HEALTH AND SPORT COMMITTEE

AGENDA

9th Meeting, 2016 (Session 5)

Tuesday 1 November 2016

The Committee will meet at 10.00 am in the James Clerk Maxwell Room (CR4).

1. **Recruitment and Retention**: The Committee will take evidence from—

   Adam Longhorn, Vice Convener, Allied Health Professions Federation (Scotland);

   Jill Vickerman, National Director, British Medical Association Scotland;

   Trisha Hall, Country Manager, Scottish Association of Social Work;

   Candy Millard, Head of Strategic Services, East Renfrewshire Health and Social Care Partnership;

   Caroline Lamb, Chief Executive, NHS Education for Scotland;

   Sian Kiely, Scottish Knowledge and Research Manager, Professional Practice, Royal College of Nursing;

   Dave Watson, Head of Policy and Public Affairs, UNISON Scotland;

   and then from—

   Gill McVicar, Director of Operations, North and West Operational Unit, NHS Highland;

   Ron Culley, Chief Officer, Western Isles Health and Social Care Partnership;

   David Hogg, Rural GP on Isle of Arran and Scottish Council Member, Royal College of General Practitioners;

   Dr Donald Macaskill, Chief Executive, Scottish Care;
William S McKerrow, Chair, Scottish School of Rural Health and Wellbeing;

Stuart Fergusson, Clinical Leadership Fellow, Royal College of Physicians and Surgeons of Glasgow, and Specialty Registrar in General Surgery;

Gillian Smith, Director, Royal College of Midwives Scotland;

James Cannon, Director of Regional Planning, North of Scotland Regional Planning Group.

2. **Delayed Discharges (in private):** The Committee will discuss the Scottish Government response.
The papers for this meeting are as follows—

**Agenda item 1**

SPICe Summary of Evidence  
PRIVATE PAPER  
PRIVATE PAPER  
Written Submissions

**Agenda item 2**

PRIVATE PAPER
Health and Sport Committee
Recruitment and Retention

During summer recess, the clerking team issued a call for written evidence to inform the Committee’s inquiry into recruitment and retention, including a focus on rural and remote areas.

The Committee also wrote to the Scottish Government and NHS Education for Scotland seeking information on current policies and initiatives to improve the retention and recruitment of staff including staff in rural and remote areas. On 23 August the Committee received a response from the Cabinet Secretary for Health and Sport. On 31 August the Committee received a response from NHS Education for Scotland.

The following is a summary of responses to the call for written evidence. In total 18 responses were received. All submissions are available on the Health and Sport Committee webpage.

Retention issues and barriers to recruitment were also addressed in the responses to the survey to IJBs.

RECRUITMENT

Clinical staff groups
A number of responses highlighted the clinical staff groups that are currently experiencing problems with recruitment these included:

- Hospital medical staff across all grades. NHS Ayrshire and Arran noted that this is “causing the organisation the most significant challenge” (RR006).
- Medical trainees (RR015)
- Consultants (RR014, RR015, RR017, RR019)
- Nursing – in particular in mental health, learning disability, child health, theatre and anaesthetic nursing (RR006, RR015, RR017, RR019)
- Midwifery (RR006, RR007, RR011)
- Radiography
- Healthcare science (RR011, RR015), specifically sonography (RR015, RR017)
- Allied Health Professionals (RR008, RR005)
- GPs (RR011, RR012, RR014, RR015, RR017)
- Pharmacy Technicians and Pharmacists (RR011)

Supply
The issue of supply was covered in a number of submissions, mostly from NHS boards (including RR008, RR008, RR017). NHS Highland highlighted the availability of trained and qualified staff as a key problem for the recruitment of staff. It
highlighted a national shortage in health visiting, medical physics, radiotherapy services, clinical physiology and medicine (RR008).

NHS Ayrshire and Arran noted that the principle barrier to recruitment was supply and made reference to the Shortage of Occupation Lists (RR006). Its submission made reference to gaps in the supply chain, such as doctors in training and GP training programmes not being fully filled. In nursing a lack of appropriately experienced staff and the non-reoccurring allocation in relation to mental health nurses was cited as a problem. In relation to midwifery NHS Ayrshire and Arran noted that there is a limited pool to recruit from and a lack of training courses for Maternity Care Assistants. It also highlighted a national supply issue for paediatric nurses and health visitors. In relation to radiography, problems related to a limited pool of graduates and a higher demand than supply. Lack of training for some healthcare science professions was also seen as a problem (RR006).

**Agenda for Change**

A number of submissions also highlighted issues with Agenda for Change¹ banding as a barrier to recruitment. Fraser Walker, Head of Service of the West of Scotland Regional Maxillofacial Prosthetics Service, stated that Agenda for Change banding “is the single biggest factor to my recruitment and retention problem” (RR003). Dr Yirrell, the Clinical Lead for Department of Medical Microbiology at Ninewells Hospital, Dundee commented that considerable lifelong pay protection has also meant that junior staff taking on a more senior role would result in a significant pay cut. It was noted that “since the introduction of the agenda for change there has been a process of downgrading posts such that existing staff are banded higher than new recruits meaning there can be a discrepancy in pay between staff doing the same job fostering discontent” (RR001).

NHS Lothian noted that in some of the Healthcare Science groups the Agenda for Change banding and corresponding salary has created a barrier to recruitment as bandings in Scotland are lower than other parts of the UK (RR015).

**Medical training**

The Royal College of Physicians of Edinburgh highlighted issues with medical training. They noted that many doctors in training to become consultants are currently receiving an inadequate level and quality of training. They cited data from the Foundation Programme Annual Report 2015 which showed that of those who completed the Foundation Year 2 programme and provided information about their next career destination only 52% were appointed to speciality training in the UK (RR009). The British Medical Association (BMA) Scotland highlighted that unfilled trainee posts places an additional pressure on the health service (RR014).

NHS Lothian highlighted the difficulties in filling out of programme gaps that arise due to people taking maternity leave or trainees going out of programme to

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¹ Agenda for Change is the NHS pay system for all staff directly employed by NHS Health Boards with the exception of some very Senior Managers and staff within the remit of the Doctors’ and Dentists’ Review Body. Across the UK, the system applies to over one million NHS staff and in NHS Scotland, approximately 150,000 NHS Staff are on these terms and conditions of service. The pay system came into operation on 1st October 2004. (Source: [The Management Steering Group](https://www.nhsconfed.org/system/files/2015-03/A4C-Feb04-Memo.pdf))
undertake research. They also noted that approximately 40% of graduates from Scottish Medical schools return to work in England and a large proportion of Foundation Trainees opt to pursue other opportunities such as posts abroad (RR015).

**Consultant Vacancies**
A number of submissions, mainly from NHS boards, noted problems filling consultant posts (RR008, RR014, RR015, RR017). NHS Ayrshire and Arran noted that a number of specialities have multiple consultant vacancies including gastroenterology, emergency medicine, acute medicine, care of the elderly, neurology, pathology and radiology (RR006). NHS Highland noted that it has problems recruiting consultants and speciality doctors in gastroenterology, oncology, ophthalmology, psychiatry, radiology and rheumatology (RR008). NHS Lothian reported difficulties recruiting to psychiatry, acute medicine, medicine for the elderly and anaesthetics (RR015). NHS Forth Valley noted difficulties in psychiatry, ageing and health and cardiology (RR017). Katherine M Whalley a Lead Clinical Embryologist noted difficulties in recruiting to specialised disciplines such as clinical embryology (RR002).

Dr Yirrell, the Clinical Lead for Department of Medical Microbiology at Ninewells Hospital, Dundee highlighted that out of five consultant posts there are two vacancies, which have been advertised three times with only one suitable candidate who declined the post to work as a locum (RR001).

NHS Highland (RR008) provided information on the approaches they had found successful in attracting interest in consultant posts:

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<td>Direct contact from a clinician in NHS Highland</td>
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**Vacancy statistics**
In its submission BMA Scotland raised the issue of vacancies, not filled through the recruitment process and posts not yet cleared for advert, being excluded from the official figures. They commented that the vacancy statistics do not “fully reflect” the heavy reliance on locum doctors (RR014). NHS Western Isles noted that they currently have ten consultant vacancies against an establishment of 18. They note that this differs from the current “live” vacancies as per the ISD definition of vacancies, which have been signed off and cleared for advert, which was recently
submitted as 5. They noted that these vacancies are currently being filled by short and long term locums both agency and NHS (RR011).

**Consultant contracts**
The Royal College of Physicians of Edinburgh commented that the “9:1 contract” in Scotland is impeding the ability to recruit new staff to high intensity specialties such as acute medicine (RR009). This was also highlighted as an issue in the BMAs submission which states that the consultant contract sets out the standard number of Supporting Professional Activities (SPAs) as 2.5 per week on average or 10 hours. However, they note that “SPA time is being eroded all across the country” (RR014).

**GP vacancies**
A number of submissions focused on problems recruiting GPs (RR011, RR012, RR014, RR015). NHS Highland noted that it has had challenges recruiting GPs for the past 15 years (RR008).

The Royal College of General Practitioners (RCGPs) highlighted a downward trend in the number of applicants and subsequent appointment to GP Speciality Training. Reasons given for this were general practice appearing as a less attractive career choice, negative attitudes and lack of undergraduate experience of general practice. From a survey of its Members, the RCGPs reported that 94% of respondents perceived difficulties in recruiting GPs to their practice area and 58% were experiencing difficulties recruiting to their practice the main reason for this was cited as insufficient applicants (RR012).

The BMA cited an increasing workload and falling resources as factors contributing to the problems recruiting doctors to train as GPs (RR014). NHS Lothian commented that the majority of GPs in NHS Lothian are now part-time and female and the traditional partnership model is less attractive (RR015).

**Midwifery**
A number of submissions noted problems recruiting midwives (RR006, RR007, RR011). NHS Western Isles highlighted challenges in recruiting midwives particularly over the last 2 years. This was attributed, in part, to changes in midwifery education. They noted that University of the Highlands and Islands used to train midwives but now only Robert Gordon University, University of the West of Scotland and Edinburgh Napier University train midwives and this has had an impact in recruitment to training for midwifery and available posts in the whole of the north of Scotland. They also noted that a single intake of students and relocation support also exacerbates the problem. A predicted problem with midwives vacancies was also reported, with a high number of retirements anticipated in the next 5 years (RR011).

**Laboratory/ Biomedical Scientists**
NHS Western Isles noted that over the past 5 years there have been either very few or no applicants or unsuitable candidates for all posts advertised (RR011). Barriers that were identified included financial including a lack of the enhancements that are

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2 In Scotland several health authorities offer full time consultant posts (10 sessions) only on a 9:1 split—nine sessions for direct clinical care and one for supporting professional activities.
http://careers.bmj.com/careers/advice/view-article.html?id=20007422
associated with shift work that people can receive in large urban hospitals, lack of training and multi-disciplinary skill requirement (RR011).

Social Work Vacancies
NHS Highland noted that the recruitment of qualified social workers is challenging, particularly specialist Mental Health Officers. They commented that this coupled with an aging workforce leads to increased turnover (RR008).

Care Services
The Care Inspectorate noted that in 2014 34% of care serves reported having vacancies with variation by service type (58% of care homes for older people, 56% of housing support services and 50% of adult social care services). In Aberdeen City, City of Edinburgh and Renfrewshire over 80% of care homes for older people reported vacancies. Problems filling vacancies was attributed to too few applicants, applicants with experience and qualified applicants. Competition from other service providers was also reported as a problem (RR013).

Europe/ International Recruitment
The College of Occupational Therapists noted that currently recruitment is easier from Europe that other international countries. They commented that Occupational Therapists wishing to practice in the UK have to register with the Health and Care Professions Council (HPCP) at a cost of £500. It was suggested that financial assistance could be given to people to support their HPCP application costs. They also commented that, like other Allied Health Professions (AHPs), occupational therapy if not on the Migratory Advisory Committee’s Shortage of Occupations List (RR005).

NHS Lothian noted that recruitment of speciality doctor and associate specialist posts are not as attractive as previously and changes to immigration at a UK level has reduced interest from outwith the EU even in specialities included on the shortage occupational lists. They commented that this reflects other countries having fewer or no barriers to entry into the medical labour market (RR015).

EXAMPLES OF INCENTIVES/INITIATIVES THAT HAVE SHOWN POSITIVE RESULTS IN RECRUITING STAFF.

