The AHPF(S) provides collection leadership and representation for the 12 Allied Health Professional Bodies. These professions work in widely different settings across all sectors. Today there is more than 13,000 AHPs making up 8.2% of Scotland’s NHS workforce (ISD 2016). We believe that the development of AHP roles and services is vital for the delivery of our aspirational strategic goals for an integrated health and social care service and for a Scotland where we live healthier for longer and in our own homes. Scottish Government’s Active and Independent Living Improvement Programme (AILIP) recognises that AHPs provide quality and cost effective alternatives to traditional service models and make effective contributions to health and care needs traditionally requiring acute hospital or medical/surgical intervention.

This evidence results from a call to Allied Health Professional bodies for their evidence and also from discussion with AHP Directors, who we thank for their input. The responses were collated, mapped against the questions and then a framework analysis was carried out to interrogate the dataset. Five urgent themes emerged and we highlight these immediately asking the Committee to give these urgent consideration:

1. Current workforce data relating to AHPs is inaccurate and numerated vacancies do not tell the story for problems in recruitment and retention for AHPs in Scotland.
2. The development of workforce predictions tools to best identify the balance of the future workforce in health and care in Scotland is of vital importance. The AHPF(S) is concerned that introduction, or mandate, of any unprofessional workforce projection tool could exclude AHPs and impact on our ability to support delivery of Scotland’s strategic goals.
3. AHPs are increasingly being recruited to roles previously carried out by other professions. We can provide examples of Occupational Therapy consultants recruited where traditional consultants could not (with very positive feedback) and of specialist paramedics working in GP surgeries where they replace a GP 1:1. These are enabled by looking at the system afresh and considering available alternatives. The AHPF(S) requests the Committee’s support in urging boards to consider alternatives to traditional models where the system supports this.
4. Responses from professions and boards highlight examples of AHP and specialist AHP roles being downgraded from bands 7/8 to bands 6/7 and we highlight this as an urgent concern and disincentive to recruiting and retaining AHP staff.
5. Finally we seek to highlight the challenges encountered by smaller professions who cannot easily quantify the extent of their recruitment/retention challenge. This can be due to small numbers of practitioners who work across a variety of sectors. The British Association of Prosthetists and Orthotists, for example, highlights that for a recent vacancy they received 2 applications for a post they would normally expect more that 12-15. The problems for these professions are critical.
Question 1; In what areas are you experiencing the greatest difficulties in Recruitment and Retention?

Responses from members and AHP Directors gave a number of interpretations of, “area”. Every response cited remote and rural settings as a key challenge and gave detailed reasons for this. However, it is also clear that all areas outwith the central belt region are experiencing considerable difficulties relating to Recruiting and Retaining AHP staff. Locations that were specifically mentioned were:

1. Aberdeen,
2. Dundee,
3. Dumfries and Galloway.

Our responses also highlighted professions that were experiencing particular difficulties:

1. British Association of Prosthetists and Orthotists,
2. College of Occupational Therapists,
3. Society and College of Radiographers,
4. British Dietetic Association,
5. Society of Chiropodists and Podiatrists
6. Royal College of Speech and Language Therapists.

The AHPF(S) seeks to highlight that smaller professions are under considerable and persistent pressure due to problems recruiting and retaining staff but who find it nearly impossible to evidence this due to non-representation in official data reports, small numbers of practitioners and non-NHS or Local Authority work settings.

A further area that AHPs are experiencing key difficulties is recruiting to senior roles. The Chartered Society of Physiotherapy report that there has been a 10% reduction in senior roles since 2010 and a reduction at every band from 6 and above between 2010 and 2014.

Question 2; What are the key barriers to recruitment in your area?

The AHPF(S) report considerable and varied barriers to recruitment. Almost half of all responses specifically cited budget constraints as a key barrier to recruiting AHP staff. The Royal College of Speech and Language Therapists report and 8.8% decrease in NHS and Local Authority funding since 2011 and that recently three local authorities have cut their budget by 100% for Speech and Language services (April 2016).

Further consistency in reports underlines that difficulties in recruiting AHPs outside of the central belt is not just a remote and rural problem. This is reported as being due to a number of factors including:

1. A lack of career opportunities,
2. Lower levels of workload,
3. Cost of living (Aberdeen),
4. Poor transport links,
5. Lack of funding for relocation costs,
6. Smaller boards and services being perceived as having less opportunity for development.

