use. Master scoring matrix for assessment centres have also been developed, tested and amended.

As part of the introduction of Values Based Recruitment it was agreed to implement pre-employment induction and to develop a new induction program. The Chief Executive was keen to attend all induction and ensure that it reflected the organisational values. In particular, Care and Compassion (How we treat our patients) and Dignity and Respect (How we treat each other) as the golden threads that wove together not only in Induction but in all Training and Development opportunities.

A core Induction which shows explicit links to Care and Compassion and Dignity and Respect has now been developed and tested. A key component part of the new induction program is to use a patient story. These types of stories have consistently been cited as powerful learning experiences for those attending. A working draft of a fuller induction programme is now being developed and lead by Training and Professional Development Department. They are also leading on the development of a plan to roll out induction to all doctors in training as part of their allocation to NHS Borders.

3.9 Current Workforce Planning / Forthcoming Changes by Staff Group

Although we recognise that workforce planning often crosses Job Families and Organisational boundaries, the following section summarises some of the main Workforce Planning challenges and recent and predicted changes broken down by staff group.

3.9.1 Medical & Dental

Consultants
Vacancy rates for consultants are approximately the national average (6%). We have had some success in the latter part of 2015 and early 2016 in recruiting new consultants to 4 shortage specialties (Acute Medicine, Rheumatology, Emergency Medicine and Medicine for the Elderly).

We have taken measures to address recruitment difficulties, mainly for consultants but for all grades, including promotion of some of our unique selling points. These measures include:

- revamped and attractive job descriptions featuring NHS values and photographs of clinical settings and the Borders area
- highlighting the new Borders railway in adverts and job descriptions (with a quote from HM Queen Elizabeth - **"The Borders railway brings so much promise for sharing and invigorating this most beautiful countryside as a place to work, live and enjoy"**)
- a new consultant / salaried GP development programme (unique in Scotland) and formal mentoring and buddy systems.
- current consultants encouraged to use all of their networks including social media to highlight our vacancies
- the NHS Borders Social Media accounts highlight our vacancies
- a medical recruitment micro-site with videos of current consultants extolling the virtues of NHS Borders and living in Scottish Borders
- a revised relocation guide which highlights some of the benefits of living and working in Scottish Borders, house prices, schools etc.

Our most significant recruitment challenge in the acute sector has been to Consultant Anaesthetist vacancies in recent years, with 2 long term vacancies from the retirement of the previous incumbents in 2014. However, a recent recruitment process has resulted in a vacancy being successfully filled. Going forward a particular workforce and recruitment challenge will be the aspiration to move to separate Anaesthesia and Intensive Care on-call rotas in the future (in line with RCoA guidelines) as BGH is one of the very few District General Hospitals with an integrated rota.

There has also been concern over Ophthalmology, as there are currently 2 vacancies. There has been no interest in permanent posts, but a temporary locum consultant has been appointed for 6 months from April 2016. There has been a redesign of the posts including the re-badging of one of the posts as a new Clinical Lead post, coinciding with a renewed international recruitment approach, offer of a proleptic appointment and the opportunity for sessions at a tertiary centre The service leads in NHS Lothian (which has 21 consultant ophthalmologists) and NHS Borders (which has 2 consultant ophthalmologists) have initiated discussion on potential regional resourcing of the service, perhaps by appointing consultants, specialty doctors and possibly senior trainees to temporary or medium-term contracts with a joint NHS Lothian / NHS Borders commitment to maintain local services. Such planning is needed at an early stage, as the alternative if there are further consultant vacancies would be very disruptive and unpopular with patients, i.e. to arrange for Borders patients to attend Edinburgh Clinics.

Finally NHS Borders had success in recruiting to 3 medical leadership posts in this last year – the Medical Director, Associate Medical Director for Primary Care and Clinical Lead in BECS. It was encouraging that there was competition for all of these vacancies with a surplus of suitable applicants and Values Based recruitment and assessment methods were used.

Training Grades

Throughout the UK there continue to be vacancies in the national recruitment schemes for Medical Training Grades and this is compounded at local level by maternity leave and out of programme gaps. The August 2015 change-over had the most significant vacancy rates at training grade level since the introduction of Modernising Medical Careers in 2008, with 14 training grade posts being unfilled from a total of 79 (14%). This, however, was one of the most favourable rates in Scotland. These gaps have been difficult to fill, and agency locums have proved to be particularly unreliable, with an unprecedented number of pre-booked locum withdrawals (27 occasions between July 2015 and March 2016). With a background of training grade gaps, our focus is to preserve compliant rotas, the training objectives of remaining trainees and cover core services.

As an alternative to traditional agency locums, therefore, NHS Borders has embarked on an exciting new initiative of Clinical Development Fellows in Acute and General Medicine from August 2016. These are service non-training posts, but with a significant development component and are aimed at Doctors who have completed Foundation Training in the last 2 years but who have not yet determined a specialty career path. The posts (which have been pioneered by NHS Lothian since 2013) provide a sound grounding for successful applicants to augment their clinical skills and assist with CV presentation in preparation for future application for training programmes. The interest from post FY2 doctors has been extraordinary, with suitable applicants exceeding available posts by a factor of 4. Appointments were made for 4 to start in August for the coming year.

Borders Emergency Care Services (BECS) GP Out of Hours

The vacancy rates for Salaried GPs in the BECS Out of Hours Service are a concern, but issues are being managed. The Salaried GP Cohort have been the mainstay of the BECS service and until recent years GP applicants exceeded available posts – since about 4 years ago all NHS Boards across the country have experience a severe shortage of GPs. At present there is an establishment in BECS of 10.5 WTE, with 3.2 WTE GPs in post and 7.3WTE vacancies – approx 75% vacancy rate. We have ongoing and rolling advertisements and have increased the scale for Salaried GPs to be more equitable with neighbouring NHS Boards, but despite this there are still insufficient applicants. This has driven some service modifications, including the centralisation of the GP cover to a hug at BGH and additional OOH nurses have been recruited and trained, funded from vacancy monies from GP posts. We are aiming for the right skills mix with the GP undertaking the role that only the GP can do, and the OOH Nurse taking on roles previously associated with a GP, particularly community visits, when appropriate. The OOH Nursing posts have proved popular, with qualified applicants exceeding vacancies, and the staff group is very receptive to role development and extended training.

General Practice – Primary Care

There are some gaps in GP recruitment although the majority of established practice positions have been filled. The gaps tend to be maternity leave, associate and retainer positions and, in common with many branches of medicine, there is no longer a reliable locum supply. The current workforce are also working to maximum capacity and in line with the National Clinical Strategy there is work and some funding from the Scottish Government to start the journey to transform primary care and ensure staff are working to the top end of their skills. This will mean GPs will be the senior decision makers and support other staff to deliver clinical care. The current method of payment for GPs is also changing from a substantial amount as a result of quality outcomes (QOF) to transitional quality arrangements and thereafter the detail of the contract is unclear. This is resulting in a period of uncertainty alongside increased workload outside of the normal day job of direct clinical care and management.

The National Primary Care Workforce Planning Survey is designed to capture aggregate workforce information from Scottish general practices and NHS Board-run GP Out of Hours services. The report provides aggregate information on GPs, registered nurses (including nurse practitioners) and other clinical staff employed by Scottish general practices. This includes:

- GPs in practice
- Practice-employed nurses / healthcare support workers / phlebotomists in post
- GP and nurse / healthcare support worker / phlebotomist vacancies and recruitment to posts
- Temporary cover for sessions / hours
- Out of hours commitments

The report also provides information from the GP Out of Hours services in each NHS Board area. This includes:

- Description of the GP OoH service and OoH periods covered by the service
- Staff working in the GP OoH service in the past year
- Challenges in filling shifts

There is national information and information for NHS Borders (and all Scottish Health Boards) and this can be viewed at http://www.isdscotland.org/Health-Topics/General-Practice/Workforce-and-Practice-populations/Workforce/national_primary_care_workforce_survey.asp

NHS Borders has made a successful application to the GP Transformation Fund for 2 year opportunities for newly qualified GPs combining BECS out of hours with day time speciality roles in Primary Care. The posts will rotate through each of four Borders rural GP practices for three months each to gain experience across different surgeries. The post is anticipated to predominantly provide additional Community Hospital GP medical cover to support the local contracted GPs; with the specific aim of augmenting complex discharge planning and immediate medical support post-discharge.

A recent pilot was undertaken of a GP supporting safe/effective discharge planning in the downstream wards of BGH. This involved the GP working on Medical Wards in conjunction with clinical teams advising secondary care clinicians on the primary care perspective on discharge thresholds, on ward rounds and in MDT meetings. Rotation to a day time service is an incentive to recruitment for posts that are predominantly out of hours; this may be a feature of a hybrid BECS / day time GP role in future.

Medical Recruitment – "Shared Services"
One option being considered is the potential to use a joint approach to recruitment for all the South East and Tayside (SEAT) Boards. There was an international recruitment event in Ireland in Autumn 2015 aimed at securing Irish doctors. A report of this event is included at Appendix 2. All SEAT boards invested in this, including NHS Borders, and this was a duplication of cost and effort. Collaboration between Boards for future events could cut costs considerably. Another potential for shared services under consideration is for a regional Medical Locum Bank to be centralised across SEAT in a mutual aid approach.

Service Redesign

Medical Unit Workforce, AAU & Ambulatory Care
There has been a significant workforce and service redesign in the Medical Unit – centring on MAU, AAU and Ambulatory Care. The current consultant physician establishment comprises 15 consultants broken down as follows:

- 1 Acute Physician
- 5 DME consultants

- 2 Stroke Consultants
- 2 Respiratory Consultants
- 2 Diabetes and Endocrinology Consultants
- 3 Gastroenterology consultants

The team provides a 24-hour, 7-day/week acute medical cover as well as speciality cover. For DME, this includes cover for community hospitals and outreach work for frail elderly.

It has been recognised that the traditional rota of a single on-call consultant has become unsustainable, with emergency activity not being responded to in a timeous fashion, elective activity being reduced due to emergency demands and extreme pressure on the consultant workforce. A number of changes have been made to on-call commitment, including increasing the period of on-call presence from 1600 to 12 midday, reducing planned commitments (clinics etc) during on-call period and splitting weekend on-call between 2 consultants to ensure overlap on weekend mornings.

After an option appraisal the Strategy Group agreed to increase the consultant physician establishment and commit to other clinical support staff:

- Appointment of an additional full time Acute Physician and an additional full time Consultant Geriatrician – this allows for an acute geriatrics service and acute physician cover in the MAU.
- Additional clinical support staff:
  - Older Peoples Liaison Specialist Nurse
  - Middle Grade Medical Staffing / ANPs to operate safely the new acute assessment and ambulatory care unit
- The model is described as “assess to discharge rather than admit to assess”. The consequent benefits are to reduce inappropriate patient admission and length of stay.

This service model would ensure the establishment of a sustainable future acute medical service, better patient outcomes and potentially deliver major reductions in length of stay and improve waiting times performance that contribute to the future redesign of our inpatient services.

Emergency Medicine “Mutual Aid”
The National Clinical Strategy promotes the use of Mutual Aid whenever appropriate. Our ED Department is a good example of how this can work well.

When our single handed ED consultant resigned in November 2015, we agreed visiting consultant cover with NHS Lothian on most weekdays Tuesdays to Fridays. The visiting consultant cover included some hands-on clinical work but also more importantly clinical leadership of the department, clinical governance, complaints advice, training and support for medical and nursing staff. NHS Lothian also now provide overnight remote clinical support on a telephone contact basis to the ED Doctor overnight, which is an essential feature of safe practice overnight – 24/7 services have been maintained by this development.

This is a front line vulnerable service – unacceptable disruption has been avoided by a cooperative approach of mutual aid. It is in the interests of both NHS Boards for the BGH ED to remain operational – avoiding the prospect of 22K new attendances going to ERI. With the appointment of new ED consultant at BGH (June 2016), a commitment has been given for a continuation of the shared arrangement with the BGH consultant spending a day in ERI for experience and professional updating and a Consultant from ERI providing a reciprocal clinical day at BGH. For the future there is the prospect of developing a long-term redesign with a BGH component being built into the job plans of consultants recruited as part of the future Major Trauma Centre development, and the BGH consultant visiting sessions at ERI as part of the resource for the trauma centre.

3.9.2 Nursing and Midwifery

The main workforce challenges currently facing the Nursing and Midwifery staff group include recruitment and retention of registered nursing staff (particularly within some specialist areas), an ageing workforce with a significant proportion of registered nursing staff over 50, and a trend for high bank and agency usage in recent months. The following section outlines these challenges and issues and outlines actions being taken forward to address these.

Recruitment Challenges
Despite running regular Nursing and Midwifery recruitment events over the past year we have experienced a shortage of registered nursing applicants. We have therefore reviewed our advertising strategy to encourage applicants from further afield. This includes the introduction of a radio advert, targeting universities (particularly with the introduction of the train line making our main hospital more accessible) and the use of Social Media to promote the Borders as a great place to live and work.

A significant proportion of the registered staff being attracted are newly qualified. Whilst it is encouraging that staff wish to commence their careers in the Borders, it does create a pressure for Senior Charge Nurses in terms of training, mentorship and support where a high number start in one area. Medical Assessment Unit (MAU) experienced particular difficulties following recruitment to Winter Surge posts due to a high proportion of successful staff being Newly Qualified. Experienced staff within Unscheduled Care were therefore offered an opportunity to rotate into MAU for a fixed term period, whilst some of the newly qualified staff were placed in the gaps they were leaving, e.g. in Ward 4, 5, 9 and 12. This approach ensured appropriate support to winter beds to ensure patient safety.

The service areas where we have had most difficulty recruiting Registered Nursing staff are Theatres (particularly Anaesthetics); Health Visitors to meet required increased numbers, and Community Hospitals. Although we have offered candidates a permanent contract with NHS Borders (initial period in Community Hospital then moving to a gap in BGH) these have not been attractive – with candidates preferring to work permanently in one location. We are now working with Senior Charge Nurses within the community hospitals to identify the most appropriate strategies for their areas, e.g. advertising in local press and across the border to attract staff from the Berwickshire area to the Knoll, and interviewing locally rather than at a generic recruitment event.

Pre-emptive Recruitment
We have a commitment to pre-emptive employment within Nursing & Midwifery where we have recruited staff for a Fixed Term post (e.g. Winter Surge, hard to fill community posts) permanently, with the intention to slot them into future workforce gaps. Again, these posts have proved popular for newly qualified staff but less attractive to experienced staff who have a preference for a particular specialty/ward. Pre-emptive employment is also being introduced as a mechanism to recruit permanent staff in advance of vacancies coming up in an effort to fill vacancies timeously. A virtual roster is being set up to ensure staff are managed effectively and placed appropriately in areas with short term gaps until a permanent post is found, and this group of staff will be considered before supplementary staff requests are placed, with the intention to reduce reliance on Supplementary Staff.

Advanced Nurse Practitioners
Advanced Practice roles in nursing are increasingly seen as key to the development and delivery of health and wellbeing services. Good governance regarding such role development and implementation must be based upon consistent expectations of the level of practice required to deliver the service.

Advanced practitioners are defined in the Career Framework for Health as:-

> "Experienced clinical practitioners with high level of skill and theoretical knowledge. Will make high level clinical decisions and manage own workload. Non Clinical staff will typically be managing a number of service areas" (Scottish Government 2009)

Following the release in early 2009 of the NHS Scotland Career Framework Guidance, CNO Directorate and Health Workforce colleagues in SGHD are keen to support the consistent and sustainable implementation of Advanced level nursing roles across services in NHS Scotland. Linked specifically to the development of the Advanced Practice Toolkit (SGHD 2008) and associated guidance on Consultant NMAHP roles, this new guidance sets out for NHS Boards the context for Advanced Practice Nursing roles and the processes through which they should be established and governed in the future.

The guiding principle is that such roles should be based upon demonstrable patient and service user need and that good governance lies in consistent benchmarking of these roles at recognised levels of practice in terms of expectations of competence, educational preparation and reward.

NHS Borders will continue to look at all aspects of service development, delivery and governance in the process, using: the Advanced Practice Toolkit (to support decision-making and planning); the existing AfC Job Matching processes (to support appropriate Job Profiles and reward); and the Professional Development Planning (PDP) and Knowledge and Skills Framework (KSF) processes (to allow review and confirmation of individual job descriptions, roles, responsibilities and objectives).

This means that, when we are considering whether the development of an Advanced Nursing Practice role is the best fit to meet the needs of patients and service, we will consider:

- service needs assessment, including local and national drivers;
- educational needs assessment, including existing workforce;
  how the anticipated impact of the role can be articulated, including key deliverables and how they will be delivered;
- evidence of support from key stakeholders;
- sustainability;
- robust governance and accountability arrangements.

One example of imaginative Workforce Planning is our out of hours service Paediatric Hospital at Night, which introduced resident ANNPs and APNPs and Consultant delivered service. This is a workforce skill mix that is not reliant on Medical Middle Grade Paediatric trainees for any out of hours services. Training opportunities for doctors in training continue during day time consultant supervised sessions for both Community Paediatrics and Acute Paediatrics at ST2/ST3+ level, however the trainees gain their out of hours exposure at RHSC / RIE in Edinburgh. The final workforce component in the out of hours service is a GPST who provides some consultant supervised evening cover for the unit. This model has worked well for a number of years, has secured the ongoing stability of the unit without service disruption and has been recognised by the SGHD as a model of good practice. Succession planning is now being factored in to future proof this service.

Nursing and Midwifery Workload Tools

NHS Borders has utilised the nationally developed Workload and Workforce Planning tools to inform service redesign. All Nursing Ward Areas have implemented a workforce establishment review and Adult Inpatient and Professional Judgement tools, have been used to inform redesigned skill mix. Where a national tool was not available (e.g. Outpatients), locally developed tools, based on a Timed Task Analysis approach, have been used to determine Workload. Since revised shift patterns were implemented in 2012, when there is an opportunity to recruit to a post, this is matched much more closely with the hours required by the rota, e.g. a full time member of staff would be recruited to do

37.5 hours, but we would recruit to 34.5 hours when this is the rota requirement. As part of our Nursing & Midwifery Workforce Planning, there was scheduled follow up time aligned to the dates the workload tools were run, to ensure that appropriate analysis was conducted against findings. This includes clinical discussions which will inform the requirement for a business case if seeking additional staff, or reallocation of resources if the tools show an oversupply in a particular area.

Leading Better Care
Leading Better Care has lead to augmented nursing establishment with Nurses across BGH and Community Hospital wards. We have introduced supervisory status for our Senior Charge Nurses in line with Leading Better Care recommendations, and backfill has been introduced to support this.

Specific Workforce Challenges by Specialty

Mental Health
The main issues affecting Mental Health nursing over the next 3 years will be the impact of the number of senior nurses retiring due to having Mental Health Officer status as part of their superannuation arrangements. This is approximately 14 staff, all at band 6 and 7, accounting for 20% of all Band 6 and 7 Mental Health Nurses. There are also issues with recruiting RMNs to the service and this is part of a national issue but is particularly challenging locally.

Dementia Services

NHS Borders and Scottish Borders Council continue to work in partnership to develop the skills of our workforce to deliver person-centred care to people with dementia whether at home, in hospital or in any other care setting. Through our dementia training strategy all staff are expected to have a baseline understanding of the needs of people with dementia, and we actively promote additional Skilled Dementia Practitioner training, Enhanced Dementia Practitioner training using NHES training components for staff whose jobs involve a greater involvement with people with dementia.

