

# **National Health and Social Care Workforce Plan**

**Part 1 – a framework for improving  
workforce planning across NHS Scotland**

# **NATIONAL HEALTH AND SOCIAL CARE WORKFORCE PLAN**

## ***PART 1: A FRAMEWORK FOR IMPROVING WORKFORCE PLANNING ACROSS NHS SCOTLAND***

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## Foreword

Publication of this Plan marks the beginning of a process to further improve workforce planning across health and social care. Its overall aim is to support organisations which provide health and social care services to identify, develop and put in place the workforce they need to deliver safe and sustainable services to Scotland's people. It sets out new thinking about the health and social care workforce across Scotland, within a framework for wider reform of our health and care systems through the Health and Social Care Delivery Plan. Its impact will be far reaching, and directly affect everyone who uses or works in and around health and social care in Scotland.

We have worked with a wide range of partners to develop this Plan, and I want to pay tribute to our health and social care workforce and the tremendous work they do. We will continue to work as closely as we can with our staff, and the organisations which represent them, as we build our capacity to plan, deliver and develop new models of working. Their on-going involvement and input is absolutely vital.

This Plan has three distinct parts, reflecting its iterative approach. This document is Part 1 of the Plan, focussing on NHS Scotland. Part 2 of the Plan will consider ways to address the challenges facing social care workforce planning post integration and will be published jointly with COSLA in Autumn 2017. This timeframe reflects the process under way to establish new leadership within COSLA, in light of the local election results in May 2017. We will work closely with key partners on the content of this document, in particular with employers in the third and independent sector. Later this year, we will also publish Part 3 of the Plan to follow the conclusion of GMS contract negotiations which will set out our thinking on primary care. In this first year, this incremental approach will enable different systems to take stock and move together towards a second full Health and Social Care Workforce Plan in 2018. From 2018, future editions of the Plan will have greater capacity to address the size and diversity of the health and social care workforce, and its workforce planning needs.

It is no accident that we are embarking on this Plan at a time when the health and social care landscape has changed and is changing significantly. While we continue to enjoy world leading health services, with highly trained and dedicated staff, those staff must respond to changing needs and demands. NHS Scotland workforce planning must also adapt to put staff in the best position to sustain the excellent treatment and care they are renowned for. NHS Boards, Health and Social Care Partnerships and Councils are working hard to put individuals and families at the centre of planning for services. We must take the right steps to plan for and deploy our future workforce effectively against this complex, shifting background. This Plan further clarifies how that needs to be done nationally, regionally and locally.

The 79 consultation responses received have added considerably to the sum of our knowledge. Throughout the consultation period, our stakeholders showed how willing they are to engage. We are grateful for their involvement, and we will build on that going forward. Many of the organisations responding represent our staff, helping to sustain close and effective partnership. Others are more closely involved in planning the staff we need, ensuring they give of their best when and where they

need to be, delivering the right treatment and care in the right way. We have listened carefully to these constructive and realistic views and they have helped us to understand the issues and arrive at solutions.

For some services, and in some areas, challenges continue and so we must improve our efforts to recruit and retain – and train and retrain - the staff we need now and for the future. That is not simply a matter of augmenting the numbers we recruit. The actions set out in this Plan will certainly improve our efforts to recruit and retain staff, but we must continue to ensure we have the right processes in place to manage workforce supply and demand. Refining these processes will help us to project our workforce needs forward more intelligently, enabling our staff to use their professional knowledge and skills to best effect in providing the high quality treatment and care for which Scotland is renowned. We also know that workforce demand and supply will change over time, so we need to link the recommendations here carefully to the arrangements to implement the Health and Social Care Delivery Plan, particularly at a regional level.

There are some specific areas where I want to see a step change in the way we work and in how we provide services, in order to ensure our health service continues to meet the changing needs of Scotland's population. Many changes are already happening. For example, General Practitioner services are moving towards a new multi-disciplinary approach, and we are introducing changes to bring about improvement in the working life of Junior Doctors, including our commitment to a maximum 48 hour working week.

But as we recognise the immense personal contribution made by our staff, we must also allow them to develop professionally to ensure patients continue to receive the best possible care. Education which supports multi-disciplinary learning and working will allow staff to take on more flexible roles, and allow them more varied and flexible careers. In recruiting the staff we need to run our services, we must also look to build and enhance fulfilling careers in our health and social care services, particularly for our young people. Making the most of those opportunities will require us to look closely and constructively not only at how we recruit, but also at our training models, and the Plan makes important recommendations about this.

We have also committed to considering safe staffing legislation, placing the nursing and midwifery workforce planning tools on a statutory footing, and it is important that the practical implementation of that goes forward in line with the developments and ideas in this Plan. Our incremental approach should allow this to proceed effectively to ensure needs are met while taking account of a changing future landscape.

There is much still to do. Many dynamics operate between respective workforces, and the Discussion Document outlined some of the key differences which Part 2 of this Plan will address in more detail. The consequences of the changes resulting from the UK's exit from the European Union also bring fresh challenges in a Scottish context, right across the health and social care workforce. So as well as continuing to build our local workforce, we must continue to welcome people from the EU who want to work in our country's health and social care system.

This Plan heralds the positive steps we must now start to take in planning the workforce for the future, so our health and social care workforce can build further on its excellent record of achievement in providing care and treatment for our citizens, young and old. I look forward to seeing good progress on the recommendations for action in this Part 1, in Parts 2 and 3 when they issue later this year, and in future editions of the Plan.

**Shona Robison**

## CHAPTER 1 - EXECUTIVE SUMMARY

1. This Chapter summarises the recommendations needed to take forward changes and improvements to workforce planning for the NHS Scotland workforce, as a step to facilitating workforce planning across the integrated health and social care sectors. The key driver for this is the Health and Social Care Delivery Plan published in December 2016, which sets out an ambitious programme of change for the NHS and wider health and social care services in Scotland.

2. The Discussion Document published by the Scottish Government in February 2017 set out a number of suggested approaches to workforce planning issues. In total, 79 responses to the questions asked in the Discussion Document, reflecting the broad range of stakeholders with whom positive discussions were held, were received.<sup>1</sup>

### Approach

3. This document is **Part 1 of the 2017/18 National Health and Social Care Workforce Plan, covering NHS Scotland** and:

- Aims to support NHS Scotland organisations, including independent NHS contractors in the community, to identify, develop, retain and support the workforce they need to deliver safe and sustainable services to Scotland's people;
- Will enable NHS Scotland organisations to work together over time to broaden this aim in order to help deliver a whole system approach to health and social care;
- Provides an overview of the current NHS Scotland workforce and an assessment of what it could look like in the future;
- Sets out how improved workforce planning can benefit NHS Scotland services at national, regional and local levels.

### Key recommendations

4. The following key recommendations arise from each of the six main consultation questions (Questions 1 to 6a) set out in the Discussion Document. Many state clearly who will be responsible for acting on them. For some, further discussion will be required as appropriate between the Scottish Government and stakeholders, or as covered by the remit for the new National Workforce Planning Group. Recognising that this Group has yet to be set up, a more detailed implementation timetable covering the recommendations will follow.

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<sup>1</sup> <https://consult.scotland.gov.uk/health-workforce/national-health-and-social-care-workforce-plan>

**Governance – a clearer authorising environment which supports NHS Boards to plan for the workforce they will need in future, and resolve capacity issues nationally, regionally and locally.**

- Nationally, a new National Workforce Planning Group will be established with broad representation from across health and social care – including NHS Scotland, local authorities, IJBs and third and independent sector and their staff side and trade union representatives.
- Terms of reference for the National Workforce Planning Group, including its membership, role and remit, will be finalised in discussion with stakeholders following the publication of this Plan. We expect that the Group will work across boundaries to support implementation of the Plan by health and social care providers; and to act collectively to advocate the Plan, raising its profile and promoting the understanding of its requirements within respective workplaces.
- The National Workforce Planning Group will meet from Summer 2017 to review the Plan’s recommendations and proposals for future work. Initially the Group will focus on the NHS workforce, but will take on a broader role which reflects Parts 2 and 3 of the Plan published later this year. The Group will strengthen a “Once For Scotland” approach, improving consistency and use of workload tools across Scotland.
- Regionally, Health Board Regional Delivery Plans arising from the Delivery Plan for Health and Social Care will include workforce planning from September 2017. Successful regional workforce planning will depend upon the further development of a clear and sustainable workforce planning infrastructure to progress regional issues.
- Locally, work will begin to share development of existing workforce tools and resources with employers, reflecting governance arrangements as they develop, by end 2017. This work, including the roles expected for NHS Boards, IJBs, local authorities and third and independent sector employers, will flow from the establishment of the National Workforce Planning Group.

**Roles – Greater clarity about who does what in terms of aligned, co-ordinated responsibility for workforce policy and planning nationally, regionally and locally.**

- Nationally: The National Workforce Planning Group will support implementation of this Plan, helping to define where workforce planning sits within the strategic direction and vision for NHS Scotland, and with strategic priorities for social care. It will identify good practice in national workforce planning – for example, how this should apply to the new elective centres - in line with main Delivery Plan and National Clinical Strategy themes.
- Work will begin to reconstitute the National Forum for NHS Workforce Planners from Summer 2017 with a new, clearer remit and reporting structure to ensure Board level links are visible nationally, and to further develop links with IJBs using practical approaches to workforce planning which can apply in an integrated context.
- Regionally: Linking to NHS Board Regional Delivery Plans, NHS Boards will undertake joint regional workforce planning (also through the refocused

National Forum for NHS Workforce Planners), to ensure patients' needs are met and resources allocated effectively, responding to and meeting the needs of IJBs and others as required.

- Locally: This will be determined over Summer 2017 in partnership with COSLA and other relevant stakeholders.

**Data – integrating statistical, demographic and labour market information on the NHS Scotland workforce to build the evidence Boards will require in future.**

- NHS Education for Scotland (NES) will provide proposals to bring together existing data sources in a new supply side “platform” by Autumn this year. This will consider the NHS Scotland workforce and how this fits wider social care and local authority needs in the context of integration.
- NES will work alongside stakeholders to bring together relevant data sources; analyse and align them to better inform workforce planning; and work to determine the data required for effective decisions on workforce and improving analysis of future demand and supply and the “pipeline” between education and employment. This work will be delivered in Autumn 2017, while being responsive to Parts 2 and 3 of this Plan and the wider, whole system approach required for the future.
- NES will lead development of a minimum standardised dataset with potential to use across different sectors, with agreed data collection and collation parameters. It is important that this work aligns with the rollout of e:ESS across NHS Boards, where much work has already been undertaken to ensure a consistent dataset on the NHS workforce. This will require a phased approach.

