Dear Cabinet Secretary for Health and Sport,

RECRUITMENT AND RETENTION

The Session 2 Health Committee carried out an inquiry into NHS workforce planning and produced a report: *Reshaping the NHS?: Workforce Planning in the National Health Service in Scotland* which was published in 2005. Their report raised various concerns around workforce planning within the NHS and we were keen to hear whether any improvements had been made since its publication.

Our work was timely coinciding with the Audit Scotland report *NHS in Scotland 2016* which inter-alia recommended the Scottish Government should develop a workforce plan outlining the workforce required, and how it will be developed. The work was carried out against a background of rising demand and rising numbers of staff. We looked across the public, third sector and private sectors within both the NHS and social care sectors.

We undertook three evidence sessions looking at NHS recruitment and retention, including from a remote and rural perspective. This consisted of two roundtables and an evidence session with yourself.

Various sources, including the BMA, Unison, RCN, Scottish Care, Royal College Psychiatrists and the Allied Health Professions Federation (Scotland) advised us that instead of seeing improvements workforce planning was actually getting worse\(^1\) and we sought to look behind these statements.

We earlier issued a general call for views and received 20 submissions.

Workforce Planning

We recognise workforce planning is not an exact science but involves a process of variables, albeit known variables. We are concerned that in the 11 years since the

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\(^1\) Health and Sport Committee Official Report 1 November 2016
previous Health Committee raised concerns planning does not seem to have become more successful.

We also appreciate the Scottish Government understands the necessity to implement workforce planning and is aiming to develop a national and regional workforce plan by 2017 (to supersede the current 2011 guidance), with a “discussion document” being published by the end of this year.

- We would be grateful if you could keep the Committee updated on the progress of this work.

In relation to workforce data the committee heard the quality of data available is variable with Unison reporting the data in social care is very poor and based largely on registration data. The committee also heard from Allied Health Profession Federation (Scotland) that workforce data for AHPs is not particularly reliable given they can work in private, public and third sector settings. The need for the development of workforce prediction tools to best identify the balance of any future workforce was highlighted.

We heard concerns around workforce planning in midwifery. We were advised in 2012 the number of midwifery training places was reduced from 220 to 100 as a result of over production which saw graduates unable to find employment as midwives. We understand the reasoning for the initial cut but are concerned this has resulted in a dramatic undersupply of midwives with training places only increasing to 183 last year.

The Royal College of Midwives Scotland expressed concern about workforce planning. They noted the NHS is currently running its third test of a new workforce planning tool.

We understand around 10% of nurses in Scotland are employed in the social care sector and were surprised to learn this area was not included when nursing intakes were calculated. All the more so, given the increasingly important role of the social care workforce in meeting the Scottish Governments 2020 vision. We wonder how a shift in the balance of care can be met when the social care sector is faced with a nursing shortfall which we understand has risen from 12% in 2013 to 18% in 2015 and is now at 28%. And we note the RCN reporting the number of nurses graduating was at its lowest level for some time.

It seems to us such situations would not arise if workforce planning was robust and covered all relevant employees and roles. Can you please indicate:

- What steps are being taken by the Scottish Government to improve the workforce data collected in the social care sector and in the allied health professions?
- What steps are being taken by the Scottish Government, integration authorities and NHS boards to develop a coherent integrated long term workforce plan for both health and social care which includes the allied health professionals and covers private, public and third sector settings?

**Vacancy Recording**

We heard from BMA Scotland and NHS Western Isles about a lack of clarity around data on vacancy recording. Both highlighted discrepancies between the actual number of vacancies in local services and the official statistics published nationally.

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2 Health and Sport Committee Official Report 1 November 2016 column 30
by ISD Scotland. ISD define a vacancy as a currently advertised post, but exclude unadvertised positions or those currently filled by locums. Thus ISD figures appear to be underreporting actual vacancy levels.

The underreporting impacts on workforce planning and staff morale. BMA Scotland noted it causes a genuine sense of people being even more put upon in the workplace.\(^3\)

We believe for clarity, the complete picture of the scale of vacancies has to be measured. This will require collective agreement on how vacant posts are measured. Can you advise:

- What the actual level of vacancies and vacant posts is at present both within the NHS and social care?
- Whether consideration will be given to developing the definitions used by ISD to monitor vacancies?

**Vacancies**

ISD’s June 2016 quarterly update of staff in post, vacancies and turnover shows there was a consultant vacancy rate of 7.5% with 3.4% of posts vacant for six months or more. The nursing and midwifery vacancy rate was 4.2% with 1.0% of posts vacant for three months or more. The vacancy rate for allied health professionals was 4.4% with 1% vacant for more than 3 months.\(^4\)

These figures confirm the written evidence we received relating to problems in recruiting staff as well as vacancies across the health professions including consultants, GPs, midwives and nurses, laboratory/biomedical scientists, social workers and care services for which we highlight the current levels earlier in this letter.