Specialist Nursing Workforce
The Specialist Nurses are running the Specialist Nurse Workload Tool in June 2016. This tool measures all aspects of Clinical Nurse Specialist work, which includes “Face to Face” contact, “Non-Face to Face” contact, Associated Work and Travel Time. The tool records the actual time taken to carry out activities and measures the complexity of the workload. It provides good quality information on the workload of this cohort, broken down by banding, to inform and support decisions on having the right number of staff, in the right place and also to provide staff with the information to help them better understand the workload.

Endoscopy

It remains our direction to provide a nurse led endoscopy service. As part of service redesigns a new role of Extended Scope Practitioner was introduced. An Extended Scope Practitioner is managing emergency cases which are repatriated back to Borders following surgery in Lothian. This is a specialist nurse role with additional training to review patients usually seen by a doctor.

As part of the regional initiative on enhancing Endoscopy capacity there has been an expansion of the Nursing Workforce (the modernised Oliver EADE suite) at both Registered and Non-registered levels.

Oncology

The haematology service had been reliant on locums for several years which highlighted the risks inherent with a small service in relation to patient care. These centred around:

- Continuity of care for patients

- Responsibility and accountability for care
- Ensuring investigations are appropriate, timely and followed through
- Timely assessment by a specialist during unscheduled care episodes
- Adherence to local and regional policy

In response to the above a Macmillan Haematology Advanced Nurse Practitioner (ANP) role was introduced the aim being to integrate with the consultant haematologists to provide a robust team approach to care utilising skills of the specialist team in the most appropriate way.

This role has been in place since November 2015 and is already having a positive impact on services. Inpatients and day patients are seen in a timely manner and any issues and or clinical decisions made. A bone marrow clinic has been developed to allow for time efficiencies within the team and a more robust system for the patients. This clinic has also freed space within the chemotherapy day unit supporting better use of resource there. The ANP has a key role in co-ordinating workup patients attending for bone marrow transplant in Glasgow or Edinburgh and supports shared care between the BGH and these centres through improved communication links. This is a developing role alongside the needs of the patient group and the haematology service.

Many of the Clinical Nurse Specialists (CNS) are also undertaking advanced practice roles to impact on patient demand and improve patient experience. There are currently 5 non medical prescribers within cancer services and another due to start the course in September. Within the breast service a band 6 CNS has been employed to support release of the band 7 and allow the development of a nurse led result clinic. This is on a temporary basis for one year and is under evaluation however early signs are that this is a safe, effective and acceptable model of care for patients which releases Consultant Surgeon time. It also supports succession planning within the breast care team

As the management and treatment for cancer continues to advance it has resulted not only in increased survival but also in an increasing number of patients attending acute units for unscheduled care. Provision of optimal care to this complex patient group in the absence of specialist oncology input presents a key challenge. Options to address the best use of current resource within the cancer services budget have been considered and an opportunity identified to remodel resources to facilitate delivery of an acute oncology service which would support this patient group as well as address service developments in central venous access management and succession planning for the Nurse Consultant Role. Macmillan Cancer Support have agreed to support this development which introduces a Band 4 Project Support / PA to work alongside the Nurse Consultant which releases her to have a defined clinical remit as well as having dedicated time to concentrate on the strategic and leadership functions within the role. It is hoped this service can be progressed if ongoing financial resourcing can be agreed.

Within the chemotherapy day unit the role of the assistant practitioner is embedded and further developments for this role are being explored e.g. subcutaneous injections and single person checking of blood products.

Renal

Due to repatriation of Renal activity there has been expansion of the Renal Nursing Workforce. The overall redesign has led to patients with renal insufficiency being treated locally instead of travelling to Edinburgh for treatment. Spaces are often used for holiday dialysis patients. There are possible future staff development opportunities within the renal directorate involving secondment to RIE.

Unscheduled Care

Out of Hours Services & Emergency Department

Given the long term sustainability of GP delivered Primary Care Out of Hours due to recruitment difficulties for GPs, additional nursing posts are vital to maintain front line services in the Out of Hours period across NHS Borders. This nursing service supports HEAT T10 plus Shifting the Balance of Care by maintaining patients within their own homes. In Primary Care out of hours, unscheduled care Nurses have replaced some GP hours in the interest of long term sustainability and this will be an ongoing phenomenon, as attendances have doubled over the last 2 years.

Within the Emergency Department, utilising triage protocols has enabled Emergency Nurse Practitioners to be trained to appropriate competence levels to augment the medical contribution to the Emergency Department. We expect ENP number to increase in the year, which is a more appropriate model for night duty and work is going ahead to develop this service.

Medical Acute Assessment Unit (MAU)

An Acute Assessment Unit was established in 8 beds within MAU in December 2015, reducing MAU to a 22-bedded ward (excluding annexe winter beds). This has significantly changed the operation of both units with up to 15 patients attending AAU each day. Workload tools have been applied to support review of Workforce Establishment across both areas.

Women and Children's Health

Maternity

In response to changes in the Medical Workforce in Obstetrics, we have, for some time promoted Skill Development for our existing Midwives. Local Midwives have completed a training programme (Assisted Birth Practitioner Module) which provides them with the knowledge and skills to assess and implement care, undertaking instrumental deliveries which have previously been the role of the junior doctor. There are currently two Assisted Birth Practitioners (ABPs) in post who work independently with Consultant Obstetricians within a 20 minute recall and a further midwife currently in training.

The age profile of the Midwife Sonography service in the Pregnancy Assessment Unit indicates 3 of 5 retirements within the next 3 years. This service is an essential part of antenatal care, previously carried out by Consultant Obstetricians. The data shows that the requirement for the service is increasing. The service will need to continue to train additional midwives as part of succession planning to ensure delivery of the service, and currently have one midwife in training with a further midwife starting training in September 2016.

Community Children's Nursing

As the service continues to develop and reduces the numbers of inpatient beds (Children and Young People's Centre project 2015, which reduces the number of inpatient beds to 4 from 10 and increases the opportunity for ambulatory care), there continues to be increased scrutiny on this service to extend the hours of working for Community Children's Nurses.

Children's Inspection

A joint inspection of children and young people's services within the Scottish Borders took place early in 2016. The Care Inspectorate inspection report was published on 28 June 2016.

It has been recognised that the Scottish Borders Community Planning Partnership was committed to improving the wellbeing of all children and young people. Strengths identified include:

- Improving trends for children and young people in terms of health, educational attainment and achievement and positive destinations and outcomes for most children and young people are steadily improving across the area
- Universal services are working well together with a positive impact for children, young people and their families
- Help and support is provided at an early stage and there is an immediate response to child protection concerns. Families welcomed the support they received to overcome adversity
- There is strong partnership working across services and through collaboration with third sector services and there is a culture of meaningful engagement across services with children and families and with other stakeholders
- The Leadership were committed to the implementation of GIRFEC and Corporate Parenting and were proactively striving to drive the pace of change, enabling improvement in some key areas.

A number of areas for improvement were identified and as a result, work that will be progressed includes developing a quality assurance framework, reviewing some child protection processes, further developing our performance management information and progressing Self-directed Support. An inspection improvement action plan is currently being developed and further information will be provided once this has been finalised and the implementation of the plan will require the input of staff across all Children & Young People's Services. As part of the Action Plan NHS Borders are in the process of recruiting 2 Registered Nurses to progress this work.

Community Nursing

Work is progressing around the GIRFEC/Children's Act requirements. Named person training continues and caseloads have been reviewed. Processes have been developed to facilitate the Named Person role when it is commenced. Some new staff are in place already with others in training. The Health Visitor pathway is being rolled out commencing with antenatal visits from April 2016. This will be monitored through 2016 - 2018 when more extra staff will be recruited and trained. Two Family Nurse Partnership nurses started in June 2015 to support under 20s with first pregnancies – this is an intensive programme where mums are seen at home once every 2 weeks, before handing over to the health visiting team at age 2.

Health Visiting

The National Health Visiting Caseload Tool, which measure the workload of the community nurses, have confirmed that we need 10 new full time Health Visitors over 3 years, of which 2 years are remaining. This will result in a 30% increase in the Health Visitor Workforce. Recruitment of Health Visitors can be difficult, and there is a current shortage of Health Visitors throughout Scotland. To meet this shortfall, we are in the process of training 4 new Health Visitors, one of whom should finish their course in September 2016 and the other 3 in January 2017. As part of our workforce we presently have 2 Specialist Practitioner HV Trainers, and they can train 2 trainees each. There are plans to train an additional Specialist Practitioner Trainer, and this person could also train one Health Visitor as part of their training. We need to train a minimum of 4 HVs per year for the next 3 years which would hopefully cover all the vacant posts plus those retirements which have been indicated. We also have 3 retired HVs who have returned to work part-time, doing 0.6 WTE each, which has provided a temporary stop gap. We are now able to advertise permanent posts and train students as the money is transferred. We will continue to need extra staff trained in order to replace staff who are retiring from service.

In addition the Health Visiting team includes 5 Nursery Nurses, and these posts have proved to be easier to recruit to and have a younger age profile.

District Nursing

The District Nursing team includes more of a skill mix, which makes it easier to provide cover for vacancies as often the Band 5 Community Staff Nurses express an interest in doing their District Nursing training. Recently 2 staff have been appointed who will now do their training. This can be either as a full time course which is 9 months, or as a part time course over 2 years, with them continuing to work as Community Staff Nurses for 50% of their time. Their course is due to start in September 2016 and we will send them full time with appropriate backfill agreed. Some further Band 5s are expressing interest in training, and we will encourage them to train modularly and continue working whilst training. We currently have one Specialist Practitioner District Nurse Trainer and she can train 2 DNs at a time with assistance from experienced DNs locally. To be qualified as a DN will in the future require Masters level training, and anecdotally in other parts of Scotland, some are leaving to work as Practice Nurses, Out of Hours Nurses or Advanced Nurse Practitioners once trained.

Schools Nursing

We currently have a headcount of 8 Schools Nurses with a whole time equivalence of 6. Of these, 2 have indicated that they will retire in the next 6 months. Whilst Schools Nursing training now differs from Health Visitor training, the previous Public Health training was interchangeable and a trained Health Visitor can work as a School Nurse and vice versa. The last School Nurse we recruited started as a Band 5, working towards Band 6 with training. As there are no Specialist Practitioner School Nurse Trainers in NHS Borders we have plans to train one. Whilst it is now recommended that all those who work in School Nursing posts should be trained School Nurses at Band 6, we have a higher %age of Specialist Practitioner School Nurses than the Scottish average, but we do still have several Band 5 School Nurses. It is hoped that some School Nurses could be recruited from Mental Health Nursing, as the skills are particularly useful.

The Immunisation Team are not part of the core School Nursing Team. These are mostly working annualised term time hours, and were initially employed on Fixed Term Contracts for a specific immunisation project. The funding has now been agreed to develop a specific Immunisation team with a Team lead and skill mix staff on permanent contracts.

3.9.3 AHP

The AHP Steering Group is exploring moving towards management and professional leadership of the currently separate AHP Services. It is proposed that, to consolidate and develop both professional clinical leadership and ensure robust operational management, the AHP services could adopt a similar approach to other clinical services, thus ensuring we have robust and clear arrangements for management and leadership moving forward. This approach proposes utilising the opportunities of vacant leadership posts in AHP services to create Clinical Manager roles and to maintain the professional leadership for each AHP service on a sessional basis, all reporting to the Associate Director of AHPs. There has been a period of engagement with staff through Open Forums and the AHP Redesign Steering Group will develop firm proposals.

It is hoped that potential new arrangements may also allow for extending the current NHS Borders AHP Practice Education Lead into a joint arrangement, which would be working across integrated AHP services, with some funding from NES and also from SBC. In addition a position of AHP Improvement Facilitator is being proposed, to be a rotational position to encourage projects across the service, and also to provide opportunities which may assist with succession planning going forward. A key opportunity for AHPs is to integrate the practice and pathways across NHS Borders and Scottish Borders Council AHP staff.

Many AHP Services have agreed and are working towards redesigned establishments, and others are currently progressing Workforce Reviews after participating in a Performance & Benchmarking exercise comparing activity and workforce to peer NHS Boards. Achievement of “Upper Quartile" in Scotland across AHP Services is the target.

Podiatry redesign has required a significant modification of available accommodation i.e. part of estates strategy in community locations. This is described as the “Locality Hub and Spoke” model and is now well through the process of implementation. The Physiotherapy service has adopted a similar approach for their MSK OP Services. Both services are in the process of moving their data, central booking and management of waiting lists onto the Trakcare patient management system.

The MSK Quality Programme has necessitated a shift in workforce to focus on MSK outpatient activity. The Associate Director of AHP services reports to the Chief Officer Health and Social Care and this is a joint appointment across NHS Borders and SBC. NHS Borders are also currently testing opportunities related to unscheduled care/patient flow and seven day services.NHS Borders are actively exploring opportunities for more integrated practice within the Integrated Joint Board, particularly in relation to Rehabilitation and Re-enablement services and pathways.

Across AHP services there have been difficulties in recruiting to Band 5 posts due to competition from the urban areas and there are some retention difficulties due to perceived lack of opportunities within some services. The increased number of Fixed Term Contracts, which has been necessary during Service Redesign processes, has contributed to this challenge. As the Service Redesign process nears completion, this situation should improve.

There are currently 8 AHP staff undertaking Fellowships through NES Career Development, and it is hoped that in the future there may be scope for developing an AHP Consultant post. Support has also been given to the Health Care Support Worker posts, and it is hoped that, through time, there will be opportunities to create generic integrated posts at this level which provide support in the home for a variety of AHP services, together with Nursing and social care services. There has also been significant workforce development to improve capacity, capability and confidence in areas of quality improvement techniques and leadership skills for improvement. Our local AHPs hosted a National Conversation event in Borders at the end of 2015, attended by the Minister for Public Health - Maureen Watt. Over 40 posters and examples of AHP practice and quality were presented on the day. The focus of the event was on how Allied Health Professionals contribute to Active & Independent Living for people. There is another Quality Improvement Workshop planned for AHPs and colleagues in the summer of 2016. The next challenge for moving forward with AHPs is the proposed National Improvement Programme called the “Active & Independent Living Improvement Programme” led by the Chief Health Professions Officer in Scottish Government.

3.9.4 Other Therapeutic Services

The Largest Staff Group within Other Therapeutic Services (Pharmacy Services) has completed a Workforce/Workload review using the six step methodology and the revised establishments have largely been implemented. The service is looking to move much of the work they do out to wards to allow for a more patient and customer centred service. Pharmacists are proactively seeking discharges so that they can be completed as far as possible on the ward and working with the patient and ward staff to only provide what is needed, and a new discharge liaison technician role has been created and appointed to. Technicians are developing their ward roles to support pharmacists and will be liaising with patients more and counselling on new medicines. From 1 April 2016, all technicians will be working to a new job description which includes becoming an accredited checker (at both Band 4 and 5). This will help the workflow. Pharmacy Assistants (Band 2) are taking on extended roles in the dispensary to free up technicians for their ward roles; this is in line with the work done by Pharmacy Assistants in community pharmacy services. In the near future this will be supported by EMIS’s electronic medicines management system.

The Prescribing Support Team is supporting the national Prescribing for Excellence vision to ensure cost effective prescribing practices and developing the clinical role of the community pharmacist.. They are taking on a caseload of patients to do polypharmacy review and other medicine reviews in practices.

It is anticipated that the integration of Health and Social Care will result in increased domiciliary patient reviews to help patients manage at home and closer working with carers to help support them in the management of patients' medicines in their homes.

Recruitment issues include Band 4 Pharmacy Technicians; and also Band 7 and 8a Pharmacists. The department is looking at ways to retain Band 6 pharmacists and provide the opportunity to develop towards these roles.

3.9.5 Healthcare Science

The Laboratory Services have been utilising 6 Step Methodology as they implement a redesign, which focuses on rationalisation, efficiency of the out of hours service and benchmarking. This has been fully implemented, and all staff have moved to their new roles.

Blood Sciences
The Blood Sciences Laboratory has had sufficient turnover to allow all staff to move to their new roles following a workforce review.

The future proposal is based upon providing the Out of Hours service by a shift system rather than "on-call" and moving to a combined Blood Sciences department with multi-discipline staff who are cross trained in different specialisms. This cross training will take several years and will strengthen the robustness of the Out of Hours service.

There has been a significant increase in the Haematology and Chemistry Laboratory workload in the last 3 years. This is country-wide, showing as a 17% average increase over Scotland, but is between 20% and 30% in NHS Borders. As there have been issues in attracting trained Biomedical Scientists to NHS Borders, the Blood Sciences Laboratory currently has 5 Trainee Biomedical Scientists in post, and a further 2 trainees have recently been appointed who are over and above the current establishment. The Service Redesign was based on historical workload and workforce may need adjustment to meet current demands.

There are currently 2 staff working towards MSC in Blood Transfusion, with fees being funded through Endowments, which will help future proof this service.

Phlebotomy
The increased workload in the Blood Sciences Laboratory is also reflected in the Phlebotomy Service where there has been an increase in demand of 60% between 2012 and 2014. This, combined with the addition of a weekend service, has resulted in a considerable requirement for phlebotomy hours being covered either by bank staff or by additional hours for existing staff. As Phlebotomy was not included in the Laboratory Workforce Review, a Workforce Review for the Phlebotomy service is planned for summer 2016, following the 6 step methodology and this will help to improve the service and also to deal with these staffing issues.

Microbiology
The Microbiology Laboratory has also completed a full Workforce Review and, being a smaller staff group with a lower turnover rate, is still working towards its new structure. It is expected that through time and natural turnover this situation will resolve itself. Where possible, the Microbiology Laboratory tries to develop staff to fill vacancies, providing training funding where possible, and there are currently 2 members of staff working towards qualifications to progress within the department.

3.9.6 Estates & Facilities

Support Services have undertaken Six Step Methodology to help inform new establishments. Domestic Services and Portering Services have implemented revised Skill Mix and reviewed ways of working across the two functions.

Implementation of new establishments for Domestic and Portering Service taking into account HEI minimum standards was implemented from April 2014. There was an increase in Domestic and Portering staffing as new permanent staff are appointed and there is a reduction in temporary contract and agency workers

The Estates & Facilities Department comprises Maintenance, Capital Projects, Medical Electronics, Facilities which includes General Services, Catering, Laundry, Telephony Services and Administration and Clerical staff. In line with other clinical and support services in NHS Borders, the Estates Department has undertaken a full service review. A tripartite approach has been utilised to determine departmental performance. Time Task Analysis (TTA) has been carried out for all management, administration and clerical staff. Data collated in the Estates Management Systems (EMS) has been analysed for the workforce and evaluated against benchmarks for other peer Health Boards.

A key element of the Estates Department's future strategic plan is the staff demographic profile. It has been identified that the majority of craftspeople are in the 51-60 year old age bracket. In order to address this situation and to ensure continuity of service, a strong case is made for the phased introduction of the Modern Apprenticeship Scheme. Modern Apprenticeships (MAs) are an increasingly important element in the workforce development of NHS Scotland. MAs provide an excellent structure to help individuals develop the skills and knowledge they need to help deliver high-quality healthcare services. As it is necessary to have a vacant Craftsman post before an Apprentice can be taken on, there are issues over the need for these to be supernumerary, to take account of the fact that they will be very restricted in the kinds of work they can undertake, combined with the fact that a Master Craftsman will have to give up time to train an apprentice.

There are issues with succession planning among the Estates Managers and Specialists, as these posts are difficult to recruit to and difficult to train towards. In addition, although a small group of staff, their age profile suggests these issues may start to have an impact before too long.

The National Shared Services Review is looking closely at a number of services within this area. This is being taken forward in Partnership with the Trade Unions and the NHS Boards.