**Recruitment and Retention – tackling persistent recruitment challenges to provide sustainable national, regional and local solutions. Building the right conditions for better retention, to ensure an NHS workforce fully fit for purpose, in the right place, with the right numbers now and in future.**

- The Scottish Government will work with NHS Boards and NES on a strategic approach to recruitment and retention, including GP recruitment and retention challenges. Actions developed over Summer 2017 will be reported to the new National Workforce Planning Group, with clear recommendations for action by NHS Boards to be drawn up by early 2018. Consideration will be given to:
  - existing work (for example work being taken forward in a Shared Services context within NHS Boards);
  - testing out new approaches, focussing on promoting and attracting applicants and making health and social care careers more attractive to young people through improved marketing and advertising;
  - exploring the interface between health and social care and further and higher education to maximise opportunities to recruit and retain staff;
  - exploring whether the regionalisation of colleges and the development of regional curricula may provide further opportunities to collaborate on recruiting and retaining the future NHS Scotland workforce; and
  - promoting better retention, ensuring the workforce has access to CPD support and structured, transparent career progression opportunities.



- This work will involve reviewing current learner and student support across the health and social care workforce to maximise the attractiveness of careers in health and social care, and work to promote them in schools; assessing how access to training and developmental opportunities can promote better retention of existing staff; and how this can help ensure the future sustainability of the remote and rural workforce.
- This work will also consider international flows, including the impact of Brexit, on recruitment and retention, and how to make more effective use of international recruitment opportunities. These will take account of developing research across the wider public sector in Scotland of the potential effects of Brexit on international recruitment.
- Recruitment also needs to be considered as part of regional service and workforce plans, including the development of further ways to fill vacancies and address recruitment issues. We expect regional workforce plans to give consideration to regional and national recruitment initiatives. These may include the following:
  - Examine extension of bursary approach, other training/developmental incentives to retain staff; increased roles working across regions; co-ordinated regional recruitment activity;
  - Work with employers on careers, liaison with FE/HE, campaigns, social media, including youth groups eg Young Scot etc;
  - Youth employment initiatives to increase supply across the NHS workforce – recognising that work with NES should help to identify new frameworks and approaches;
  - Work to consider retention initiatives, including potential for employers to outline Regional Retention Strategies including e.g. “bonding”, and increasing returners.
- Progress made in this area must take account of contributions already being made by COSLA and local authorities, the Improvement Service, Scottish Care, Scottish Social Services Council, Care Inspectorate, CCPS and others. Further discussion on recruitment and retention issues between all relevant health and social care stakeholders will be required following publication of this document, and in advance of the publication of Part 2 of the Plan later this year.

**Guidance – providing high quality workforce planning support to NHS Boards throughout a period of change, building on clear principles to provide and further develop better data, intelligence and tools to predict future needs.**

- Scottish Government will work with NHS Scotland stakeholders to refresh workforce planning guidance for NHS Scotland by end of 2017, with potential to link to other sectors as appropriate, taking account of Part 2 of this Plan, to be published later this year.
- The refreshed guidance will need to fully reflect the post-integration environment, complementing and supporting workforce planning undertaken

within Primary Care, Integrated Joint Boards, local authorities and other health and social care providers.

- NHS Education for Scotland will work together with other organisations to develop training resources to assist adoption of the workforce planning guidance in NHS Boards.

**Student and Post-Graduate Training Intakes – designing and developing an improved process so that national decisions on student intakes are more closely linked to addressing future demand, with closer ties to NHS Board workforce planning priorities.**

- Nationally, NES will work together with other organisations to use specialty profiles and other data sources across professions to design a “pipeline” approach demonstrating how supply via training and recruitment numbers will meet estimated demand. This work will help to achieve better alignment between training providers and services and will begin in Summer 2017, leading to a shadow process in 2018 and then full implementation in 2019. These timescales recognise that many organisations are involved, with long training lead-in times and resource implications.
- The current workforce projections process in NHS Scotland is limited in its ability to project forward nursing and medical staff intakes in the longer term. The impact of local demographics – for example retirements in 3 years due to an ageing workforce - should be more consistently factored in to national intake projections. The new National Workforce Planning Group will consider, in consultation with other organisations, how this process should be adjusted.
- NES should also assess how the nationally controlled student intake process might extend to other professions beyond nursing, medical and dental staff. This will be beneficial if it is closely linked to recruitment, retention, youth employment and potentially bonding, taking account of current trends in supply and demand. This work should also link to career paths and opportunities across the health and social care sector.

## CHAPTER 2 – SETTING THE CONTEXT

### Purpose of this Plan

1. The main purpose of Part 1 of this Plan (and Parts 2 and 3 issuing later this year), is to support organisations which provide health and social care services to identify, develop and put in place the workforce they need to deliver safe and sustainable services to Scotland's people. This will enable them work together over time to help deliver a whole system approach to health and social care.
2. Putting in place improved arrangements for workforce planning has multiple benefits and should be seen as an investment, not a cost. Insightful and intelligent workforce planning plays an important part in improving population health, which in turn benefits economic growth and encourages employment opportunities.<sup>2</sup> The Plan's recommendations are therefore directly relevant to employers in health and social care, independent contractors in the community, professional groups and organisations, trade unions and individual employees. Their effects will directly benefit services, people in Scotland who receive them, and the staff who provide them.
3. The overall aim can be summarised as follows:

**Getting the right people into the right place, at the right time,  
to deliver sustainable and high quality health and social care  
services for Scotland's people.**

4. This aim has many active components. It must make practical sense within different working environments, and apply across different systems and professions - nationally, regionally and locally.<sup>3</sup> It must:
  - describe the type of workforce planning that needs to happen **nationally** (for example projecting anticipated demand or determining final training numbers); **regionally** (allowing locally integrated health and social care services to work in a wider context); and **locally** (at the point of contact between health and social care systems and people);
  - be relevant to all people who work across health and social care to provide care, support and treatment;
  - provide the focal point for staff to develop their skills and to continuously improve within the context of reform set out in the Health and Social Care Delivery Plan, and of other strategic priorities across health and social care.

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<sup>2</sup> <http://www.who.int/hrh/com-heeg/en/>

<sup>3</sup> The World Health Organisation's Global Forum on Human Resources for Health<sup>3</sup> also provides a useful wider context to consider labour market factors - see <http://www.who.int/hrh/governance/en/>

5. Workforce planning is a dynamic and evolving work programme that needs to be robust, but also able to adapt over time. The Discussion Document published on 1 February was clear that health and social care is extremely diverse and consists of many staff, engaged by different employers, operating in different environments. This document - Part 1 of the Plan - makes workforce planning recommendations specific to NHS Scotland. Part 2, to be published jointly with COSLA later this year, will also develop over time, and its progress – and how it links to Part 1 - will be determined through further dialogue with and between different organisations across health and social care.

## Scope

6. It is important that the overall scope of this Plan is clear. The Discussion Document said that the Plan would aim to cover the workforce engaged in providing **all health and social care services in Scotland** - provided by public sector, third and independent sector employers - including:

- NHS Scotland services;
- Adult social care services;
- Children’s social care services;
- Mental health services;
- Primary care services, including General Practice and independent contractors.

7. Parts 1 (NHS Scotland), 2 (Social Care) and 3 (GP supplement) of this Plan recommend actions for different parts of the system and will be undertaken using a phased approach, reflecting on-going discussions between NHS Scotland, local authorities, primary care, professional and regulatory bodies, trade unions, Integration Joint Boards and the third and independent sector. Each Part needs to give due regard to service developments, the pace of change and the different timescales and priorities which operate across health and social care. Though published at different times, the intention is for all three Parts cumulatively to demonstrate a “whole system” approach. From 2018, future editions of the Plan, merged to reflect this, will have greater capacity to address the size and diversity of the health and social care workforce, and workforce planning needs across the whole system.

8. Workforce planning can be influenced by, but remains separate from decision-making around terms and conditions of employment. Employers in different sectors must be able to manage their workforces proactively and with agility to meet local demands. There are challenges, for example, in minimising barriers to effective workforce planning that may potentially arise out of different terms and conditions of employment across the health and social care landscape. It is recognised that this can have an impact on getting the right people into the right place at the right time.

9. Many workforce planning decisions are already taken so that resources are better targeted, aligning demand and supply. A better understanding about how this can work, particularly at a regional level, needs to be developed to meet future health and care needs. Current challenges are persistent: difficulties in filling vacancies; agency use; using workforce data intelligently; or striking the right

balance in achieving organisational priorities. Developing a longer term horizon for workforce planning will also involve planning and modelling sustainable, affordable multi-disciplinary teams to support health and social care integration. This should also recognise that many financial and budget setting processes in NHS Boards are undertaken annually, and resource allocation decisions should be informed by the need to enable and support integrated workforce planning.

### **Responding to changing demand**

10. Health and social care in Scotland is shifting away from hospital and residential care toward community based services. These services are supporting people to live well and die well, independently in their own homes and on their own terms, wherever possible. While Scotland's ageing population and workforce poses continued challenges for the longer term, there are also opportunities because the workforce is at the forefront of the shift to the community, directly involved in improving patient care and outcomes.

11. The NHS was set up for medical, episodic care and when it was created in 1948, only 10% of the population were aged 65 or over. The current (2016) figure is 18%, reflecting advances in treatment and care, improvements in overall health and standards of living and a number of other societal changes. Health and social care services are dealing with more older people than ever before, but it is the increase in numbers of the very elderly, and of older people with long-term conditions that will have most effect.<sup>4</sup> Their more complex and long-term health care needs will require further changes in the approach to workforce planning.

12. In the near future, continuing growth in demand for health and social care services is expected to arise from:

- management of multiple long-term conditions;
- care and enablement in the community;
- mental health support;
- specialist elderly care.

13. As new services are developed in response to changing demand, they must also keep pace with further change. Though many people are now living longer lives, they often do so with multiple long-term conditions which require long-term reactive treatment and care. That in turn requires adjustments to the supply of our health and care workforce, and requires staff to develop new skills, combining them in different ways. For GPs, that may mean a significantly enhanced role in caring for people with undifferentiated or complex conditions, with support from multi-disciplinary teams. For medical and nursing staff, it may mean providing much more flexible and complex care outside hospital settings. The focus is already shifting towards health improvement measures which can prevent these conditions from occurring in the first instance.