GP vacancies (and other GP issues) are covered in more depth in our letter of 9 November 2016.

NHS boards noted problems filling consultant posts with NHS Ayrshire and Arran stating a number of specialities have multiple consultant vacancies including gastroenterology, emergency medicine, acute medicine, care of the elderly, neurology, pathology and radiology.\(^5\) NHS Western Isles noted over the past 5 years there have been either very few or no applicants for all laboratory/biomedical scientist posts they advertised.\(^6\)

Nursing posts were also noted to be difficult to fill due to the current low level of graduates. This coupled with high retirement numbers is leading to a “concerning” level of nursing vacancies. Can you advise:

- What immediate steps are being taken to address the high vacancy rate for consultants and nursing and the allied health professions, in particular posts that have been vacant for more than 3 months?
- What immediate steps are being taken to mitigate the increased number of vacancies as a result of people retiring and lack of supply?

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\(^3\) Health and Sport Committee Official Report 1 November 2016 COL 6

\(^4\) Health and Sport Committee Official Report 8 November 2016 COL 23


• What level does the Scottish Government consider to be an acceptable tolerance for vacancies?

**International Recruitment**

We have in earlier correspondence\(^7\) mentioned concerns around Brexit implications on the NHS workforce (as well as social care and third sector). During our inquiry into recruitment and retention we were given figures which paint a worrying picture for Scotland should EU nationals be unable to work here.

We heard that if EU nationals were not allowed to stay and work within the medical and residential care sector it would have a “devastating” impact on the delivery of health and social care in Scotland.

NHS Education for Scotland noted approximately 20% of the medical undergraduate population in Scotland is from either Europe or overseas. As an example of the scale of the potential problem Western Isles Health and Social Care Partnership advised of the 13 consultants working in the Western Isles hospital only one is Scottish with the remainder being from outside the UK\(^8\)

The figures available, albeit anecdotal, suggest that EU nationals are fundamental to the successful running of our NHS and social care services.

Given the health and social work sector in Scotland employs around 12,000 EU nationals, accounting for 3% of total employment in this sector\(^9\) can you advise:

• What work the Scottish Government is undertaking to find out the exact number of EU nationals working within the NHS and social care?

• How the possible outcomes of Brexit (including the possibility EU nationals will not be allowed to remain to work) are being factored into work force planning calculations?

**Training**

One of the main barriers to recruitment highlighted in the written submissions was the lack of supply of new graduates and recruits to certain professions. This includes medical and nursing specialties but also the allied health professions such as radiographers, pharmacists and maternity care assistants. We understand the number of undergraduate places for medicine, dentistry, nursing and midwifery is controlled by the Scottish Government which sets annual target intakes. However, no similar approach occurs for other health professionals. Can you advise:

• What input do the NHS and Scottish Government have on the number of training places for other health professions?

• Would there be advantages from having a degree of national direction when it comes to training places for the non-controlled subjects?

• Is the current intake for the controlled subjects currently adequate to meet current and future shortages (i.e. medicine, nursing, dentistry, midwifery)?

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\(^7\) Letter to Cabinet Secretary Health and Sport dated 26 October 2016 re Social and Community Care Workforce

\(^8\) 3 non-EU and 8 EU

\(^9\) Spice briefing 16/86 and PQ answer S5W 04332. Equivalent UK figures for overall EU nationals suggest a higher percentage at 4.9% of the UK population are EU nationals compared to 3.4% in Scotland.
The National Clinical Strategy envisages changes to the way healthcare services are delivered throughout Scotland with a move to more community based care. This suggests a need to increase numbers in occupations such as AHPs, advance nurse practitioners, social care staff and mental health officers. The Committee also feels it is important to extend training to ensure it covers sectors outside the NHS.

- Can you advise how training places are being modified to take account of this proposed shift in care?

We heard from NHS Education for Scotland a need to “ensure the sort of kids we want to be doctors have the aspiration and opportunities to become doctors”\(^\text{10}\) We think it important to note the need to ensure children have the aspirations and opportunities to become part of the NHS in any capacity. Any push to widen access to medical schools should be replicated by colleges for example to enrol physiotherapists, AHPs and all other health occupations.

- Can you advise if work is being done to widen access to all health professions to encourage greater Scottish uptake of places?

Social Work Scotland expressed concerns about a shortage of mental health officers. We were advised this was due, in part, to a difficulty in releasing staff from their busy normal duties to undertake study to a level equivalent to a Masters degree. We know this aspect has been considered by the Government’s social work adviser without it would appear much success.

- Can you advise what is being proposed to assist local authorities to release social workers to undertake such courses?

