NHS CHIEF EXECUTIVES JOINT SUBMISSION

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1. Introduction

This submission reflects on the responsibilities and recommendations for boards and regions identified in the Auditor General’s report on ‘NHS Workforce Planning – the clinical workforce in secondary care’. It also reflects on the key themes and issues for boards and regions identified in the Official Report of the Committee’s evidence session on Thursday 21 September 2017 with the Auditor General.

The submission is based on the invited Chief Executives collective experience of workforce planning within the NHSS, responsibilities as the Chief Executive of a Health Board and as Regional Implementation Lead responsible for leading regional service, financial and workforce planning.

2. Summary

We would agree with the analysis within the Audit Scotland Report that improvement is required in a number of key aspects of workforce planning, within the NHS. Over the last 10-15 years across NHS Scotland there has been progress in workforce planning compared to where we were. This submission identifies the main recommendations and themes, provides a response to each and, where possible, provides further detail and examples. We also note that the report focuses on the secondary care workforce and that we have not therefore included evidence on the GP workforce at this stage.

The key to successful workforce planning is having robust quantitative and qualitative workforce information and intelligence on which to base decisions. It also requires engagement with those working within the service, to assess a range of assumptions relating to workforce supply and demand and the changing economic, population and health service delivery context.

The range of service provision and diverse geography makes effective health sector workforce planning highly complex. This is, in part, due to the wide range of roles and staff groups within healthcare. There are c350 different NHS roles many of which have different training and education pathways. Within each of those, there are sub-specialities and roles which can vary greatly between departments, services and organisations.
Boards and regions planning processes will need to reflect the significant financial pressures they face in the coming years. The next round of public spending review is likely to require boards to make a financial saving of between 7% and 10% over 3 years. The expectation is that boards adopt an integrated service, financial and workforce planning approach to deliver this. The challenge for boards will be to continue to deliver safe, efficient and effective services whilst meeting rising demand and delivering the required saving from their paybill costs. Boards remain obliged to deliver affordable workforce plans.

We welcome the recommendations set out by the Audit Scotland for the Scottish Government and NHS boards. These, coupled with the recommendations and next steps set out in the ‘National Workforce Plan – Part One’, provide a way forward. We look forward to working collaboratively in order to deliver this challenging but essential planning agenda.

3. Key recommendations for Boards identified in the Auditor General’s report on “NHS Workforce Planning – the clinical workforce in secondary care

There are three main recommendations for boards included in the Auditor General’s report. Whilst we agree with the recommendations we would also like to draw out some key issues for consideration and provide examples of where boards are already making progress:

3.1. Recommendation 1 - ‘Produce future plans based on demand as well as supply criteria. This would include:

   a. projecting their future workforce against estimated changes in population demography and health factors
   b. producing plans which detail the expected workforce required, supported by analysis of workforce supply and demand trend’

Workforce Planning Guidance & Processes for Boards

CEL 32 – ‘Revised Workforce Planning Guidance’ (2011) sets out the requirements for Boards to produce annual Workforce Plans. It also sets out the requirement for Boards to produce workforce projections for 3 years, (it was previously 5 years), as this is aligned to the normal spending review period. The projections for the controlled undergraduate group of doctors and dentists are currently only required to look forward 1 year. Numbers of undergraduate places for Nurses and Midwives are also controlled and are projected over 3 years. The longer term workforce planning process is led by the Scottish Government (SG) and supported by NHS Education for Scotland.

NHS 2020 Local Delivery Plan guidance (2013) required boards to include workforce planning within their LDPs and, in particular, an assessment of any workforce pressures or risks that could impact upon service delivery or quality. Boards have produced annual Workforce Plans, annual 3 year workforce projections and summarised boards’ own key workforce risk assessments within their LDPs. In effect these are their assessment of current and future short to medium term workforce demand pressures. These are submitted to the SG to support national
workforce planning processes, in particular the commissioning of undergraduate and post graduate professional education for controlled groups.