The recruitment process itself is reported as a barrier with responses highlighting that it takes too long and that when appointments are made it can take months for the successful candidate to be released from previous work settings. Further process barriers relate to a lack of funding for student placements which the College of Occupational Therapy reports can cost up to £600 per student and these costs are often incurred by the student (these placements are cited as invaluable in showcasing workplaces to students for future recruitment). Further barriers exist for recruitment from outside the UK where initial registration can take up to 16 weeks and cost individuals £500. AHPF(S) requests support in addressing these barriers.

Pay levels vary between NHS, Local Authority, third sector and private companies. Many respondents report that staff can often be paid more working in the private sector or as bank staff.

Smaller professions experience very specific barriers to recruiting their staff. The British Association of Dramatherapists report that there is no specific training for their role in Scotland with an associated difficulty in identifying practice placements for their students.

The reprofiling of staff roles is again cited as a significant barrier to recruiting staff and professions report considerable difficulty recruiting to senior and specialist roles.

Question 3; Please provide examples of incentives/initiatives that have shown positive results in recruiting.

A wide range of incentives and novel initiatives have been reported in responses to this question. However there is a consistent message that much more needs to be done.

The most successful incentive is cited as explicit support for professional development and clear career pathways. Provision of relocation packages is very successful where this can be offered; NHS Tayside reports success through offering 6 months accommodation in packages to recruits. Flexible working arrangements; including rotating roles through specialities and also clear family friendly policies are also cited as important to new staff and success is reported in overcoming barriers through delivering these.

The College of Paramedics reports that the Scottish Ambulance Service (SAS) has very recently introduced a new vocational qualification as entry to their Ambulance Technician role. This opens access to the role to a much wider group of people facilitating recruitment to this role. The training and recruitment processes have been simplified meaning that the SAS is now better placed to quickly fill vacancies and also backfill posts to facilitate more Paramedic and Specialist Paramedic recruitment.

Several responses report that campaigning to encourage students into an area and the provision of high quality practice placements for existing students to advertise settings is effective here.
Charitable funding for new projects is reported as attractive to applicants. However this is absolutely vital for smaller professions to develop their services.

**Question 4: What are the key barriers to retaining staff in your area?**

There was considerable consistency throughout the responses to this question from both AHP professional bodies and directors.

The single greatest barrier to retaining AHP staff is felt to be the lack of a clear career pathway and opportunities for professional development. This links to the second key theme of staff recruited to non-central belt services (including remote and rural) who return to the central belt when possible for further development. There are also multiple reports of challenges due to staff leaving temporary posts midway to take up permanent posts resulting in interruptions to key work streams and restarting the recruitment process all over again.

The changing demographic of staff is also a key challenge in AHP services. Most professions report that they now have a predominantly female workforce (British Association of Prosthetists and Orthotists cite a 96% female: 4% male ratio). This has resulted in more staff moving to a post closer to their partner’s workplace, increased maternity leave and a reduction in hours worked when returning from leave. One respondent suggested that there is a need to increase employment options in all sectors beyond the central belt to help retain staff here.

The reported down-banding of staff is a vital concern and the AHPF(S) requests the Health and Sport Committee’s support here.

Further barriers reported include a widespread increase in workload allied to a general decrease in workforce and challenges in recruiting replacement staff promptly. Respondents also cite a lack of understanding of AHP and specialist AHP roles among health and social care colleagues as a barrier to retaining staff.

**Question 5: Please provide examples of incentives/initiatives that have shown positive results in retaining staff.**

A variety of initiatives and incentives have been tried to increase retention of AHP staff. In the most part these reflect the points made in earlier questions.

The provision of high quality professional development opportunities is clearly the most successful from the responses given. This also links to other successful examples of providing a clear and explicit career pathway for AHPs and also to enabling AHP staff to become involved, and lead, service improvement work. Respondents also report that development opportunities and secondments are effective in engaging and developing AHP staff.

Additional examples of successful initiatives and incentives include: improved preceptorship and mentoring models; improving leadership, both clinical and senior; recognising staff who excel; improving Wi-Fi/broadband services; creating social media accounts to link workplaces together reducing isolation; job sharing roles; making temporary posts permanent where possible; and improved family friendly policies.