Health Facilities Scotland are currently funding a number of staff through education courses: 2 Catering Staff and 1 Estates staff member are working towards Facilities Management Degrees through Sheffield University; and also one Medical Electronics Staff member is working towards an HND at Esk Valley College of Technology.

Health Facilities Scotland have produced a workbook which aims to ensure that new Estates and Facilities employees are made fully aware of the special issues and considerations that must be taken into account when working as a member of the Estates Services Team within the NHS. It highlights that working within the NHS can mean working in specialised circumstances, in sensitive environments and with vulnerable people. This requires those who work within NHSScotland's Healthcare Facilities to have additional knowledge and skills over and above those they would normally need to carry out their work in other situations i.e. technical competency. It is not a training course but it does provide a structured approach to assessing, developing and demonstrating capabilities and is now being used throughout this staff group in NHS Borders.

3.9.7 Administrative Services and Management

A management redesign has been progressed to support implementation of health & social care integration. This has resulted in a clearer structure with more distinct areas of responsibility. The General Manager for Primary Care, the Associate Director of AHPs, the General Manager for Mental Health & Learning Disabilities and the Head of Children's Services are now managed through the Integrated Joint Board structure. These will continue to work closely and collaboratively with management employed within Acute Services.

A review of the Administrative Services team which supports management has also resulted in a more efficient and stream-lined service. At the same time a review of Administrative Services in Community Health Centres has resulted in some skill mixing, with staff having more clearly defined roles.

The Medical Secretarial Team is working towards a new improved structure following a service redesign. Using existing Fixed Term Contract posts, a significant amount of skill mixing has been possible with a minimum amount of disruption. This is working well and clinical staff are supportive of the new system. There has also been a new Improvements & Training post created to ensure the efficiency of processes and procedures and that all staff have the appropriate training, particularly for new initiatives. Secretarial staff have the opportunity to rotate between teams, allowing for flexibility, for Business Continuity and also for staff development. It is planned to encourage staff to shadow work colleagues to encourage career progression and 3 staff from this team are currently attending in-house Management Training sessions.

Work & Wellbeing

Work & Wellbeing services report recruitment issues with trained staff. Work & Wellbeing comprises 4 areas: Occupational Health Services, Healthy Working Lives, Working Health Services and Fit for Work Services. The latter 3 strands are all funded centrally with ring-fenced short-term funding, which results in staff being employed on a series of Fixed Term Contracts, which further hinders recruitment and retention of staff. The Occupational Health Service supports the education and training of their own Specialist OH Nurses and currently have one nurse undertaking a BA in Public Health Nursing (Occupational Health). The training is funded by the income created by the external work carried out by the OHS. The service has looked creatively at skill mix and seriously considered employing a Band 4 support worker. However, the geography of the area meant logistically that this would not be effective.

OHS is not an integrated service and SBC have a separate OHS provider, although the Moving & Handling Service is already integrated as part of a 3 year rolling contract. The OHS is a Nurse-led service contracting with a sessional doctor 2 days per week, in contrast with most other NHS Scotland Boards, who commonly have a Consultant-led service.

IM&T

Information Management & Technology have been working towards a Service Redesign for some time. This has been temporarily paused to allow time to develop an IM&T Strategy, which will allow technologies to be mapped against skills, identifying any gaps. The hope is to have the redesign agreed by September 2016 and implemented by the end of the year. They currently carry 6 management vacancies, which should provide the flexibility for the redesign and also assists towards making the savings target in the meantime, but these have resulted in some gaps in the service. There are some significant recruitment difficulties in this service, even where there are permanent posts, owing partly to the high levels of pay available in the IT Sector and also to the requirement for a broad range of skills for a small team. Agency use for recruitment to senior and specialist posts has proved to be the most successful route and a new management post has recently been filled in this way. Succession planning has been particularly difficult because of work volumes and capacity.

IT Services are currently being considered as part of the Shared Services Review and one area which may move forward is the possibility of partnering NHS Lothian for Trakcare. This would be a mutually beneficial partnership arrangement and the new support model may have an impact on some local staff. The increasing complexity together with increased footprint and reliance on technologies brings challenges to a small NHS Board to provide in-house support. Whilst the Integration Agenda may raise the question of whether a more integrated IM&T service is possible, the very different technical infrastructures mean this is unlikely to happen without considerable investment and therefore is a more long-term consideration.

Retention is not normally an issue in IM&T, although there is a high turnover of staff in Medical Records. This is partly due to the shift system required by this service and partly because it is often seen as a stepping-stone post into higher banded administrative posts. There have also been a high number of Fixed Term Contracts in this area, but many of these have now been made permanent and it is hoped that this will help to improve this situation.

Clinical Governance and Quality

This is a very person-dependant service, which requires staff with specific unique skill sets. This can result in issues for recruitment and a pending retirement has been planned for with a crossover time to allow for handover and training. All those working at Band 7 level require Advanced Improvement and Data Analysis skills, and all have been, or are being trained through the Scottish Improvement Leaders Course.

The new National Adverse Event Framework now requires all significant adverse events to be reviewed in detail using root cause analysis techniques. In addition, there has been an increase in complaints in Borders in line with the increase seen across Scotland of around 10% per annum, in addition a new complaints handling process has been introduced involved detailed review and face to face discussion and reflection with patients, their families and staff. There has been no increase in staffing level to accommodate the increase in activity in the areas of feedback and complaints and adverse events but the team have re-profiled where they can to provide additional support.

One of the main issues around staffing in Clinical Governance is that over 50% of the team (both Headcount and Whole Time Equivalent) are on Fixed Term Contracts as they are working on short term improvement projects with external funding. Bids for improvement project funding are submitted, with benefits to NHS Borders when successful. For example NHS Borders are one of four test sites working with the Institute for Healthcare Optimisation and the Scottish Government to improve patient flow with an initial focus on surgical care, have 3 active Health Foundation projects in the area of patient safety and have been selected as the national test site for work on Venous Thrombo-Embolism.

CG&Q also lead on several national and local improvement initiatives including Connected Care a programme of improvement spanning health and social care.

Public Health

Public Health is a joint service and supports NHS Borders and Scottish Borders Council as well as the wider Community Planning Partnership. The service has had internal restructuring in the last 12 months and will need to respond to the outcome of the Shared Services review, due to report in the autumn of 2016. Public Health has a role in workforce development in providing support and training to NHS staff to improve health and reduce health inequalities and more specifically to deliver on objectives of the Health Promoting Health Service.

The team has had staff participating in the IHI Early Years Collaborative Improvement Adviser Programme: 1 in 2014 and 2 in 2015. This was a year long programme that has built capacity for

improvement in child health services. The NHS Borders Health Improvement service is taking part in a UKPHR scheme, with 5 other Scottish Boards, to support practitioner registration. A national practitioner registration is expected to be introduced in the coming few years. Currently we have 2 staff taking part in this scheme.

3.10 National Shared Services

The National Shared Services Programme has been identified as a key enabler of quality, safe and financially sustainable clinical services. Shared Services will provide increased efficiency, increased effectiveness and longer-term sustainability for the NHS in Scotland and will be managed and delivered in a consistent way where it is appropriate to do so. The remit for this work on behalf of NHSScotland is being taken forward by NSS, who have adopted the appropriate project methodology.

NHSScotland's Shared Services will:

- transform the way support services are delivered by integrating services and working across boundaries
- support Scotland's health with a sustainable, consistent and effective service which meets customer's requirements
- be fully accountable to their customers for the quality and effectiveness of their services
- exploit economies of scale to increase efficiency, reduce costs and maximise returns from continuous improvement
- embed governance to set strategic direction, prioritise service improvements and resolve day to day issues

Programmes include:

- Facilities Management
  - Capital Planning & Energy
  - Laundry
  - Portering
  - Catering
  - Sterile Services
  - Fleet & Logistics
- Public Health
- Pharmacy
- Human Resources
  - Recruitment
  - Employee Services
  - Medical Staffing
  - Occupational Health
  - Health, Risk & Safety
  - Training & Professional Development
  - Organisational Development
- Finance
- eRostering
- Procurement
- Laboratories
- Radiology
- Medical Physics/Electronics

A local Shared Service Working Group was established in April 2016 to support local stakeholders involved in the national programme. The group meets on a monthly basis and the aim of the group is to ensure engagement is appropriate and sufficient to achieve full definition of service requirements for any future Shared Service. This will be achieved through scrutiny of Shared Services engagement activity as well as facilitation of engagement with appropriate service / user groups and professional communities.

Step 4 – Workforce Capability - Available Workforce

4.1 Workforce Demographics

This section helps us to understand the available workforce and our current staffing. We know that 20% of all jobs in the Scottish Borders are public sector health jobs.

The charts following illustrate NHS Borders workforce as at 31 March 2016.

This chart shows all staff of NHS Borders split to show the proportion of the total staff in each Job Family. This illustrates clearly the fact that the Nursing/Midwifery staff make up the largest numbers of staff, at 43.84% of the whole of NHS Borders workforce. Of these 74.52% are Registered Nurses & Midwives.

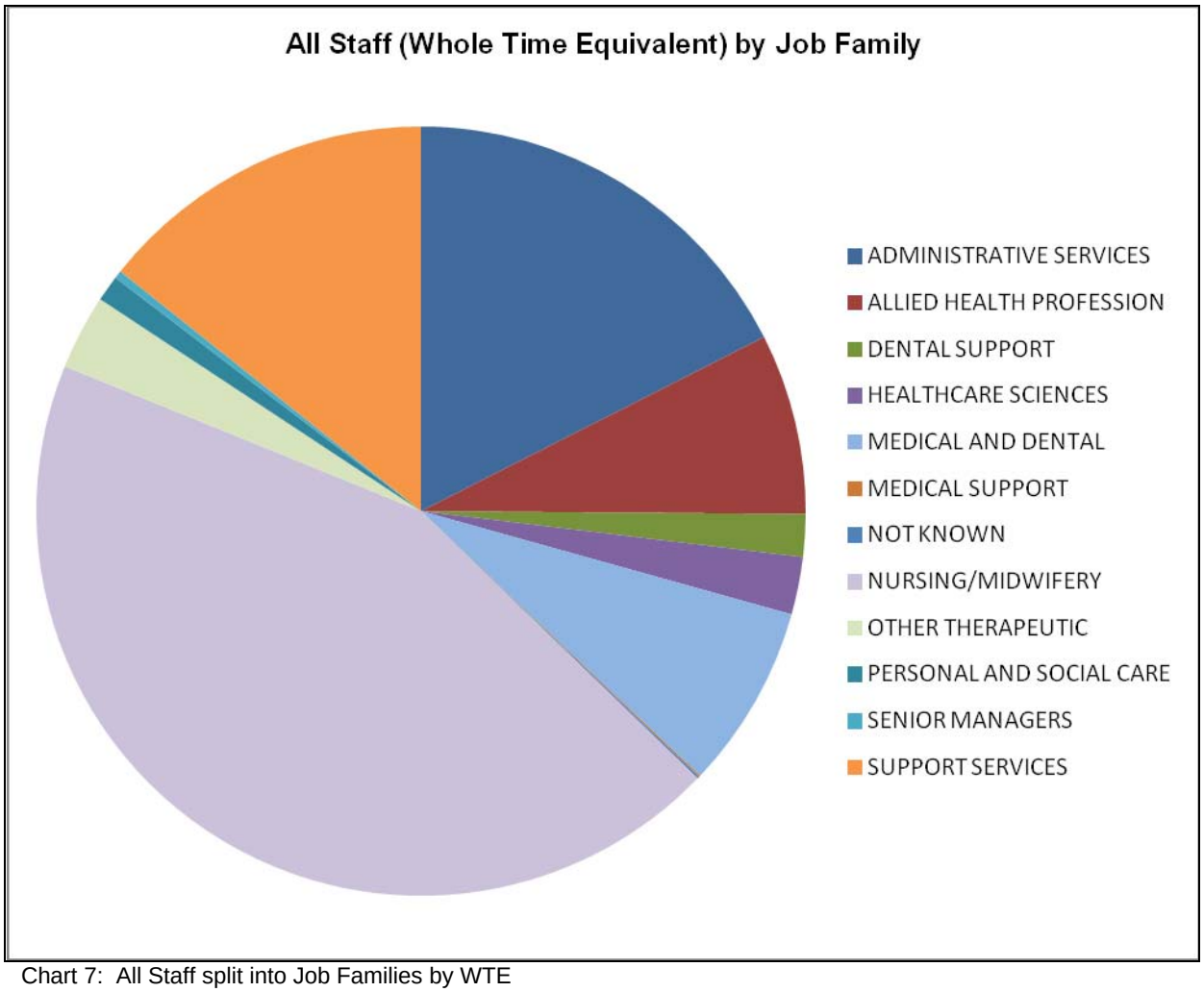


Chart 7: All Staff split into Job Families by WTE

The Workforce Tree Chart below shows all NHS Borders staff by Band as at 31 March 2016. It shows Band 5 as the predominant band, as many registered nurses, midwives, AHPs, etc fall into this band, with numbers in higher bands gradually declining, as you would expect.

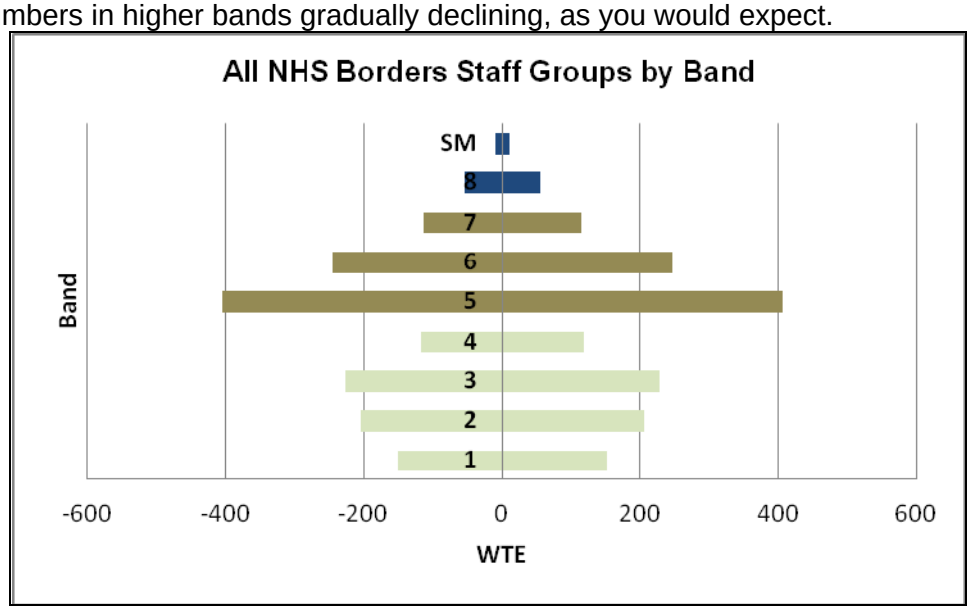


Chart 8: Workforce Tree for all NHS Borders Staff broken down by Band

Age Profiles

The charts below help us to understand the age profile of our workforce. The average age across the workforce at 31 March 2016 was 45.55, compared to 45.59 in the previous year, showing a slight improvement in the overall age profile across the organisation.

This chart shows the age profile of all NHS Borders Staff, comparing 2015 and 2016. It shows an increase in staff numbers in the 20 – 35 age group, which is reassuring, however there has been a similar increase in the over 55 age group which is concerning, but is predictable as retirement ages increase.

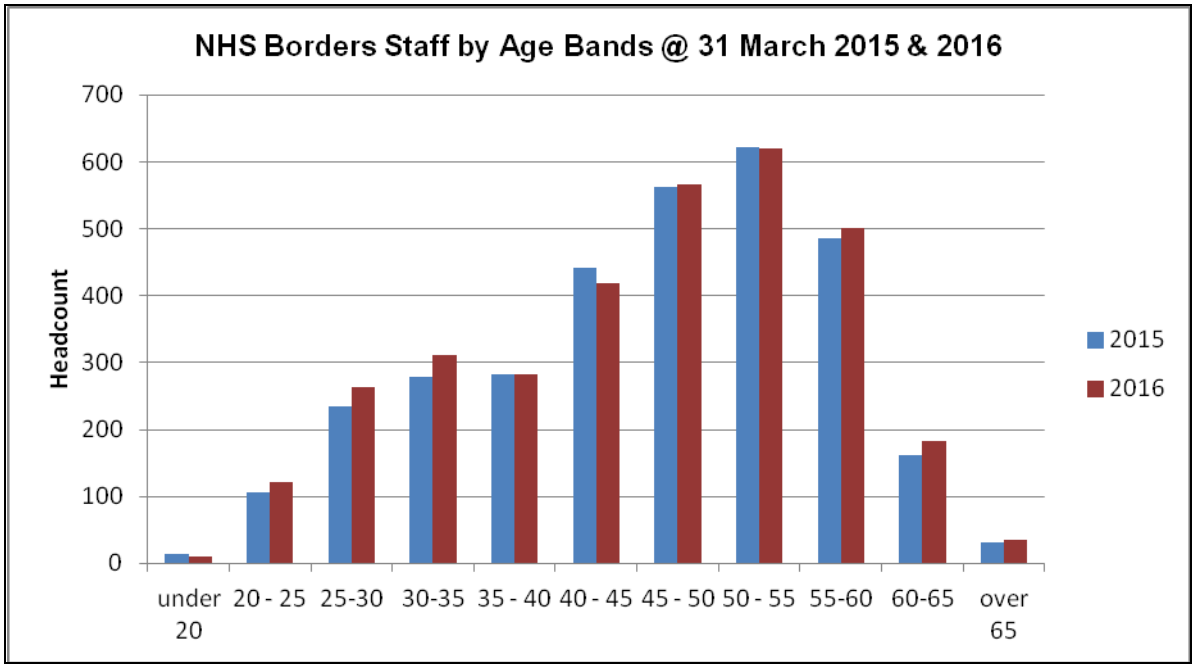


Chart 9: All NHS Borders Staff by Age Bands at 2015 and 2016

The chart below shows the age profile of the whole staff at 31 March 2016 as a bar chart and shows the Nursing/Midwifery, AHP and Medical & Dental staff groups as line charts for comparison purposes. You will note that the Nursing/Midwifery chart follows much the same line as the total staff, i.e. a high proportion of staff over 45, whereas both AHP and Medical & Dental show overall a younger workforce, suggesting successful recruitment of newly qualified staff. (It should be noted that Training Grade Doctors are not included in Medical & Dental.)