Workforce planning is not an arithmetic exercise. The longer the planning cycle, as in medical workforce planning, the greater the number and influences with a range of internal and external variables, are likely to have on the process. For example: public sector pay freezes; BREXIT; changes in pension schemes; changes in taxation of pension benefits; changing gender balance within the medical workforce; changes in immigration regulations; workforce shortages in UK and international markets; millennial generation career expectations; university funding changes; and student intakes across the UK have all had, or will have an impact on workforce supply and demand. The impact of each is difficult to predict, hence the need for more sophisticated scenario planning with clinical involvement at all stages.

**Current Supply Challenges**

Whilst the overall NHS workforce has increased, so too has service demand and the complexity of caseload associated with the demography and epidemiology of the population i.e. more older people with more co-morbidities. The workforce supply in some specialties and professions has not kept pace, and are far less be able to subsume changes in clinical practice, which in turn stimulate further service demand. There are significant consultant recruitment difficulties in both Scotland (this differs by board and regions) and the UK in a number of medical specialities which are experiencing high service demand as a result of the ageing population, including:

- Clinical radiology
- Dermatology
- Geriatric medicine
- Histopathology
- Medical oncology
- General surgery
- Otolaryngology
- Paediatrics
- Trauma & Orthopaedics
- Obstetrics & Gynaecology
- General Psychiatry
- CAMHS
- Old age Psychiatry
- General Practice.
- Emergency Medicine
Given it takes in excess of 15 years to train a consultant (from enrolling in medical school), the current training pipeline is unlikely to fill these vacancies in the short to medium term. Boards are looking at service and workforce redesign in order to sustain these services.

For example, the growth in diagnostics has seen a significant increased demand in radiology interventions. However, the supply of consultant radiologists has failed to keep up with demand and the lack of consultants is now reaching a critical level in many boards.

Boards have been investing in regional service redesign solutions to address service gaps and in workforce redesign, using radiographer reporting of plain film x-rays in order to reduce the consultant radiologist workload.

3.2. Recommendation 2 – ‘Fully cost the workforce changes needed to meet policy directives, such as the shift to community-based care, proposed elective centres, safe staffing levels and more regional working.’

Reshaping and Adapting
The future focus for workforce planning within boards and regions will not be on workforce growth per se, but on reshaping and adapting the existing and available future workforce to work differently across the health and social care service spectrum.

Scottish Government set policy direction and it is essential that the implications of both financial and non-financial risks, e.g. workforce demand and supply, are identified. It is not within the scope of either regions or boards to set policy directives; however, they do clearly have an operational role to implement.

We see the future board and regional workforce planning processes characterised by:

- Taking place at the appropriate level – IJB, board, regional or national – with clear and understood links between each;
• Becoming more multidisciplinary and multi-agency in its focus, including the commissioning of undergraduate and post graduate education and training provision;
• Being based on a realistic assessment of known workforce supply and demand, including the known and significant demographic challenges within the existing workforce;
• Staff working at the top of their skills set, with an appropriate skills mix;
• Delivering flexible employment opportunities that meets the career expectations of the future workforce including ‘growing our own’ workforce through apprenticeship programmes;
• Driving workforce redesign that supports sustainable service redesign;
• Operating within a quality improvement and safe staffing framework;
• Being based on an agreed approach, methodology and data set and collaborative approach across the H&SC services;
• Driving the education and training agenda that will deliver the workforce required, focusing on both the existing and the future workforce, including remote and rural challenges;
• Ensuring the provision of educational pathways supporting career progression.
• Delivering solutions for the smaller occupational groups who are essential to service delivery;
• Meeting local system needs and addresses all aspects of the H&SC workforce from the large tertiary service to the remote and rural service;
• Providing the basis for recruitment and retention initiatives nationally, regionally and locally; and
• Challenging current employment practices and how services can make better use of an ageing or retired workforce.

Integration Joint Boards (IJBs) are also required to produce Workforce Plans. These are only just emerging and boards are working closely with IJBs in how these will sit alongside board workforce plans and the wider planning process.

3.3. **Recommendation 3 – ‘Improve the accuracy of budgeting for agency spending.’**

We would seek to assure the Committee that all Boards as part of their standing financial procedures and processes are acutely aware of their expenditure on agency, and indeed wider supplementary staffing solutions. These costs are routinely reported through established governance mechanisms, which are intrinsically linked to the reporting, control and use of these solutions. However boards are also clear that they have to provide safe and sustainable patient care and will, when required, use agency staffing to ensure this.