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<sup>4</sup> [http://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(17\)30091-9/abstract](http://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(17)30091-9/abstract)

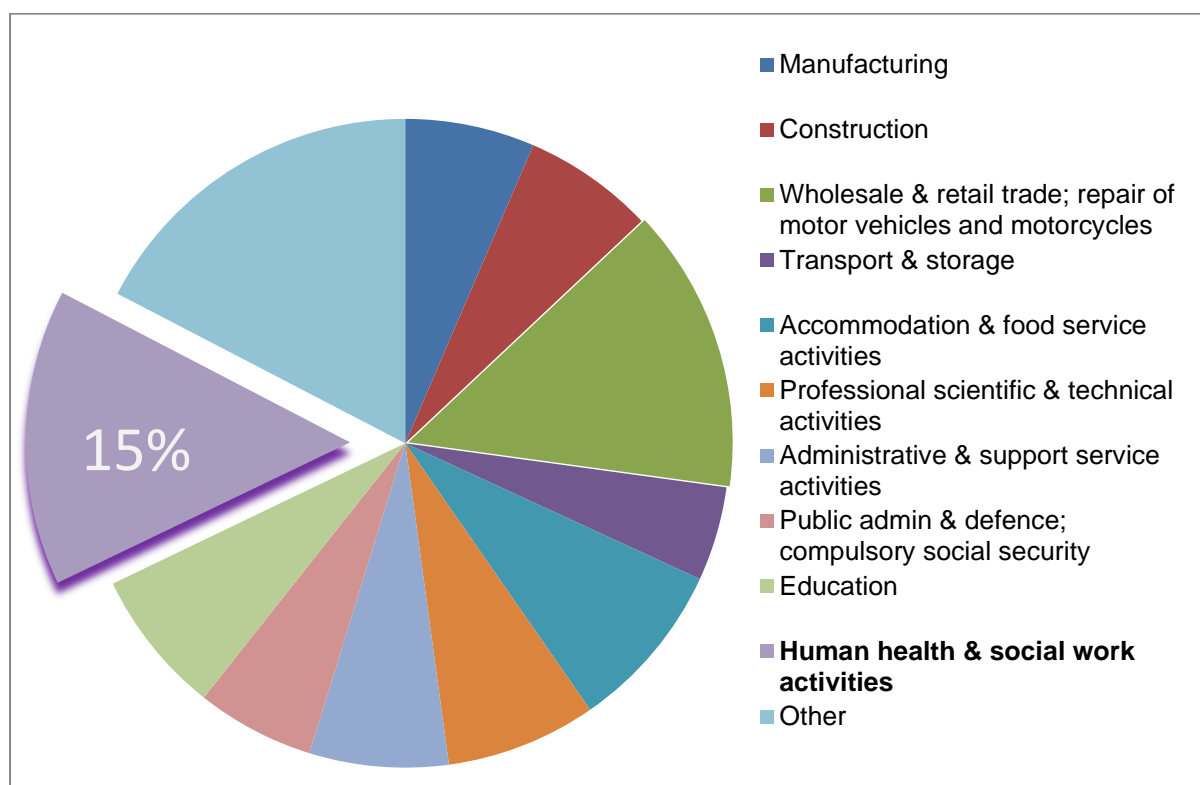
14. It is mainly in the areas above where workforce demand will increase in the future. In response to these challenges, a range of strategic commitments operate on employers in different sectors. The main strategic commitments as they apply to NHS Scotland are set out at **Appendix A**. These address changing demand for health and social care and in turn influence the training, development and deployment of the NHS Scotland workforce. Although these commitments do not apply uniformly across different sectors and services, they can influence the care and treatment people receive in social care settings. Part 2 of this Plan, when it is published later this year, will say more about this.

15. The time is now right to begin working together in more consistent, targeted and effective ways to alleviate the rising pressures on our workforce caused by increasing and changing demand - nationally, regionally and locally. In supporting a whole system approach to workforce planning across health and social care, this Plan recognises that improvements made in one part of the system can benefit others. It recognises that better, more convincing evidence is needed about the impact on individual staff who experience daily pressures and challenges. And it sets out how on-going improvements to workforce planning can help sustain the delivery of high quality, integrated services to those people who need them.

## CHAPTER 3 - PLANNING THE CURRENT NHS SCOTLAND WORKFORCE

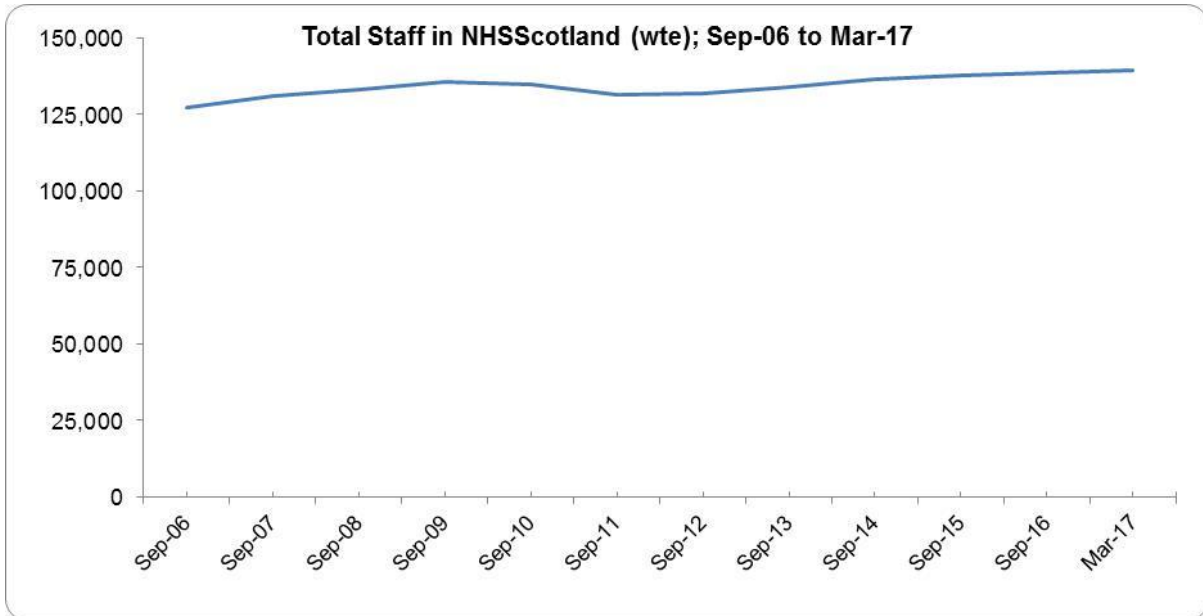
1. Around £6 billion is spent on the NHS workforce annually and 99.6% of all NHS care is delivered by NHS staff. Those staff do an excellent job, often in challenging circumstances, and people receiving treatment and care in Scotland can be assured that staff are in place in the right numbers. To continue delivering high quality care into the future, our staff will also need to be doing the right things, in the right place and at the right time.

2. Fifteen per cent of the workforce in Scotland is employed in health and social work, representing over 400,000 staff in Scotland. The diagram below shows its size relative to other industrial sectors:

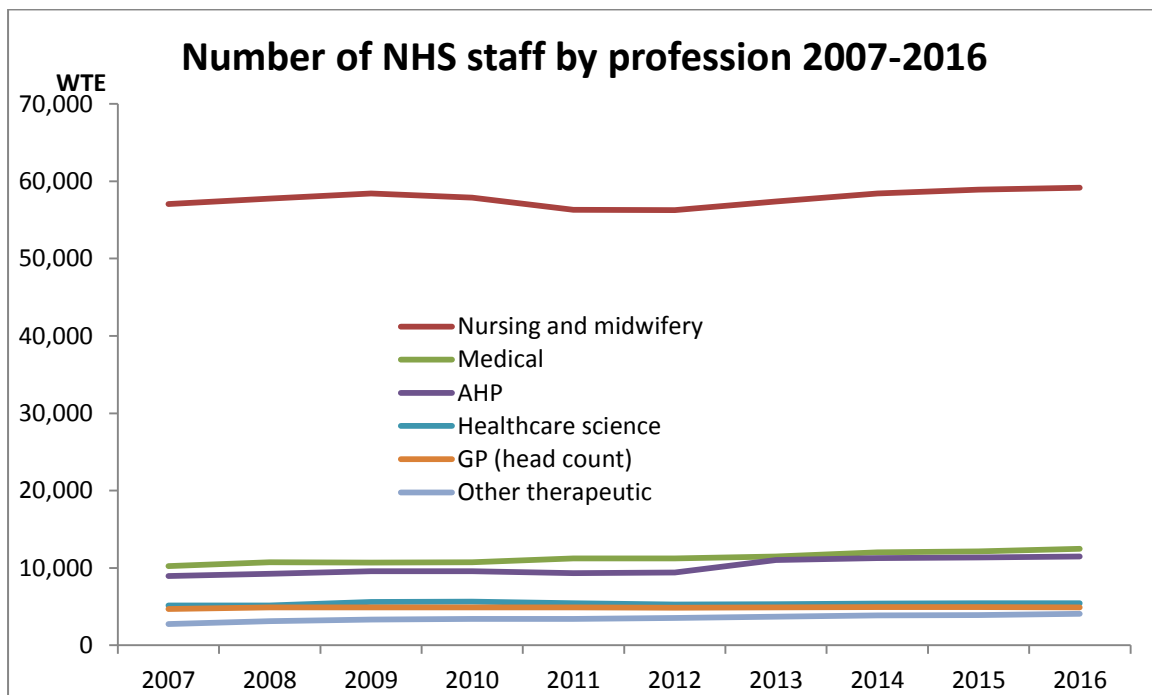


3. The most recent NHSScotland workforce statistics were published on 6 June 2017 by ISD Scotland and show data recorded as at 31 March 2017. The data shows that a record number of NHSScotland staff are now delivering care in response to the ever more complex demands. Since September 2006, NHSScotland staff have increased by 12,646 headcount (12,369.0 wte), up 8.4% (9.7% wte).<sup>5</sup>

<sup>5</sup> The small difference between headcount and WTE change suggests that nearly all net change involves staff employed on a full time basis, and is relevant in considering flexible hours and working patterns within NHS Scotland.



4. For NHSScotland<sup>6</sup>, the nursing and midwifery workforce is the largest staff category by some way, with almost 60,000 whole time equivalent (WTE) nursing and midwifery staff in employment within NHS Scotland in March 2017. The medical and Allied Health Professions workforces account for around 12,000 WTE and 11,500 WTE respectively. Healthcare Science has around 5,500 WTE and there are almost 5,000 GPs in Scotland (though this is headcount rather than WTE). An “other therapeutic” category numbering around 4,000 WTE includes a range of other professional groups, including pharmacists, who do not fall within the main medical, nursing, AHP or healthcare science categories. The chart and table below set out the numbers from 2007 to 2016.



<sup>6</sup> Many non-NHS providers in Scotland employ nurses: Part 2 of this Plan will say more about this.