The call for evidence asked for examples of incentives and initiatives that have shown positive results in recruiting staff. A number of examples were provided. These fell into the following categories:

Fellowships
- Using options such as Clinical Teaching fellows, Clinical Development Fellows, Medical Training Initiative Doctors (RR006)
- Clinical Development Fellows were introduced to NHS Highland in 2015. They are doctors in training that are typically between Foundation and Specialty and are employed for a year in a variety of clinical areas (RR008).
- Clinical Development Fellow programme to provide people with the opportunity to build experience in acute and general medicine while undertaking an MSc qualification (RR015)
- Primary Care Clinical Development Fellows (RR015)
GP Rural Fellowship scheme - this scheme is organised by NHS Education for Scotland (NES). NHS Highland currently has six GPs on the fellowship scheme, five of whom are in the NHS Highland area (RR008)

Exploring the potential for GP Developmental Fellowships (RR006)

Two proposals for Rural Fellowships for 2016/17 (RR011)

Training and work experience

- The provision of a local podiatry bank that allows new graduates to gain experience whilst awaiting permanent employment (RR004)
- Opportunities for learning, development and mentoring (RR005)
- Providing maternity placements to HNC students (RR006)
- Recruitment of Band 5 staff to train as qualified health visitors with guarantee of a post on completion (RR006)
- Development of placement programme and provide work experience to young people and trainees (RR011)
- Increased exposure to general practice in the undergraduate medical curriculum (RR012)
- Health visiting training (RR017)

Ways of working

- Autonomy to do innovative service delivery (RR005)
- Strong supervision and support locally (RR005)
- Organisational strategic Change Programme focused on primary care (RR006)
- Mental health – agreeing longer term contracts, creating permanent “rotational” posts and new models of care and facilities as means to attract staff (RR006)
- NHS Scotland highlighted a number of programmes including the Being Here Programme - a Scottish Government funded programme to look at trying alternative models of primary healthcare in remote and rural Highland (RR008)
- There are 2 Advanced Practice Pharmacists employed in Caithness that work across Primary and Secondary care (RR008)
- A Recruit and Retain medical staffing group has been established (RR011).
- A Scottish Dental Access Initiative grant was awarded for the provision of a new independent dental practice (RR011)
- Examples provided by the RCGPs included The Govan SHIP project, Dundee GP role which combined a NHS contract and portfolio career, speed dating run in Aberdeen, Action research as part of the Scottish Government “Being Here” project (RR012)
- The Scottish Government’s Golden Hello scheme to incentivise trained GPs to take up substantive posts in deprived or remote areas (RR015)
- In relation to health visiting NHS Lothian has taken a number of steps to assist with recruitment including the use of a generic recruitment model, 8 week notice period, revised model of Health Visiting service, accessed staff from partner agencies (RR015)
- Development of roles such as Advance Nurse Practitioners (RR017)
- Development of multidiscipline teams in GP practices (RR017)
- Medical Workforce Age Profiling and proleptic appointments (RR017).
Use of Modern Apprentices (RR017, RR019).
NHS Orkney have recruited to joint appointments with NHS Highland have appointed Clinical Development Fellows (RR019)
Practice Emergency Care Fund (RR015)

Advertising
- National advertising campaign for mental health (RR006)
- Allied Health Professions - prospective advertising – asking qualified AHPs with an interest in living in the board area to make contact in order to discuss potential upcoming opportunities. Use of social media to publicise vacancies, relocation packages and increasing hours and grades of posts (RR008)
- Promoting the positive attributes of working in a rural area along with good links for university courses (RR010).
- Promoting posts using social media (RR011)
- Marketing – RCGPs highlighted a number if twitter marketing campaigns such as #why GP #TeamGP and #ProudtobeAGP (RR012)
- Use of a targeted advertising campaign (RR015)
- NHS Highland has taken number of initiatives including recruitment videos and a recruitment campaign in Holland (RR008).

Returners
- NHS Lothian provided examples of schemed to assist with the recruitment of GPs including Local GP Returner Scheme and locum pool of recently retired GPs (RR015)
- In health visiting NHS Lothian has used flexible arrangements to support retired staff return to practice (RR015)

RETENTION

Lack of Career Opportunities
A number of submissions noted that lack of career opportunities impacted on the retention of staff (RR006, RR011, RR015). This was highlighted in relation to Biomedical Scientists (RR010) and AHPs (RR008), in particular Occupational Therapists (RR005) and Speech and Language Therapists (RR010). This was highlighted as a particular problem in remote and rural areas. The Royal College of Speech and Language Therapists noted that “newly qualified therapists tend to train up as expected and then move on with more opportunities being available in more urban areas”(RR010).

Short Term Funding
NHS Ayrshire and Arran highlighted short term funding based on Scottish Government allocations can have a negative impact on the retention of staff that this was a particular issue for mental health nurses. They noted that that the short term nature of contracts, particularly in addiction services, was not attractive to applicants and that staff were more likely to move to permanent positions when they became available (RR006).
Low Skilled Posts
It was noted that retention can be a problem in jobs such as Medical Laboratory Assistant, which requires low level of qualification, due to repetitive un-stimulating tasks (RR001).

Loss of Staff to Other Health Boards
Variation in the Agenda for Change banding by board can result in staff moving to better paying health boards (RR001, RR004). NHS Ayrshire and Arran noted that its proximity to a new large teaching hospital is a potential draw for its employees (RR006).

Loss of Staff to Rest of the UK
Better prospects for promotion, Agenda for Change banding and a lack of training in Scotland compared to England and Wales was highlighted as a problem (RR003). NHS Lothian noted that the main retention issue for healthcare science is more attractive pay, terms and conditions being offered in other areas of the UK (RR015).

Age Profile
This was highlighted as a future problem in a number of submissions (RR006, RR016, RR017). NHS Lothian noted that the main barrier to retention across all disciplines is associated with the aging population, it was highlighted as a particular issue in nursing (RR015). A number of submissions noted that a number of senior clinicians are set to retire in the near future. For example, of 19 prosthetists five are set to retire in the next 5-10 years (RR003). NHS Highland commented that 50% of registered midwives are over the age of 45 with a significant number of retirements anticipated in the coming years (RR008).

Workload
The Royal College of Physicians of Edinburgh noted that there is a high workload intensity especially in acute medicine. They noted that a significant contributor is the highly complex landscape of targets and standards (RR009). The RCGPs highlighted that workload arrangements are a key contributor to people leaving the profession (RR012).

Financial
The Royal College of GPs noted that pension arrangements and tax legislation contributed to people leaving the profession they commented that financial incentives are a useful strategy (RR012)

EXAMPLES OF INCENTIVES/INITIATIVES THAT HAVE SHOWN POSITIVE RESULTS IN RETAINING STAFF.

Examples that were provided included:

Changes in working practices
- The Royal College of Physicians of Edinburgh highlighted innovative ways of such as Physician Associates, Advance Nurse Practitioners and considered that physician extenders should be “further examined to create a workforce fit for the future” (RR009)
• Introduction of single use instruments and introduction of a paper-free service (RR004).
• Encouraging staff to practice at the maximum of their competencies (RR004)
• Autonomy to do innovate service design (RR011)
• Support for innovation and research (RR006)
• Some services have created “developmental” posts that encourage lower grade roles to gain experience and show initiative redesign and developing programmes or services (RR010)
• IT has been used in some areas to try and reduce some of the negative aspects of working in remote areas (RR010)
• The development of the Quality Primary Care Clusters (RR011)
• More diverse services provided by a range of professionals in Multi-Disciplinary Teams (RR011)
• A post has been developed for a GP to divide his time equally between in-hours Practice work and work in the Out-of-Hours (OOH) service (RR011)
• Rural fellowships to allow GPs in salaried positions to take leave where locum cover might have been relied on (RR012)
• Stronger general practice teams (RR012)
• Encourage and support return to practice (RR012)

Training and development
• Investment in continuing professional development, opportunities for developmental posts and secondments (RR004, RR006, RR010, RR011)
• NHS Western Isles highlighted that opportunities for learning and development, strong supervision and support locally and mentorships help retain staff (RR011)
• A Professional Development Award in Perioperative Practice to provide underpinning theory and to advance skills and abilities of Assistant Perioperative Practitioners (RR015)

REMOTE AND RURAL

Applicants

A number of submissions provided information on who was likely to apply for posts in remote and rural areas. People from rural backgrounds were reported to be more likely to be interested in working in a remote/rural setting (RR007). Stuart Ferguson who has investigated the views of surgical trainees noted that more training opportunities in remote and rural surgery at an early stage, stronger links between rural surgeons and larger district general hospitals and better promotion may be beneficial in addressing recruitment issues (RR007).

Further information was provided by NHS Western Isles which was a lead partner in the international research project Recruit and Retain between 2013 and 2015. The research found that important indicators of whether someone will apply for a post in a rural area were:
• Previous exposure to either living in or preferably as part of the training rotation or work experience
- Employer reputation (including evidence of supportive training and development)
- Effective information about the organisation, the post within the organisation and about living in the rural community

Limited career opportunities (either real or perceived) impacted on decisions to apply for posts. Professional and social isolation were important factors in staff applying for posts and remaining in them (RR011).

**Barriers to Working in a Remote/ Rural Area**

**Infrastructure**

NHS Highland noted that perceived lack of responsive transport networks was a barrier to recruitment (RR008, RR010). The Royal College of GPs made reference to its *Bering Rural* report published in 2014. It noted that the challenges caused by poor infrastructure – including digital connectivity, physical transport links and access to an integrated healthcare team rank higher than traditional barriers such as access to training, locum cover and remuneration (RR012).

**Higher cost of living**

The higher cost of living in a remote/ rural community and on the islands was highlighted in a number of submissions (RR005, RR010, RR019). The College of Occupational Therapists noted that there is a Distant Island Allowance of £947 but this may need to be reviewed (RR005). NHS Orkney identified the cost of living (including increased travel costs) as a significant barrier for applicants (RR019).

**Financial incentives**

Remote and rural work was also considered in some submissions to have inadequate financial remuneration (RR007). The College of Occupational Therapists suggested the use of relocation packages to assist with the recruitment of senior and specialist posts (RR005).

The College of Occupational Therapists suggested that consideration could be given to finding ways that practice placements in remote and rural areas could be incentivised and encouraged with some financial support (RR005). Its submission highlighted that the cost of completing a placement in a remote/rural area can cost the student an extra £600. The lack of and cost of accommodation and transport availability has been a barrier for AHP students accepting rural placements (RR008).

NHS Orkney offers assistance with making travel and accommodation arrangements for applicants attending interviews as well as reimbursing costs associated with attending interviews. Successful candidates receive a relocation allowance of up to £8,000 (subject to eligibility) and all employees receive a distant island allowance of up to £1,148 per annum per rata. A recruitment and retention payment has also been approved by the Scottish Terms and Conditions Committee for Estates staff until 2018 in order to keep their salary more in line with rates paid by other local employers. NHS Orkney also meets the costs of approximately 40 employees who travel to Orkney to carry out their work (RR019).
Training
NHS Highland noted the issue of professional isolation when living and working in a small community. Maintaining skills and access to training was highlighted as an issue (RR008). The Royal College of Speech and Language Therapists noted that some rural areas highlighted difficulties getting student placements as the undergraduate training is provided in Glasgow and Edinburgh (RR005). NHS Highland commented that AHP students are trained mainly in the central belt and Aberdeen. They commented that students leave remote and rural areas to take up training elsewhere and don’t return. It also highlighted the unavailability of undergraduate courses for people in remote/rural areas (RR008). NHS Orkney noted that consultants are being given the opportunity to spend 2 weeks working with a larger hospital on the mainland (RR019).

Career progression
The Royal College of Speech and Language Therapists noted that posts in rural areas tend to be more generalist and potentially less attractive to graduates who want to work in a particular field (RR010). Fewer career opportunities in rural areas was also mentioned in the submission from NHS Orkney (RR019).

Skill mix
The skills needed in remote and rural areas were identified as being more generalist in nature. It was noted that in some cases surgeons feel their skill are too specialised to cope with range of work (RR007). NHS Western Isles noted that there were challenges recruiting experienced Allied Health Professional staff with the broad skills needed to deliver services in small teams across large geographical areas, particularly in Speech and Language Therapists, Podiatry and Occupational Therapy (RR011).

The Royal College of Speech and Language Therapists noted that rural areas were struggling to recruit above Band 5 level (Newly Qualified Practitioner) and some areas were responding to financial pressures by downgrading more senior posts to Band (RR010).

Workload
Remote and rural work was considered by some to have a high burden of out of hours responsibility (RR007)

Opportunities for family members
A number of submissions highlighted that a lack of work and training opportunities for family members acted as a disincentive to applying for rural posts (RR007, RR008, RR010).

Lizzy Burgess
SPICe
27 October 2016

Note: Committee briefing papers are provided by SPICe for the use of Scottish Parliament committees and clerking staff. They provide focused information or respond to specific questions or areas of interest to committees and are not intended to offer comprehensive coverage of a subject area.
Recruitment and Retention
BMA Scotland

Introduction
The British Medical Association is a politically neutral registered trade union and professional association representing doctors from all branches of medicine. The BMA has a total membership of over 154,000, which continues to grow each year. In Scotland, the BMA represents over 16,000 members.

Recruiting, retaining and valuing doctors
Consultants and GP vacancies are at high levels, trainee and specialist posts are going unfilled. Every position that goes unfilled increases the burden on existing medical staff, adding to already unsustainable workloads.