The national Managed Agency Staffing Network (MASNet) team provide monthly reporting of nursing and medical agency spend allowing trend analysis and benchmarking across NHS Boards. There are Executive Director Leads responsible for medical locum spend in every board who liaise with MASNet to share good practice and Scottish Executive Nurse Directors group has an action plan in place to reduce agency nursing spend. However there are limitations at reporting and managing these costs at a regional level but plans are in place as part of the Regional Delivery Plans to take this forward.
4. Key themes and issues for Boards and Regions identified in the Official Report of the Committee’s evidence session on Thursday 21 September 2017 with the Auditor General.

In reviewing the transcript of the Auditor General’s evidence session on 21 September, the following themes and issues are identified as important for boards to consider and act on either individually or collectively as regions.

4.1 Workforce planning leadership and responsibility within boards

Workforce Planning Complexity
Workforce planning is complex and the planning landscape has changed significantly since the extant workforce planning guidance, via ‘CEL32 (2011) - Revised Workforce Planning Guidance 2011’ was issued in that the guidance pre-dates the introduction of Integrated Joint Boards and there was no requirement for regions to produce a regional workforce plan, this was introduced following the publication of the Health & Social Care Delivery Plan in December 2016 and the associated arrangements arising from the introduction of Regional Delivery Plans.

Workforce planning operates at different levels and it may be useful to think of two inter-related processes:

- Top down – strategic planning, focused on medium to longer term, alignment with wider service policies and strategies, environmental and technological scanning, scenario planning, concentration on developing the workforce for next 3-10 years; and

- Bottom up – operational planning, short to medium term, alignment with operational delivery, focus on workload, headcount, recruitment, performance indicators i.e. absence, concentration on getting the workforce for today, tomorrow and next 1-3 years.

The Scottish Government leads the processes for the commissioning of under and post graduate education and training for the controlled groups of doctors, dentists, nurses and midwives.

Significant work within boards has been carried out on the bottom up planning processes, however, as the Audit Scotland Report points out, there needs to be greater focus on the longer term, more strategic, top down process and better alignment between the bottom up and top down processes. We agree with this assessment.

Workforce Planning Methodology
The 6 steps process (Appendix A) has provided a consistent methodology for NHS Scotland. This creates a challenge in that other H&SC partners such as independent contractors within primary care, local authorities and 3rd sector have either different, or no established methodology. This makes workforce planning across the entire health and social care economy in a board or a regional a challenge. However boards are already working with local and regional partners in adapting the existing 6 Steps methodology to support wider health and social care planning.
Going forward the need to consider the entire health and social care economy is implicit and this is across the entire whole workforce not just ‘specialist’ registered clinicians. For example, home care assistants and nursing assistants play a critical and significant role in stemming the demand for acute services and facilitate the desired balance of care shift.

**Future Focus for Workforce Planning**
Demand for NHSS services continues to grow, however, the continued growth of the workforce as a response is not feasible. This approach would fail to meet two of the three workforce planning criteria (Affordable: Adaptable: Available) laid out in Scottish Government workforce planning guidance. A continual expansion of the workforce would be neither affordable nor available.

Current workforce supply issues have been outlined earlier. Current modelling for a number of medical specialties suggests that NHSS medical training programme outputs will not be sufficient to increase existing numbers of trained doctors in a number of specialities, including General Practice. Similarly, given the current nursing and midwifery workforce demographic and the acknowledged shortfall in undergraduate output until 2020, it is unrealistic to plan for an expansion in nursing and midwifery numbers. The focus will therefore be on how we utilise the existing workforce and available future workforce differently and more effectively in the future.