5. Many efforts are being made to help secure this workforce, recognising the diverse skills they possess and their high levels of training, dedication and professionalism:

**Commitments to secure the NHS Scotland workforce**

- **Over £23 million invested to increase the number of medical school places.**
- **50 additional undergraduate places and the introduction of a pre-medical year and a graduate entry programme with a primary care focus.**
- **100 more training places for GPs, moving from 300 to 400: from 2019 onwards, additional GPs will be available to work in the community.**
- **4.7% increase in trainee nurses and midwives for 2017/18 – a fifth successive rise.**
- **NHS Scotland now continues to meet the Royal College of Midwives recommended midwife to birth ratio.**
- **500 additional Health Visitors - significant numbers of whom are in training to deliver this Scottish Government commitment.**
- **The development of innovative nursing and midwifery workforce planning tools mandated for use across NHS Boards**
- **Investment in the wider Primary Care team, with substantial increases in Paramedic numbers, pharmacists and other health professionals to support GPs in creating sustainable primary care solutions.**

6. Although statistical evidence also shows that vacancies for consultants and nurses have increased slightly, many new posts created in NHS Boards have helped increase overall numbers, benefiting from the mandatory nursing and midwifery workload and workforce planning tools which help NHS Boards to plan staffing levels. Combined medical & nursing agency spend represents just 2% of the overall NHS Scotland staffing spend – less than a third of that in NHS England - and bank and agency staff help NHS Boards to cope with peaks in demand and provide service continuity during times of planned and unplanned staffing gaps. Significant priority is given to working with NHS Boards to reduce the overall use of agency staff, which will be assisted by establishing Regional and National Staff Banks, which give NHS Boards greater access to a high quality temporary NHS workforce. The Scottish Government is also working with NHS Scotland to reduce both the use of locum doctors, and their cost to the health service, through a “preferred supplier” framework contract for agencies that supply medical locums.

7. The picture of the NHS Scotland workforce given by current statistical evidence is only partial. More proactive planning is needed to enable NHS staff to fully respond to the significant changes being made to NHS Scotland services and to the people whose care they provide. Workforce planning needs to evolve so in the medium to longer term, the service is better able to determine the workforce it will require in future. The purpose of this Plan is to provide a framework in which to achieve this aim at national, regional and local levels – for example, by:

- projecting forward to meet national needs on reported workforce statistics;

- enabling NHS Boards to identify opportunities to share efforts regionally to alleviate capacity issues and provide clarity between hospitals and elective centres; and
- to enable more consistent local reporting by NHS Boards, reflecting current and potential challenges to workforce issues at NHS Board level, and allowing progress with multi-disciplinary teams to be tracked.

### **Future planning - broadening the approach**

8. Each NHS Board must take account of a range of factors, including clinical need or geographical location, in determining the right blend of skills, knowledge and expertise to provide high quality services for the people it serves. Ultimately it is how the professional groups combine to deliver this care most effectively that has the biggest influence on outcomes for people. Workforce planning must be able to meet changing models of care as set out in the Health and Social Care Delivery Plan.

9. The Health and Social Care Delivery Plan sets out a vision for health and social care services that focus as much on prevention, early intervention and enablement as they do on the effective treatment of illness, injury and multi-morbidity. As these new models of care become embedded, workforce development must reflect the optimum skill mix that makes best use of the talents of the whole team to underpin effective multi-disciplinary working. This will ensure staff can work at the top of their clinical skill set and people who use services are able to access health care professionals with the right skills at the right time.

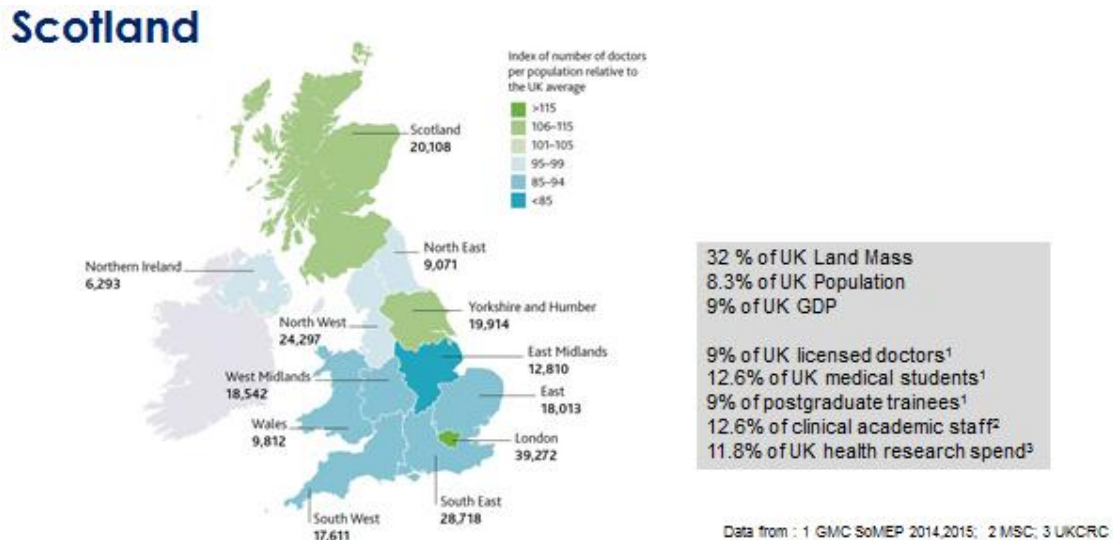
10. Planning for the future NHS Scotland workforce has often focussed on individual professions and in particular on those where staff numbers are “controlled” by student intakes. It now needs to involve a broader range of professions, recognising the inter-dependence of staff groups and a more distributed model of professional leadership - combining “first point of contact” practitioners with advanced practitioners from across the disciplines. This stronger multi-disciplinary approach should provide more sustainable services and help reduce the need for agency staff expenditure and outsourcing.

11. While there needs to be a new emphasis in future on multi-disciplinary approaches, many issues for the main professional groups must also be considered. The importance of a “whole of workforce” integrated view should be underlined, built on teams, with full recognition given to the different skills and qualifications that different workers bring – whether they are delivering care, or supporting those who deliver care.

12. Workforce planning will need to develop further to describe clearly how multi-disciplinary working will enable the shift. That will be assisted by the scenario planning model we are developing by Autumn, and by the work being done by NES to reorganise workforce data nationally, regionally and locally. Future editions of the Plan will include reference to developing models for multi-disciplinary working which apply at each level, taking account of existing developmental work in primary care. This work will also be considered in the context of the developing remit for the new National Workforce Planning Group.

## Medical workforce

13. National statistics have shown increasing numbers of doctors within NHS Scotland, with over 28% more doctors over the last 10 years<sup>7</sup>. Numbers of consultants, the most senior grade of doctor, have increased in the same period by a record 46.2% since 2006. The General Medical Council has published data which demonstrates that Scotland has more licensed doctors per head of population on both the GP and specialist registers, and that it also has significantly more medical undergraduates and doctors per capita compared to the UK as a whole, as demonstrated in the following graphic:

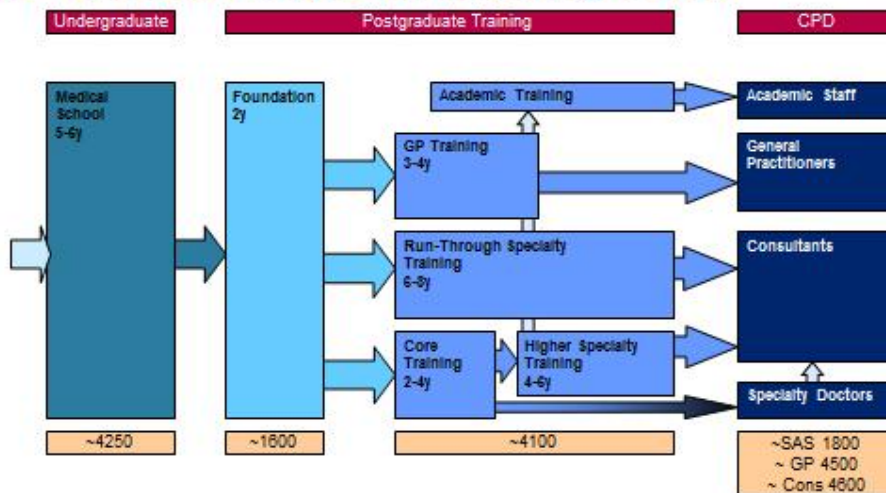


14. However, continued difficulties in filling posts for individual specialties, at particular times and in particular parts of Scotland have demonstrated that while numbers in employment are important, what people are trained in is also highly relevant. For this reason, Scottish Ministers have committed to investing over £23 million to increase the number of medical school places.

15. The diagram overleaf shows medical training flows.

<sup>7</sup> 28.4% more doctors over the last 10 years, increasing to 12,325.9 WTE as at 31 March 2017 (or by 2,725.9 WTE between Sep-06 and Mar-17). (ISD Scotland)

## The Current Shape of Training : 2017



16. Scotland is currently addressing a number of key challenges for the medical workforce with a view to better matching undergraduate education and post graduate training to service need. These challenges occur at various stages of training, as follows:

- A long training 'pipeline' from entry to medical school to end of postgraduate training of up to 15 years;
- Ensuring the supply of trained doctors meets the future requirement for GPs and consultants. Detailed medical specialty supply/demand profiles are providing increasingly specific modelling on this. This depends on effective modelling, requiring flexibility in high quality training capacity and in funding (with potential to realign current agency and locum spend to meet training and service need);
- Matching what services are needed to match graduates' ambitions, and adjusting university curricula accordingly:
  - Only 19% of graduates from Scottish medical schools are in GP training in Scotland 4 years after qualification. For General Practice, there is a pressing need for locally-recruited students to return to work in their communities;
- Ensuring sufficient medical graduates to fill foundation programmes in the context of a recently emerging overall UK undersupply position. This is being addressed by initiatives to increase Scottish medical graduate output;
- Ensuring sufficient Foundation programme completers to fill an expanding requirement for specialty training. This requires both sufficient Foundation capacity and improved retention of completers in Scotland;
- Understanding and addressing the factors which result in only 50% of graduates from Scottish medical schools being in training in NHS Scotland 4 years later. This will require more systematic use and development of available evidence about the proportion of graduates who are of international origin, or who may not be able to stay in Scotland.

17. Many different effects apply at each of these stages. However these challenges demonstrate the need to engage with the higher education sector and

post graduate training providers more closely to match the medical workforce with what services, and crucially the people who receive them, actually need.

18. Much work is already underway to increase medical student numbers and training places, to invest in training and to address the sustainability of the medical workforce. Improvements to workforce planning hold much potential to support further changes to existing arrangements. But because it takes years for clinicians to complete their training, some changes, particularly those to education, cannot have immediate effect. This presents challenges to all organisations involved in medical workforce planning, requiring in-depth discussion on training and development issues.

#### **Increasing the number of radiologists in Scotland**

##### **What is being done?**

- Radiology training posts increased by 26 in 4 years.
- This 20% increase in training numbers is in response to medical supply/demand data revealing an ongoing undersupply.