Doctors are dealing with rising demand, unmanageable workloads and increasing pressure in a service that is clearly struggling to cope with shortages. This situation is not sustainable and doctors in Scotland are working under significant pressure and increasingly having to cover gaps in the face of rising vacancies. There are a number of actions which could be taken by government to address disincentives for doctors to work in Scotland including removing unnecessary hurdles which stand in the way of doctors returning to work and addressing the problem of health boards not adhering to nationally agreed contracts.

GP vacancies
The increasing intensity and complexity of GP workload, the shift of more specialist care from hospitals into local communities and extended access initiatives mean that general practice has reached saturation point. Without additional resources and capacity, it will be impossible for general practice to respond to the rising demand of an ageing population.

The BMA is working with the Scottish Government to develop a new GP contract for 2017 that once again makes becoming a GP an attractive career option, but until then the priority must be ensuring that GPs in communities across Scotland have the support they need to provide the care patients rely on.

A recent BMA survey1 found high vacancy rates in GP practices in Scotland, which are leaving practices struggling to cope. 28% of the practices who responded had at least one GP vacancy.

Scotland is facing significant GP recruitment problems which are being further exacerbated by difficulties in securing locum cover. An ever increasing workload, combined with falling resources, has led fewer doctors choosing to train as GPs, while senior GPs are choosing to retire early or work abroad for a better work-life balance. A high vacancy rate translates into a decline in the number of available appointments - reducing access to general practice at a time when we are trying to treat more people in their communities.

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1 BMA survey of GP practice vacancies, 19 June 2016
Consultant numbers and vacancies
National figures suggest that there are around 5115 WTE consultants working in the NHS in Scotland. The data also shows that there were 355 WTE consultant vacancies in March 2016, a total vacancy rate of around 6.5%. Of these vacant posts, 166 WTE had been vacant for more than six months.

Vacancies not filled through the recruitment process and posts that are not yet cleared for advert are generally not included in the official figures. Moreover ISD figures do not fully reflect the heavy reliance on locum doctors that boards are using to cover vacant consultant posts. The use of locums is a temporary solution and does not provide long term sustainability. It is therefore vital that these posts are included in vacancy data to enable proper workforce planning.

Vacant posts place immense pressure on the service. When NHS boards cannot fill a post other doctors within the team have to cover the workload or the service provided may be reduced. Staff are asked to work increasingly longer hours and more intensely to fill the gaps. Audit Scotland reported that vacancy rates, staff turnover rates and sickness absence levels all increased during 2014/15. Recruitment and retention of staff on permanent contracts remains a significant problem for many boards. As a result boards are now hiring more temporary staff to help keep services running. This is not a viable long term solution.

Trainee posts
Unfilled trainee posts are a further source of pressure on the health service that can leave services struggling to cope with gaps in healthcare teams. This problem is particularly pronounced around certain training specialties.

For example, this year only 68% of GP trainee vacancies were filled. Mental health specialties have faced particular problems in filling trainee vacancies for a number of years, with a fill rate of just 69% this year.

Ensuring that trainees are attracted to work in Scotland needs to remain a priority. The Scottish Government’s announcement that it will not unilaterally impose a new contract on junior doctors in Scotland is a positive step in this direction and may have been an important factor in the increased number of graduating doctors who have chosen Scotland as their first choice for foundation year posts this year.

Staff and Associate Specialist doctors (SAS)
SAS doctors can play a potentially significant role in addressing medical workforce pressures in the NHS however the absence of any opportunity for career progression to Associate Specialist since the closure of the grade in 2008 has served to make being a specialty doctor in Scotland less attractive than previously. As ISD do not collect vacancy data on SAS posts, it is impossible to quantify the scale of the problem across Scotland. However, we repeatedly hear anecdotal reports of unfilled

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2 ISD Workforce report, June 2016 http://www.isdscotland.org/Health-Tops/Workforce/Publications/index.asp#1662


4 NHS Education Scotland.
posts across a number of specialties and locations across Scotland, leaving some departments under considerable pressure, and resulting in expensive over-reliance on short-term locums.

The BMA’s Scottish Staff and Associate Specialist Committee (SSASC) continue to make representations to the Scottish Government and NHS Scotland employers seeking support for proposals for the re-opening of the Associate Specialist grade in Scotland. This would offer an attractive career progression pathway for SAS doctors, and have a positive impact to ease recruitment and retention issues in NHS Scotland.

**Adhering to nationally agreed contracts**

Consultants have always been leaders in developing and improving the delivery of patient care. Since 2004, a clear and specific amount of time has been allocated in consultants' job plans to recognise this work, which is called SPA time (Supporting Professional Activities). SPAs are at the heart of what it means to be a consultant and exemplify the added value that consultants bring to the NHS. It is during the time made available through SPAs that consultants are able to improve and hone their skills through auditing their practice, research and innovation, teaching medical students and junior doctors, developing new techniques and building new services. Such activities are essential to the long term maintenance and improvement of the quality of the service provided to patients alongside more readily recognisable direct, hands-on patient care.

The consultant contract sets out the standard number of supporting professional activities, 2.5 per week on average or 10 hours (paragraph 4.2.25), that should be made available to a full time consultant, with variation from this standard being subject to agreement between the employer and the individual consultant.

However, SPA time is being eroded all across the country, and many consultants are on contracts with fewer than 2.5 SPAs a week, such as a split of 8.5 to 1.5 or even 9:1. The driver for this is to ‘get more hands-on time’ from a consultant. The logic of this falls down if we want a health service which continues to excel and develop with the next generation of doctors properly trained.

SPAs are vital in allowing consultants the time and space to develop their skills, train junior staff and maintain and improve services and techniques which directly benefit patient care and safety.

SPAs form a key part of the job plan and the BMA is clear on the issue - any deviation from 2.5 SPAs should be questioned by the consultant concerned and the consequences fully understood. By maintaining appropriate SPA levels the BMA seeks to defend the quality and safety of care that patients receive.

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5.2.2 Unless otherwise agreed, a full-time consultant will devote 7.5 programmed activities per week to direct clinical care, and 2.5 programmed activities to supporting professional activities. Part-time consultants will require an allocation for supporting professional activities that is higher than the pro-rata allocation.
Dear Mr Findlay

Recruitment and Retention

Many thanks for your letter dated 20th July 2016 on behalf of the Health and Support Committee seeking a response from NHS Education for Scotland (NES) on issues relating to recruitment and retention, with a focus on remote and rural recruitment.

We note your observations on the data published by Information Services Division (ISD) and that you are seeking to understand how the training and education system is coping and adapting to ensure there are sufficient numbers of graduates to fill medical posts and that they are then retained within the NHS.

1. Context

In addition to our role in medical training, NES plays an increasing role in supporting recruitment and retention within other areas of the NHSScotland workforce. As the national training and education board for NHSScotland we have a key remit in supporting the whole service to deliver on all five strands of the Everyone Matters: 2020 Workforce Vision: Healthy Organisational Culture; Sustainable Workforce; Capable Workforce; Integrated Workforce; and Effective Leadership and Management. The principal role of NES is in the education and training of the NHS Scotland workforce. While we provide significant quantities of information on the workforce-in-training, decisions on the numbers in training (particularly in the so-called controlled subjects of medicine, nursing and dentistry) are for Scottish Ministers on the advice of officials.

2. Medical Workforce Data

The medical workforce is complex, and the time taken to train a doctor is prolonged. Training a general practitioner requires a minimum of 10 years (5 at medical school, 2 in foundation training, and 3 in GP specialty training), and training a hospital consultant can take up to 15 years (typically 8 years in specialty training) – so the state of the trained medical workforce today largely reflects decisions taken over a decade ago.

The selection, recruitment and education of medical undergraduates is under the control of medical schools across the UK. In Scotland, the Scottish Funding Council provides funding to medical schools, while NES provides funding (in the region of £78m) to NHS Boards to support medical undergraduate education and training in the clinical workplace.

NES is responsible for the selection, recruitment, funding, and quality assurance of doctors in training. During 2016, we supported 5,855 doctors in training across 293 GMC approved training programmes. We provide data on the numbers and progression of doctors in training to the Medical Undergraduate Numbers Group, and to the Scottish Shape of Training Transitions Group, where these data are used to support the development of medical specialty profiles, which in turn support advice to ministers on medical undergraduate intakes, and numbers of places for doctors in training programmes in Scotland.

3. Non-Medical Workforce Data
We provide support for workforce modelling through the provision of timely and accurate data on vocational dental practitioners in post in Scotland for NHS NSS national statistics; support for the Dental Intake Reference Group; an annual pharmacy workforce report, and support for a community pharmacy workforce survey. In addition, we work with Directors of Pharmacy and Scottish Government to undertake pharmacy workforce analysis to support workforce planning as part of Scottish Government Strategy Prescription for Excellence.

We also work with partners to acquire, analyse, and report on a broad range of data in relation to education and training, professional registration, employment, clinical activity and access to healthcare services. Further activities include reporting to support workforce planning for healthcare support workers, and labour market data for a wide range of healthcare professionals and other NHSScotland staff.

4. Non-medical Recruitment and retention

We work in partnership with NHS boards, education institutions and professional and regulatory bodies to deliver education and training for not only for doctors, but also for dentists, pharmacists, nurses, midwives, allied health professionals, psychologists, healthcare scientists, optometrists, healthcare chaplains, healthcare support workers, and management trainees.

We also play an increasing role in promoting the wider range of professions the NHS needs to operate, such as administrative and clerical services, finance, IT, estates and facilities and many others.

4.1 NHS Careers website: www.careers.nhs.scot

In conjunction with Skills Development Scotland we have recently developed a national NHS Careers website which promotes the wide range of careers available in NHSScotland. The site offers information about modern apprenticeships, job profiles, video clips of NHSScotland staff and links to current vacancies.

4.2 Nursing, Midwifery and Allied Health Professionals (NMAHP)

As a key part of our role in the performance management of undergraduate nursing and midwifery programmes in Scotland, we carry out a comprehensive annual analysis of undergraduate nursing and midwifery recruitment, progression and completion data, including individual cohort demographics, variation between institutional performance and evidence of trends across all providers. These detailed outputs directly support workforce planning, commissioning and funding decisions.

4.3 Dental

We managed the process by which, in 2015-16 all students from dental schools in Scotland who wished to undertake training in Scotland secured vocational training places. During the same year, pre-registration dental nurse training was successfully completed by 160 candidates ensuring a supply of fully qualified dental nurses eligible for GDC registration. In addition, we provided post-registration training to over 120 dental nurses to achieve enhanced skills beyond the minimum regulatory requirements.

We support improved retention of the dental workforce through the Keeping in Touch and Return to Work schemes. We also train mentors to provide support for the TRAMS programme (Training Remediation and Mentoring Support) for dentists in difficulty.

4.4 Pharmacy

In 2015-16, we worked with NHS boards and pharmacy professional organisations to recruit and train 170 funded PRPS (Pre-Registration Pharmacy Scheme) trainees. In addition, we delivered a national
training and quality management system for the PRPS trainees with a registration exam pass rate of 96%. Within the Scottish Pharmacy Vocational Training Scheme, we provided training and assessment for 120 Scottish hospital pharmacist VTS (vocational training scheme) trainees supported by a network of tutors.

4.5 Psychology

In 2015-16, we commissioned and recruited to programmes for 53 clinical psychology trainees, 21 MSc trainees in psychological therapies in primary care and 17 MSc trainees in applied psychology for children and young people. Doctoral level pre-registration training was successfully completed by 50 clinical psychology trainees, with 19 MSc trainees in psychological therapies in primary care and 15 MSc trainees in applied psychology for children and young people. We also support trainee health psychologists

4.6 Optometry

During 2015-16 we supported a total of 16 optometrists to undertake the MSc in Primary Care Ophthalmology. We also funded the training of 36 pre-registration optometrists on a one-day training course at Glasgow Caledonian University.

5. Supporting Remote and Rural Healthcare

Turning to the issue of supporting remote and rural healthcare, NES has a range of educational initiatives in place to support the rural workforce. In 2014 a collected set of Remote and Rural Actions was produced in response to the 2013 NES Board Paper Supporting Remote and Rural Healthcare.\(^1\) An updated copy of this Action Plan is included as Annex 2.

This paper contained 19 recommendations grouped into five themes:

1. Promoting awareness and understanding
2. Improving recruitment and retention
3. Alignment of education and training with workforce plans
4. Educational leadership to support service redesign and improvement
5. Leadership of a national Technology Enabled Learning programme for Scotland

The Action Plan at Annex 2 provides the detail of how these themes are being taken forward across the health and social care environment, both within NES and with partner organisations and groups.

These recommendations were placed in the NES Board Paper in the context of the WHO’s ‘Global Policy Recommendations on increasing access to health workers in remote and rural areas through improved retention’,\(^2\) which gathered the global evidence and presented it under four sets of recommendations: educational, regulatory, financial incentives, and personal and professional support. You have specifically asked for an updates on where the educational recommendations are being put into practice and we have understood the specific questions in your letter to relate to medical practice.