**What We Have Achieved to Date**
Workforce planning has developed in NHS Scotland over the last 10-15 years. Although we acknowledge that more work is required significant achievements have been delivered including:

- There are more NHSS staffing than ever before and, in particular, more doctors, nurses and midwives and other clinical facing staff delivering clinical services to more patients
- We have moved from a consultant led to an increasingly consultant delivered service
- Modernising Medical Careers, New Deal and EWTR. have been implemented and robust systems are in place to better manage and enhance the quality of medical training and employment in partnership with SG and NES
- New roles have been developed and implemented to address workforce gaps including Physicians Associates (PAs), Clinical Development Fellows (CDFs) Advanced Nurse (ANPs) and AHP Practitioners and Perioperative Practitioners
- SG recommended 6 Step methodology is now embedded in board planning processes
- Tools have been developed to identify and quantify workforce risks, for example the Age Profile Tool, Medical Workforce Risk Assessment Tool
- Nursing workload and workforce planning tools have been developed and implemented successfully across the vast majority of the nursing workforce
- Ongoing work with Further and Higher Education providers has ensured that educational programmes fit with the requirements of the service
- In collaboration with SG, ISD and NES workforce data quality has improved significantly and there have been collaborative work to use this data to better model the future workforce supply e.g. Medical Workforce Profiling
• Significant amount of work has taken place on updating and improving NHS workforce data i.e. improving the data quality of the community, paediatric and neonatal nursing workforces
• Educationally sound Return to Practice programmes have been established to encourage those who have left medical and nursing professions to return to work
• Boards continue to deliver workforce plans, workforce projections and an assessment of workforce risks in their LDPs annually.

4.2 Affordability of the workforce and workforce projections

Current and Future Workforce Challenges
Boards plan using a ‘bottom up’ workforce planning approach. Extending this to involve partners across health and social care will provide a more considered workforce plan. However planning across these partners at four different tiers: national, regional, board, and IJBs/H&SCPs will be complex. Balancing the unique, but mutually dependent, workforce requirements and needs arising from each will be a difficult process and influenced by a number of factors. There is a balance to be struck between detail and strategy. How this will be done is not yet clear but it is believed that the new National Workforce Planning Group will provide leadership on how this will be done. The reinstated National Workforce Planning Forum will provide technical support and advice.

Affordability of plans
Boards are required to deliver affordable workforce plans. Limited information on future funding coupled with the SG requirement to provide workforce projections for three years is insufficient for longer term planning purposes. This is significantly more challenging when considering the medical workforce, boards are currently only required to provide a single year projection, despite a training period of 15+ years. As boards work with both multi-disciplinary and multi-agency teams, there is a need for a medium-longer term focus and to utilise scenario planning to understand the future workforce requirements in terms of roles, skills, numbers and most importantly affordability of the workforce.

Boards are required to project their workforce requirements annually for the next three years. Recently, boards have generally ‘flat lined’ their workforce projections reflecting both the financial projections for both boards and the public sector and the requirement to meet existent national guidance i.e. it needs to be affordable and financial allocations are currently made on an annual basis. Workforce planning is part of a tripartite planning approach linked with service and financial planning. It is required to meet the three SG criteria of Affordable, Adaptable and Available. The requirement to deliver financial balance therefore requires any Workforce Plan to be affordable.

Workforce Data
The quality and accuracy of NHS workforce data has improved significantly. Boards will have to continue to work on the accuracy and quality of their data as well as seeking access to other sources to inform future workforce plans. The workforce data, however, from other stakeholders, is less comprehensive, less contemporary and not available centrally. Work will be required to create an H&SC workforce data set for future planning purposes.
Whilst NHSS collects lots of workforce data its accessibility needs to be improved to support board and regional planning. Data is currently ‘owned’ by a number of individual organisations and can be difficult to access on a consistent and comparable basis. For example boards hold workforce data on employees on a variety of different IT systems (HR, rostering, SSTs, consultant job planning, etc.), ISD report on workforce data nationally (using board payroll data), NES report on student and medical trainee data, MASNET report on Bank and Agency usage and costs nationally, etc. Work is underway to try and bring key workforce data together into a single platform which will support analysis of the data, and the creation of multiple scenarios and which will be accessible to all those who need it. This work is being led by NES.