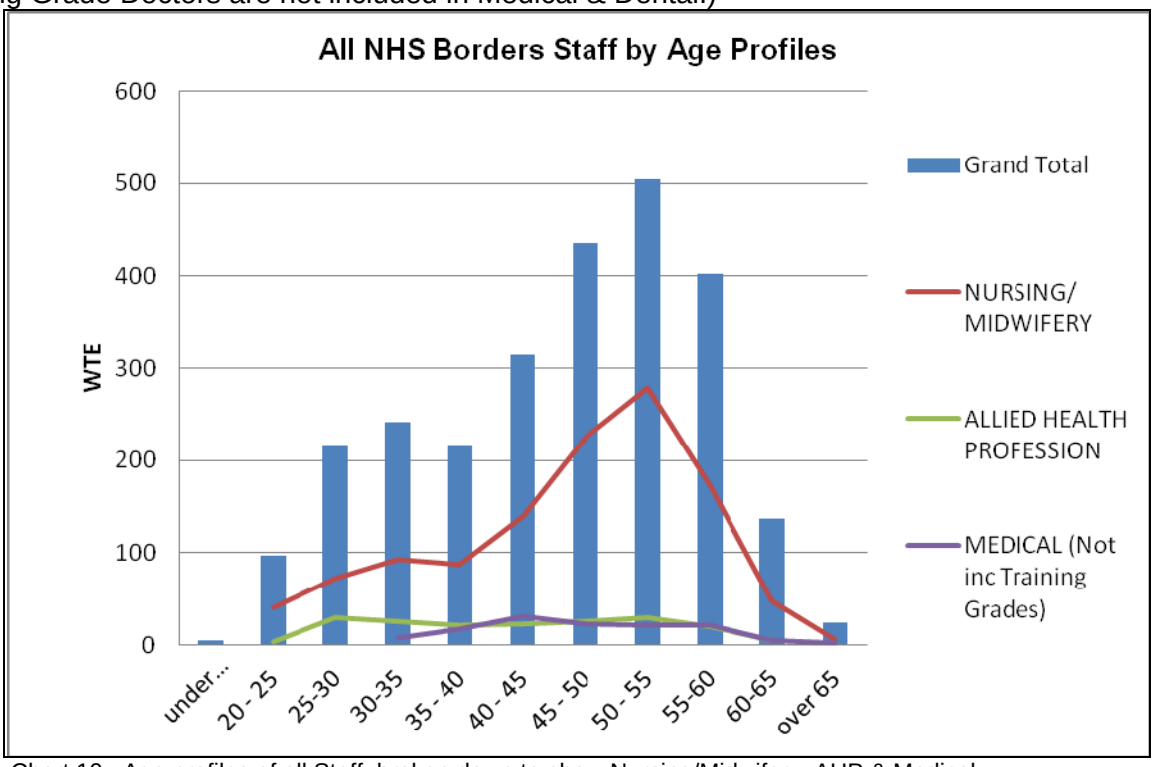


Chart 10: Age profiles of all Staff, broken down to show Nursing/Midwifery, AHP & Medical

This chart shows the percentages of staff under the age of 40, under the age of 50 and over 55, comparing 2015 and 2016. It shows that nearly 30% of the staff are under 40 and this has risen slightly since 2015, just under 60% of all staff are under 50 and this has fallen very slightly, and just over 20% of all staff are over 55 years old and this has risen very slightly. It is positive to see an increase in the under 40 group which is greater than the increase in the over 50s.

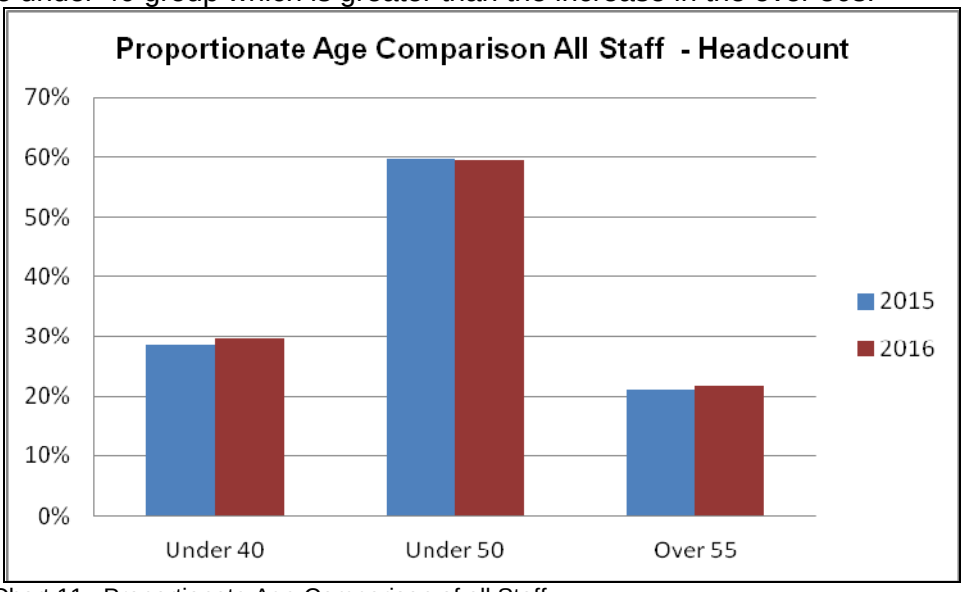


Chart 11: Proportionate Age Comparison of all Staff

This chart shows the average age in each Job Family and compares it to 2015. You can see that the changes are very slight overall, but that the overall average age is slightly lower which is encouraging. Hotspots for succession planning have been identified.

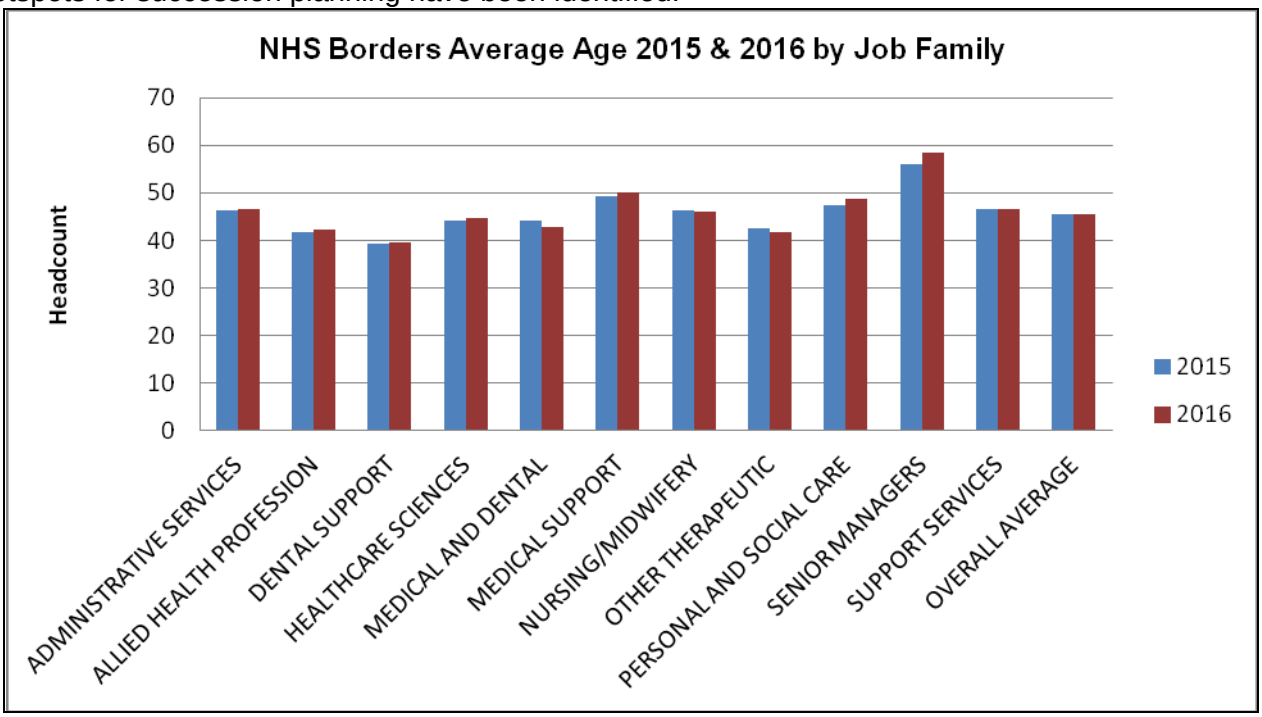


Chart 12: Average Age of all Staff for 2015 and 2016 broken down by Job Family

The chart below shows the gender split in each Job Family. It shows clearly that our workforce is predominantly female. It does however, show that the split is closer to equal in Medical & Dental and also that Support Services have a more mixed staff.

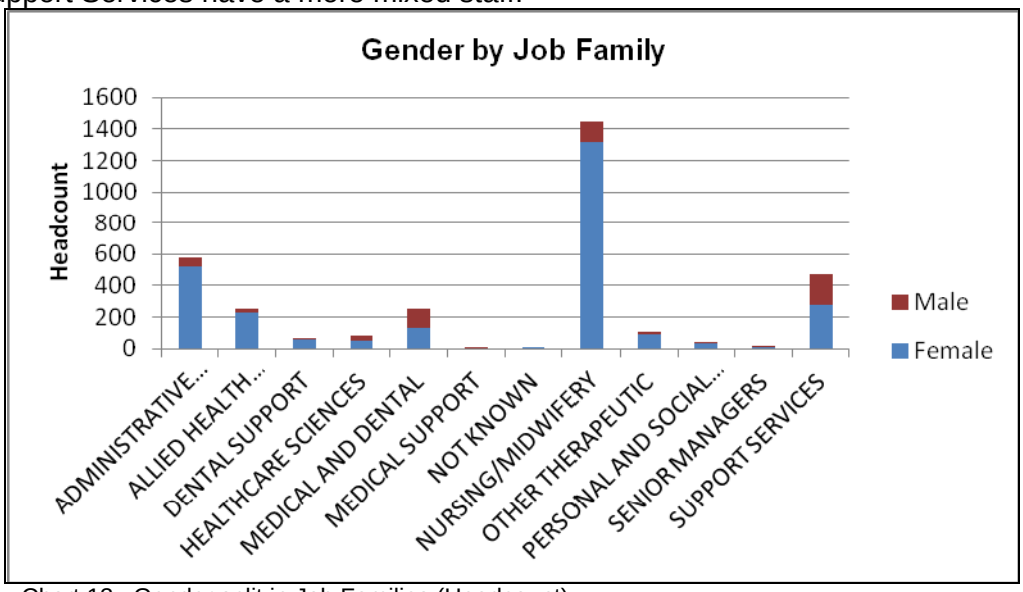
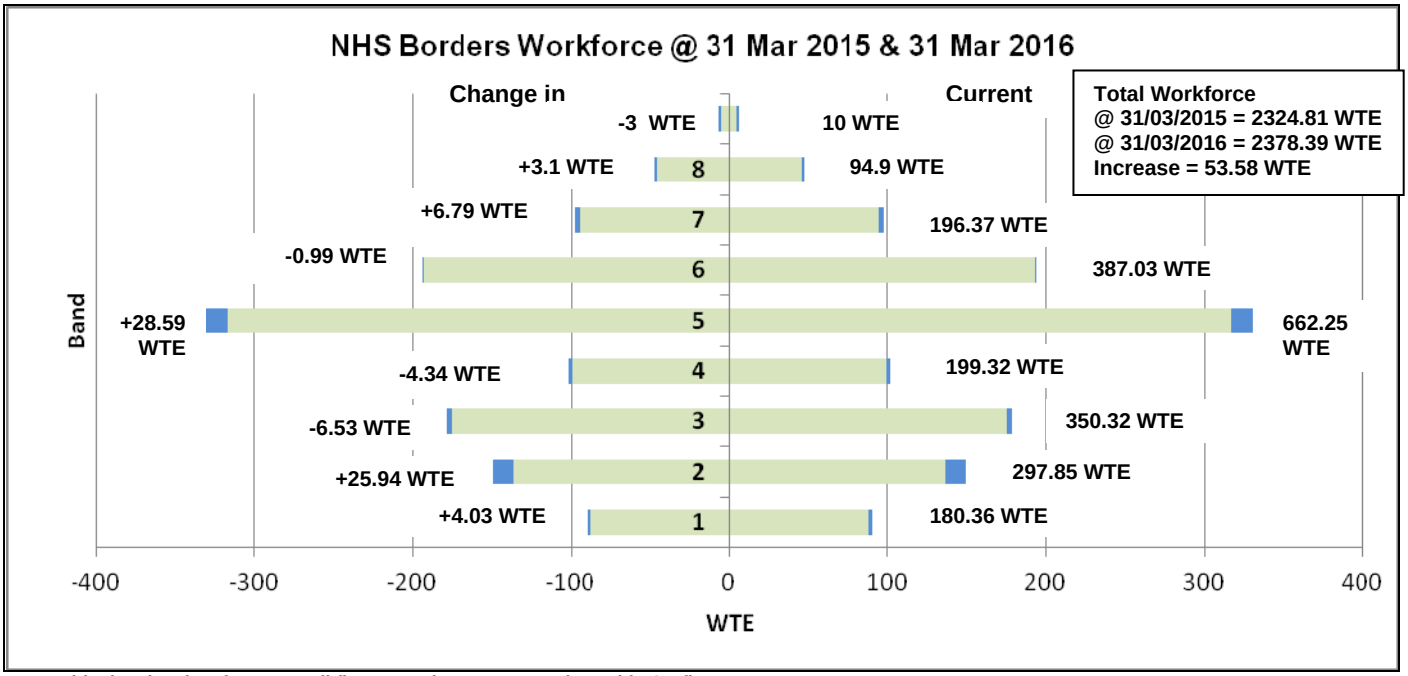


Chart 13: Gender split in Job Families (Headcount)

4.2 Skill Mix Changes

The chart below illustrates the distribution of changes to the workforce between 1 April 2015 and 31 March 2016 by Band. It shows that Band 2 has risen by 25.94 WTE and Band 5 by 28.59 WTE over the period, showing our commitment to increase our Nursing/Midwifery staff, with other minor adjustments, including a drop of 3 WTE in Senior Managers. Overall there has been an increase of 53.58 WTE.



This data is taken from Payroll figures and may not correlate with ISD figures.

Chart 14: Changes in Workforce by Band between 2015 and 2016

This table provides the detail for the chart above, showing the changes in employee numbers broken down by band at point in time on a rolling 12 month period.

	Staff Levels at 31 Mar 16 (WTE)	Staff Levels at 31 Mar 15 (WTE)	Staff Levels Change (WTE)
Band - 1	180.36	176.33	4.03
Band - 2	297.85	271.91	25.94
Band - 3	350.32	356.85	-6.53
Band - 4	199.32	203.66	-4.34
Band - 5	662.25	633.66	28.59
Band - 6	387.03	388.02	-0.99
Band - 7	196.37	189.58	6.79
Band - 8	94.9	91.8	3.1
Band - SM	10	13	-3
Total WTE	**2378.39**	**2324.81**	**53.58**

Table 3: Changes in Workforce by Band between 2015 and 2016

Changes in Employees broken down by Staff Group

The Christmas Tree analysis chart and table on the previous page illustrate the distribution of changes to the Workforce by Band. The same information is broken down by Staff Group in the table below.

	Staff Levels at 31 Mar 16 (WTE)	Staff Levels at 31 Mar 15 (WTE)	Staff Levels Change (WTE)
Admin & Clerical	464.01	457.66	6.35
Allied Health Professionals	183.77	182.17	1.6
Unallocated	3.00	1	2
Healthcare Sciences	65.96	69.62	-3.66
Medical Dental Support	45.99	45.7	0.29
Medical & Dental	229.48	225.53	3.95
Nursing & Midwifery	1,169.87	1,130.99	38.88
Other Therapeutic	86.96	77.57	9.39
Personal Social Care	22.78	21.79	0.99
Senior Managers	10.00	13	-3
Support Services	326.05	325.31	0.74
Total	**2,607.87**	**2,550.34**	**57.53**

Table 4: Changes in Workforce by Job Family between 2015 and 2016

This chart illustrates the changes detailed in the table above.

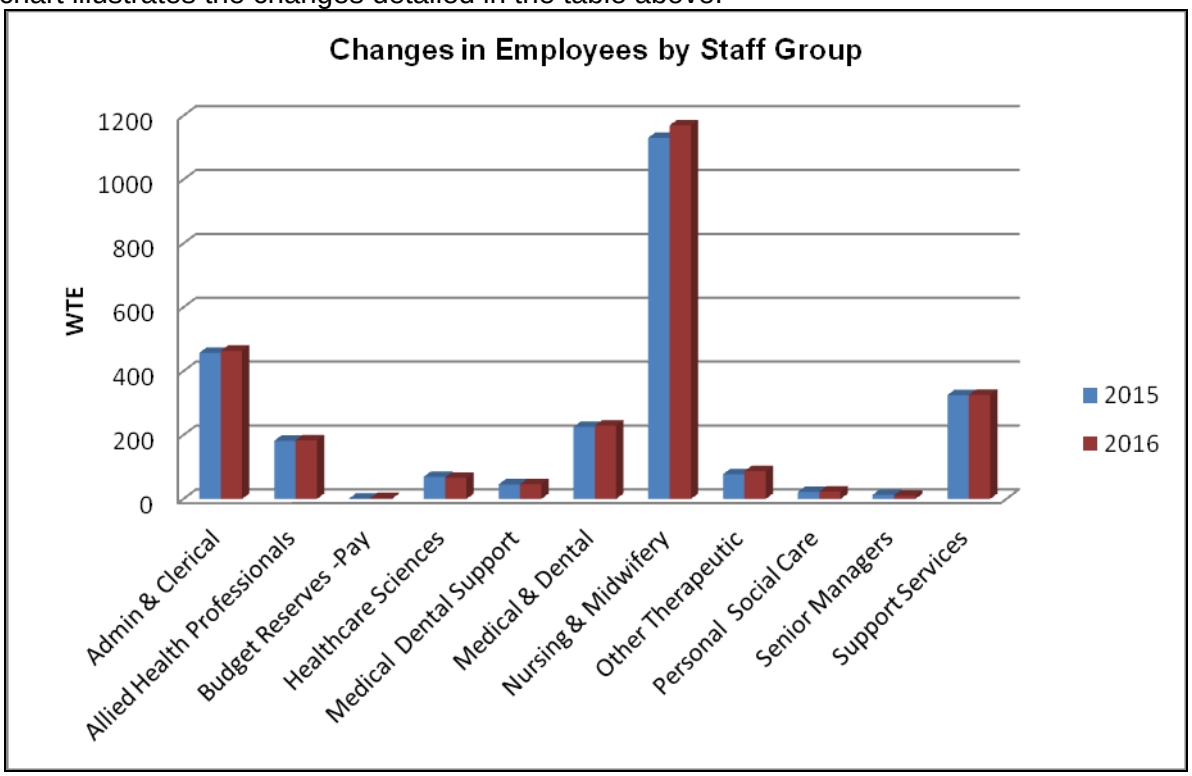


Chart 15: Changes in Workforce by Job Family between 2015 and 2016

This chart shows the percentage change in the Whole Time Equivalent in each Staff Group in the year 2015-16. It shows increases in most Staff Groups, with a reduction in Healthcare Sciences and substantial percentage reduction in Senior Managers (3 staff equating to 30% in this small group).