**Temporary Staff**

Audit Scotland noted in their report *NHS in Scotland 2016* the average costs of nursing staff. We have since received updated figures for 2015/16 that show the average cost of salaried nursing staff was £38,172 per WTE\(^\text{11}\) whereas agency nursing staff cost more than twice at £84,777 per WTE\(^\text{12}\). The average cost of a bank nursing staff was £31,390 per WTE\(^\text{13}\).

We recognise temporary staff have a role to play during transitional periods or for holiday or emergency relief but should not be used to cover long-term vacancies. Their use impacts on the continuity of care and can also affect the quality of care leading to amongst other outcomes risks to patient safety.

In evidence you stated through workforce planning the use of agency staff would reduce and there was currently a national programme of work underway considering more effective management of all temporary staffing.\(^\text{14}\)

- Can you advise when the national programme of work will be completed and how quickly recommendations would be expected to be implemented?

\(^{10}\) Health and Sport Committee Official Report 1 November 2016 COL 9


\(^{12}\) [http://www.isdscotland.org/Health-Topics/Workforce/Publications/data-tables.asp?id=1725#1725](http://www.isdscotland.org/Health-Topics/Workforce/Publications/data-tables.asp?id=1725#1725)

\(^{13}\) [http://www.isdscotland.org/Health-Topics/Workforce/Publications/data-tables.asp?id=1725#1725](http://www.isdscotland.org/Health-Topics/Workforce/Publications/data-tables.asp?id=1725#1725)

\(^{14}\) Meeting of the Parliament Official Report 2 November 2016 COL 21
• Is the trend in the use of temporary nursing and midwifery staff replicated in other professions? If so will they all also be covered by the national programme?

**Agenda for Change**

A number of submissions\(^{15}\) to the Committee highlighted Agenda for Change\(^{16}\) banding as a barrier to recruitment. We heard this appears to have affected career progression with the following instances highlighted;

- junior staff taking on a more senior role could experience a significant pay cut;
- differing levels of pay between staff doing the same job fostering discontent;
- varying bands across health board areas which can entice staff away to other areas; and
- banding and corresponding salary creating barriers to recruitment as bandings in Scotland are lower than other parts of the UK.

We also heard\(^{17}\) that long pay scales created by Agenda for Change can result in equal pay challenges as scales no longer reflect some staffs current role or responsibilities. It was suggested health boards have some control over banding under the Agenda for Change given they control job descriptions. Can you advise:

- What the Scottish Government is doing to address unintended issues pay protection may have on individuals career development
- What the Scottish Government is doing to ensure that Agenda for Change bandings are applied equitably across all health boards
- What the Scottish Government is doing to ensure that variations in Agenda for Change bandings for posts are not being used as a recruitment incentive by health boards

**National Pay Contracts**

The Committee has previously heard it is hoped GP recruitment and retention issues will be addressed through the revised GP contract, from April 2017. However, for all other staff paid via Agenda for Change, the consultant contract or the junior doctors’ contract we understand there are no plans to revise contracts. While most of these contracts started out as UK contracts this is no longer the case with increasing divergence across the UK in recent years.

BMA Scotland discussed consultant contracts with us in relation to an ongoing problem with the 9:1 element. We were advised out of 10 four hour weekly working sessions a consultant is expected to spend 7.5 on direct patient contract and 2.5 contributing to the wider development of the NHS. In practice they are spending most of their time in direct patient work to address increasing demand. The result we were advised is low consultant morale which is having an impact on the attractiveness of consultant posts in Scotland.

- Can you advise what action is intended on the 9:1 split to better address the difficulties we heard about?

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\(^{15}\) NHS Lothian, Fraser Walker, Dr Yirrell

\(^{16}\) Agenda for Change is the pay system for most staff directly employed by the NHS.

\(^{17}\) Dave Watson Official Report 1 November 2016 column 17
Rural Issues

Rural issues were discussed passionately both in written evidence and during the oral evidence sessions. It became clear that people from rural backgrounds were reported to be more likely to be interested in working in remote/rural settings in the future. We heard about the widening access agenda and welcome the work being done in remote and rural schools.

There was much discussion about the centralisation of services and the impact this has on rural areas and the staff working in these areas. We recognise this is in part being driven by increased specialisation within the professions. We heard from the Scottish School of Rural Health and Wellbeing about the possibility of looking at a different model of staffing smaller hospitals. Caithness General Hospital and The Mackinnon Memorial Hospital were given as examples where elective surgery and medical services are undertaken by a larger hospital and emergency services are provided by well-trained rural practitioners.

We are concerned that the age profile in some rural areas means that services will be affected by a high number of people retiring in the near future. The ageing population, especially in nursing and midwifery is a major concern with 50% of midwives in NHS Highland being over the age of 45.

- What ongoing assessment is the Scottish Government undertaking of the age profile of staff working in rural communities?