Regional workforce planning processes were guided by the Regional Planning Guidance HDL 46 (2004) and in particular focused on the key aim of developing integrated workforce planning for cross Board services. This work continues and any workforce planning requirements associated with regional services are included in the workforce plans of the relevant boards and specifically those delivering the regional service. The focus for regional working however also became focused on supporting the board, regional and national introduction of Modernising Medical Careers (MMC). The publication of the Health and Social Care Delivery Plan in December 2016 required boards to come together and plan on a population basis for their region and this expanded the scope of regional workforce planning to include the whole Health and Social Care (H&SC) regional workforce.

The focus of the existing board workforce planning processes is mostly short – medium term i.e. within the next 3 years. This is both a response to the requirement of the extant guidance that plans must be affordable and that boards cannot be certain of funding levels beyond this. We agree with the Audit Scotland report that the SG should lead on the medium to longer term workforce scenario planning; regions and boards will collaborate and support this work.

Developing a Single NHS Scotland approach

Boards have to date, developed workforce plans that address their own and regional service requirements. This has had the potential to produce projections and plans that reflect some health economies better than others; for example, the demands of larger boards can potentially skew the NHSS position to the detriment of smaller boards in the absence of sensitivity analysis. There is also the potential for staff to move to larger boards to take advantage of perceived career progression, education or research opportunities. This can destabilise services in smaller boards. Whilst there are already good examples of boards working together to minimise the impact of this it is hoped that a revised workforce planning framework will build on existing good practices to stabilise services across the region and nationally and support the sustainability of those operating within a remote or rural setting.

4.3 Planning to support new ways of working and new roles including the contribution of non-clinical staff

Workforce Supply

Workforce planning also requires a whole system approach. The impact of a shortage in one service or profession impacts on others; the training pipelines and
their ability to respond are crucial. Implementing a workforce change can have a wider impact.

For example the requirement to increase Health Visitor (HV) workforce nationally by 500, within a 4 year period has had a significant ‘ripple effect’ across the service. The HV workforce already had a high vacancy rate of c10-15% and a high percentage of staff over the age of 50. Those in this age bracket are likely to have special class status (which means they can retire from the age of 55) and are more likely to retire within the next 5 years. To meet the national expansion target would therefore require anything up to an additional 1,000 HV to be recruited and trained by boards within the required time period. The additional requirement for 500 posts had not been fed into the nursing undergraduate intake numbers in advance and this would contribute to a shortfall in supply of newly qualified nurses, as described in the National Workforce Plan – Part One. The existing HV training pipeline was too narrow to train the numbers required within the timescales set, given the need for training on the job and a historical ratio of 1 supervisor to 2 trainees. Boards needed to train more supervisors; this takes up to 12 months and reduces service capacity in the interim period. Universities increased their educational capacity to train HVs but recruited experienced HVs from the service to support delivery. The increase in demand for HVs attracted staff from other services that had, and still have, existing vacancies thus impacting on those services. It has taken boards time to implement new ways of working and training to address the above. Many boards still report high levels of HV vacancies; as at 30th June 2017 the NHSS HV vacancy rate was 7.3%.

Organisational Development Challenge
In spite of the prevailing supply issues, there continues to be innovation to create both complementary and substitute roles. This can often lead to significant changes in roles, responsibilities and relationships within teams which require support and supervision from key professional groups. However this may be hampered by insufficient staff to facilitate the change and provide the mentorship and supervision required e.g. developing HCS pathologist roles. In some cases the proposed changes may challenge existing professional roles e.g. implementing radiographer reporting roles etc. Expert management of change and organisational development support, along with clinical leadership, is critical to successfully implementation of the desired workforce changes. Investment in building OD capacity and capability is often a critical requirement for successful workforce innovation.

The NHS Workforce
The Audit Scotland Report concentrated on the medical, nursing and midwifery and AHP professions, which accounts for 62.5% of the NHS workforce. However the scope for workforce planning within boards is the whole workforce and boards adopt a whole system approach to planning to ensure skills maximisation. The remaining 37.5% of the workforce includes many job families who play a critical role in delivering patient care either directly (e.g. Health Care Scientists; physiological technicians; and psychologists) or indirectly (e.g. medical secretaries, porters, catering and domestic staff).