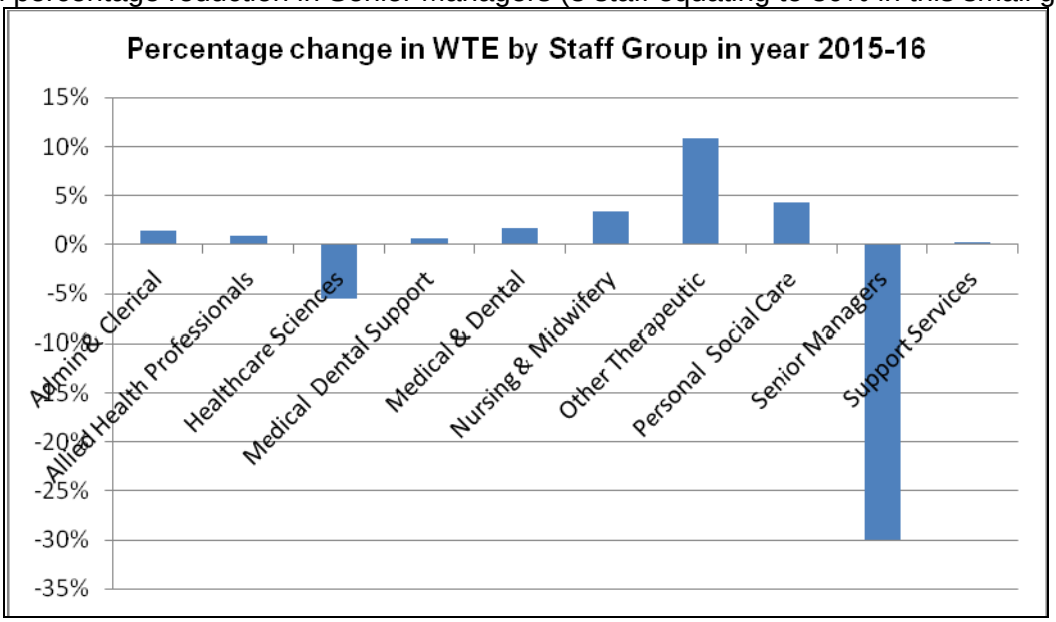


Chart 16: Percentage change in WTE by Job Family between 2015 and 2016

4.3 Recruitment Monitoring and Vacancy Rates

NHS Borders have developed a Vacancy Monitoring Process where detailed reports are provided to the Executive Team on a weekly basis to monitor the number of current vacancies going through the process and the length of time taken from interview to start date (with a target of less than 8 weeks), monitoring across all staff groups. Since monitoring commenced on 1 September 2015 the Resourcing Team have worked hard to ensure that vacancies are filled as soon as possible after the interview date. There are several common circumstances where it is not possible to complete the recruitment process in under 8 weeks. These include delays in the return of the Occupational Health Questionnaire, delays in the return of references (which are often chased up repeatedly) and issues around delays in start dates, including extended notice periods.

The chart below shows the number of vacancies which were filled, showing the length of time from Interview Date to Start Date, broken down by staff group. It shows that the vast majority of Nursing/ Midwifery and Administrative Services posts are filled in under 8 weeks.

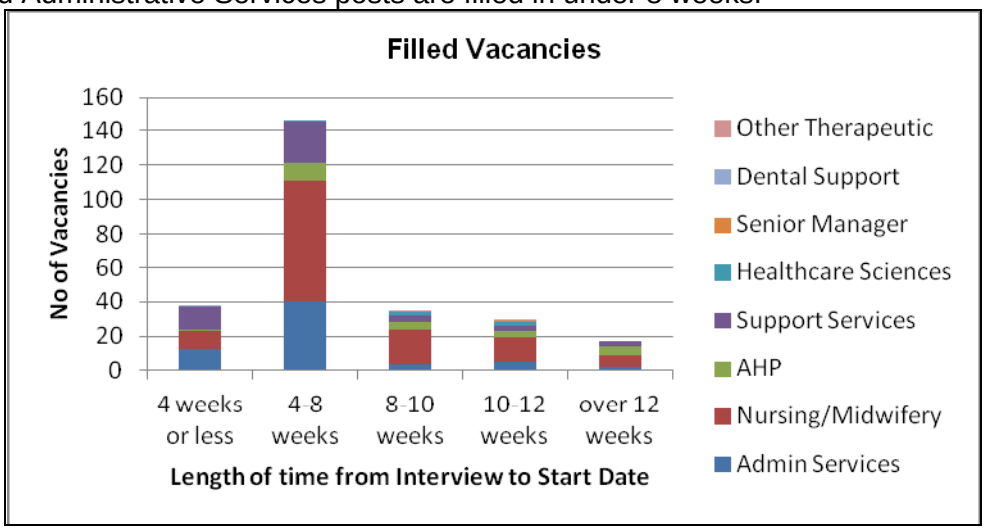


Chart 17: Number of Filled Vacancies showing length of time from Interview date to Start date

4.4 Employability

NHS Borders Employability Programmes

NHS Borders currently benefits from a varied employee base, reflecting the diversity of the local population. This diversity enables NHS Borders to balance the need for socially responsible recruitment and meet the needs of the service. Employing young people in particular represents an investment in the future of NHS Borders and contributes to the NHS Borders Corporate Objective "Improve the Health of our Population". The Scottish Government made a commitment to young people through 'Opportunities for All' guaranteeing all young people between 16-19 years a place in study, work or training. NHSB are actively supporting this guarantee as follows:-

Sector Based Work Academy

T&PD have developed a successful Sector Based Work Academy in collaboration with Borders College, Skills Development Scotland and Job Centre Plus. T&PD have jointly developed and delivered several successful pre-employment programmes for Care and Support services.

The following programmes are available within the Sector Based Work Academy:

Catering for Life – Is the successful 10 week programme which helps unemployed people in the Borders with mild and moderate health conditions and disabilities to progress towards securing and sustaining employment. The programme focuses on the removal of actual and perceived barriers by enhancing the trainee's employability skills and building self-confidence by the provision of a range of short courses with transferable work and life skills. Work placements take place within NHS Borders and in Community projects.

Borders College deliver accredited qualifications such as Elementary Food Hygiene certificate, Basic Health and Safety, First-Aid, Computer and online basics. A further cohort is being planned for October 2016.

Train to Gain (Administration) /Train to Care (Nursing) - The 6 week administration and nursing programmes include NHS Borders placement and NHS Borders Statutory and Mandatory training such as Corporate Induction, Prevention and Management of Aggression and Violence and Moving

and Handling plus training organised by Borders College. The participants are job ready on successful completion of the programme and receive a guaranteed interview for the Nurse or Admin Bank respectively.

10 students have been selected to commence the administration programme in July 2016 with a further cohort planned for September 2016. Successes from the administration programme include 2 former student securing permanent administrative posts within NHS Borders.

The following employability programmes are also available:

T&PD continue to work collaboratively with Partners to offer opportunities to disabled people, offer Modern Apprenticeships and are offering Certificate of Work Readiness placements, all of which contribute directly to the local Workforce Plan and Everyone Matters 2020 workforce vision implementation plan.

Modern Apprenticeships (MAs) provide an increasingly important element in the workforce development landscape in NHSScotland.

The range of Modern Apprenticeship Frameworks now available in Scotland means that they are suitable for supporting the learning of new recruits in a wide range of service areas. From pharmacy technicians to electricians, from dental nurses to administrative assistants, and from laboratory technicians to designers - these are just a few of the roles which NHS Modern Apprentices are learning to fill. They all have one thing in common - they are setting out on a new career supported by a major national training programme. The question “Is this post suitable for MAs” has been introduced into the vacancy authorisation process, with preference being given to formerly looked after children and those from deprived areas. NHS Borders is committed to supporting and promoting this and currently have 3 Modern Apprentices, 2 in Business Administration and 1 in Care.

Looked After Children - A joint Looked After Children Modern Apprentice (MA) programme in partnership with SBC Employment service has been recruited to with 4 students. In addition to contributing to socially responsible recruitment, this helps to address the NHSB Corporate Parenting responsibilities. All students have been placed with 2 students in NHSB and 2 in SBC. The students received their induction on 19th April 2016 and prior to starting MA in October the students receive stage 2 & stage 3 training programmes, which the SBC Employment service are delivering. This will prepare and test the student’s commitment prior to the MA starting in October.

Project SEARCH – is a unique, employment focused education programme for 16 – 24 year old students with a learning disability which takes place entirely at the workplace. The 39 week programme consists of a seamless combination of classroom instruction, career exploration, and relevant job-skills training through strategically designed internships. NHS Borders as host employer is working in partnership with Scottish Borders Council Employment Service, Learning Disability Service and Borders College. 8 students have been selected to commence the programme in August 2016.

Professional Careers Programme – In January 2015, NHSS Chief Executives supported the establishment of the Glasgow Centre for Inclusive Living (GCIL) Equality Academy’s Professional Careers Programme within all NHS Boards. The overall aim of the programme is for NHSS to provide a 2 year employment opportunity for disabled graduates by providing them with a challenging and rewarding experience of employment, thus helping to set them up for a long-term sustainable career. We have 1 graduate in post, within the Workforce & Planning Directorate.

4.5 Full-time and Part-time Split

The chart below shows the split between full time and part time for each Job Family. It shows that Medical Support staff and Senior Managers are 100% full time staff, while the highest level of part time staff is in Personal & Social Care. Whilst over 60% of Nursing & Midwifery staff are shown as part-time, a proportion of these are working 34.5 hours which best suits current rosters.

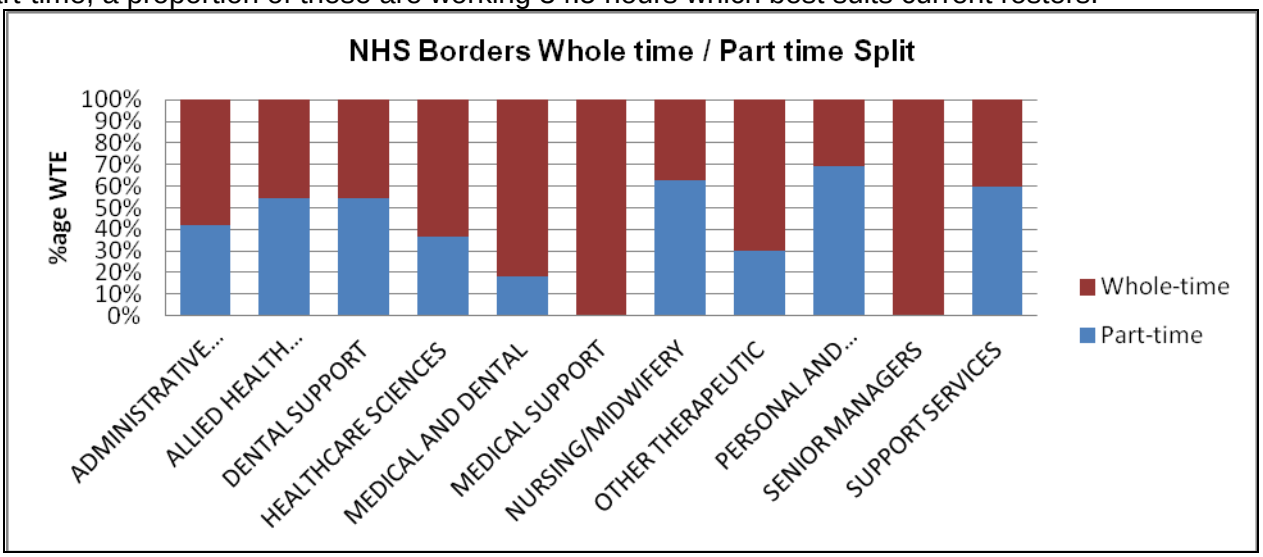


Chart 18: Whole time / Part Time split by Job Family - %age WTE

The chart below shows the average whole time equivalent for staff, comparing 2015 and 2016. It shows that overall the average WTE is just under 0.8 and has risen ever so slightly since 2015, meaning we have a higher proportion of full time staff than last year.

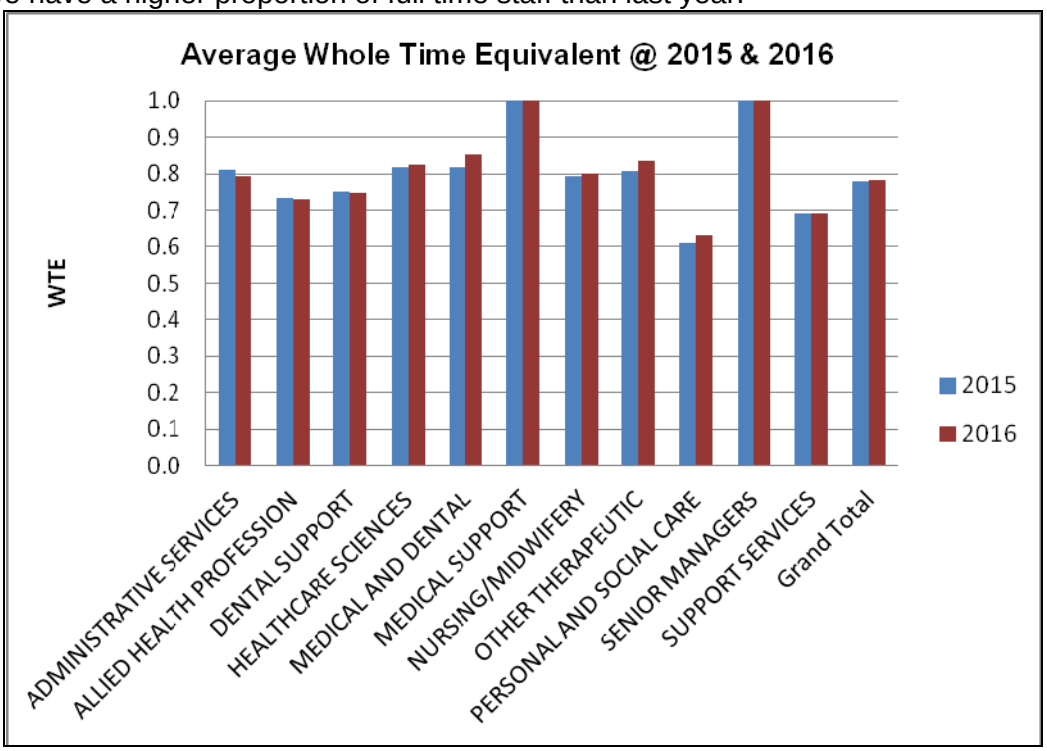


Chart 19: Average Whole Time Equivalent @ 2015 and 2016

These charts show the gender split for all full time staff by Job Family. They show that of the male staff in Nursing/Midwifery, the majority are full-time, whilst approximately 60% of the female Nursing/Midwifery staff are part-time. They also show that in Support Services, the majority of males are full-time. They also show that overall staff are predominantly female, with a high proportion being part-time. Part-time workers offer significant flexibility to the workforce, however can account for a higher proportion of training time being required.

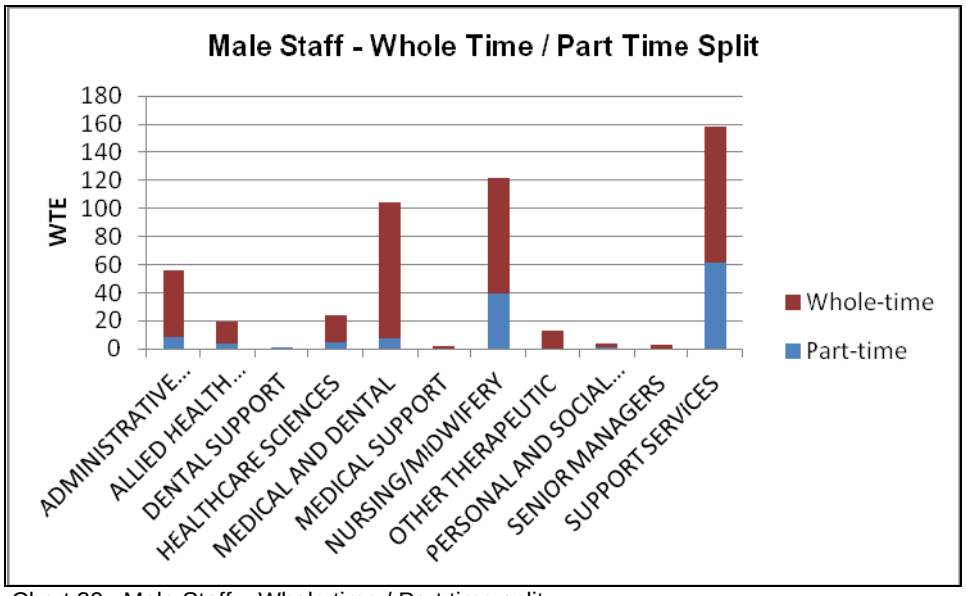


Chart 20: Male Staff – Whole time / Part time split

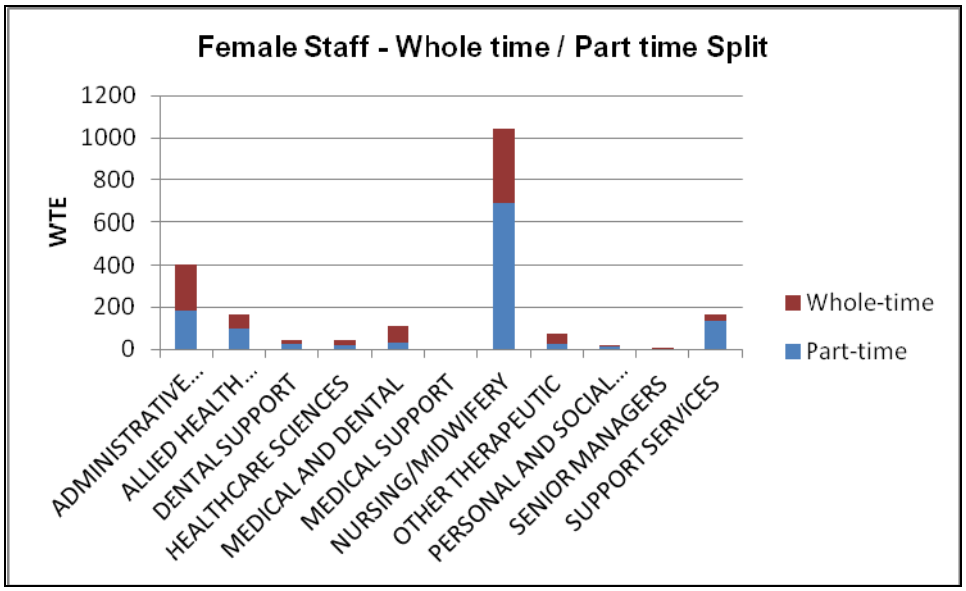


Chart 21: Female Staff – Whole time / Part time split

4.6 Permanent and Fixed Term Contracts (FTC)

This section highlights the proportion of staff who are on Fixed Term Contracts (FTC). Overall, during the period 1 April 2015 to 31 March 2016 Fixed Term Contracts have gone down from 203 to 162 (137.56 to 117.74 Whole Time Equivalent). During Workforce Reviews, it was necessary for vacancies to be filled on a Fixed Term basis to allow flexibility for reorganisation where necessary. The current reduction in FTCs has resulted in a greater sense of job security for the staff involved and a more settled workforce. The charts below illustrate the way in which the contracts are split.

This chart shows the percentage of each staff group in Permanent and Fixed Term Contracts at 31 March 2016. Unsurprisingly the highest percentage of FTCs is in Medical & Dental, being mostly the doctors in training. After that Other Therapeutic and Personal & Social Care have between 20% and 25% FTCs.