Rural Training

One of the main topics discussed in oral evidence centred on the lack of rural training places. We heard in particular there were issues around the uptake of rural training places and also about the practice on courses of offering rural placements towards the end.

The Royal College of Speech and Language Therapists noted some rural areas highlighted difficulties getting student placements, linked we understand to undergraduate training being provided in Glasgow and Edinburgh. NHS Highland commented that AHP students are trained mainly in the central belt and Aberdeen. They also commented students leaving remote and rural areas to take up training elsewhere don’t return.

During graduate study, particularly for general surgery, we understand rural placements are only made available towards the end of courses. Clearly the later during a course placements take place the less influence they will have on career choices. Many students will have established relationships, set up ‘homes’ and be less inclined to relocate on completion of their studies. We agree with the Scottish School of Rural Health and Wellbeing in this regard.

The response to us from NES provided information on current educational initiatives in place to support the medical rural workforce. In evidence members heard medical students are more likely to apply for posts in rural areas if they come from a remote or rural area or if some of their training has been delivered in this setting. However, it is not clear what is being done to support such training opportunities for non-medical staff. Can you advise:

- What consideration has been given to the use of targeted admission policies for people from remote/ rural areas?
- What steps are being taken to ensure training providers and universities offer non-medical students placements in remote/rural areas?
What work could the Scottish Government do to influence royal colleges and universities on the timing of remote and rural placements?

Barriers to working in a remote or rural area

We have noted above the issues surrounding training in a remote or rural area however there are numerous other barriers we have heard throughout this short inquiry such as infrastructure issues including problems with digital connectivity.

Financial barriers

One of the main topics discussed focused on the financial barriers to working in a remote/rural area. We heard higher living costs can act as a barrier to recruitment. NHS Highland noted housing was a huge issue being expensive in remote and rural areas, partly as a consequence of holiday lets. The College of Occupational Therapists noted the Distant Island Allowance of £947, approximately £20 per week suggesting this needs to be reviewed to cover all additional costs. They also highlighted the cost of completing a placement in a remote/rural area can cost the student an extra £600.

Whilst we are aware of, and welcome, the Scottish Government scheme which offers some a £20,000 bursary to take up places in general practice in remote and rural areas, we learned from RCGP they were initially unaware of this initiative until reading the BBC website. They indicated ongoing difficulties in engaging with the process.

NHS Orkney informed us they offer assistance with travel and accommodation for applicants attending interviews as well as reimbursing interview costs. Successful candidates can receive a relocation allowance of up to £8,000.

We are pleased to hear there are schemes to help people move into rural or remote locations to take up employment but believe more must be done to standardise incentives across all health board areas. Can you advise:

- If any consideration has been given to implementing a rural weighting allowance?
- What action is the Scottish Government taking to provide more financial support for students undertaking rural placements?
- Will any work be undertaken to standardise or set a minimum level of support to encourage people to take up remote or rural posts?

Opportunities for family members

Even when staff choose a rural or remote post it can fail to reach fruition. One of the main disincentives is a lack of local employment opportunities for family members. We were advised NHS Highland were pivotal in promoting the idea there should be a relocation officer who finds employment opportunities for others who might be considering moving to a rural area. This role of a relocation officer seems to have merit to us. We would be grateful if you could respond to the following:

- Can you advise if the Scottish Government supports the idea of a relocation officer and if they will help to roll-out such support across all relevant health boards?
- In what ways does the Scottish Government seek to utilise wider economic policy to create employment opportunities in rural areas?
To what extent are restrictions in broadband capabilities seen as restricting wider employment opportunities and what actions are the Scottish Government taking to address this?

Retention

We received various written submissions covering retention of professions and reasons why retention was so low in some occupations.

Some of the reasons for low retention of staff we were told about are:

- lack of career opportunities for biomedical students and AHPS, specifically occupational health therapists and speech and language therapists
- short term funding – the short term nature of contracts was not attractive to applicants and staff were more likely to move to permanent positions when they became available
- loss of staff to other health boards or the rest of the UK – variation in the Agenda for Change banding by health board and country can result in staff moving.
- financial – RCGP, RCN and the BMA each noted pension arrangements and tax legislation contributing to people leaving the occupation.

These are just some of the issues we have heard during our short inquiry into recruitment and retention. We feel that for a successful move to balanced multidisciplinary teams more work needs to be done on the recruitment and retention of all staff working in the NHS and social care settings. We would be grateful if you could respond to the following:

- Can you indicate what work is being undertaken to address these and other problems in relation to recruitment and retention?
- Are any national recruitment campaigns being planned extolling the virtues of a career in the NHS and social care?

I would be grateful if you could respond on the specific issues raised above and also advise of any other ongoing or planned work the Scottish Government has to tackle recruitment and retention issues across all health and social care roles.

I would welcome your response by the 13 January.

Kind regards,

Neil Findlay
Convener