5.1 Use targeted admission policies to enrol students with a rural background in education programmes for various health disciplines, in order to increase the likelihood of graduates choosing to practise in rural areas.

- REACH initiatives to widen access, including those from rural areas\(^3\)

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3. [http://www.universities-scotland.ac.uk/bite-size-briefings/widening-access-to-medicine/](http://www.universities-scotland.ac.uk/bite-size-briefings/widening-access-to-medicine/)
5.2 Locate health professional schools, campuses and family medicine residency programmes outside of capitals and other major cities as graduates of these schools and programmes are more likely to work in rural areas.

- Recent Scottish Government announcement that a new graduate medical school will be a joint enterprise between the Universities of Dundee, St Andrews and the Highlands and Islands
- NES’s postgraduate rural-track training options
  - Foundation Programme
  - Rural-track GP Speciality Training
  - GP Rural Fellowships (with recent survey showing that over 70% of graduates are retained in rural Scotland)
  - Fellowships in acute specialties to prepare consultants for work in Rural General Hospitals including Rural Fellowships as highlighted in the Royal College of Surgeons of Edinburgh’s recent *publication Standards informing Delivery of Care in Rural Surgery*

5.3 Expose undergraduate students of various health disciplines to rural community experiences and clinical rotations as these can have a positive influence on attracting and recruiting health workers to rural areas.

- University of Aberdeen’s undergraduate medical remote and rural programme
- University of Dundee’s implementation of Longitudinal Clinical Clerkships in NHS Highland and NHS Dumfries & Galloway
- Recent Scottish Government announcement that a new graduate medical school will be a joint enterprise between the Universities of Dundee, St Andrews and the Highlands and Islands
- Scottish Government Remote & Rural Educational Development Group with representation from all universities and NES, and the aim to improve access to rural placements for all undergraduates in Scotland

5.4 Revise undergraduate and postgraduate curricula to include rural health topics so as to enhance the competencies of health professionals working in rural areas, and thereby increase their job satisfaction and retention.

- University of Dundee’s implementation of Longitudinal Clinical Clerkships in NHS Highland and NHS Dumfries & Galloway with a focus on rural practice
- Mandated rural attachments for students of both the Universities of Aberdeen and Dundee
- NES’s GP rural fellowships
- Work currently under way to design a ‘credential in rural medicine’ as highlighted by the GMC as a priority for Scottish Government in its consultation on credentialing

5.6 Design continuing education and professional development programmes that meet the needs of rural health workers and that are accessible from where they live and work, so as to support their retention.

- NES’s Clinical Skills Managed Educational Network, including the Mobile Skills Unit

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6 [http://www.scotmt.scot.nhs.uk/media/926836/Programme-Descriptor-North-Rural-Track.pdf](http://www.scotmt.scot.nhs.uk/media/926836/Programme-Descriptor-North-Rural-Track.pdf)
8 [https://www.rcsed.ac.uk/media/414252/rural-surgery-report-march-2016.pdf](https://www.rcsed.ac.uk/media/414252/rural-surgery-report-march-2016.pdf)
9 [http://www.abdn.ac.uk/smmn/undergraduate/medicine/remote-rural.php](http://www.abdn.ac.uk/smmn/undergraduate/medicine/remote-rural.php)
10 [https://sites.dev.dundee.ac.uk/discovermeded/2016/07/25/asmegmc-excellent-medical-education-award-win-for-new-longitudinal-clerkship-at-dundee/](https://sites.dev.dundee.ac.uk/discovermeded/2016/07/25/asmegmc-excellent-medical-education-award-win-for-new-longitudinal-clerkship-at-dundee/)
14 [http://www.csmen.scot.nhs.uk/#page=page-1](http://www.csmen.scot.nhs.uk/#page=page-1)
- NES’s CPD Connect initiative including the Practice-based Small Group Learning programme\(^\text{15}\)
- The ‘Being Here’ initiative (see Annex 2) with its bi-annual ‘Non-bypass Community Hospital Refresher Course’.
- The Scottish Rural Medical Collaborative (see Annex 2), with its objective to improve access to peer support, educational support and professional support

While NES’s prime focus is on education and our main area of impact will be on the educational recommendations listed by the WHO it is worthy of note that there are important actions relating also to the other three sets of recommendations; supporting the development of credentialed ‘Rural Practitioners’ for acute community hospital work (regulatory recommendations), piloting the provision of a £20,000 bursary to recruit GP Specialty Trainees to hard-to-recruit areas (financial incentive recommendations), and supporting the development of educational and professional networks (personal and professional support recommendations).

I hope that this information is of help to your committee. Please do not hesitate to contact me if we can be of further assistance.

Yours sincerely,

Caroline Lamb
Chief Executive

\(^{15}\) [http://www.cpdconnect.nhs.scot/](http://www.cpdconnect.nhs.scot/)
NES Supporting Remote and Rural Recruitment & Retention
Action Plan Update 2016

Current NES Initiatives

NES has a range of educational initiatives in place to support the rural workforce. In 2014 a collected set of Remote and Rural Actions was produced in response to the 2013 NES Board Paper Supporting Remote and Rural Healthcare 2013.1

NES Remote & Rural Action Plan

The NES Remote and Rural Action Plan 2014-2015 brought together key remote, rural and Island objectives and programmes of work from across NES to ensure streamlined delivery in the key areas. Work to develop educational resources and support systems that assist the work of the Boards in improving recruitment and retention have continued to build on these key areas in collaboration with education providers and partner agencies. The information provided below gives an overview of recent programmes of work, and examples of resources and reports that have been developed to support improved recruitment and retention of staff and quality of service.

A/ Promoting awareness of remote, rural and Island workforce needs

The Remote and Rural Healthcare Alliance (RRHEAL) within NES, works to develop and promote remote and rural inclusive education solutions. Remote and rural staff require access to high quality education and support that is accessible, affordable and sustainable. Education programmes need to be remote and rural appropriate not only in terms of format but also suited in content to the remote and rural context. RRHEAL works to promote these needs across Scotland with education partners. In this way working to ensure healthcare staff have access to appropriate knowledge support, skills maintenance and development opportunities to support their work as remote and rural practitioners. RRHEAL works to promote remote and rural exemplars of dynamic and innovative education solutions that are transferable across other parts of Scotland and the UK to assist in raising the profile of working in remote and rural areas.

RRHEAL at Distance Quality Assurance Guide

Preventing Falls Resource

Recognition and assessment of the sick child: a skills maintenance tool

Pregnancy Induced Hypertension

1 http://www.rrheal.scot.nhs.uk/media/185252/remote%20and%20rural%20healthcare%20updated.pdf
**Post-partum Haemorrhage (PPH)**

**B/ Supporting improved recruitment and retention of healthcare staff**

**Northern Peripheries & Arctic “Recruit & Retain Project**

RRHEAL were partners within the European Funded *Recruit and Retain* Northern Peripheries Project NPP between 2011 and 2014. The project was designed to identify and pilot test ‘solutions’ to the continuing challenges of recruiting and retaining health professionals in rural areas. The project included partners from Scotland (NHS WI, NHS H, RRHEAL/NES), Sweden, Greenland, Iceland, Ireland, Norway, and Canada. We identified 29 ‘solutions’ covering activities such as advertising, administration, relocation officer roles, marketing of the rural location, changes to how services are delivered, career development support, support for families and partners, and education and training. *Recruit and Retain* finished by documenting the key characteristics of each of the 29 solutions and outlining these within the Business Model. Full details of the Recruit & Retain Products & Services can be found here in the [solutions brochure](http://www.rrheal.scot.nhs.uk/what-we-do/reports/rrhealnorthern-peripheries-programme-aspx).

RRHEAL and Scottish partners went on to develop *Why Rural brand* and a range of publications promoting Scottish remote and rural working.

- [Why Rural Recruitment Booklet](http://www.rrheal.scot.nhs.uk/what-we-do/reports/rrhealnorthern-peripheries-programme-aspx)
- [Why Rural Retention Booklet](http://www.rrheal.scot.nhs.uk/what-we-do/reports/rrhealnorthern-peripheries-programme-aspx)

**Making it Work – Recruit & Retain 2015-2018**

*Recruit and Retain* was the beginning of an international process which aims to build capacity in rural organisations and communities to address their workforce challenges. RRHEAL are part of the expanded Scottish Group who have been successful in securing European funding to help implement a further programme of work supporting improved remote and rural recruitment & retention across Scotland and the Northern Peripheries and Arctic areas. Next steps are to implement the Business Model ‘on the ground’ in Scotland and across partner countries. Five of the of partner countries from *Recruit and Retain* agreed to work together on a follow-up project: *Recruit and Retain 2: Making it Work*. The new project will implement the business model to re-design and sustain systemic change in remote and rural workforces across the partnership.


Within Scotland the *Making it Work: Recruit & Retain Project* builds on a number of successful
rural recruitment and retention projects and programmes of work.

**Being Here**

NES are partners within the NHS HIGHLAND led the "Being Here Project. It is a major initiative to find different and innovative ways of sustaining health and care services in remote and rural communities. The three-year project was launched in 2013 with funding totalling £1.5 million from the Scottish Government and NHS Highland's brief was to devise and test innovative ways of recruiting and retaining healthcare professionals and particularly GPs.

NHS Highland is also working with other organisations to promote and enhance the image of North Highland and Argyll and Bute as a place to live and work, and is looking at issues such as accommodation, transport and IT connectivity. It recognises that training and career development are important for health-care professionals, and through *Being Here* NES are working with NHS Highland in implementing a programme of accredited training, workshops and awareness-raising.

Recruit & Retain Project and make use of products, services and the evidence base provided by the previous NPP Recruit & Retain Project.

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**The Scottish Rural Medical Collaborative (2016-2018)**

This new project has been successful in securing funding of £505,000 over two years from the Scottish Government to assist Rural Health Boards and partner organisations across Scotland to work collaboratively to address rural practitioner/GP recruitment and retention issues. This programme will build on the outputs from RRHEAL educational networks/programmes, NES and 'Being Here' to promote and support working in rural Scotland as the best place to be a rural practitioner/GP today. This programme of work will also link closely with the Making it Work Recruit & Retain Project and make use of products, services and the evidence base provided by the previous NPP Recruit & Retain Project.

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**C /Aligning education and training with workforce plans**

**Rural Teams Competency & Education Programme**

RRHEAL are working to support a range of projects aimed at identifying and designing education to support a range of new and expanded roles within rural teams. This work includes development of education support pathways for Rural Advanced Nurse Practitioners, Rural Generic Support Workers and Rural Practitioners working with Paediatrics. This work will
continue throughout 2016/2017.

**Rural Generic Support Worker**

RRHEAL led the development of educational mapping and competency frameworks to support the implementation of the first Rural Generic (Health & Social Care) Support Worker Roles in Scotland. RRHEAL continues to support the Boards in developing these roles by sharing and hosting of RGSW network events.


**D/Educational leadership to support service redesign and improvement**

The provision of high quality and technology enhanced education opportunities is one of the key methods through which we can ensure the remote, rural and Island workforce can continue to access high quality education and support to deliver improved care.

**Video conferenced Education Networks:**

Using existing and readily available technology RRHEAL have established a range of video conferenced education networks in response to the needs of the remote, rural and island workforce. These are tailored to meet specific priority topic areas and at educational levels relevant to specific workforce groups. They provide accessible, affordable and high quality educational opportunities for our dispersed workforce across Scotland.

**RRHEAL VC Education Network**

Multi professional topics this year have included: *Falls Update Apps for AHPs, Seasonal/Winter Illness focusing on Bronchiolitis and Croup, Stabilisation and Management of the Critically Ill Child Prior to Transfer, and Debriefing Essentials amongst others.*

**RRHEAL VC Education Network Summary Report 2015/2016**

**Rural Practitioner/GP Education Network**

RRHEAL together with Medical Directorate colleagues have piloted a series of four new Rural
GP VC Education sessions. These facilitated sessions focused on rural practitioner hot topics such as Acute Coronary Syndromes, Major Trauma remote and rural response, assessing those at risk of suicide and managing frailty in rural settings.

RRHEAL Rural GP VC Education Network: Evaluation of initial education series

Rural General Hospital Workforce

RRHEAL have established the NES Rural General Hospital (RGH) VC Education Network to support specific education needs across this workforce.

RRHEAL RGH VC Education Network Summary Report March 2016

Further VC Education Networks are planned for 2016/2017 these have been streamlined to meet the demands and needs of the following workforce groups.

1/ Rural General /Advanced Nurse Practitioners       2/Rural Paediatric Workforce

E/ Leadership of the technology enabled workforce learning programmes

Technology Enabled Learning (TEL) for the workforce

RRHEAL have established a number of programmes of work in aimed at supporting the remote and rural Boards development of a technology enabled workforce. This work involves collaboration with a range of education and third sector partners and builds on the evidence base of the NES 2014 TEL Baseline Survey.