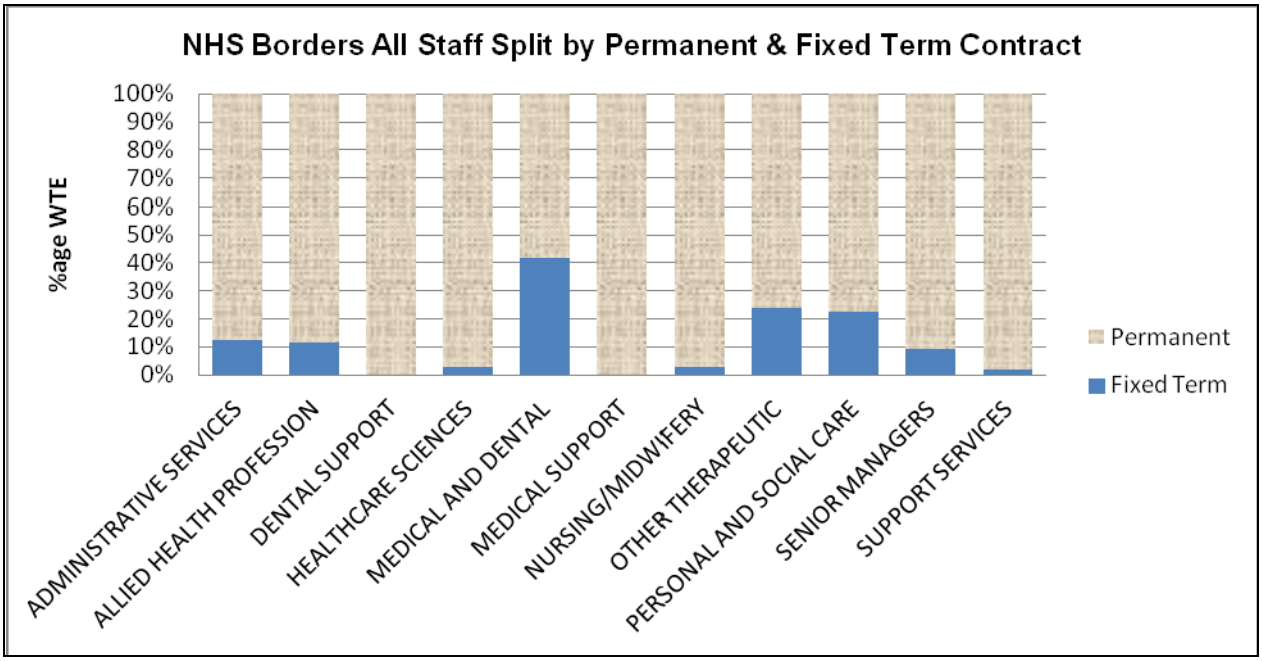


Chart 22: Permanent and Fixed Term Contracts by Job Family - %age WTE

4.7 Sickness Absence

In 2015/16 NHS Borders had a cumulative (April 2015 – March 2016) SA rate of 4.36%. This is a 0.35 % decrease in SA rate from March 2015 rate of 4.71%.

The month on month SA rate for NHS Borders is illustrated in the chart below

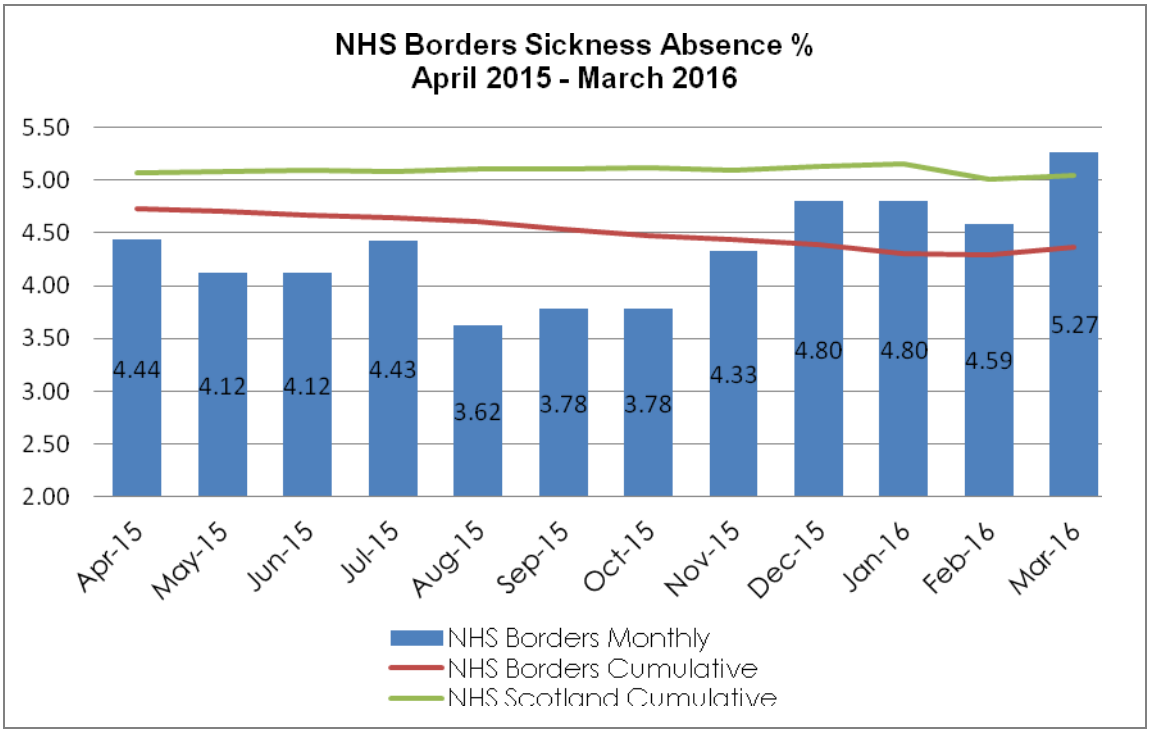


Chart 23: SWISS SA Month on Month and Cumulative Rate April 2015 – March 2016

This chart also demonstrates the cumulative rate for NHS Borders and the cumulative rate for NHS Scotland. This would indicate that:

- NHS Borders cumulative rate is 4.36%
- NHS Scotland's cumulative rate is 5.16%

In comparison with NHS Scotland's cumulative figure, NHS Borders remain 0.8% below the national average. NHS Borders reports the lowest year end figure of the territorial boards which is 0.35% lower than last year.

As the workforce ages, the rate of sickness absence per employee increases, although episodes of absence decrease, suggesting a higher proportion of long term sickness. This will have an impact on the sickness absence rates across Nursing and Midwifery. The chart below shows sickness absence for all Nursing and Midwifery staff has consistently been significantly above the 4% trajectory across all Clinical Boards. A research project is underway to identify the impact on wellbeing of older workers and how we can support staff to remain active in the workplace.

The month on month SA rate for NHS Borders Nursing /Midwifery in the past year is illustrated in the chart below. Further analysis of this has shown significantly higher Sickness Absence rate for Healthcare Support Workers (8.1%) compared to Registered Nurses and Midwives (5.4%).

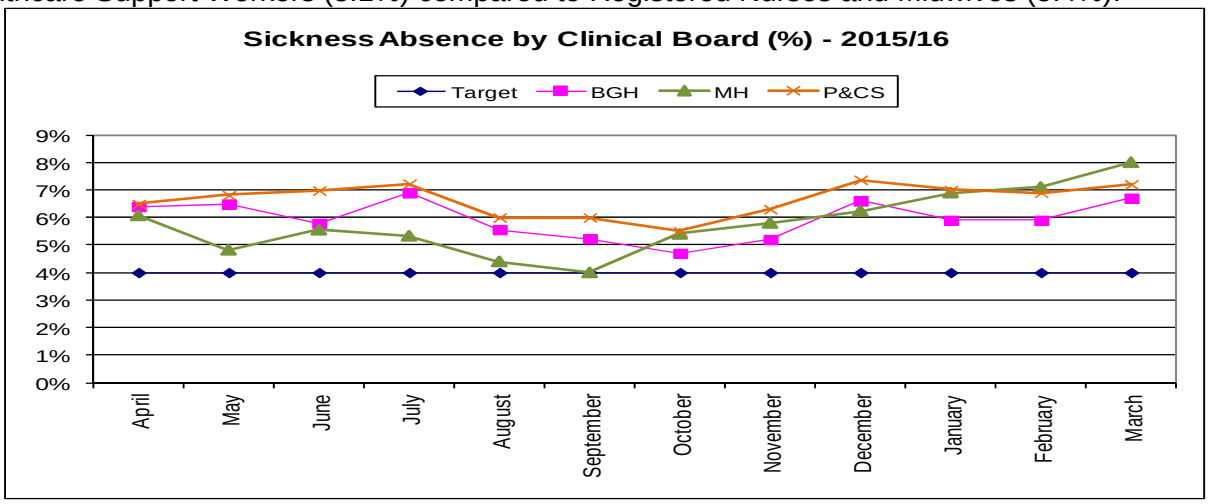


Chart 24: Sickness Absence by Clinical Board for year 2015/16 (Please note LD staff are included in MH figures)

The following chart illustrates that there is an above average SA rate in Medical & Dental Support, Registered Nurses & Midwives and Unregistered Nurses and Personal & Social Care. The latter group rate looks high, but this is a small staff group consisting of approximately 28 people. This data would suggest that there is more work to be done in terms of understanding the relatively high rate of SA in Unregistered Nursing staff.

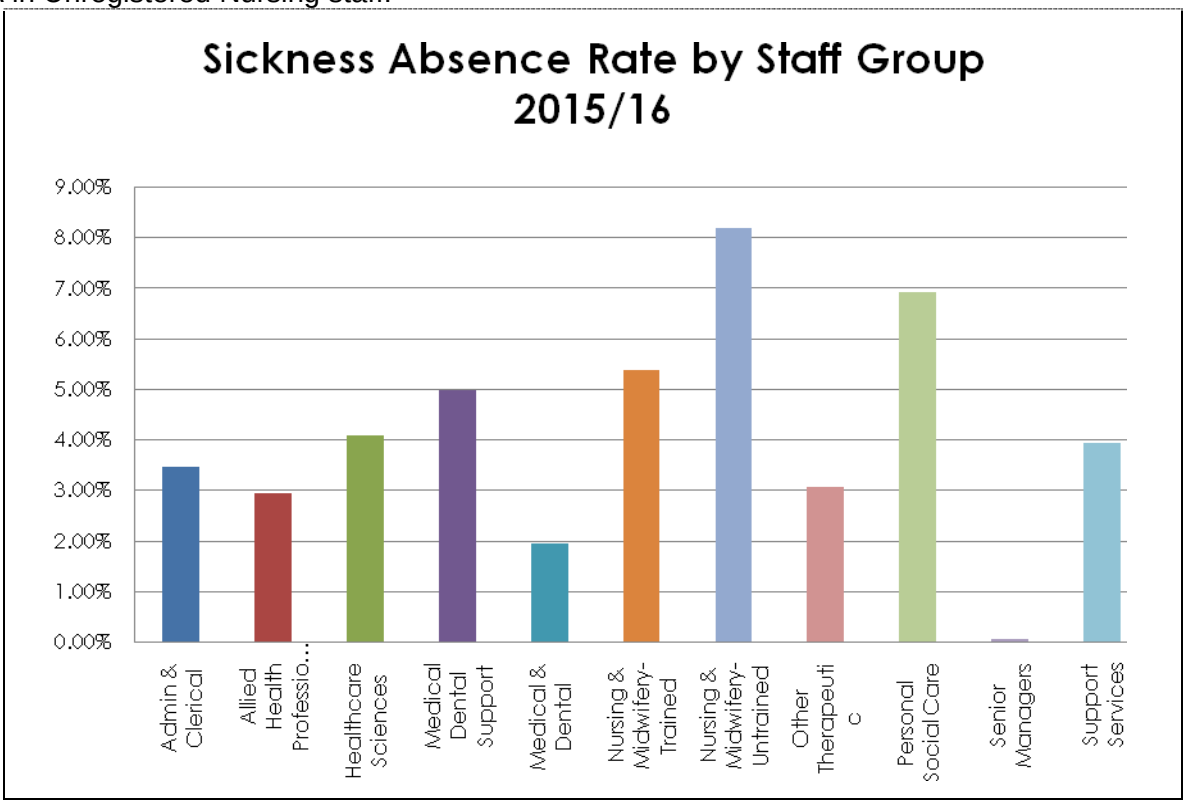


Chart 25: Percentage Absence Rate for each Staff Group 2015 / 2016

Reasons for Sickness Absence

The chart below demonstrates the overall SA reason picture. The main issues, where we know the reason, remain musculo-skeletal problems (23%) and mental well being issues (25%). In terms of musculo-skeletal health the staff physiotherapy service has a key role to play in assisting staff back to work as early as possible. The Mental Well-being at Work Group continues to maintain and support delivery on an action plan for addressing issues in a pro-active way along with providing self help and resilience training and staff support via the Counselling Service.

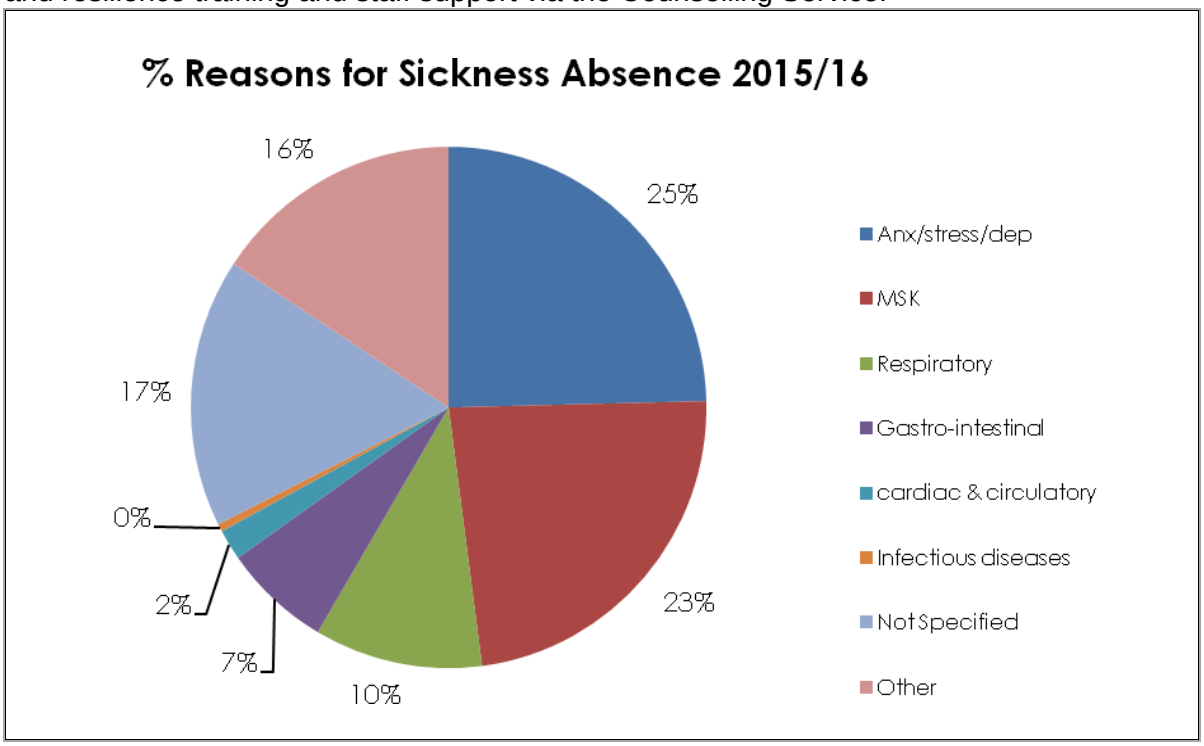


Chart 26: Reasons by Sickness Absence 2015/16

The % of staff with musculoskeletal problems (including injury, fracture and back problems) also increases significantly as staff age and this is particularly evident for Nursing and Midwifery staff as illustrated in the chart below, which shows that 25.61% of absence for staff under 55 is due to musculoskeletal issues, rising to 34% for staff over 55. An analysis of the reasons for absence correlated to age will form part of the research project outlined above.

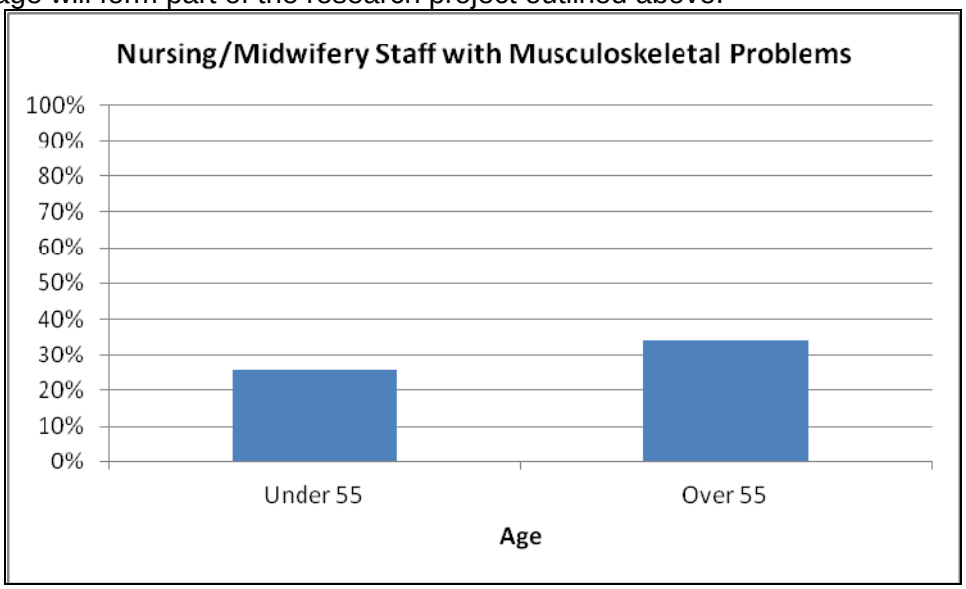
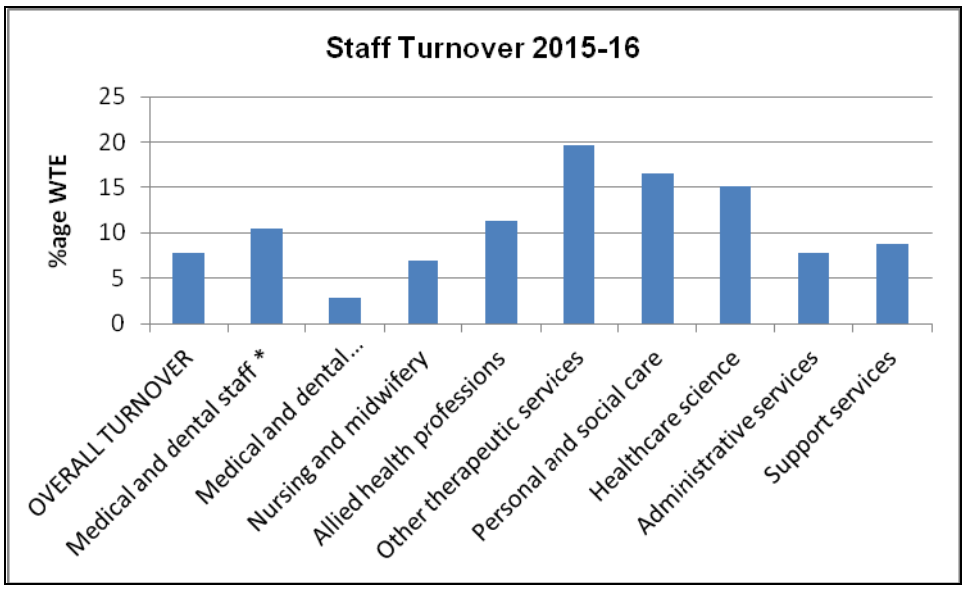


Chart 27: %age of Nursing/Midwifery staff absent with musculoskeletal problems by age

4.8 Staff Turnover

This chart illustrates that the turnover rate for NHS Borders for the year of 2015-2016 was 7.8%, which is unchanged from 2014-15, and higher than NHS Scotland at 6.5%. The higher levels of turnover shown are within smaller staff groups so even small changes lead to high percentage changes. Although an ageing workforce is evident in Nursing and Midwifery, the turnover rate is only 7%, which is slightly up from 6.8% last year, and similar to the rate for NHS Scotland which is 6.9%. This indicates a stable Nursing and Midwifery workforce although a sufficient level of turnover to support succession planning.



*Excludes training grades. This is to avoid the distortion caused by the frequent rotation of staff in training placements.