##### **What will this add?**

- Improved recruitment of consultant radiologists
- Better ability to meet the National Cancer Strategy

19. Current recruitment and retention challenges in both hospital specialities and general practice are well documented, and several strands of work aim to enable medical staff to feel both valued and engaged in NHS Scotland work. National and regional initiatives linked to staff wellbeing and engagement include resilience training in NHS Tayside, use of the Professional Compliance Analysis Tool (PCAT) by workforce planning, and the NES-led StART (Strategy for Attraction and Recruitment) Alliance promoting measures to improve recruitment and retention. This work is being mapped to help share best practice more widely.

#### **Valuing the Medical Workforce**

##### **What is being done?**

- Over £23 million investment over next 5 years increasing number of medical school places by 50 a year (from 850 to 900) - with a new entry level programme for students from deprived backgrounds.
- Creating first Scottish graduate entry programme for medicine, with a strong focus on primary care and remote/rural component - both to encourage entry into general practice.
- Mapping of national and regional initiatives relating to workforce wellbeing
- Expansion of PCAT 's health and wellbeing strand
- Developing NES strategy on engagement

20. However, sustainable recruitment to medical specialties and GP needs concerted, long term action, especially for remote and rural areas or in areas of

higher socio-economic deprivation. This begins with recruiting the correct absolute numbers at each stage of training, builds through high quality training and education and is consolidated by best practice employment behaviour.

## **Undergraduate medicine**

21. Scotland currently has five world class medical schools which are an attractive destination for students from across the world. While this is a strength in the context of a competitive, global marketplace, the requirement for a sustainable medical workforce for NHS Scotland is important given the length of medical training and the high costs associated with it. Current priorities for Scottish Government include producing more graduates who are likely to enter training for GP and other shortage specialities. But there needs to be a clearer systematic focus on recruiting the doctors of the future with training and education which reflects the needs of patients and service providers, the changing demographic of the population and the fact that more care will require to be delivered in the community.

22. More graduates from Scottish medical schools also need to stay in Scotland, to work in NHS Scotland. Recent increases in places will potentially amount to 250 additional medical trainees by 2021. **Scotgem**<sup>8</sup> – Scotland’s first graduate medical school, will open in autumn 2018 with a curriculum focussing on GP and remote and rural medicine as well as an element of “bonding” - likely, in this instance, to involve an element of return of service to NHS Scotland in exchange for a bursary. The Scottish Government is also funding two pre-medical entry courses for entrants from less socially advantaged backgrounds which commence in Autumn 2017.

23. Further work is however required to address challenges around undergraduate education, such as how to recruit students with the right values into medical schools; how teaching and culture in medical schools needs to adapt to ensure a closer match between student learning and experience and the needs of NHSScotland; and how to retain more graduates from Scotland’s medical schools in NHS Scotland and encourage them into the specialities that NHS Scotland needs.

## **Postgraduate training**

24. Postgraduate training pathways also need to adapt. Professor Sir David Greenaway’s *Shape of Training* review recognised that medical training must adapt to meet the changing needs and expectations of patients, and to meet the needs of service providers. Preparatory work is already underway to implement the key recommendations from this review.

25. National decisions taken to support high quality training can have a profound impact on local service delivery. Scotland is competing with the rest of the UK and the rest of the world and remains an attractive destination for students, so the training it offers to health and social care professionals must remain competitive in the wider market. There is therefore a case to look again nationally at reducing the barriers to overseas recruitment as part of a more co-ordinated initiative to market Scotland as a desirable place to live and work in.

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<sup>8</sup> <http://medicine.st-andrews.ac.uk/blog/tag/scotgem/>

26. For specialty and associate specialist (SAS) doctors, an SAS development guide<sup>9</sup> was recently agreed by Health Education England, NHS Employers, the BMA and the Academy in England, which describes actions that can be taken to ensure best practice is applied in the development of SAS doctors and dentists. This joint working has been in place in Scotland for some years and is manifest in the SAS Development Programme, funded by Scottish Government, managed by NHS Education for Scotland.

### **Medical Specialty Profiles**

27. Medical Specialty Profiles use modelling information from several sources to develop a picture of the medical education and training “pipeline”. This data is used to identify and inform responses to differences in the supply of and demand for doctors. To date, detailed specialty profiles have been completed for all established hospital specialties. These profiles have been used for a wide range of specialties to:

- Provide advice in the context of annual setting of training numbers;
- Develop strategies in response to anticipated shortages;
- Address “gap management” issues – ie informing the process of filling gaps in service rotas.

28. The profiles are now being developed further to predict the sustainability of particular specialties in shifting care to the community and determining new multi-disciplinary staffing and service delivery models. The profiles’ predictive capacity can be used to inform the recruitment and retention strategies NHS Boards use to fill gaps and vacancies. The profiles are an important tool, and further discussions with NES, working with ISD Scotland, will help to determine how NHS Boards might use them as part of a suite of effective workforce planning tools covering the majority of the NHS workforce. The aim is to have a project specification and plan ready by July 2017.

**Medical Specialty Profiles** are used to describe how training programmes meet both population and local service requirements, with intake numbers set by future demand for trained GPs and consultants.

#### **What is being done?**

- 115 more specialty training posts since 2014, targeted to areas of need.
- 25-30 posts less than full-time training posts, improving supply for “hard to fill” specialties;
- GP training places increased by 100.

#### **What do the Profiles add?**

- More insight into training and trainee destinations.
- Better evidence base to support action for medical specialties with difficulty in recruiting consultants.
- More targeted support for medical specialties from allied health professions.
- Improved demand forecasting, taking account of changing specialty workforce participation and growth.

<sup>9</sup> <http://www.nhsemployers.org/your-workforce/retain-and-improve/managing-your-workforce/sas-doctor-development-workshops-and-survey>

## Junior Doctors

29. Junior doctors are NHS Scotland's future medical leaders and Scottish Ministers are committed to making Scotland as attractive a place as possible for them to work. The Scottish Government has identified a need for improving the way the day to day hours of junior doctors are managed through a system called DRS Real-time which is designed to automate this process, provide real-time online access to rosters, allow the easy management of these by employers and employees, and provide real-time working hours information for all junior doctors.

30. There has been considerable success in improving the working hours and conditions for Junior Doctors by implementing the Working Time Regulations; ending 7 full night shifts in a row and ensuring that rotas comply with guidance that no junior doctor should be rostered to work more than 7 days or shifts in a row. Delivering a maximum 48 hour working week for Junior Doctors has many implications for services and staffing, with an impact on future workforce planning arrangements. On-going work is being undertaken to assess this impact and once an initial evidence base has been developed, further work will ensure these complex arrangements are fully understood. A phased approach will ensure that this is delivered in a safe and sustainable manner.

## General Practice

<b>GPs</b>	
<b><u>What has been done?</u></b>	<ul style="list-style-type: none"><li>• Training places increased from 300 to 400</li><li>• Investment in bursaries</li><li>• Investment in recruitment and retention increased to £5m</li><li>• Funding more pharmacy work in GP practices to reduce GP workload</li></ul>
<b><u>What more will be done following this Plan?</u></b>	<ul style="list-style-type: none"><li>• Publish evidence based target numbers</li><li>• Improve Primary Care Workforce Survey</li><li>• Plans to attract more GPs via schools and universities</li><li>• Enhance Multi-Disciplinary team working</li><li>• GP Pharmacy Fund expanded to £12m from £7.8m</li><li>• Develop supply/demand profiling work.</li></ul>

31. General Practice is facing unprecedented challenges through increased workload; increased risk relating to staff and premises; and in recruitment and retention of new and existing GPs. Although "headcount" numbers of GPs have increased substantially in recent years, numbers of whole time equivalent GPs are reducing, with the workforce increasingly choosing to work part-time against a backdrop of increasing demand on GP services, an ageing population and a continuing drive to shift the balance of care from acute to primary and community settings.

32. For those reasons, Scottish Ministers have committed to increasing the number of GPs working in communities, and have augmented the number of GP



training places from 300 to 400 a year, bringing the total GP training establishment up to 1,200 from 2017.

33. Simultaneous action is needed to improve arrangements for GPs' education and early career and recruitment and retention. There is potential for considerable impact from educational changes, but they will take many years to deliver. There are plans to generate interest in GP as a profession through schools and universities and attract students from socio-economically deprived backgrounds. The Scottish Government has also set up a Recruitment and Retention fund, increasing from £1m in 2016/17 to £5m in 2017/18 (as part of the £60 million in direct support of General Practice in 2017/18). This increased investment will enable the scheme to expand and continue to explore with key stakeholders the issues surrounding GP recruitment and retention across Scotland.

34. GP shortages affect the sustainability of primary care services in the out of hours (OOH) period, which is after 6pm in the evening and during the weekends when GP surgeries are closed. Across Scotland, out of hours services are under pressure due to an increasing lack of GPs willing to participate.

35. A national review of primary care Out of Hours Services "*Pulling Together: Transforming Urgent care for the People of Scotland*" was published in 2015. It included recommendations for the future contributions of the GP workforce, as well as the nursing, pharmacy, paramedical, other allied health professionals and social services workforce. It recognised that while GPs will continue to be an essential part of multidisciplinary teams providing clinical leadership and expertise, particularly for complex cases, they will no longer be the default health care professionals to see patients for urgent care.

36. GP contract negotiations will play a key role in determining what further progress can be made, and how quickly. To ensure that the appropriate actions are taken forward, a supplement to this Plan – Part 3 - will be published towards the end of this year, following these negotiations. Workforce numbers will be an important part of the GP contract, and the supplement will address GP workforce matters and will include an evidence based target of numbers of GPs needed to maintain and sustain high quality General Practice services.

## **Primary Care**

37. Primary Care sits at the heart of an integrated health and social care system, offering GP and community services including district and community nursing, mental health, dentistry, community pharmacy, and optometry, as well as social care services, third and independent sector provision. These are services which are the responsibility of the new Integration Authorities.

38. General Practice increasingly involves team working. More multidisciplinary teams (MDTs) working in practices will help ensure that people see the right professional at the right time to better meet their needs. While leading their MDTs in improving the health of the wider population, GPs must also have the space they need to focus on complex issues including end of life care. MDTs are the right approach because they enable better health outcomes, more efficient use of

resources and enhanced job satisfaction for team members. These teams consist of a range of professionals whose core members already exist in Primary Care - including GPs, Practice Nurses, Practice Managers and Receptionists. New roles (clinical, non-clinical, social care and Third Sector) are already evolving and others will need to be introduced to ensure teams meet patient needs.