Boards are very cognisant of the need to keep non clinical costs to a minimum and, through workforce planning and service reorganisation, managed to reduce senior manager costs by 437wte during the period 2010-15, a 33.1% reduction which exceed the Scottish Government target of 25%.
We are also cognisant of the role and contribution the entire workforce play, including non-patient facing support services, in enabling clinicians to be focused on the delivery of care. For example, solutions to managing a number of long term conditions and reducing the demands they place on services may lie in investment in eHealth and digital technologies to support innovate ways of delivering better, safer care more efficiently and more effectively. Investment in eHealth capacity and support will be required to develop, implement and sustain this ambition.

4.4 Supplementary workforce – bank and agency utilisation

Supplementary Staffing
The level of vacancies in key professions and/or specialties has created pressures in the market for agency staffing. Given the need to ensure sustainable and resilient services and safe and effective staffing has meant boards have had, on occasion, to use agency staffing in some shortage specialties. Some staff also choose to work with agencies given the advantageous rates of pay.

There will always be a requirement for supplementary staffing; however, the emphasis in boards is being placed on maximising utilisation of ‘in house’ solutions, such as bank, excess part time hours and overtime in order to reduce the requirement for external agency solutions. Boards are also addressing sickness absence levels, improving rostering, increasing flexible working options and improving recruitment practices to relieve pressure.

As illustrated in the chart below there is an increasing trend in the volume of vacancies within the three largest clinical job families within NHS Scotland:

<table>
<thead>
<tr>
<th></th>
<th>Mar-12</th>
<th>Mar-13</th>
<th>Mar-14</th>
<th>Mar-15</th>
<th>Mar-16</th>
<th>Mar-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>167.3</td>
<td>202.5</td>
<td>324.8</td>
<td>408.6</td>
<td>355.4</td>
<td>418.7</td>
</tr>
<tr>
<td>Nursing &amp; Midwifery</td>
<td>1027.9</td>
<td>1609.1</td>
<td>1637.5</td>
<td>1991.8</td>
<td>2211.4</td>
<td>2818.9</td>
</tr>
<tr>
<td>AHPs</td>
<td>271.8</td>
<td>425.3</td>
<td>452.5</td>
<td>402.1</td>
<td>435.1</td>
<td>463.0</td>
</tr>
</tbody>
</table>

NHSS boards are committed to reducing agency spend by 25% in 2017-18 and steady progress is being made. However despite this there may still be a requirement to utilise medical agency staff given the skills shortages at Scottish, UK and international levels.
The current Migration Advisory Committee list for health at Scottish and UK levels illustrates this:

<table>
<thead>
<tr>
<th>UK Shortage Occupation List</th>
<th>Scottish Shortage Occupation List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants in:</td>
<td>Consultants in:</td>
</tr>
<tr>
<td>• Emergency Medicine</td>
<td>• Anaesthetics</td>
</tr>
<tr>
<td>• Clinical Radiology</td>
<td>• Paediatrics</td>
</tr>
<tr>
<td>• Old Age Psychiatry</td>
<td>• Obstetrics &amp; Gynaecology</td>
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<td></td>
<td>• Psychiatry</td>
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<tr>
<td></td>
<td>• Clinical Oncology</td>
</tr>
<tr>
<td>Medical non-consultant, non-training posts in:</td>
<td>All grade medical (other than consultant roles) in:</td>
</tr>
<tr>
<td>• Emergency Medicine</td>
<td>• Anaesthetics</td>
</tr>
<tr>
<td>• Paediatrics</td>
<td>• Paediatrics</td>
</tr>
<tr>
<td>• Old Age Psychiatry</td>
<td>• Obstetrics &amp; Gynaecology</td>
</tr>
<tr>
<td></td>
<td>• Psychiatry (excluding CP1)</td>
</tr>
<tr>
<td>Medical training grades:</td>
<td>Non-consultant, non-training roles and trainees at CT2 and ST4-7 in:</td>
</tr>
<tr>
<td>• Psychiatry (core trainees)</td>
<td>• Clinical Radiology</td>
</tr>
<tr>
<td>• Emergency Medicine (CT3 and ST4-7)</td>
<td></td>
</tr>
<tr>
<td>Non-medical roles:</td>
<td>Specialist nurses in:</td>
</tr>
<tr>
<td>• Diagnostic radiographer (including MRI)</td>
<td>• Neonatal</td>
</tr>
<tr>
<td>• Sonographer</td>
<td>• Intensive Care</td>
</tr>
<tr>
<td>• Nuclear medicine practitioner</td>
<td></td>
</tr>
<tr>
<td>• Radiotherapy physics scientist or practitioner</td>
<td></td>
</tr>
<tr>
<td>• Neurophysiology practitioner or healthcare scientist</td>
<td></td>
</tr>
<tr>
<td>• Prosthetist</td>
<td></td>
</tr>
<tr>
<td>• Orthotist</td>
<td></td>
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</tbody>
</table>