Chart 28: Staff Turnover during year 2015/2016

The Age Profile of leavers and their reasons for leaving have been illustrated in the charts following, showing a high proportion of leavers over the age of 55 and often due to retirement. There is also a high proportion of staff who move to other roles within NHS Scotland, including promotion, etc.

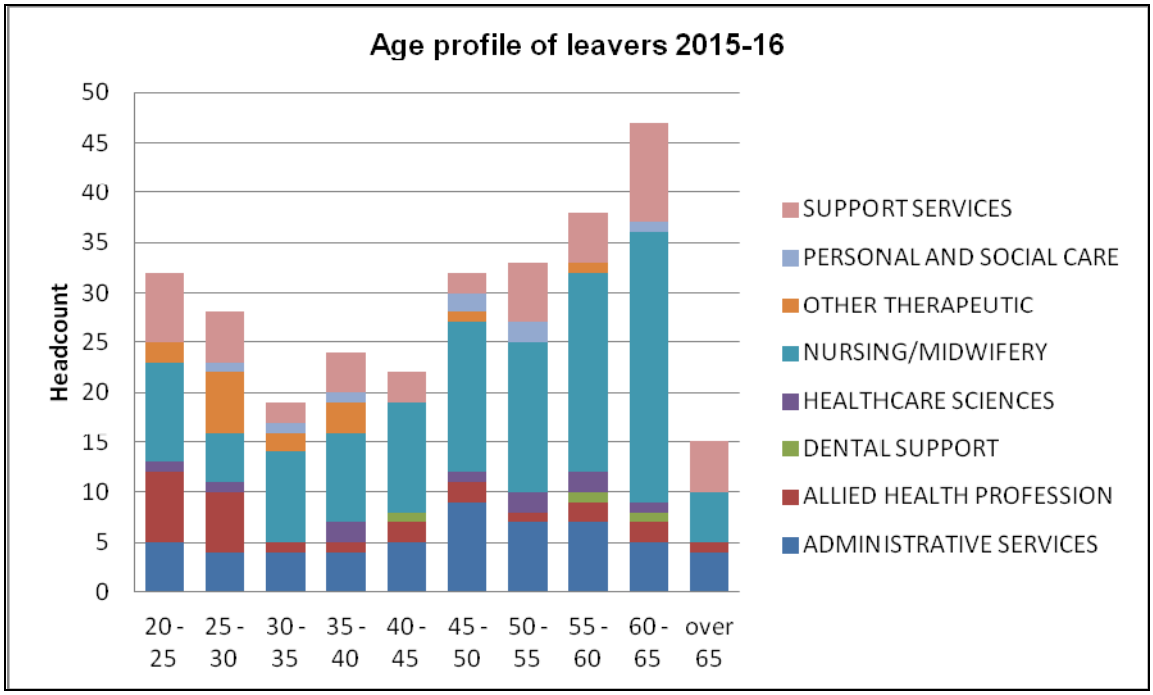


Chart 29: Age profile of leavers in year 2015/16

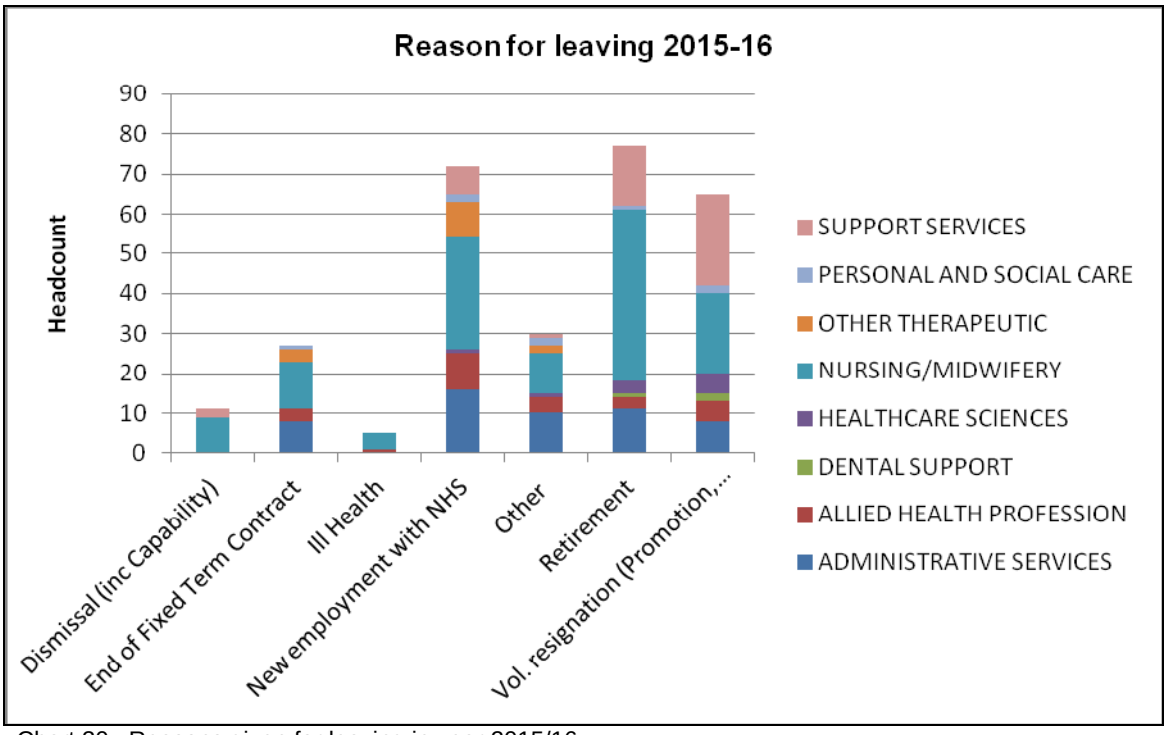


Chart 30: Reasons given for leaving in year 2015/16

This table shows how many staff in each Job Family have retired at each age since 2005. Of the over 65s, 44 were 66+. The numbers of people retiring at 66 years old and up has not substantially altered over the last 10 years.

	under 55	55	56	57	58	59	60	61	62	63	64	65 & over	Grand Total
Admin Services	2	3	3	9	2	24	29	17	11	10	12	26	148
AHP	1	2	4	6	1	12	10	2	2		3	4	47
Dental Support					1		1	1					3
Healthcare Sciences	2	2	1	1	2	4	7	2	1	1	2	3	28
Medical & Dental	12	5	3	5	11	25	37	13	4	3	2	8	128
Nursing/Midwifery	26	59	21	20	15	86	82	36	35	18	38	37	473
Other Therapeutic	2				1	3	2	2	1	1		1	13
Personal & Social Care							1	1		1	1	5	9
Senior Managers	2	2			1	1	1	1				1	9
Support Services	3	2	3	3	3	21	20	13	12	8	35	37	160
Grand Total	**50**	**75**	**35**	**44**	**37**	**176**	**190**	**88**	**66**	**42**	**93**	**122**	**1018**

Table 5: Retirements since 2005 by Job Family, showing the age at which staff have retired

This Chart illustrates the table above. It shows retirement peaks at 59 and 60, and again, although less so, at 65.

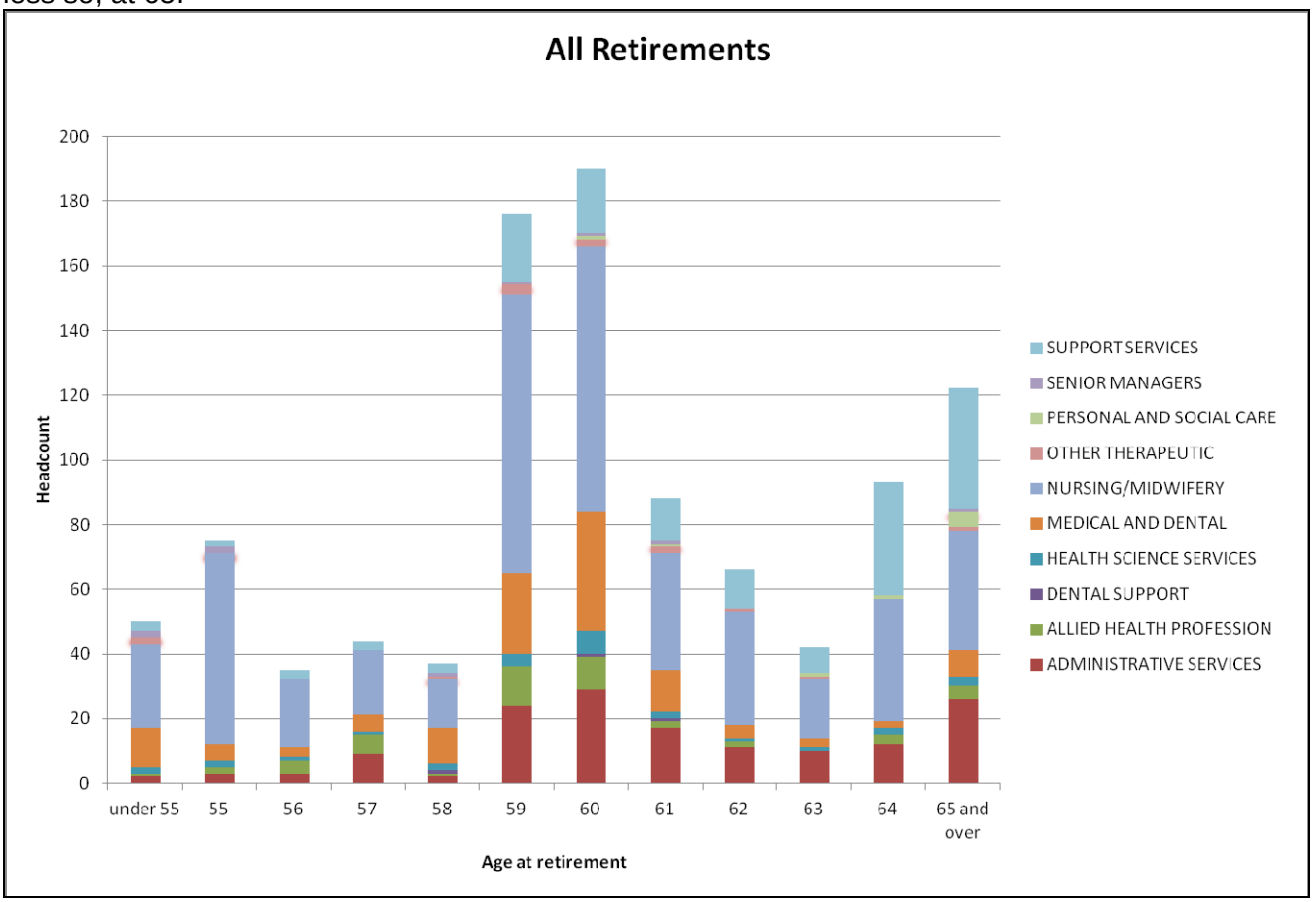


Chart 31: Age at Retirement by Job Family (all retirements since 2005)

This chart shows the ages at which Nursing/Midwifery staff have retired since 2005, split between Registered and Non-registered staff. It shows that most have retired at 60 years old, with other peaks at 55 and 65. Registered Nurses most commonly retire at 60 or 55 and unregistered nurses most commonly retire at 60 or 65.

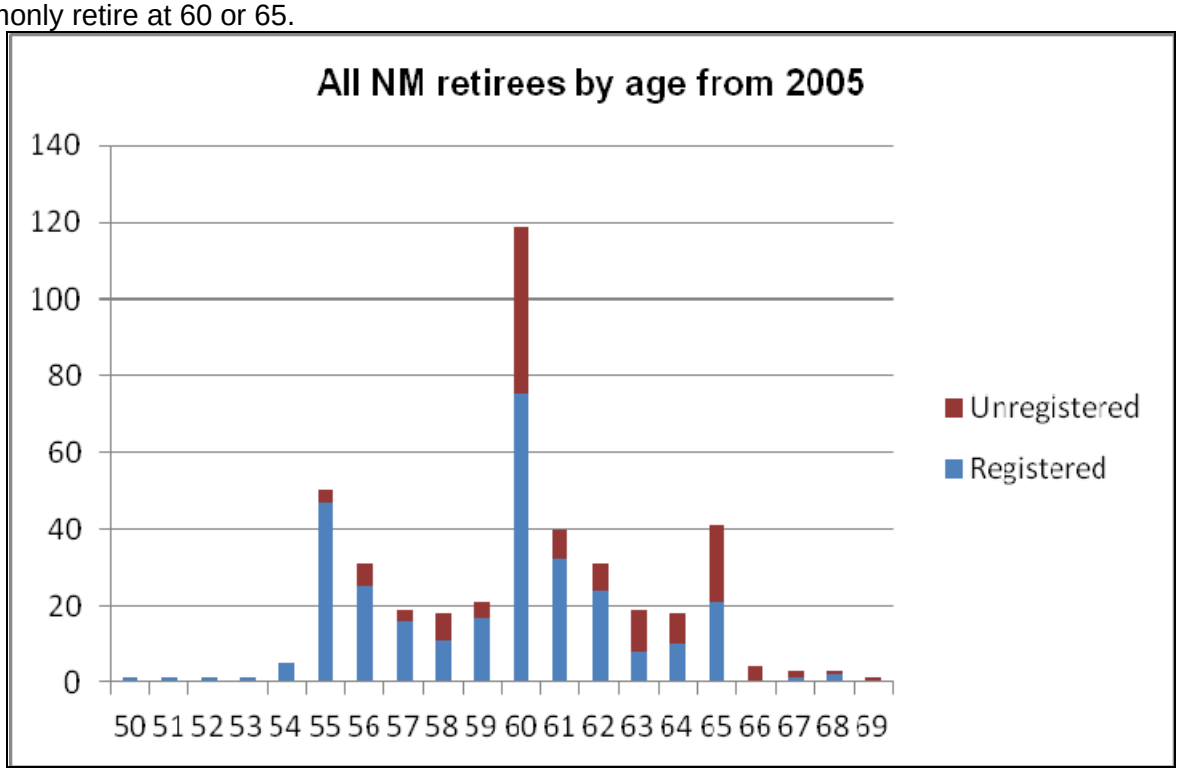


Chart 32: Nursing Midwifery Retirements by Age, split between registered and unregistered staff

The following chart shows the times of year at which most Nursing and Midwifery Retirements have taken place. It shows that these peak in the Spring and at Christmas. However, further analysis of the statistics shows that approximately 56% of Nursing/Midwifery retirements take place on or around a birthday.

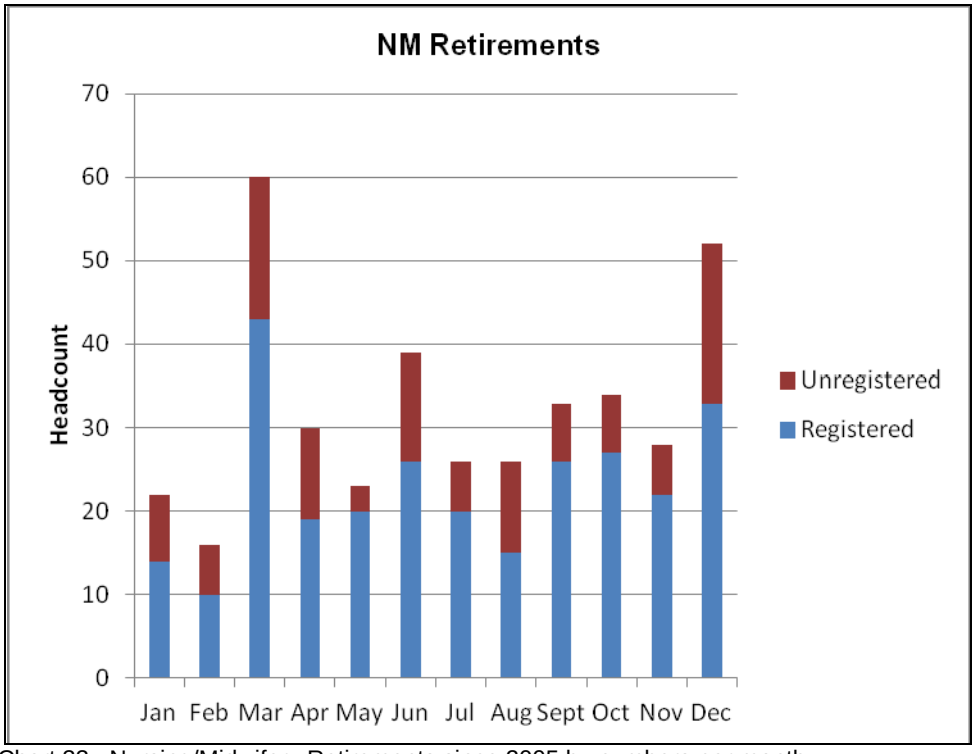


Chart 33: Nursing/Midwifery Retirements since 2005 by numbers per month

This chart shows the months in which Nursing/Midwifery staff have left over the period since 2005. It shows much less pronounced peaks, compared to the retirement chart. The March and September peaks may be inflated by Fixed Term Contract end dates.

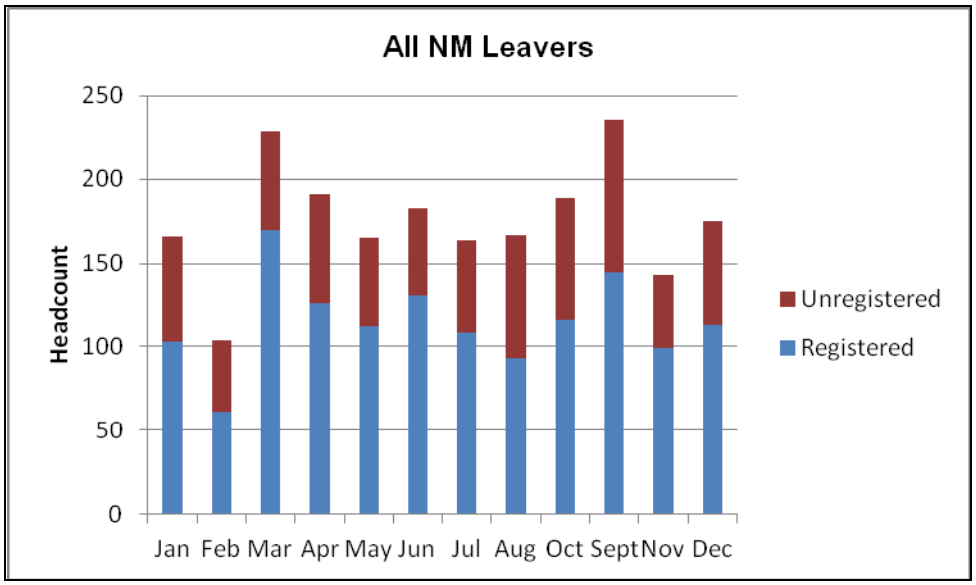


Chart 34: All Nursing/Midwifery leavers, by month in which they left, split registered and unregistered

Step 5 – Action Plan

Workforce Planning feeds into many Action Plans across NHS Borders, and we are currently drafting a specific Action Plan which will be added to the final version of this Workforce Plan. The Action Plan will be developed as part of the Consultation, taking account of feedback from our staff and cross referenced to current organisational Action Plans.