#### **General Practice is about teams**

- **£2 million is being invested in 2017 in training for General Practice nurses (training of new ones or additional training of current ones), who are core to effective multi-disciplinary teams and good patient care.**
- **At least 250 Community Link Workers are being recruited to work in GP surgeries, directing people to local services and support.**
- **1,000 more paramedics will be trained over the next five years to work in the community, helping to reduce pressure on A&E services.**
- **A further £500,000 is being invested to develop the skills of practice managers and other non-clinical staff such as practice receptionists, delivering primary care through multi-disciplinary teams, with GPs and social care partners working in clusters of practices.**
- **General Practice nurse roles and educational requirements are being refreshed under the Chief Nursing Officer's *Transforming Nursing Roles* programme.**

39. General Practice nurses in 2012/13 accounted for 33% of GP and practice nurse contacts, an increase of 5% from 2003/4.<sup>10</sup> They are essential to the future of general practice. General Practice Nursing provides primary care services, mainly through GP independent contract employment, with general nursing skills and extended roles in health protection, urgent care and supporting people with long term conditions. There has been a continued increase in numbers of consultations for general practice nurses compared to GPs, illustrating the continuing shift of chronic disease management from GPs to nurses.

40. In parallel with these developments, it is particularly important that the quality of primary care workforce data allows for effective workforce planning to be undertaken for the future. Current workforce planning arrangements are informed by a biennial Primary Care Workforce Survey, which gives incomplete information. There is therefore a pressing need to strengthen the data currently collected. Ways to access and use the robust GP workforce data required to strengthen planning are being explored by the Scottish Government and Scottish General Practitioners Committee of the British Medical Association as part of negotiating the new GP contract. Wider discussions are also proceeding between the Scottish Government, NES, ISD Scotland and others about how to improve the range, frequency and quality of primary care workforce information.

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<sup>10</sup> The latest available information on GP and practice nurse contacts is from 2012/13: [https://www.isdscotland.org/Health-Topics/General-Practice/Publications/2013-10-29/PTI\\_Oct13\\_Fig1\\_ContactsByDiscipline.xls](https://www.isdscotland.org/Health-Topics/General-Practice/Publications/2013-10-29/PTI_Oct13_Fig1_ContactsByDiscipline.xls)

## **Dental**

41. Within independent dental contractors' services, there is also broad agreement to a shift towards prevention, building on successful work in preventing dental disease in children. This reduces pressure on the acute sector, where theatre time is currently used to treat people with advanced decay, and there is scope to move other secondary care services into primary care. The increasing needs of the frail dentate older person who cannot be treated in a surgery also require to be met.

42. All of these developments impact on the dental workforce, and therefore on the workforce planning necessary to meet these service aims. At one end of the skills spectrum, dental practitioners continue to be expected to work at the limit of their scope of practice, for which they will need training. At the other, more input from dental care professionals, such as Therapists and Hygienists, will help to implement more preventive dental services.

## **Pharmacy**

43. Pharmacists are core members of the healthcare workforce within community pharmacy teams, supporting GP practices with everyday medicines-related care. In hospital and specialist care services, they work with other clinicians to ensure the best pharmaceutical care decisions are taken and are appropriate to the patient's condition. Significant progress has already been made to meet changing healthcare needs: for example, over a quarter of all practising Pharmacists are qualified as independent prescribers, and pharmacy undergraduate education is being strengthened.

## **Optometry**

44. There are 1,453 Optometrists and 3 ophthalmic medical consultants listed to provide general ophthalmic services (GOS). 142 of these Optometrists have been funded to become independent prescribers through NHS Education for Scotland. The development of general ophthalmic services (GOS) to support community eye care has reduced the burden on GPs and has allowed more patients to be discharged from the hospital eye service. Age is the greatest risk factor for developing eye conditions, and training is being developed to enable safe and high quality community care for patients with long-term ophthalmic conditions. However more capacity within the community is needed to reduce demand on hospital provision. While rising workload and recruitment outside the central belt present challenges, numbers of optometrists entering Scotland from elsewhere in the UK have started to increase.

## **The Allied Health Professional (AHP) workforce**

45. The 13 main AHP professions (such as Physiotherapists, Dieticians, Speech and Language Therapists, and Podiatrists) play a key part of the Delivery Plan's aims, providing prevention, early intervention and enablement support to people of all ages to live well, be physically active, manage their own conditions, remain in or return to employment, and live independently at home. Over the last 10 years, the AHP workforce has increased by over 30% - from 8,800 in 2006 to around 11,500 in

2017. This reflects the growing need for professionals with a diverse range of specialist skills who can make a vital contribution as first point of contact practitioners to diagnostics, early rehabilitation and enablement.

AHPs are already supporting the shift in the balance of care from acute to primary care and the community - where increasingly they are working – as in the examples below:

#### **AHP roles supporting a shift in the balance of care**

- **Radiography “plain film” diagnostic reporting frees up (consultant) Radiologists, addressing the annual 15% increase in demand for diagnostics and reducing agency spend and outsourcing of services.**
- **More Physiotherapists and Occupational Therapists will be required in multi-disciplinary teams within primary care and A&E departments. In acute settings, evidence shows that 1 hour of therapy time can reduce in length of stay by 1 day.**
- **Physiotherapists treating MSK patients in GP practices can free up GPs’ time to see more urgent cases.**
- **The Specialist Paramedic role developed by the Scottish Ambulance Service will help to reduce unnecessary hospital admissions and to relieve pressure on general practice.**

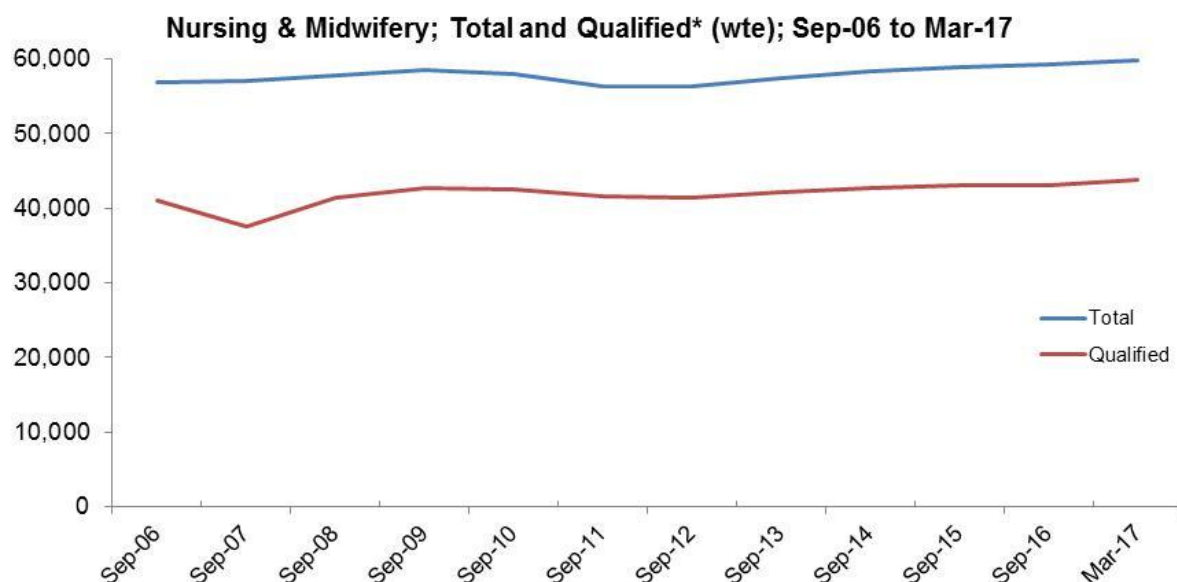
46. Future demand for AHPs is likely to rise, alongside the increase in demand for services associated with an ageing population. The numbers entering the AHP professions are not currently controlled, and are largely determined by supply and demand factors. The potential for a more controlled approach to workforce planning for those training to become AHPs, particularly in the three largest professions – Radiography, Physiotherapy and Occupational Therapy – is being explored. We will also need to engage with NHS Board AHP Directors and workforce planners to set out their potential demand needs and projections for the AHP workforce going forward, and to consider how we engage with higher education institutions to help build that into their supply.

47. This process needs to be informed by better targeted, more predictive workforce planning which fully recognises the significant contribution made by the AHP workforce in developing NHS Scotland services. Recruitment issues have persisted for some AHP professions, suggesting a need for a more evidence-based approach to workforce and workload measurement. Nationally, action is already being taken to explore an AHP workforce planning tool to help predict future need as well as capture current and future ways of working. *Allied Health Professions Co-creating Wellbeing with the People of Scotland*<sup>11</sup>, launched in June 2017 under the Active and Independent Living Programme in Scotland, sets out more detail on this. AHPs will also play a central role in meeting workforce planning needs at regional level. And locally, action is being taken to develop advance practice and support worker roles that use nationally agreed definitions, ensuring AHPs are working effectively and in an integrated way across health and social care. The

<sup>11</sup> <http://www.gov.scot/Publications/2017/06/1250/0>

recommendations in this Plan will help ensure a more robust data platform for AHPs can better support workforce analysis, intelligence and modelling.

## Nursing and Midwifery



Footnote: Qualified nurses for September 2007 excludes nursing and midwifery staff who had not assimilated into new *Agenda for Change* (AFC) terms and conditions.

48. As at March 2017, Nursing and Midwifery staff represent 43% of NHS Scotland's total workforce and play a vital role in achieving the vision for health and social care in Scotland. There is growing evidence about the relationship between registered nurse staffing and educational level, quality of care and patient outcomes. In March 2017, there were 59,798.6 whole time equivalent Nursing and Midwifery staff in post, representing an increase of 0.7% in the last year. There are over 3,300 WTE more Nursing and Midwifery staff working in NHS Scotland compared to 5 years ago, with 5 years of consecutive growth. The number of community Nursing and Midwifery staff has increased by 473.1 WTE (4.1%) in the past year alone.

49. As at March 2017, around 73% of the nursing and midwifery workforce are qualified (registered) staff<sup>12</sup>. The number of qualified Nurses and Midwives in NHSScotland has increased by 6.7%, by 2,731.7 WTE to 43,757.9 WTE since 2006. We have more qualified nurses and midwives per 1,000 population in NHSScotland (8.1 WTE – March 2017) than in NHS England (5.6 WTE – March 2017).

50. There are around 10,000 student nurses and midwives in training in Scotland, with an average of around 1,000 more nurses and midwives in training each year between 2007-2015 compared to 2000-2006. Recent supply and demand trends point to:-

- higher demand for nursing and midwifery staff since 2012, with additional posts being created within NHS Boards;

<sup>12</sup> The combined size of the registered nursing and midwifery workforce across health and social care and the private sector in Scotland is estimated to be 58,545 (headcount).

- short-term downturn in student numbers and in subsequent supply of newly qualified nurses and midwives - although this trend is reversing as five successive increases in intakes begin to flow through the system;
- uncertain future supply of staff due to variable retirement patterns and a competitive higher education and employment market, making it more difficult to attract and retain newly registered staff in Scotland (this is replicated across the UK);
- current and future recruitment challenges in different areas and specialities;
- evidence that roles need to be more responsive to demographic changes and changing service needs.