The MASNet Team was established to take forward national initiatives aimed at reducing expenditure on agency staffing. The Audit Scotland report acknowledges the progress that has been made in this area, whilst recognising that there is still much to be done. One of the areas in which Boards are seeking to address the challenge is by ensuring that all doctors who wish to work additional hours for NHS Scotland have the opportunity to do so employed by an NHS bank. We are also taking forward options for banks working across regions for both doctors and nurses.

4.5 Workforce stability – vacancies, age profile, retirements

Workforce Demographics
The demography of the current workforce is well understood. However there is a need for further work to understand the detailed risks associated with the changes in both occupational and state pensions and the generational expectations of the workforce. This will include both the increasing numbers retiring over the next 5+ years but also the employment challenges and opportunities in having employees working until they are 68 years old. Although there are sensitivities surrounding age that, makes forecasting challenging, the opportunities and risks associated with the ageing workforce could be significant for NHSS.

Absence and Age
Absence rates are directly related to the age profile of the workforce, historical data for nursing and midwife shows that sickness absence begins increasing once an
employee reaches 50 and continues to increase thereafter. This is driven mostly by age related long term conditions and related ill health. This will impact on boards sickness absence rates overall and will present challenges in keeping individuals in work that matches their capabilities. For example, in Mental Health and LD nursing, which has over 40% of nursing staff over 50, there may be significant pressures resulting from nursing staff being unable to remain in existing physically demanding roles. There may also be significant pressures for certain sites or services where there are known to be a high proportion of staff aged over 50, including a number of community based services.

4.6 Vacancies in the trainee medical workforce.

In Scotland, NHS Education for Scotland (NES) oversees the management of postgraduate medical education and training. Training is delivered within the NHS through a network of trainers. All sites where doctors are undertaking training must be approved prospectively by GMC, and while in training, doctors in training follow a specialty specific GMC approved training curriculum which is delivered through rotational placements within the NHS and may be in primary or secondary care. The postgraduate training pathway is complex, (as shown in the diagram below). It commences in foundation, following graduation from medical school, and usually extends to completion of training as a consultant or GP. Doctors in Training are a very important element of the NHS Workforce.

The total number of acceptances to UK medical schools has changed little over the past decade. Scotland has significantly more (almost 50% more) medical school places per capita than the rest of the UK. Scotland also has more doctors (according to the GMC register) per head of population than the UK average, and more than any other part of the UK other than London.

Supply into undergraduate education is not as strong as popular belief would perceive it to be. Numbers of school leavers applying to medicine are falling across
the UK. Last year (2016) 860 Scottish domiciled school leavers applied to medicine through UCAS for the first time. Scottish medical schools were seeking to fill 834 home fee (UK and EU places) in that year.

Scottish medical schools recruit large number of overseas students and large numbers of entrants from the rest of the UK. Of the 2016/7 intake to Scottish medical schools 49% are from Scotland, 20% are from the rest of the UK, 24% are from overseas and 10% will graduate outwith Scotland 495 of the total intake of 1,011 students were Scottish.

NES is now able to track progression of graduates through the UK post-graduate training system. We can see that significant numbers of graduates from Scottish schools leave UK training after FY2 and many move to England to train. 4 years after graduation, only 50% of graduates from Scottish schools are in training in Scotland. Of those doctors who complete training in Scotland, most (80%) continue to work in Scotland.