Supporting Technology Enabled Learning June 2016

TEL Baseline 2014 Executive Summary

Digital Highland 2016

RRHEAL are health partners within this multi-agency Highland project aimed at ensuring people within Highland communities and the workforce providing services to them are supported to make best use of available technologies. RRHEAL are working with partners to
implement a range of programmes that support increased use of digital technology across the healthcare workforce in remote areas of Highland. This work builds on the partnership established with Citizensonline who have assisted with providing tutors, hardware and "Digital Champions Programmes" for health and social care staff in Highland.

Highland TEL /Learning & Development Staff 2016

RRHEAL worked with NHS Highland to develop the first Scottish TEL digital technology skills programme for learning and development NHS staff. This RRHEAL funded programme has been developed by UHI and will be delivered across Highland from October 2016.

Highland Care at Home Staff TEL

RRHEAL worked with Citizensonline in the design and delivery of introductory TEL/digital technology awareness and skills sessions for health & social care colleagues who provide care at home. Currently delivering to 2nd cohort.

Western Isles Care at Home Staff and TEL

RRHEAL have supported Western Isles develop a sustainable, accessible model for current Care Home/ Care at Home Workers core education. This has included a useful collaboration with Citizensonline, promoting engagement and application of technology in both the home and workplace.

Further details of RRHEAL programmes of work, open access resources, reports, guides and information specific to the remote, rural and island workforce can be found here on the RRHEAL Platform www.rrheal.scot.nhs.uk
Recruitment and Retention
NHS Highland

1. In what areas are you experiencing the greatest difficulties in recruitment and retention?

General Practice
Recruitment of staff, particularly GP’s, has been a longstanding challenge across the rural and remote parts of Highland. More recently, it has also become a problem affecting the more urban places as well. NHS Highland has faced almost continuous GP recruitment challenges over the past 15 years. During this period, the board’s primary care team has built strong relationships with all GP practices and are aware of many, but not all, of the challenges that each of them face.

There are 100 GP practices scattered across the NHS Highland area. Of these, 19 (as at August 16) are salaried practices run by the health board. The other 81 are run by GPs under a General Medical Services (GMS) contract.

The first practice in Scotland of any size to close was in NHS Highland in 2012 (the 5,600-patient Riverbank Practice in Thurso); this year Riverview Practice in Wick, (7500 patients), will also pass into NHS Highland control. Our learning from these difficult transitions has been and will be shared with colleagues from across the country.

There is no easy or exact answer as to how many doctors are required or how many we are short as each practice is making its own decisions on how to replace doctor vacancies. It is worth noting that very few GP’s now work what would traditionally be thought of as “full-time”. Increasing numbers have portfolio careers working a set number of sessions as frontline GP’s. The precise level of doctor activity in a practice cannot therefore in any way be equated against the number of doctors who work in the practice.

We currently have ** vacancies or adverts out for xx GPs

Rural General Hospitals
NHS Highland have three RGHS (Lorn and Islands in Oban, Belford in Fort William and Caithness General in Wick)

The vulnerability of services in the RGH’s are well documented and evidenced by significant recruitment & succession planning challenges with high agency and locum use. A number of staff groups are impacted, including; Consultants in all specialities, Midwifery, Pharmacy and Biomedical Science.

Medical Staff
District General Hospital (Raigmore)
A number of hospital based specialties at Consultant and Specialty Doctor grade are experiencing recruitment difficulties, including:

- Gastroenterology
- Oncology
- Ophthalmology
- Psychiatry
- Radiology
- Rheumatology

**Midwifery**

Significant challenges have been faced in sustaining the required midwifery workforce across Highland. Full establishment reviews have been carried out with work underway to recruit to additional posts in areas where required. 50% of the registered midwives are over the age of 45 years with significant number of retirements anticipated in the coming years. Work is underway with the HEIs (Robert Gordon University and University of West of Scotland) to ensure recruitment of appropriate student numbers. It is hoped that shortened programmes can be delivered by the HEIs and this is currently at discussion stage between SG NMAHP Directorate and with Lead Midwives for Education (LME).

**Allied Health Professions**

Recruitment and retention is proving challenging, in particular remote and rural vacancies have a high impact on service continuity; small teams covering a large geography resulting in a limited ability to flexibly use resources without impacting other areas of service provision. There are limited bank staff resources to support service continuity due to a small pool of available local staff that are not in employment.

Certain remote and rural geographical locations are proving more challenging regarding recruitment across a broad spectrum of Allied Health Professions. Commonly posts require several advertisements which leads to months of gaps in local service delivery due to an inability to attract an applicant – this can be across all grades.

**Social Work**

Recruitment of qualified social workers is challenging, particularly specialist, for example, Mental Health Officers. There is an ageing workforce profile that is causing increased turnover as officers retire (and who have leadership roles and significant SW experience). The nearest SW training is in Aberdeen (RGU). However, we have implemented a social work trainee scheme which will support workforce supply more locally in the future.

**Care at Home and Care Homes**

In some areas, particularly in remote and rural areas being able to staff care homes and provide care at home is a concern

2. What are the key barriers to recruitment in your area?
The availability of appropriately trained and qualified staff. There are recognised national shortages in a number of professions including:

- Health Visiting
- Medical Physics
- Radiotherapy specialities
- Clinical Physiology – Echocardiography, GI physiology and Neurophysiology
- Medicine – as listed in question 1.

Smaller professions such as orthoptics, prosthetics and orthotics are challenging with regard to succession planning and sustainability. NHS Highland has had some success around recruitment and retention of the workforce in these professions in the past but will experience a vacancy in orthotics in early 2016/17 which may prove difficult to fill.

**Allied Health Professions**

AHP students are trained mainly in the central belt / Aberdeen, so there is an inability to “grow our own”. They often leave remote and rural areas to take up training but don’t return; or support workers that have young families but would like to train are unable to access the undergraduate courses. Some of the undergraduate courses have moved to split practice placements (combining work based experience with academic study in the university each week) this has proved a barrier to the provision of rural experience when training and probably results in a lower uptake of rural positions. Lack of / cost of accommodation and transport availability has also been a barrier to students accepting rural placements.

Regarding attracting qualified AHP staff; there are no incentives to attract people to remote and rural areas. This is not just a premia issue, but also relates to access to good accommodation and social facilities for the workforce.

Additionally;

- lack of familiarity with the area
- lack of social life / activities that are associated with central belt for young staff
- limited opportunities for single people to meet others in remote locations
- access to travel / transport links and distance from other areas
- lack of information about the benefits of working in some of our remote and rural areas (there is a big focus on medical recruitment around this but not other professions, as yet)

**Barriers**

Some of the barriers we face are around jobs for partners; housing and distance from family linked to perceived lack of responsive transport networks. There is also the issue for some of professional isolation feeling of being in a ‘gold-fish bowl’ when living and working in a small community. Maintaining skills and access to training at a distance.
3. Please provide examples of incentives/initiatives that have shown positive results in recruiting?

Being Here Programme
This is a Scottish Government funded programme to look at trying alternative models of primary healthcare in remote and rural Highland. The new models are associated with a multi-disciplinary team approach, practice mergers, with less reliance on individual GPs and single handed practices.

One of the four project work-streams is to target the recruitment and retention of rural GPs. The Being Here programme launched a co-ordinated recruitment campaign in 2014/15 which has been associated with the recruitment of 12 rural GPs. Some supplementary work is required to ensure that this targeted approach is tied in to future recruitment demand and workforce planning activity. Long term – the ‘rural pipeline’ for newly qualified GPs, rural fellows, placements and electives are all associated with tackling the root causes of lack of retention and the need to be ‘growing our own’. These models will rely on the throughput of suitably qualified rural GPs to supplement and eventually replace the current GP workforce through succession planning.

GP Rural Fellowship scheme
The results of a study into the national scheme which gives newly-qualified doctors a taste of life and work in remote and rural areas has evaluated very positively.

The scheme which is organised by NHS Education for Scotland (NES) is one that the board has always strongly supported as part of our approach to recruiting and retaining medical staff in some of our more remote areas. There are currently six GPs on the fellowship scheme, five of whom are in the NHS Highland area. As well as gaining experience of working in remote and rural practices, the rural fellows are given 13 weeks of protected time and a financial allowance to support a learning programme based on the person’s needs. Educational time is spent attending courses, clinical attachments in both hospital and primary care, and studying.

Clinical Development Fellows
Clinical Development Fellows (CDF’s) were introduced to NHS Highland in 2015. They are doctors in training that are typically between Foundation and Specialty and are employed by us for a year in a variety of clinical areas. They also have a significant amount of time allocated to personal development through participation in quality improvement, research or audit.

Development of Advanced Practice Roles in Pharmacy
There are now 2 Advanced Practice Pharmacists employed in Caithness that work across Primary and Secondary care. In addition to the clear benefits to patients of this model, the contractual arrangements whereby the Pharmacists are employed by NHS Highland & contacted to practices, enhances leadership and governance arrangements.

Allied Health Professions
Prospective advertising – asking qualified AHPs with an interest in living in the Board area to make contact in order to discuss potential upcoming opportunities.
Use of social media to publicise vacancies, relocation packages and increasing hours and grades of posts

4. What are the key barriers to retaining staff in your area?

Allied Health Professions

A lack of promotional opportunities in a small specialist workforce or the need to extend the breadth of experience, and some cite professional isolation. Some newly qualified staff see the benefits of coming to an area where there is a lot of variety initially and greater breadth of experience due to limited staffing, but soon out grow this and go to a similar grade post in a busier, more populated environment where they can consolidate this initial experience of being fairly autonomous as a junior staff member (specific examples of this in OT and dietetics). However, a high number of leavers have identified personal reasons – partner’s career prospects; lack of social opportunities for new graduates; moving closer to family.

In small teams any vacancy can have a high impact on workload and the unavailability of local temporary staffing in rural areas can result in high caseloads and increased stress which can contribute to people leaving posts.

Additionally, access to easy travel and transport links.

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

We have taken a number of other initiatives which may not have had a direct positive result, however, have been positive in demonstrating to staff and communities that we have pursued a number of routes such as:

Recruitment Video for consultant oncology –
https://www.youtube.com/watch?v=aZw62YwKkGI

Recruitment Video for consultant radiology –
https://www.youtube.com/watch?v=HyWTFsPGduM

Recruitment Campaign in Holland (direct flights to Inverness via Easy Jet)
http://www.nhshighland.scot.nhs.uk/News/Pages/DutchdoctorswantedinHighland.asp

New ways of working

Part of our approach has been to overcome challenges in recruitment. For instance GP Practices in all settings are starting to find a wide range of innovative ways of replacing doctors who leave. Sometimes they do manage to source a replacement doctor, but often they seek other healthcare professionals to assist and to take on some aspects of work previously undertaken by the doctor. For example, nurses of all grades and skills, prescribing pharmacists and pharmacy technicians, healthcare assistants, Allied Healthcare Professionals (AHPs) and ambulance technicians and paramedics are all in the mix.

Over the past 15 years the board has taken every opportunity to coalesce and amalgamate small practices together, particularly in the more rural settings. This has now happened on 12 occasions, 10 of them orchestrated by the health board and two by GMS practices themselves. The most recent merger has been Durness with Kinlochbervie and Scourie. So, while the actual number of practices appears to
have reduced, no practice has “dissolved”, but many have merged with neighbouring practices. We are supporting practices all of the time with most practices at some point having asked for some assistance, if only to think through their options for replacing doctor vacancies.

**Collaboration**

We are working closely with partner agencies such as local chamber of Commerce to work collaboratively to support targeted recruitment

**Other**

In terms of recruiting, Consultants rated the following approaches as being successful in attracting interest in Consultant posts:

<table>
<thead>
<tr>
<th>Approach</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct contact from a clinician in NHS Highland</td>
<td>89.4%</td>
</tr>
<tr>
<td>Previous experience of working in NHS Highland</td>
<td>87.1%</td>
</tr>
<tr>
<td>Where adverts are placed</td>
<td>85.1%</td>
</tr>
<tr>
<td>Quality of job description materials and adverts</td>
<td>81.9%</td>
</tr>
<tr>
<td>Having an organisational CV</td>
<td>26.9%</td>
</tr>
<tr>
<td>Promotion via social media</td>
<td>26.1%</td>
</tr>
<tr>
<td>Presence of Linkedin</td>
<td>8.0%</td>
</tr>
</tbody>
</table>

**Allied Health Professions**

Re-invigorating new graduate support groups to bring isolated practitioners together but this hasn’t yet proved the test of time.
Recruitment and Retention
RCGP Scotland

The Royal College of General Practitioners (RCGP) is the academic organisation in the UK for general practitioners. Its aim is to encourage and maintain the highest standards of general medical practice and act as the ‘voice’ of general practitioners on education, training and issues around standards of care for patients.