51. These patterns also vary across – and within - each of the five main branches of nursing - Adult, Mental Health, Learning Disabilities, Children’s Nursing and Midwifery.

52. Nursing and midwifery vacancies have increased, driven in part by the creation of new posts in NHS Boards (for example, for health visiting) - reflecting patients’ needs and informed by application of nursing and midwifery workload and workforce planning tools. There were 2,818.9 WTE nursing and midwifery vacancies in NHS Scotland at 31 March 2017, equating to an overall vacancy rate of 4.5%. ISD Scotland has noted that increased vacancy rates in the last year are also due to improved recording. Vacancy rates vary across regions (highest in the North of Scotland); between Boards; and across specialties. The highest vacancy rates are currently in health visiting (reflecting the Scottish Government’s commitment to deliver 500 additional Health Visitors to meet the requirements of the Children & Young Persons Scotland Act), paediatrics, district nursing, adult and mental health nursing.

53. The age profile of the nursing and midwifery workforce is also changing, and the proportion of those aged 50 years and over has increased significantly in recent years. A high proportion of nurses and midwives fall within the current retiral band of 55 to 60 years. Further detail is provided in Chapter 4.

54. In 2015, a Short Life Working Group identified the demographic challenges facing the midwifery profession, with an ageing workforce and a reduction in qualified midwives. Work has been undertaken with NHS Boards to map the issues and to ensure robust forward planning.

55. Further consideration is needed about how to enable the older workforce to remain in post. NHS Scotland employers should recognise that the unique skills, knowledge, experience and wisdom of the older workforce underpins its overall capacity and capability, and make appropriate arrangements to facilitate working longer.

56. Ensuring a sustainable supply of appropriately skilled nurses and midwives is a key challenge, not just for Scotland but for the rest of the UK and internationally. Among other factors, the wider UK nursing and midwifery labour market influences the supply of available nurses and midwives within Scotland. Across the UK, attention has focused on the potential impact of Brexit on supply of registered nurses, and changes in migration rules on the UK nursing and care workforce. In

March 2016, the Migration Advisory Committee recommended that nurses remain on the Home Office's shortage occupation list (SOL), driven in particular by evidence of current shortage of nurses in England.

### **Ensuring a sustainable, high quality Nursing & Midwifery workforce**

57. Much is already being done to deliver sustainable solutions to nursing and midwifery workforce challenges. Some key building blocks are in place, including evidence based workload and workforce planning tools; significantly higher numbers of qualified staff; well developed and strengthened student intake planning; work to transform nursing roles; and a clear strategy for nursing education (*Setting the Direction for Nursing & Midwifery Education*<sup>13</sup>). Example of measures being taken include:

#### **Measures to address Nursing and Midwifery demand and supply**

- **Creating 1,000 extra training places in the lifetime of current Parliament;**
- **A 4.7% increase in student intakes for 2017/18 - the 5th successive rise;**
- **2015 investment of £450,000 over 3 years in Return to Practice;**
- **60 additional training places for the North East in 2017/18, enhancing access to training in remote and rural areas;**
- **Commitment to enshrine safe staffing in law, placing nursing and midwifery workload and workforce planning tools on a statutory footing, to further support consistent, evidence based planning;**
- **Work to transform nursing roles and education and to widen access to nursing and midwifery education and careers.**

58. Scotland has led the UK in its development of evidence based nursing and midwifery workload and workforce planning tools. The Nursing and Midwifery Workload and Workforce Planning Programme provides a validated framework and suite of tools to enable NHS Boards in Scotland to make decisions regarding Nursing and Midwifery workforce requirements. These tools help determine the right number of nurses and midwives depending on clinical needs of patients, professional judgement and particular specialty areas.

59. A suite of 12 tools is now available, covering 98% of clinical service areas. Application of these tools has been mandatory for all NHS Boards since April 2013, as part of Local Delivery Planning. The tools were developed in partnership with staff representatives, and are endorsed by the Royal College of Nursing Scotland and the Royal College of Midwives.

60. Steps are now being taken to enshrine safe staffing in law - placing the tools on a statutory footing - to support more consistent approaches and assure the

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<sup>13</sup> <http://www.gov.scot/Publications/2014/02/4112/downloads>

required levels of nursing and midwifery staff are in place. The Scottish Government is currently consulting on proposals that would require organisations to:

- Apply nationally agreed, evidence based workload and workforce planning methodologies and tools;
- Ensure that key principles – notably consideration of professional judgement, local context and quality measures – underpin workload and workforce planning and inform staffing decisions;
- Monitor and report on how they have done this and provide assurance regarding safe and effective staffing.

61. Proposals focus intentionally on the approaches to nursing and midwifery workload and workforce planning tools because we already have a validated approach and suite of available tools. As part of the consultation, we are also exploring whether the approach to nursing and midwifery workload and workforce planning could be extended to other staff groups and care settings.

62. The current model for the Nursing and Midwifery Student Intake Planning Process is the well-established, well-developed process for projecting the required numbers of newly qualified nurses and midwives required in 4-5 years' time and, thereby, the number of students that therefore need to commence training programmes now. Further detail is provided in Chapter 4.

63. To help secure future workforce supply, in January we announced a 4.7% increase in intakes to pre-registration Nursing and Midwifery programmes for 2017/18 – an extra 151 places across Adult, Mental Health, Learning Disabilities, Children's Nursing and Midwifery - the fifth successive rise, equating to 3,360 entry places. To take account of remote and rural challenges, we are funding 60 additional training places for North East of Scotland training providers in 2017-18, over and above existing numbers.

64. We have also retained free tuition and the nursing and midwifery bursary to help attract and retain our future workforce, are providing enhanced financial support to students most in need to ensure we continue to attract a diverse future workforce. There have been an average of 9,939 students in training each year between 2007-2015, compared to 8,950 between 2000-2006.

65. Although applicants to pre-registration programmes in Scotland have fallen in recent years, nursing and midwifery training places continue to be oversubscribed. Latest UCAS applicant data (April 2017) indicated a 2% drop in the number of Scottish domiciled applicants making at least one choice to nursing, although applicants aged 25 and over increased by 1%. This contrasts starkly to the 19% fall in applicants across the UK overall and, in particular, the 23% decrease in the number of English domiciled applicants to nursing.

66. As well as training new nurses and midwives, we are also encouraging former registrants to retrain and re-enter employment. In 2015, to expand short-term supply, we reintroduced funding for the national Return to Practice scheme and to date



round 290 former nurses and midwives have completed or are currently undertaking retraining – exceeding our initial target of 75 places per year.

67. Although Scotland already attracts and supports individuals from diverse backgrounds into nursing, Scotland’s Chief Nursing Officer has recently launched a Commission to review ways to support and widen access to Nursing and Midwifery education and careers; this will report later this year. CNO’s *Transforming Roles* programme is also helping to develop nursing, midwifery and AHP (as well as some Healthcare Science) roles to meet the current and future needs of Scotland’s health and care system.

68. Evolving or emerging nursing roles, such as Advanced Nurse Practitioners (ANPs), and Physician Assistants can also contribute to new models of care, and we therefore need to know how many we will require in future. The *Transforming Nursing Roles* Group has produced guidance on the ANP role and 500 additional ANPs are being trained by 2021, supported by £3m funding.

69. This is not just about having the ‘right numbers’. *Setting the Direction* (2014)<sup>14</sup> – the strategy for nurse education - focuses on nurses’ roles, skills and education over the course of their careers. A new “Transforming Nursing, Midwifery and Health Professions (NMaHP) Roles” group is also helping to develop nursing, midwifery and AHP (as well as some Healthcare Science) roles to meet the current and future needs of Scotland’s health and care system.

## Healthcare Scientists

70. Healthcare Scientists are the fourth largest clinical group, and their work underpins over 80% of all clinical diagnoses.<sup>15</sup> The NHS Scotland workforce covers over 50 different scientific specialities in the three main strands of healthcare science – life sciences, physical sciences and physiological sciences. Healthcare Scientists respond directly to advancing scientific and technological change and their work has a significant impact on waiting times. No modern evidence-based healthcare service could operate without the core services Healthcare Scientists provide to primary and secondary care. Further technological advances will bring many more opportunities for Healthcare Scientists to work across disciplines and NHS Board boundaries, consistent with the regional agenda set out in the Delivery Plan.

71. Healthcare Scientists already provide many solutions to clinical teams, through task shifting and role substitution, in the context of rising demand and cost. However a number of healthcare science professions experience difficulties in recruitment and retention, recognised by the inclusion of some on the Migration Advisory Committee’s UK Shortage Occupation List, and these challenges are often compounded in remote and rural settings. In a Shared Services, “Once for Scotland” context<sup>16</sup>, some of these issues are being explored for laboratory services:

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<sup>14</sup> <http://www.gov.scot/Publications/2014/02/4112/downloads>

<sup>15</sup> As at 31 March 2017 there were 5,492.4 WTE Healthcare Scientists in NHSScotland. (ISD Scotland)

<sup>16</sup> <http://www.sharedservices.scot.nhs.uk/health-portfolio/programmes/laboratories/>

### **Healthcare Science – planning the laboratory workforce**

**As part of the Shared Services Portfolio, a programme has been put in place to explore a shared services approach to workforce planning for laboratory services that will meet the future needs of NHSScotland. A national approach to delivering an appropriately designed and resilient healthcare science workforce could deliver significant benefits:**

- **improved sustainability through a scalable, flexible, innovative service;**
- **improved resilience through an ability to transfer work across borders;**
- **improved equity of service across the country through standardisation of service offering and approaches;**
- **access to latest technologies at enabled centres accessible to all Boards;**
- **increased efficiency to either realise cost savings or increase capacity through reduced waste and economies of scale.**

72. Workforce planning needs to take fuller account of the part played by Healthcare Scientists in enabling accurate and timely clinical diagnostics and developing their roles around assistive technologies, mobile devices and telemedicine. That will require better quality information about Healthcare Scientist numbers and more detailed intelligence about the shape of this workforce.

73. To initiate this, a more robust data platform needs to be developed, enabling the constituent professions within Healthcare Science to be identified, tracked and analysed for workforce planning purposes. This should enable multi-disciplinary workforce modelling to be supported, developed and implemented across this important workforce, and particularly for those professions which are experiencing sustainability challenges.

### **Psychology Services**

74. ISD Scotland currently publishes quarterly reports on Workforce Planning for Psychology Services in NHSScotland.<sup>17</sup> These provide statistics and commentary on characteristics of this workforce, which extends across a number of professions engaged in delivering Psychology services.