	Action	Leads	Timescale	Evidenced by	Outcome Measure
1	Establish a Recruitment & Retention Strategy for NHS Borders to ensure continuity of service and reduced long term vacancies. Initially focus on target groups where we are experiencing difficulties recruiting including: • Consultants, Salaried GPs and other medical and dental posts, featuring values based recruitment and with emphasis on trainee (training grade doctor) engagement. • Registered Nursing and Midwifery Staff	Medical Director, Nursing & Midwifery, HR and Finance Leads.	Medium to Long Term	• Lower number of concurrent vacancies • Success in recruitment to high priority specialties • Viable workforce and succession plan for key Medical & Dental and Nursing & Midwifery posts	• Sustainable Workforce – maintained patient safety • Reduction in supplementary spend • NHS Borders follows effective procedures when recruiting staff and carries out appropriate qualifications, skills and training, references and background checks. • NHS Borders is confident that staff delivering care are suitably trained and use their learning to ensure care is safe, effective and person-centred
2	Support staff to work longer, utilising Retirement Policy and changing cultural attitudes, to make flexible working part of normal career development. Establish a Returning Process to assist with this	WD&P/ Occupational Health	Medium to Long Term	• Higher proportion of staff who choose to stay at work longer or return after retirement leading to increased numbers of experienced staff	• Stable, happy workforce leading to better patient care
3	Monitor Turnover rates/trends to inform projections of future recruitment requirements and succession planning	WD&P/Finance Leads	Medium Term	• Up to date trajectory matching projections with actual leavers/starters	• Reliable data to inform succession planning
4	Promote NHS Borders as an organisation that supports Return to Practice across relevant staff groups e.g. Nursing & Midwifery, AHP Services etc.	Nursing & Midwifery	Short Term	• Improved response rates to Recruitment Adverts Reputation as a Board who supports staff to return to practice	• Higher Proportion of Vacancies filled by experienced registered nurses/ AHPs (on successful completion of RTP) leading to high quality of patient care.

5	Support the planning, roll out and feedback of Nursing and Midwifery Workload Tools, and communicate outcomes to relevant groups within agreed timescales	Nursing & Midwifery/ WD&P	Medium Term	• Up to date information on outcomes of Workload Tools	• Assurance around workforce numbers ensuring safe patient services • Reduction in supplementary spend due to up to date funded establishments.
6	Ensure the wider organisation is aware of the corporate values and monitor the feedback of recruits who have been recruited via a values-based process	Workforce Leads/Line Managers	Long Term	• No of Staff Trained and familiar with Behavioural Framework • IMatter employee engagement scores	• NHS Borders has effective leadership and governance and promotes an organisational culture committed to continuous improvement and shared learning.
7	Monitor uptake and impact of iMatter	BET	Long Term	• iMatter response rates • Employee Engagement scores • Percentage of action plans completed	• Staff experiences and feedback are used to inform and shape improvements in the delivery of care. • Engaged workforce • Reduced turnover
8	Progress Joint Workforce Planning Actions once signed off by IJB and work towards Joint Workforce Planning where appropriate	NHS Borders and SBC WD&P Leads	Medium to Long Term	• Improved understanding of Workforce Issues across organisational boundaries	• Shared Workforce Information and Methodologies
9	Ensure workforce issues and risks identified in the Workforce Plan are recorded on the Risk Register and monitored appropriately	WD&P / Identified Leads	Short Term	• Clear understanding and monitoring of key Workforce issues and risks	• Reduction/mitigation of identified workforce risks and potential negative impact on patient care

Step 6 – Implementation and Review

This Workforce Plan will be implemented and actions reviewed on a regular basis throughout 2016-2019.

Appendix 1

Irish Medical Careers Fair, Dublin, 20 - 21 October 2015

BACKGROUND

The event was supported by the Irish Medical Times, promised a large number of delegates, and as well as supporting recruitment stands offered a number of talks on various aspects of career planning.

The hopes were that attendance at this event would give NHS Borders the opportunity to make delegates aware of the organisation, of potential medical career grade and GP vacancies and expected vacancies (particularly anaesthetics, ophthalmology, emergency medicine, respiratory medicine and GP out of hours), and to demonstrate the many attractive features of living in the Borders.

PLANNING

The group felt that our unique selling points include:

- An organisation that is sufficiently small to allow easy access to other staff groups for example senior management, and this minimises barriers to innovations in care and practice
- A hospital which, whilst small, performs to a high level eg the only Scottish hospital in the CHKS top 40, many publications and innovations eg enhanced recovery programme, critical care outreach
- Strong links with Edinburgh university with teaching and research opportunities
- An area of outstanding natural beauty with many opportunities for outdoor pursuits
- Lower property prices compared with many parts of Scotland and the rest of the UK

Material that was generated for the stand included:

- Information/brochures about properties currently for sale in the Borders provided by a number of local estate agents
- Videos of a number of consultant and 1 GP members of staff. Their talks highlight the positives of working for NHS Borders as well as the many advantages of the Borders as a place to live
- Business cards with a QR code for the videos which are on the HR microsite for NHS Borders allowing delegates to access these after the event
- A large pull up banner featuring quotes from the video material (this can be reused)
- An NHS Borders table runner (also reusable)
- Posters from various departments which have been presented at national meetings which highlight some of the innovations in care from within the organisation
- Postcards featuring photographs of scenes from the Borders
- A video of photographs of scenery and outdoor pursuits within the area which could alternate with the videos of staff members
- Post-it notes and pens with the details of the HR department

THE EVENT

The fair was run across 2 days in a hotel approximately 2 miles from central Dublin. Organisations represented included a number of Irish hospitals and medical schools, the Irish military, locum and recruitment agencies for posts both in Canada and Australia and 4 Scottish health boards (Borders, Fife, Grampian and Lothian).

For our stand a TV was hired to allow the videos to run on a continuous loop. The stand is shown below

Any visits from delegates tended to be during coffee and lunch breaks. Where any interest in working for NHS Borders was expressed, the details of the delegate were taken.

POSITIVES FROM THE EVENT

- The stand looked very good compared with those of stands of similar sizes
- The pull up banner was very eye-catching, it was this that often drew delegates to the stand. This can be reused for other events. The estate agent brochures did draw significant interest
- Overseas doctors (including those from Ireland) were frequently unaware of differences between the NHS in Scotland and elsewhere in the UK
- Much of the material generated is attractive and reusable. The videos are now on the recruitment website and can be expanded or added to as necessary

- It became clear through speaking to delegates that NHS Borders is not known about as a health board even by clinicians practising in Scotland. Attendance at an event such as this does serve to raise the profile of the organisation which may pay dividends in the future, even if attendance at this particular event may not result in any appointments
- There has been at least 1 contact to the HR department by a doctor interested in working here at registrar level

LEARNING POINTS FROM THE EVENT

- The numbers of delegates that were expected at the event did not appear to materialise. There were large numbers of unclaimed badges (the event was free of charge), and those who did come did not appear to stay for long periods of time
- The event was primarily aimed at doctors in the early stages of their careers or those looking for locum work, rather than seniors looking for substantive career grade posts
- Stand position is important, this stand was on the back row and saw little “passing traffic”
- The multimedia set-up drew a lot of interest, and the interviews with subtitled highlights were particularly eye catching. However each interview was too long (5-8 min) and delegates tended to watch a fraction on one interview and then drift away. These videos, when used for this purpose, should be shortened to <30s.
- A couple of more pull up banners or posters would have highlighted our unique selling points – 1 with a montage of local scenes and 1 highlighting the hospital (bed numbers, teaching and research opportunities etc – see below for another stand that had just that).
- Delegates were generally unaware that NHS Borders is a Health Board within a geographical area. Some delegates had interpreted ‘Borders’ as political: e.g. related to customs, or overseas aid. A map of the UK with the Scottish Borders highlighted would be useful – even for recruitment events held in Scotland/UK

SUGGESTIONS FOR FUTURE EVENTS

- Maintaining a presence at recruitment events is vital to develop and maintain the profile of the health board within the job market
- A recruitment fair for senior staff and substantive GP appointments would be more appropriate for the recruitment requirements for NHS Borders than a careers fair aimed at more junior grades. Unfortunately we had just missed a BMJ recruitment fair in London which attracted 1900 delegates the previous year, and we should target this in 2016.
- An NHS Scotland event might be an opportunity for wider recruitment whilst still allowing individual boards to highlight their own unique selling points and vacancies. This would also reduce the competition with overseas recruiters and locum agencies. It might be an opportunity to offer talks about how to manage the transition if moving from overseas or other parts of the UK
- It would be worth investing in some additional visual material similar to the banner in the above photograph

RESPONSES
The names and contact details were recorded for four doctors attending the event – three of whom have not pursued their interest.

One overseas doctor, working in Ireland at the time, has subsequently undertaken a 2 week clinical observership in cardiology / GIM at NHS Borders in January 2016. At the conclusion of the observership the doctor was interviewed with a view to a locum registrar role in general medicine / cardiology. The doctor has accepted the offer.

We had been seeking locum SHOs to provide supplementary medical cover for some of the winter plan extra capacity e.g. Ward 8 / Surge Ward / Boarders / AAU / Extra MAU cover. The doctor supported capacity at an appropriate level at a significant lesser cost than agency locum – the differential for the 3 months would equate to £16,000.

Appendix 2

Extract from Health & Social Care Integration Commissioning & Implementation Plan - Objectives for Year 1

Local Objective 1
We will make services more accessible and develop our communities

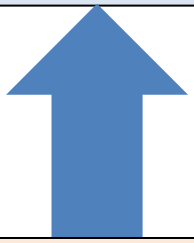
Strong communities are a real asset of the Borders. Community capacity building makes a big improvement to the health and independence of people.

How delivery of our services will help us to meet this Objective

- **Review Primary Care Premises Modernisation programme to review and increase capacity for services available to local communities and assess opportunities for co location**
- **Development of Community Capacity Building delivered through the Eildon work and Locality planning and implementation.**
- Development of Locality Plans by Locality Co-ordinator posts
- Home Care Tender to ensure we meet requirements at a locality level.
- Further develop Local Citizen's Panels
- **Improve access to social care and health from local communities and GP practices (test first point of contact model)**
- Development of Veterans Mental Health Services
- **Review Day Hospitals providing day services delivered within a locality model and providing a local resource to the wider communities for health and social care**
- Development of Child and Adolescent Mental Health intensive support
- Improvement work to increase capacity to deliver Psychological Therapies
- Redesign services and develop processes under the Transitional Quality arrangements of the GP Contract for 2016/17, to suit a locality approach.
- Further development of Local Area Co-ordination to increase independence, resilience and local resources.
- Provision of Emergency Dental Services 7 days per week
- Work with partners to remove barriers to access dental services within the community
- Review Day Services and preventative services to ensure they meet needs within each Locality
- Provide Health Literacy Training for staff to improve accessibility of information about self-management and access to services.

Local Objective 2
We will improve prevention and early intervention

Ensuring that people attempting to manage independently are quickly supported through a range of services that meet their individual needs.



How delivery of our services will help us to meet this Objective

- Ongoing creation and review of existing Anticipatory Care Plans.
- **Ensure that Anticipatory Care Plans (eKIS) are updated remains an essential focus and will feed in to the Transitional Quality Arrangements for 2016/17 in the revised GMS contract.**
- **Personalised care planning and self management as part of the Long Term Condition management improvement work (supported by ICF)**
- Develop preventative services that involve the third and independent sector
- Promote good physical and mental health through well-being advisors.
- Develop an Integrated health and social care transitions pathway for young people moving from children's to adult services.
- Reduce the amount of drug and alcohol use through early intervention and prevention approaches
- **Promote healthier lifestyles for patients, staff and visitors through our health improvement campaign 'small changes, big difference'.**
- Increase referrals to Lifestyle Advisory Services, Quit4Good, as well as signposting to community resources such as 'Walk It' groups.
- Deliver the Long Term Conditions project to support people to self manage their conditions better, promoting social contact and reducing isolation.
- Promote the uptake of health screening opportunities and immunisation programmes
- Raise awareness of the signs and symptoms of health conditions and encourage people to get checked e.g. Detecting Cancer Early, Suicide Prevention Training.

Local Objective 3
We will reduce avoidable admissions to hospital

By appropriate support in the right place at the right time, we will ensure people are supported to remain in their own homes.

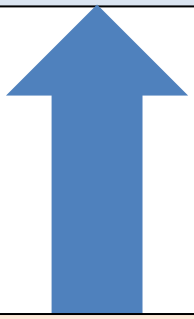
How delivery of our services will help us to meet this Objective

Opportunities to reduce emergency admissions will include development and review of Anticipatory Care Planning, District Nursing Services, Social Care Services, GP clusters and new GP contract, Out of Hours Services, models of Intermediate Care, and the use of Technology Enabled Care, all of which will support people through all stages of the care pathway.

- **Development of the Eildon Community Ward and links with the Health & Social Care coordination project to provide a proactive case management approach for people with multiple complex co-morbidities most at risk of hospital admission and readmission. (supported by ICF)**
- **GP Enhanced Services to support the management of patients in the community or at home, such as near patient testing, warfarin and services to people in care homes.**
- Health and Social Care coordination projects Services will support the 'Reducing Inappropriate Emergency Admissions Working Group' to achieve its objectives.
- Hawick Paramedic Practitioner Pilot. Two GP Practices are working directly with SAS to test a different model of in-hours response to emergency calls to GPs. (Unscheduled Care Project)
- **GPs working with BGH consultants via direct access by phone to discuss any cases for early ward or clinic review by a Specialist team**.
- The 2015/16 Unscheduled Care Project work streams will be mainstreamed within local services and will include a range of initiatives to support this objective;
- Ambulatory Care and Acute Assessment - A new Ambulatory Assessment Unit has been established and the model is being evaluated in line with agreed improvement methodologies.
- **Review Mental Health Crisis Team input to the Emergency Department – discussions are underway to identify the most appropriate location for the team to ensure timely access and support for patients attending in crisis**.
- Ongoing collaboration with local GPs and District Nurses to ensure that Anticipatory Care Plans (eKIS) are updated remains an essential focus and will feed in to the Transitional Quality Arrangements for 2016/17 in the revised GMS contract.
- Effective Psychiatric Liaison Services operating within hospital settings
- Effective Community Mental Health Rehabilitation Services
- Increasing uptake of Self-Directed Support to increase effective individualised community support arrangements.

Local Objective 4
We will provide care close to home

Accessible services which meet the needs of local communities, allows people to receive their care close to home and build stronger relationships with providers.



How delivery of our services will help us to meet this Objective

- District Nursing and Treatment Room services will continue to provide care delivered in a locality model that; ensures people achieve the best possible health outcomes – promotes self-management and independence – uses skilled assessment working with a person and their family to develop their care plan – focuses on prevention and anticipatory care – avoids unnecessary hospital admission/supports early discharge – offers a care management function and improves coordination of services – ensures collaboration and interface with third and independent sector – uses knowledge of local community resources and networks
- **We will work with care providers to develop different models of care that will support people to stay at home for as long as possible.**
- Specialist Outreach clinics and screening services will be delivered in localities
- **Development of Technology Enabled Care models to maintain independence and care closer to home**.
- Long Term Care will be reviewed to ensure care homes are providing high quality care across the localities
- **We will commission 24 Specialist Dementia care beds to support people with high level dementia care needs and provide specialist in-reach nursing services to support providers**.
- We will commission effective community support and supported accessible housing options with our communities
- NHS Dental Services will be available across the region with domiciliary care to those cared for at home or in long term care facilities.

Local Objective 5
We will deliver services within an integrated care model

Through working together, we will become more efficient, effective and provide better services to people and give greater satisfaction to those who provide them.

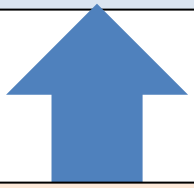
How delivery of our services will help us to meet this Objective

- **Quality agenda within the Transitional Year GP Contract to develop processes with the full involvement of Practices**.
- Creation of Quality Clusters in Localities.
- Review assessment and care management to ensure teams across the partnership are able to work efficiently and enable further integrated working.
- Ongoing HB engagement with GP representative bodies regarding development work and best use of Primary Care funding.
- Ongoing use of the Primary Care Feedback facility to identify interface issues affecting everyday working, e.g. with Secondary Care.
- START staff based in Community Hospitals and working the hospital and community MDTs
- Deliver projects supported by the Integrated Care Fund to maximise integrated working for Health and Social Care.
- Discharge Hub Developments (supported by Connected Care)
- Complete integration of Community Mental Health teams and continue to deliver services within an integrated governance structure incorporating service providers, users, professionals and other stakeholders.
- Joined up Adult Protection services and response.
- **Linking to GP practices to ensure communication and speedier access**
- **Linking to the third and independent sector locally to improve access to services and coordinate between the services**
- Facilitating the development of locality plans based on local needs and co produced in the context of local partnership arrangement.
- Working with services across the NHS and Council to redesign services locally to meet the needs of the local population, local communities and in line with improved outcomes, using localities group
- In consultation with partners, make recommendations to the Localities group on future arrangements to support locality planning and integrated organisational arrangements on an ongoing basis.

Local Objective 6

We will seek to enable people to have more choice and control

Ensuring people have more choice and control means that they have the health and social care support that works best for them.

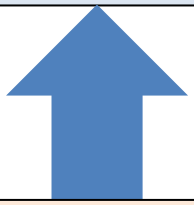


How delivery of our services will help us to meet this Objective

- Further the development of personalisation and outcomes approaches to assessment
- **Embed co-production within the care management and assessment approach and deliver at a locality level**
- **Complete the review of the Physical Disability Strategy**
- **Increase overall uptake of Self Directed Support**
- Public involvement and representation in teams working on the redesign and development of services.
- Multidisciplinary presence in projects developing new services.
- Increase the use of patient/service user feedback processes.
- Lifestyle advisory services will work with communities offering support with a specific emphasis to vulnerable groups.

Local Objective 7
We will further optimise efficiency and effectiveness

***Strategic Commissioning requires us to constantly analyse**, plan, deliver and review our services which give us flexibility to change what we do and how we do it.*

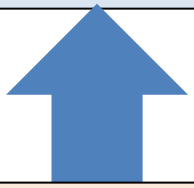


How delivery of our services will help us to meet this Objective

- **Continue to employ service improvement methodology across a range of services to enable staff to spend increasing time with service users and patients improving the quality of service provision**.
- Creation of Quality Clusters with clear set of outcomes and their improvement through repeating cycles of work and evidence bases approach to their improvement.
- Review of current management arrangements towards a more integrated model that delivers efficiency and effective use of resources
- Joint approach to Efficiency Planning by partners
- Commission a review of assessment and care management teams to ensure they are able to meet future demand and deliver services efficiently and effectively.
- Commission care at home through a tender process.
- Ensure intelligence is available from locality planning processes to inform any commissioning cycles.

Local Objective 8
We will seek to reduce health inequalities

Ensuring that people do not miss out on services due to, for example, a health condition, or lack of easy access to transport.



How delivery of our services will help us to meet this Objective

- **Through the development of locality plans we will identify how to include those who are hard to reach within our communities**
- We will ensure that we carry out Equality Impact Assessments across all strategic developments
- Representation at the Health Equalities steering group.
- We will ensure Rural Proofing is carried out
- GP Keep Well Enhanced Service, targeting populations in the most deprived areas.
- Ensure intelligence is pulled from locality planning activity and considered in any future service reviews.
- **Revision of the Mental Health Commissioning Strategy**

Local Objective 9
We want to improve support for Carers to keep them healthy and able to continue in their caring role.

How delivery of our services will help us to meet this Objective

- Acknowledge the significant role carers have in meeting health and social care needs of our population.
- Review of Carers Strategy to identify the key areas of development over the next 3 years
- **Ongoing identification of carers within GP Practices and signposting to carer support such as the local Carer Centre**.
- Carer's assessments carried out by the main stream services.
- Engagement with carers on Strategic Planning Group and emerging Locality Planning groups.
- **Ongoing information and education for carers across the range of health and social care services**
- **School Nursing Services will continue to support young carers and their physical and mental wellbeing**.