On a UK basis there are now insufficient graduates from UK medical schools to fill the UK foundation programme, and there are insufficient doctors completing foundation training to fill the requirement for ST1 posts across the UK. In 2016 there were over 1,000 more ST1 posts advertised than there were FY2 completers. As a result specialties and geographies that are perceived to be less attractive will fail to fill. The recent announcements by Scottish Government of an increase in undergraduate medical places and the establishment of the Scottish Graduate Entry Medical Programme will contribute towards addressing this issue.

Rota gaps caused by the absence of Doctors in Training are due to (in roughly equal measure): parental leave, time out of programme for research/training and failure to fill posts. Gaps have not increased significantly compared to the past; however, the abolition of permit free training in 2006 has significantly impacted on the number of international medical graduates in training in Scotland. These doctors previously filled many rota gaps.

These trainee gaps require to be filled in most cases to ensure sustainable rotas and this is one driver for the use of supplementary staffing, although vacancies in consultant posts account for the majority of expenditure.

In addition to the gaps resulting from the circumstances outlined above, we are also seeing an increasing number of trainees training on a less than full time basis. The number of these has increased from 458 in 2014 to 553 in 2017. This shift in working patterns has an impact on the ability of Boards to fill rotas, it also increases the length of time that it will take a trainee to complete their training, and may be an indicator that they will opt to work less than full time once they have finished training.

Addressing the Vacancies

Boards are taking forward a range of initiatives to address the current vacancy levels including: return to practice; attending Careers Fairs; ‘growing our own’ workforce through development of healthcare academies to develop staff in-house; working with education partners to improve careers, pathways and marketing; international recruitment to encourage international candidates and expats to return to work in Scotland; using social media to advertise jobs and promote NHSS as an employer of choice.
Boards have also been creating new roles such as Clinical Development Fellows, Physician Associates and Peri-Operative Practitioners; apprenticeship programmes; and developing advanced roles for nurses, midwives, pharmacist and allied health professionals. We need a national approach which considers partners around these roles so that there is consistency, governance and an improved supply.

**Small Occupational Groups**

Many supply challenges will not have short term fixes, however, using alternative approaches and thinking about where and how services are offered on a regional basis may help to alleviate supply issues. Not all workforce challenges will be addressed by a single board or region, in some instances, there will need to be an agreed national approach to resolving supply issues. This is true for many specific specialist roles within the healthcare science (HCS) workforce. The HCS workforce includes 29 different disciplines working in for example laboratory, medical physics and physiological services. The numbers of newly qualified staff required in specific disciplines, such as, cardiac physiologists and maxillofacial prosthetics, for Scotland are very small. In some instances education provision is only offered by a single College or University in Scotland and may only have an intake every second year (physiology); in others the provision of undergraduate training is only provided in England (maxillofacial prosthetics).

**4.7 Medical Job planning**

As part of the consultant recruitment process job plans for consultants are designed and advertised in order to both attract potential candidates to the vacancy and to meet service requirements. The detailed job plan will be negotiated and agreed prior to an offer of employment. Only a minority of consultants are employed on a 9:1 basis (9 direct clinical care sessions; 1 supporting session), with the majority appointed on an 8:2 or better. For example, across our boards (Ayrshire and Arran, Grampian and Lothian) less than 3% of consultants are currently employed on a 9:1 contract. Boards are acutely aware of the need to plan individual consultant posts that balance attractiveness of the post and service requirements.

**5 Conclusion**

We believe the Audit Scotland recommendations for Scottish Government and NHS boards, coupled with the recommendations and next steps detailed in the National Health and Social Care Workforce Plan – Part One will provide the workforce planning frameworks within workforce planning in the NHS can improve further and tackle the significant challenges it faces over the forthcoming years. We look forward to working with the Scottish Government in jointly planning an H&SC workforce for the future that is affordable, adaptable and achievable.

October 2017
Appendix A - NHS Scotland 6 Step Workforce Planning Methodology

- **Step 1:** Defining the plan
- **Step 2:** Visioning the future/Mapping service change
- **Step 3:** Defining the required workforce (Demand)
- **Step 4:** Understanding workforce availability (Supply)
- **Step 5:** Developing an action plan
- **Step 6:** Implement, monitor and refresh.