The College in Scotland came into existence in 1953 (one year after the UK College), when a Scottish Council was created to take forward the College’s interests within the Scottish Health Service. We currently represent around 5,000 GP members and AiTs throughout Scotland. In addition to a base in Edinburgh, the College in Scotland is represented through five regional faculty offices in Edinburgh, Aberdeen, Inverness, Dundee and Glasgow.

This response refers to recruitment and retention issues for the general practitioner workforce. The call to focus on remote and rural issues is noted but the scope of this report extends beyond the issues for remote and rural Scotland due to the current, much wider, serious challenge facing the general practice workforce. The recruitment and retention problems now facing urban areas are placing general practice services in some towns and cities in an even more critical position than the longer standing issues for remote and rural general practice. The evidence for this is summarised in this response.

RCGP has repeatedly highlighted the difficulties in recruiting and retaining GPs.

We published A blueprint for Scottish general practice in July 2015, outlining some of the main issues affecting general practice, bringing attention to rising workloads, unmanageable and unsustainable workloads, a shortage of GPs, declining resources and falling share of NHS investment. It called on the government to shift NHS funding into general practice; set a clear target for increasing the proportion of the NHS budget spent on general practice to 11%; to publish regular statistics monitoring how much NHS funding is being directed towards primary care; and to set up a new, five year transformation fund. The Blueprint also explains how expanding the primary care workforce to support the hub of general practice could ease workload and better use resources.

Our manifesto for the 2016 Scottish Parliamentary Election: Promoting General Practice is central to the future of the NHS in Scotland. It aims to promote solutions in order to safeguard general practice.

A BMA survey of Scotland’s GP practices revealed the extent of the recruitment gaps in general practice in Scotland. This snapshot GP vacancy survey of all 975 practices in Scotland received 500 responses and found that on 15 February 2016,
26% of practices had at least one GP vacancy of which 41% had been vacant for six months or longer. A further BMA Scotland survey found that on 01 June 2016, 28.5% of Practices had at least one vacancy.

**DIMINISHING GENERAL PRACTITIONER WORKFORCE**

In June 2016, the Information Services Division (ISD) of NHS Services Scotland published the results of the [Primary Care Workforce Survey Scotland 2015](#). These official national statistics confirm the evolving reduction in the amount of GP manpower available to deliver care to patients.

Key points from the survey:

- Decrease in the number of Whole Time Equivalent (WTE) GPs across Scotland. The estimated number of Whole Time Equivalent (WTE) GPs declined by 2% between 2013 and 2015 (from 3,735 to 3,645).
- Age distribution for sessions worked indicates that a significant proportion of GPs who currently work eight or nine sessions are due to reach retirement age in the next five years, representing a greater proportion of pending sessional loss to the workforce than actual WTE headcount.
- Gender distribution indicates that male GPs tend to work more sessions so the gender shift trend towards more women in the GP workforce also points to a compounding proportionate reduction in total sessions worked for the same WTE headcount.
- An increase in the number of GP vacancies since the last survey in 2013. 22% of practices responding to the survey reported that they had vacant GP sessions at 31 August 2015. A large proportion of the vacancies reported in the survey that were still unfilled had been vacant for over six months.
- The headcount of GP vacancies reported by practices was 150, equating to WTE vacancies of 114. The vacancy rate (vacant sessions as a percentage of total sessions) was 4.8% (Table 1.25 and Table 1.26). Highest rates were in Western Isles and Shetland.
- 60% of practices regularly unable to recruit locums for unplanned absences.
- GP Out of Hours (OOH) services are reliant on a relatively small number of GPs carrying out a notable proportion of the hours worked and a significant proportion are within five years of retirement age posing a further imminent threat to the OOH GP workforce.

A measure of the current position is reflected in the increasing number of practices on special measures. There are currently believed to be 11 practices (July 2016) on special measures in Lothian alone. In October 2015, data indicated that 49 practices were run by their respective health boards. In the last twelve months, a total of ten practices have been placed in the hands of NHS boards.

**INCREASING WORKLOAD**
This diminishing GP workforce is facing an exponential increase in workload demand for GP practices. Current workload trends indicate that the number of consultations in general practice in Scotland has increased from 21.7 million in 2003 to 24.2 million in 2013 with a 11.5% rise in consultation rate per patient over ten years. This is in the context of an ageing population and a rise in the number of people suffering from one or more long term condition with a resulting increase in the complexities attached to each consultation of managing patients with multi-morbidity. The shift of more and more care away from hospitals into the community requires more GPs to provide the spiraling increase in medical care delivered at home.

DIFFICULTIES WITH RECRUITMENT AND RETENTION OF GENERAL PRACTITIONERS

In order to reflect the experiences and views of the wider RCGP Scotland membership within the content of this response, RCGP Scotland conducted an online questionnaire survey for a two-week period during July 2016 to answer the questions set out in the Health and Sport Committee’s call for evidence. Responses were received from 203 RCGP Scotland members.

94.6% of responders perceived difficulties in recruiting GPs to their practice area and 58% are currently experiencing difficulty recruiting to their practice. The main reason for difficulty is due to insufficient applicants with many responders specifying not enough GPs, a lack of desire for GP partnership, workload, and many indicated the lack of desirability for the location of the practice area.

82.1% of responders perceived difficulties in retaining GPs in their practice area with 42.2% reporting actual experience of difficulties in retaining GPs within their practice. Workload was the most commonly named reason for difficulty in retaining GPs in the practice and within the practice area, with pension arrangements, early retirement and stress contributing to the problem of retention.

A full summary of the results of the survey including quotes from members can be found in Appendix 1.

A national survey of GPs by the BMA in 2015 found factors which negatively impact on personal commitment to continuing a career in general practice.
A ComRes survey conducted on behalf of RCGP and published on 28 April, 2016, surveyed 150 GPs in Scotland between March and April 2016 and found that almost a tenth (9%) of Scotland’s GPs are planning to leave general practice in the next year and a staggering 58% of respondents say they are planning to either leave or reduce their hours in the next five years. For GPs in Scotland, 77% worry about missing something serious with a patient because of their workload. 93% of GPs also believe that, without more resources, waiting times for appointments will increase, despite frequent reports of patients waiting for three weeks already.

RECRUITMENT TO GENERAL PRACTICE SPECIALTY TRAINING IN SCOTLAND

There has been a downward trend in the numbers of applications and subsequent appointments to GP Specialty Training in Scotland as indicated:

<table>
<thead>
<tr>
<th>% places filled</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCOTLAND</td>
<td>90.59%</td>
<td>99.71%</td>
<td>90.54%</td>
<td>96.03%</td>
<td>91.80%</td>
<td>89.37%</td>
<td>79.14%</td>
</tr>
<tr>
<td>WALES</td>
<td>97.64%</td>
<td>91.91%</td>
<td>99.14%</td>
<td>82.03%</td>
<td>96.15%</td>
<td>89.68%</td>
<td>87.20%</td>
</tr>
<tr>
<td>NI</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>98.46%</td>
<td>100.0%</td>
<td>96.92%</td>
<td>100.0%</td>
</tr>
<tr>
<td>ENGLAND</td>
<td>96.70%</td>
<td>102.35%</td>
<td>99.48%</td>
<td>99.34%</td>
<td>99.14%</td>
<td>87.09%</td>
<td>88.84%</td>
</tr>
</tbody>
</table>

Sourced from data on https://gprecruitment.hee.nhs.uk/Resource-Bank

The fill rate for GP Specialty Training in 2016 in Scotland is 74%. Current trends and fill rates from NHS Education for Scotland (NES) data confirm the continuing reduction in fill rates for general practice as compared with 100% fill rate in most other specialties.
In addition to the perceived challenges currently facing GPs (as summarised in the BMA and ComRes surveys above) which make general practice appear to medical students to be a less attractive medical career choice, there are a number of additional factors contributing to this downward trend in recruitment to GP training places: [http://bit.ly/2aRWh5q](http://bit.ly/2aRWh5q)

Recent evidence published by the Royal College of Psychiatrists highlighting the ‘badmouthing’ about their own specialty, has revealed the extent of the negative attitudes to general practice conveyed to undergraduates in medical schools.

RCGP is currently undertaking work on attitudes to teaching within medical schools which will add to the evidence.

Survey data on the career choices of final year medical undergraduates tells us that experience of a specialty has a significant influence on career choice and Medical Teachers are known to exert an influence as role models. Exposure to general practice as an undergraduate varies across the medical schools in Scotland and the amount of exposure to training in general practice appears to correlate with the output of doctors choosing to be general practitioners although it is acknowledged there are other contributors. These continue to be determining factors among foundation doctors but personal factors including geography also have a greater influence by this stage.

Data from the UKFPO (UK Foundation Programme Office) has revealed a year on year reduction in the percentage of doctors completing foundation training who apply for specialty training in the UK (Table 2). In 2015 just over 50% applied to any specialty training programmes when they became eligible to do so at the end of their Foundation Programme. With most other medical specialties in Scotland successfully filling all their training places, the number of foundation doctors applying to general practice specialty training in Scotland as their first choice or as a second choice back up was inevitably reduced with only 18% of foundation doctors entering GP Specialty Training in 2015\(^1\).

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\(^1\) F2 Career Destination Report 2015 – The Foundation Programme. The UK Foundation Programme Office.
National career surveys have provided data on the factors which influence the career choices of Doctors but there is little published evidence on why doctors are not currently choosing general practice. However, the circumstantial evidence indicates that this is not perceived as an attractive career option at this time.

RCGP Scotland believes that the key barriers to recruiting GPs are:

- A lack of Scottish medical students who subsequently choose to train in general practice in Scotland
- Insufficient experience of GP during undergraduate and foundation training and an inherent negative attitude to general practice as a career choice
- Research has shown that GPs feel their current workload is unmanageable and unsustainable.

### DIFFICULTIES WITH RETENTION OF GPs

Figures indicate that there are a large number of GPs leaving the profession mid career. Due to the fluid nature of multiple Performers Lists it has not been possible to obtain accurate national figures but it should be possible to formulate a reliable data set once a single national Performers List for Scotland is established. Many GPs are retiring earlier than previously. Reasons include pension arrangements, tax legislation, and appraisal and revalidation requirements but evidence now indicates that current workload arrangements are a key contributor. The BMA and ComRes surveys cited above have shown that GPs feel their current workload is...
unmanageable and unsustainable. We know that some GPs take a career break for family reasons, including a lack of any child support arrangements, but there is also an exodus of GPs moving overseas.

In the last year it was reported that there were around 900 UK RCGP members working in Australia. On 21 July this year 608 UK members were working in Australia, 250 UK members were in Canada, 335 UK members are in Egypt.

GENERAL PRACTICE IN REMOTE AND RURAL AREAS

In the Being Rural report published by RCGP Scotland in 2014, a number of priority areas were highlighted for improving rural recruitment and retention. Challenges caused by poor infrastructure - including digital connectivity, physical transport links and access to an integrated supportive healthcare team - rank higher than even 'traditional' barriers such as access to training, locum cover and remuneration. Strikingly, Sir John Dewar noted similar challenges in his report in 1912, and despite that there has been a paucity of progress in these areas.

The negative impact which wider policies in Scotland can have in the remote and rural context needs to be recognised and acknowledged and new policies must be rural-proofed.

Rural recruitment and retention needs to benefit from a more joined-up approach with a recognition of the numerous stages of developing career interest in rural healthcare - from work observation for school pupils, to effective professional supports for newly-moved rural GPs.

RCGP Scotland has done much to report the key issues, and the Being Rural report was a milestone providing an updated assessment of the situation. There is much to learn from international experience, and effective collaborative opportunities are already available through the connections of RCGP membership.

Our GP colleagues working in remote and rural Scotland call for solutions formulated from strategic planning and overview, which is built from connecting with those at 'grass roots level' - particularly as that is where much of the innovation and collaboration is already happening, and it is also where the despondency, pressure and threat from inadequate response lies: which serves to exacerbate the retention issue.

The needs of the 'mobile GP' should be recognised - increasingly there is a 'fly in fly out' approach to provision of rural healthcare, where GPs often live and work in separate areas. Changes such as the move to a single GP Performers List are welcome.

The Scottish Rural Medical Collaborative (brought together by the Scottish Government's recent GP Recruitment and Retention Fund) offers the potential to
look at how to capture some data that is more relevant to the GP workforce in remote, rural and island areas.

Some anecdotal and informal examples of how things have unfolded in different ways as workforce gaps have appeared are described in Appendix 2.

**PLANNED AND POTENTIAL SOLUTIONS TO THE RECRUITMENT AND RETENTION DIFFICULTIES IN GENERAL PRACTICE**

**GP Career Flow**
RCGP Scotland has developed the GP Career Flow concept and adopted the mind map flow diagram (Appendix 3) to represent the GP career journey and its influencing factors from the time of making career choice as a school pupil to post retirement activity. This prompts us to target the workforce deficit at all points on the map and has been viewed as a valuable tool by other stakeholders who have responsibility for areas of the GP workforce.

Research from 2015 reviewed worldwide strategies to recruit and retain GPs - [http://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-016-1370-1](http://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-016-1370-1). Interventions could be broadly categorised into 13 groups: retainer schemes, re-entry schemes, support for professional development or research, specialised recruiters or case managers, well-being or peer support initiatives, recruiting rural students, rural or primary care focused undergraduate placements, rural or underserved postgraduate training, marketing, delayed partnerships, international recruitment, financial incentives and mixed interventions. The strongest evidence was for financial incentives.

**Medical Student Career Choice**
Longer term solutions to GP recruitment target the influence on medical student career choice. RCGP Scotland welcomes initiatives to increase exposure to general practice in the undergraduate medical curriculum. Extended periods of teaching based solely in general practice will be offered through the longitudinal clerkships being developed. With rigorous evaluation to prompt an iterative process of appropriate revision, this new initiative will need to be extended more widely across all the Scottish medical schools.

The new Graduate Medical Schools in Aberdeen and Dundee aim to deliver the curriculum through community-based learning activity which is expected to engineer professional development towards a continuing career in community settings.

**Marketing General Practice**
There needs to be a concerted effort to market general practice as an attractive, stimulating and rewarding career option. RCGP Scotland is developing a programme of recruitment roadshows and faculty based career support to promote general practice as a career. Support is also being given to the undergraduate GP Societies which are becoming more active in the Scottish Medical Schools. RCGP UK members have developed a number of marketing initiatives promoted via twitter - #whyGP #TeamGP #ProudtobeaGP
The College launched a campaign, *Put patients first: Back general practice*, on 16 November 2013. The key aim of the campaign was to ask that the percentage of NHS budget spent on general practice is increased, in each of the four UK nations, to 11% by 2017. This campaign has consistently highlighted the difficulties in recruiting and retaining GPs. The *Put patients first* campaign activity in Scotland aims to create opportunities to highlight in the media how success in the campaign objective for increased investment in general practice will secure a very attractive, stimulating and rewarding career option. There is also a plan for the newly formed and formally ratified RCGP Scotland AiT and First5 Committee to further develop the marketing strategy to promote a career in general practice to school pupils, medical undergraduates and foundation doctors. The RCGP Scotland Patient Group (Patient Partnership in Practice - P³) is also keen to explore ways in which patients can contribute to raising the profile of general practice in a positive light.

The potential longer term benefits of increasing the number of GP training places in Scotland from 300 to 400 each year is warmly welcomed by RCGP Scotland but this is a bitter sweet gain in the short term without success in filling existing places. Financial incentives have been made available to encourage recruitment to training programmes which have historically been more difficult to fill. Funding to support new initiatives within GP training such as the ‘out of programme’ Scottish Government research fellowships, which have been developed in collaboration with the other Royal Colleges, would be welcomed by RCGP Scotland to broaden the appeal of GP Specialty Training.

NES offers various post Certificate of Completion of Training fellowship posts which provide continued educational and structured support for further professional development and which are designed to be attractive career options for GPs who have completed GP Specialty Training. These are fixed-term posts some of which are offered as less than full time providing the opportunity to compliment this with locum or other sessional clinical work.

The rural fellowships are partly funded by NES and partly funded by territorial health boards. The boards are able to use the rural fellow to provide some service provision, such as allowing GPs in salaried practices to take leave where locum cover might otherwise have been relied upon for the additional manpower. The marketing of these posts highlights the educational component. Over the course of a year, a GP will visit practices in several locations as part of the rural fellowship. This will require travel, although there is a stable salary paid over this time. The other fellowships include Inequalities fellowships, Medical Education fellowships and the newer Community Hub fellowships.

An increase in the number of fellowship posts to enable these to be offered more widely to GPs on completion of specialty training could provide a further career incentive to recruitment and increase retention in the general practice workforce.

**Stronger General Practice Teams**
Build stronger general practice teams with the optimum skill mix to deliver care to patients making more efficient use of GP skills to achieve a more manageable and sustainable workload for GPs. RCGP Scotland and the Royal Pharmaceutical Society are working on a joint statement outlining the role of the Practice Pharmacist in general practice. The training and development of this enhanced Practice Pharmacist workforce will require initial pump priming and sustained investment. RCGP Scotland also welcomes the call for a mental health professional and community links worker attached to all practices in Scotland.

**Encourage and support return to practice after a career break or a period working outside the UK or out with NHS general practice.**

NES manages the Scottish GP Retainer and Enhanced Induction Programmes. This scheme offers a funded educational programme to those whom Medical Directors of Health Boards feel need such a programme to support their return to the GP workforce in Scotland. NES have redesigned the website to provide an enhanced information resource which provides the relevant information and signposts doctors to help with their return to practice in Scotland ([http://www.nes.scot.nhs.uk/gp-return-induction](http://www.nes.scot.nhs.uk/gp-return-induction)).

To inform the marketing campaign for these programmes, NES commissioned Wild Heather Research to conduct a GP Induction and Returners Survey targeting individuals with the potential to be GPs in Scotland but not currently operating as GPs in Scotland to explore reasons for leaving practice, intention to return, barriers and enablers, and knowledge about the Retainer and Induction Programmes. The results of the survey were reported in June 2015. Many participants were recently retired GPs and the main reason for leaving was workload, however a significant number were mid career and cited personal reasons for not returning to practice. Results indicated that the Retainer and Induction Programme would encourage some to return to practice. The national campaign to raise awareness of the schemes resulted in an increase in the number undertaking the programme. It is crucial that the programme continues to be adequately funded to avoid waiting lists. Sustained marketing is essential to ensure awareness of the schemes is maintained.

There is now a link to the redesigned NES website on the main RCGP website and there is additional summarised information on the RCGP Scotland website promoting the Programmes and directing interested GPs to the NES resources. RCGP are now offering one year’s free membership to GPs returning to clinical practice after a break of more than two years.

The GP Retainer Scheme managed by NES offers an alternative option to work in a more supported role for up to four sessions in practice for up to five years for GPs whose domestic circumstances benefit from this arrangement.

Increasing the numbers of GPs remains the key objective for RCGP Scotland to address the workload demands and to deliver an effective, safe, patient-centred and high quality service which meets the standards set by RCGP.

**Other Schemes and Initiatives that have shown positive results in recruiting GPs**
- The Govan SHIP project has managed to recruit GPs through investment. Four Govan Deep End practices share two additional GPs, paid as long-term locums. Two of the initial appointments have become GP partners.
- Dundee is currently offering new GPs a supported (NHS contract) role which allows for a portfolio career i.e. a mix of clinical service delivery with another option, e.g. specialised clinical service delivery like MFE or an academic role.
- ‘Speed Dating’ sessions run in Aberdeen by Dr V. Gutherie.
- Action-research and test-for-change activity that occurred as part of the ‘Being Here’ project with funding from Scottish Government.

There are a number of additional schemes and initiatives outside Scotland that RCGP Scotland is aware of that are providing solutions to recruitment difficulties in general practice from which lessons can be learned. RCGP also has a forum for GPs to submit ‘Bright Ideas’ to inform practice and share best practice:

<table>
<thead>
<tr>
<th>Scheme/Initiative</th>
<th>Area context</th>
<th>Information</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Dublin City GP Training Scheme</td>
<td>Area of 'blanket deprivation' where there were real issues with GP recruitment</td>
<td>There’s more information about its unique approach (the curriculum includes modules on self-care, change management, research and arts) in the attached document, from 2014.</td>
<td><a href="http://www.icgp.ie/go/become_a_gp/training_programmes/B6A4FA53-19B9-E185-83CAFD6FC0B651A8.html">http://www.icgp.ie/go/become_a_gp/training_programmes/B6A4FA53-19B9-E185-83CAFD6FC0B651A8.html</a></td>
</tr>
<tr>
<td>Connecting with our future</td>
<td>Large (16k) practice on the northern edge of Sheffield</td>
<td>To encourage schoolchildren in our area not to write themselves off as potential future doctors. As we prove everyday, you need a good heart but not Einstein’s brain to be a doctor!</td>
<td><a href="http://www.rcgp.org.uk/clinical-and-research/bright-ideas/chapelgreen-practice-sheffield-connecting-with-our-future.aspx">http://www.rcgp.org.uk/clinical-and-research/bright-ideas/chapelgreen-practice-sheffield-connecting-with-our-future.aspx</a></td>
</tr>
<tr>
<td>Proposed Wales student incentivisation scheme (under consideration)</td>
<td></td>
<td>Pay off student debt</td>
<td></td>
</tr>
</tbody>
</table>

Dr Elaine McNaughton, Deputy Chair (Policy) RCGP Scotland. August, 2016.
Appendix 1

RCGP Scotland recruitment and retention survey – August 2016

In order to supplement the evidence on recruitment and retention for the Health and Sport Committee and to provide a more representative experience and viewpoint from RCGP Scotland, we issued a survey to our members in July 2016. This was sent to 3,743 members. Due to the short timescale to develop the survey, to disseminate it to members during the holiday period and to collate results, a low response rate was anticipated. 203 Members responded representing 5.4% of the membership. This was clearly too low to apply any statistical significance to any quantitative data collected, which is presented for interest, but also includes the experiences and views of sufficient numbers for the qualitative data to be considered generally representative of the RCGP Scotland membership and to reflect the current recruitment situation across Scotland.

The following questions were asked of members in relation to recruitment and retention:

<table>
<thead>
<tr>
<th>All members (203)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you currently experiencing difficulties in recruitment of GPs within your practice?</td>
<td>58%</td>
<td>42%</td>
</tr>
<tr>
<td>Is there current difficulty with recruitment of GPs in your practice area?</td>
<td>94.6%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Are you currently experiencing difficulties in retaining GPs within your practice?</td>
<td>42.2%</td>
<td>57.7%</td>
</tr>
<tr>
<td>Is there current difficulty in retention of GPs within your practice area?</td>
<td>82.1%</td>
<td>17.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Members in rural areas (27)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you currently experiencing difficulties in recruitment of GPs within your practice?</td>
<td>51.9%</td>
<td>48.1%</td>
</tr>
<tr>
<td>Is there current difficulty with recruitment of GPs in your practice area?</td>
<td>92.6%</td>
<td>7.41%</td>
</tr>
<tr>
<td>Are you currently experiencing difficulties in retaining GPs within your practice?</td>
<td>23%</td>
<td>76.3%</td>
</tr>
<tr>
<td>Is there current difficulty in retention of GPs within your practice area?</td>
<td>65.4%</td>
<td>34.6%</td>
</tr>
<tr>
<td>Members in semi-rural areas (56)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>----------</td>
<td>---------</td>
</tr>
<tr>
<td>Are you currently experiencing difficulties in recruitment of GPs within your practice?</td>
<td>52.7%</td>
<td>47.3%</td>
</tr>
<tr>
<td>Is there current difficulty with recruitment of GPs in your practice area?</td>
<td>96.3%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Are you currently experiencing difficulties in retaining GPs within your practice?</td>
<td>38.9%</td>
<td>61.1%</td>
</tr>
<tr>
<td>Is there current difficulty in retention of GPs within your practice area?</td>
<td>82.7%</td>
<td>17.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Members in urban areas (83)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you currently experiencing difficulties in recruitment of GPs within your practice?</td>
<td>63.9%</td>
<td>36%</td>
</tr>
<tr>
<td>Is there current difficulty with recruitment of GPs in your practice area?</td>
<td>95.3%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Are you currently experiencing difficulties in retaining GPs within your practice?</td>
<td>49.4%</td>
<td>50.6%</td>
</tr>
<tr>
<td>Is there current difficulty in retention of GPs within your practice area?</td>
<td>83.3%</td>
<td>16.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Members in deprived areas (46)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you currently experiencing difficulties in recruitment of GPs within your practice?</td>
<td>60.9%</td>
<td>39.1%</td>
</tr>
<tr>
<td>Is there current difficulty with recruitment of GPs in your practice area?</td>
<td>93.5%</td>
<td>6.52%</td>
</tr>
<tr>
<td>Are you currently experiencing difficulties in retaining GPs within your practice?</td>
<td>46.7%</td>
<td>53.3%</td>
</tr>
<tr>
<td>Is there current difficulty in retention of GPs within your practice area?</td>
<td>75.6%</td>
<td>24.4%</td>
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</tbody>
</table>
### Members working in Out of Hours practice

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you currently experiencing difficulties in recruitment of GPs within your practice?</td>
<td>42.9%</td>
<td>57.1%</td>
</tr>
<tr>
<td>Is there current difficulty with recruitment of GPs in your practice area?</td>
<td>85.7%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Are you currently experiencing difficulties in retaining GPs within your practice?</td>
<td>28.6%</td>
<td>71.4%</td>
</tr>
<tr>
<td>Is there current difficulty in retention of GPs within your practice area?</td>
<td>57.1%</td>
<td>42.9%</td>
</tr>
</tbody>
</table>

### Recruitment of GPs

The main difficulties identified by members at this time in **recruiting GPs in practices** are:

1. Lack of applicants (39%)
2. GPs not seeking partnerships (16%)
3. Workload (12%)
4. Not enough GPs (9%)
5. Location (7%)
6. Lack of locums to cover recruitment (3%)
7. Salary (3%)
8. Unattractive job (2%)
9. Only wanting part time work when advertising full time post (1%)
10. No jobs available for partner as well (1%)
11. OOH requirement (1%)

In rural areas, the main difficulties are location, lack of applicants and GPs not wanting partnerships. In semi-rural areas the main difficulties are lack of applicants, GPs not wanting partnerships, not enough GPs and workload. In Out of Hours, the main difficulties are GPs only seeking part time work, not enough GPs, lack of applicants and lack of locums. In deprived areas the main difficulties are lack of applicants, GPs not seeking partnerships and not enough GPs available. In urban areas the main difficulties are lack of applicants, GPs not seeking partnerships and workload.

Quotes from members indicate some of the problems they are experiencing:

“*We have had ten cycles of recruitment to replace three now retired partners in six years.*”
“We recently advertised for a partner for four months and had NO applicants. Five years ago we had 27 applicants.”

The main difficulties identified by members at this time in recruiting to practice areas are:

1. Lack of available GPs (24%)
2. Practice area is undesirable location (23%)
3. Excessive / increasing workload (19%)
4. Partnership seen as undesirable (14%)
5. Lack of applicants (12%)
6. Preference for locum work over salaried work (7%)
7. Pay not enough to attract applicants (4%)
8. Lack of trainees (3%)
9. Preference for part-time work over full-time (3%)
10. Deprivation of area (2%)

In rural areas, the main difficulties are location of practice area, lack of available GPs and excessive or increasing workload. In semi-rural areas the main difficulties are location of practice area, lack of available GPs and lack of applicants. In Out of Hours, the main difficulties are deprivation of practice area, dislike of Out of Hours work and stress. In deprived areas the main difficulties are lack of GPs, location of practice area and excessive / increasing workload. In urban areas the main difficulties are excessive / increasing workload, location of practice area and lack of available GPs.

Quotes from members indicate some of the problems they are experiencing:

“Registrars fear the commitment of partnership as they are uncertain about the future of the profession.”

“Most ex trainees want to work as locums or in OOH as they can earn as much as a full time partner on fewer hours and no paperwork.”

The key barriers to recruiting to general practice were identified by members as:

- Workload
- Negative perception of general practice
- Long hours
- GPs not wanting to be partners within practices and preferring locum work
- Negative press regarding general practice

Quotes from members highlight the responses in relation to this:

“The way GP is portrayed from the minute medical students join medical school…it’s always portrayed as the worst specialty that anyone with no aspirations...
goes into which as we know is very untrue. We need to change the way all the doctors in secondary care portray GP to students and the way that medical schools portray general practice.”

“Students see and hear why so many of us older guys are so unhappy with the way our jobs have been messed around and why we are all taking early retirement. How many GPs now would recommend GP to their children?”

Retention of GPs
The main difficulties identified by members at this time in retaining GPs in practices are:

1. Workload (34%)
2. Pensions (8%)
3. Early retirement (8%)
4. Work/Life balance (5%)
5. Attractiveness of locum GP positions (4%)
6. Stress (4%)
7. Burnout (4%)
8. GPs emigrating (3%)
9. Low morale (2%)
10. Geography of where practices are located (2%)

In rural areas, within practices, the main difficulties identified are workload, workforce, salary, and work/life balance. In semi-rural areas, the main difficulties are workload, pensions, early retirement, work/life balance, attractiveness of locum work and GP burnout. In deprived areas, the main difficulties identified were workload, early retirement, stress, workforce, work/life balance, GPs emigrating and geography of practices. In urban areas, main difficulties identified were workload, early retirement, pensions, work/life balance and salary.

What is most prevalent is highlighted by these quotes from members:

“There are so few locums now that the locums can pick and choose when and where they want to work setting out to a practice how much they wish paid and what they will do for that pay. Why take on the stress and responsibilities of partnership when this is on offer?”

“Can earn more money working as a locum seeing fewer patients and without the responsibility of being a partner i.e. paperwork / insurance reports / employer of staff / surgery running costs.”

“No incentive with pension to stay on past late 50s.”
The main difficulties identified by members at this time in retaining GPs within practice areas are:

1. Workload (36%)
2. Pensions (9.3%)
3. Stress (8.7%)
4. Early retirement (8.6%)
5. Lack of GP Workforce (5.6%)
6. Attractiveness of locum work (5.3%)
7. Work/Life balance (5.3%)
8. Salary (4.6%)
9. Burnout (4.3%)
10. Geography of where practices are located (4.3%)

In rural areas, the main difficulties identified are workload and lack of support. In semi-rural areas, the main difficulties are workload, stress and the location of practices. In deprived areas the main difficulties identified are workload, pensions and better opportunities. In urban areas the main difficulties identified are workload, pensions and early retirement.

The key barriers to retaining GPs as identified by members were similar to the main difficulties and include:

1. Workload
2. Salary
3. Pensions
4. Stress
5. Burnout

Additional RCGP Scotland Members’ Comments (submitted in freetext):

Incentives to recruitment:
Workload initiatives – 15 minute appointments and 5 minute telephone appointments; Practice nurse for minor illness; being a training practice; self-funding additional GP (resulting in drop in income for all GPs); involvement in projects eg LINKS

Helping recruitment: – ‘look after locums’; positive, forward thinking practices, create ‘hybrid’ posts; golden ‘hellos’; initiatives to attract trainees: increase in flexible GP training; maintain a good supportive team and positive training experience; North of Scotland trainee recruitment blog; offered to pay part of CSA fees to successful candidates
Appendix 2

Anecdotal and Informal Remote and Rural examples

Acharacle, The Small Isles and Durness are all examples of where service change has been needed because of a lack of interest when the health board tried to recruit using the previous service model.

In Acharacle there were problems around providing Out of Hours commitment. A couple of dynamic GPs were in post with much of their careers still ahead of them. In 2011, feeling the strain, they had asked for a reduction in the amount of OOH they were personally required to do, then both resigned after failing to get support they wanted from the health board.

In May 2012, the Small Isles suffered the unexpected death of their resident GP. NHS Highland provided some locum cover, then tried to restructure the service.

There were initially hopes that the Mallaig and Arisaig practice could lead the formation of a new practice that also covered Acharacle and the Small isles. The West Lochaber Medical Practice was the name of the project but it never really got up and running. There were big, glossy adverts placed in the BMJ. Despite some interest, very few GPs were willing to sign up for the salaried doctor positions that the new model would have depended upon. NHS Highland then turned to their salaried doctors on Skye to cover the Small Isles.

In Durness, Alan Belbin was a single-handed GP who retired around the time that he was expected to. The post was widely advertised a few times with no applicants. Dr Anne Berrie is a GP salaried by NHS Highland who was working in the neighbouring Scourie and Kinlochbervie Medical Practice. These practices have now been merged together by NHS Highland with the GP having a 24-7 commitment, covering the Out of Hours duties for the area. Dr Berrie is part time and is only in the area two and a half weeks a month.

Riverside Medical Practice in Inverness took over a small practice, the Loch Ness East and Strathnairn in Foyers, where a husband and wife GP team were retiring. The likely reasons why another practice might take an interest in Foyers include being a dispensing practice with relative proximity to the city and the lack of an Out-of-Hours commitment.
Appendix 3

GP Career Flow Mindmap

Scottish GP Career Flow

- Secondary Education
  - GP societies
  - Dewar Bursaries
  - Workplace experience
- Medical School
  - Admissions
  - Widening participation
- Foundation Programme
  - Broad based training
- Hospital Specialty Training & career
- GP Specialty training
  - Enhanced 4yr training
  - Leadership & Academic opportunities
- Recruitment/Selection
- MRCGP exam
- Fellowship
- Early
- Mid
- Late
- Trainer status
- Career break
- GP Bumout or ill health
- Retiral
- Emigration
Author background

This is a contribution to the Health and Sport Committee’s request for written evidence pertaining to current recruitment and retention issues facing the NHS workforce in Scotland, with a focus on remote and rural areas. I am a Specialty Registrar in General Surgery but am currently a Scottish Clinical Leadership Fellow, based at the Royal College of Physicians and Surgeons of Glasgow, and employed by NHS Education for Scotland. However, the administration and interpretation of this survey was conducted in a personal capacity. I have a long-standing interest in remote and rural surgery and intend to practice surgery in a Scottish remote and rural environment once my surgical training has been completed.

Nature of Evidence

In collaboration with a fellow surgical trainee, Miss Ella Teasdale, I have undertaken a recent survey of current Scottish surgical trainees, at all stages of training in general surgery. This survey aimed to describe the attitudes of current surgical trainees to remote and rural surgery. Surgical posts in remote and rural areas are particularly difficult to recruit to¹ and we wished to explore reasons why. Our survey covers a number of the areas which your committee is interested in.

Our data collection began in June this year and is still ongoing but in view of your committee’s deadline for submissions of 17th August, I present an interim report. This data was collected both by online and paper-based methods. If this work is of interest to the committee, I would be happy to provide final results or further information in due course.

Summary of Evidence

Survey Participants

Our survey has so far captured responses from 129 Scottish surgical trainees (response rate 45%), from across all regions. 84 respondents were male (65%). Twenty-two respondents were in “core” surgical training, which are the first 2 years of training (23%).

Thirty-five respondents (27%) reported having lived in a rural location for at least 12 months before attending medical school. Thirty-seven respondents (29%) had

undertaken part of their medical training in a remote and rural location, and 35 respondents (28%) had worked as a doctor in a remote and rural location.

Interest in Remote and Rural Surgery
Only 12 respondents reported being likely or very likely to work long-term in a remote and rural environment (9.8%). However, 108 (84%) felt that training should be offered in a remote and rural environment and 56 (43%) were personally interested in undergoing part of their training in a remote and rural environment. Further insights:

- Core trainees (at the beginning of surgical training) were much more likely to express an interest in working as a remote and rural surgeon (27%, versus 5.3% of later-stage trainees).
- Of those who had previously lived in a rural environment, 20% were interested in working as a remote and rural surgeon, versus 5% of individuals who had not previously lived in a rural environment.
- Of those who had worked in a rural environment, 17% were interested in working as a remote and rural surgeon, versus 6.7% of those who had not.

Barriers to working as a Remote and Rural Surgeon
Respondents were asked their opinions on the most important barriers to recruitment of remote and rural surgeons. Of ten options offered, the five most frequently rated as of first importance were, in order:

1. “unattractive geography/climate”
2. “lack of work/training opportunities for immediate family members/partner”
3. “surgeons feel that their skills are too specialised to cope with the breadth of work”
4. “high burden of out of hours commitment/responsibility”
5. “inadequate financial remuneration”

Written comments regarding the question of how to make jobs more attractive included a number of recurrent suggestions, including:

- More training opportunities in remote and rural surgery, particularly at an early stage.
- Stronger links between rural surgeons and colleagues in larger district general hospitals, for the purpose of clinical support, training, career development and research.
- Better promotion of this kind of surgical job, with more information offered.
- Better remuneration.
Conclusions

Our survey of Scottish surgical trainees finds that a small number of surgeons in training (10%) express an interest in working long-term in a remote and rural environment. Those more likely to be considering a remote and rural career are at the beginning of their training, are from rural backgrounds (in keeping with previous international research\(^2\)), and have had experience of working in a rural hospital.

Important barriers identified to remote and rural recruitment include factors related to the nature of rural living, the demands of these jobs and perceived lack of opportunity for competitive remuneration.

In terms of improving the attractiveness of rural jobs, trainees have suggested improving the quantity and quality of training offered in rural hospitals, improving the links between rural hospitals and larger centres, promoting remote and rural working more effectively, and offering financial incentives.

As highlighted recently by The Herald’s health correspondent Helen Puttick\(^1\), the current staffing situation in Scottish rural surgery is precarious, with recurrent difficulties in filling vacancies.

Scottish surgical training programmes and the surgical community as a whole need to be sensitive to the need to produce some general surgeons who are capable and motivated to work in rural environments, and should take account of the suggestions offered here in improving recruitment. Attention is drawn to the recent remote and rural surgery report published by the Royal College of Surgeons of Edinburgh (RCSEd)\(^3\), which recommends that a 4 to 6-month attachment in rural surgery is offered to all Scottish surgical trainees. The data from this survey suggests that there would be considerable interest in taking up such an opportunity. The RCSEd report also advocates for carefully optimising rural consultant pay and conditions, with generous access to study leave and time in larger units being very important. Again, trainee comments in this survey would suggest that these moves would prove helpful. Scotland’s unique geographical features within the UK present a particular challenge in providing surgical care and we must rise to this.

On 27 October Stuart Ferguson provided a link to the following report: Royal College of Surgeons Edinburgh, Standards informing delivery of care in rural surgery.

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http://www.searo.who.int/nepal/mediacentre/2010_increasing_access_to_health_workers_in_remote_and _ruralAreas.pdf