75. Though a small professional group, it is instrumental in service delivery. There has been a considerable increase in the number of professionals working in psychological therapies in recent years, and the expansion and modernisation of Psychology training is now leading to more well trained professionals entering the workforce. While the work Psychologists do to deliver faster access to CAMHS and psychological therapies is backed up by significant funding for mental health, there is scope to link statistical data, and the effects of increasing service demand on this

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<sup>17</sup> As at 31 March 2017 there were 1,315 headcount, 1,097.3 WTE clinical staff working across all professional groups in Psychology Services in NHSScotland.

workforce, more closely to the rest of the NHS Scotland workforce so we have a clearer picture of what is available for mental health. There is also a need to understand more about how this Plan can apply to the Public Health and Mental Health workforces, which include many who work in different sectors.

### **Small Occupational Groups**

76. Within the NHS Scotland workforce, there are a number of small occupational groups, broadly defined as having less than 100 whole time equivalent (WTE) staff. Examples of these smaller staff groups include:

- Sonographers
- Operating Department Practitioners (ODPs)
- Clinical Perfusionists

77. While the very specific roles these staff play in clinical settings are important, gaps have persisted in national workforce planning intelligence around the sustainability of, and risk management for, some of these staff groups. Shortages for some health professional staff groups, such as Sonographers, are defined in Home Office immigration rules and are included on UK-wide and Scotland-only Shortage Occupational Lists, informed by evidence from the UK Migration Advisory Committee.<sup>18</sup> A more co-ordinated approach to workforce planning for these groups is required across NHS Scotland.

### **Non-professional staff**

78. Many different non-professional roles within NHS Scotland - including care assistants, ancillary staff, call handlers, technicians and others - are critical to achieving and sustaining services. While statistical data is collected on these groups to allow for local workforce planning purposes, there is further scope a) to consider the adequacy of available data and how this is relevant for Part 2 of the Plan; and b) to analyse and compare workforce information for these staff with available data for similar workers in the social care sector. This would give a better, more integrated understanding of supply and demand issues as they affect health and social care in different parts of the country. It would also help illuminate what is known about labour markets nationally, regionally and locally, and lead to better co-ordinated steps taken to recruit and retain staff across the health and social care sector as a whole.

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<sup>18</sup> Full lists of UK and Scotland-only Shortage Occupations are at: <https://www.gov.uk/guidance/immigration-rules/immigration-rules-appendix-k-shortage-occupation-list>.

## CHAPTER 4 – THE CHANGING SHAPE OF OUR WORKFORCE

1. Getting the right people in the right place at the right time involves estimating patterns of the demand and supply of health and social care workers. This Plan considers what the future shape our medical and nursing and midwifery workforces will look like going forward.

2. This Plan offers an initial set of projections of future supply and demand. Much evidence already exists, but data is held in different places and does not always use the same metrics. There is scope to improve its co-ordination to give a more sophisticated picture of future supply and demand requirements across all the professions working in NHS Scotland.

3. This will require continued and close working between NHS Scotland workforce planners, service planners and clinical staff in developing scenarios, agreeing planning assumptions and parameters, refining methodologies and sense checking data used for modelling. In doing so, we will be able to take forward work that will assess:

- How known and anticipated pressures affecting demand and supply should be reflected in workforce projections;
- How planning the NHS workforce should reflect medium - and long-term trends in demand for healthcare;
- The potential impact of an ageing workforce and retirement patterns;
- Changing patterns of employment and workforce profile, how these influence supply, and what measures should be used to address them;
- How training, education and supply factors interact, and how they need to continue to evolve in future to address anticipated demand;
- The shift in the balance of care from acute to community settings;
- Inter-sectoral and cross-border flows, taking particular account of the potential effects of Brexit.

4. The answer cannot always be to grow a workforce which accounts for 15% of the total workforce in Scotland. A multidisciplinary and flexible approach should be at the heart of future workforce planning and system sustainability.

5. Scotland currently has good quality data to support workforce planning but as healthcare changes, the methods used to project the future workforce need to be developed further. NHS Boards need to project their future workforce against estimated changes in population demography and health factors, alongside changes in the way healthcare is delivered. The workforce plans they produce must be able to set out the actual expected workforce required, supported by analysis of workforce supply and demand trends, and taking account of available financial resource, including staff costs as part of the overall picture.

6. In Scotland, there is a need to enhance capacity to project future supply and demand, using scenario planning. This is relevant for all employers across health and social care, involving input from economists, service and workforce planners, statisticians and policymakers. There is also considerable scope to learn from the

approaches to workforce planning being taken by the OECD<sup>19</sup> and by other health systems in EU countries, such as in the Netherlands<sup>20</sup> and from reviews of those approaches.<sup>21</sup>

7. Along with the other recommendations in this Plan, the National Workforce Planning Group will need to support NHS Scotland workforce planners to develop and refine local and regional workforce forecasts based on future demand and supply. These will inform workforce decisions by:

- providing a national picture to manage and address risks;
- enabling more accurate scenario planning which factors in future population, demand, and workforce supply changes (eg retirements) - informing the care provided to people; and
- informing decisions taken about future skills mix and how multi-disciplinary teams can best work to meet service demands.

### **Projecting the future workforce**

8. Examples of projections for the Medical Workforce and for Qualified Nursing and Midwifery have been included in this plan to highlight the on-going work to model demand and supply. These build on well-established processes and project over a longer timeframe with varying demand and supply scenarios.

9. It should be noted that this modelling work requires further development, reflecting the phased approach involved in achieving improved workforce planning.

10. Although the examples illustrated here are relevant only to the medical and nursing workforces within NHS Scotland, the underlying principles and workforce demand and supply planning technical approaches can also apply to other key groups such as Allied Health Professionals, Nursing and Midwifery Support Staff and GPs.

### **Projecting the Consultant Medical Workforce 2017-2022**

11. Much work has been undertaken in recent years to address challenges in the medical workforce, with workforce numbers expanding.<sup>22</sup> For example, recognising the need for increased speciality numbers, training post numbers have increased by 115 since 2014; for General Practice, training places have increased by 100; and to help meet different working patterns, there has also been an increase so far in part-

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<sup>19</sup> [http://www.oecd-ilibrary.org/social-issues-migration-health/health-workforce-planning-in-oecd-countries\\_5k44t787zcvb-en](http://www.oecd-ilibrary.org/social-issues-migration-health/health-workforce-planning-in-oecd-countries_5k44t787zcvb-en)

<sup>20</sup> [http://www.capaciteitsorgaan.nl/wp-content/uploads/2017/01/2017\\_01\\_13-Capaciteitsplan-2016-Hoofdrapport-Engelse-versie-DEF.pdf](http://www.capaciteitsorgaan.nl/wp-content/uploads/2017/01/2017_01_13-Capaciteitsplan-2016-Hoofdrapport-Engelse-versie-DEF.pdf)

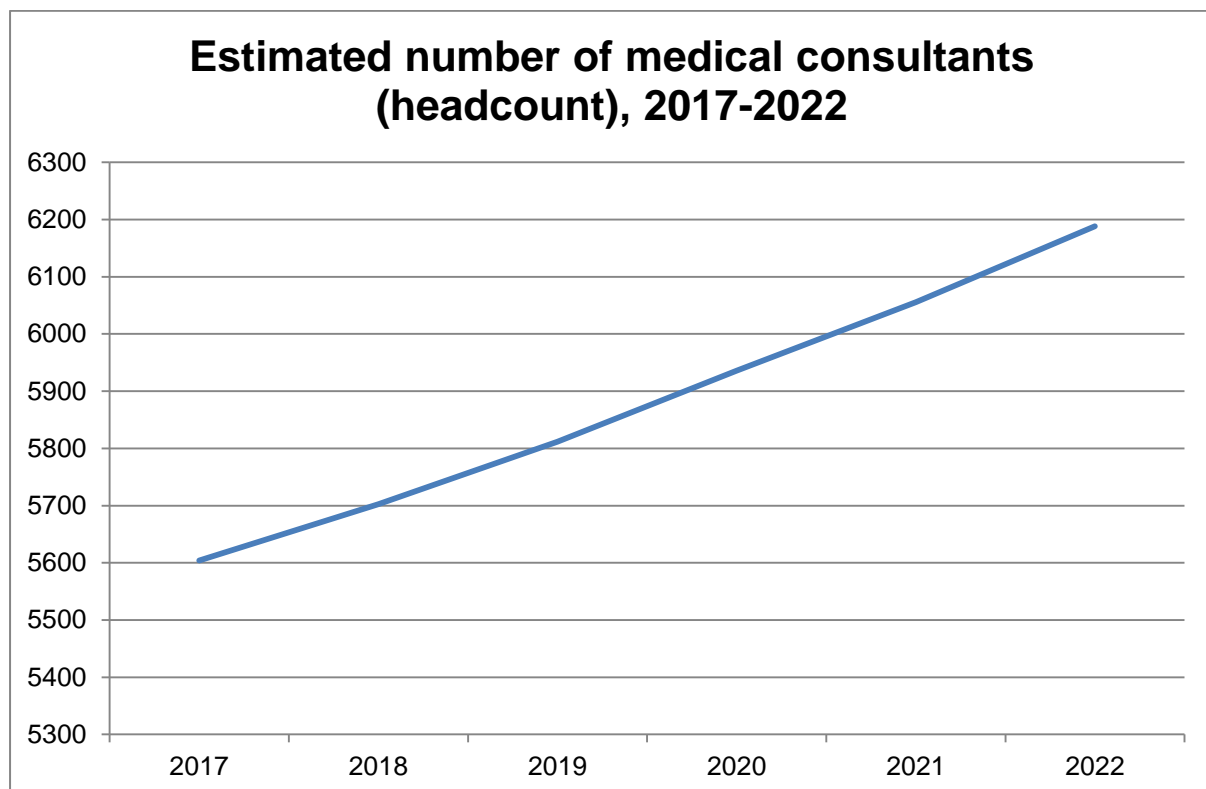
<sup>21</sup> <https://human-resources-health.biomedcentral.com/articles/10.1186/1478-4491-10-21>

<sup>22</sup> Staffing numbers in the consultant grouping increased by 1,679.2 WTE, or by 46.2% to a record high 5,315.7 WTE between 30 September 2006 and 31 March 2017; numbers of GPs rose by 315 headcount, or 6.9% to 4,913 headcount (between 30 September 06 and 30 Sept 2016). (ISD Scotland).

time training of around 35 extra places to compensate for less than full time. This increase will be adjusted annually.

12. The process of establishing training numbers for medical and surgical specialities is supported by the Medical Specialty Profiles, which offer a single comprehensive source - combining data and triangulating intelligence across the complete range of medical specialties - to give us an understanding of supply and demand drivers across NHS Scotland.

13. The graph below outlines **estimated numbers of consultants (headcount) required over the period 2017-2022**.

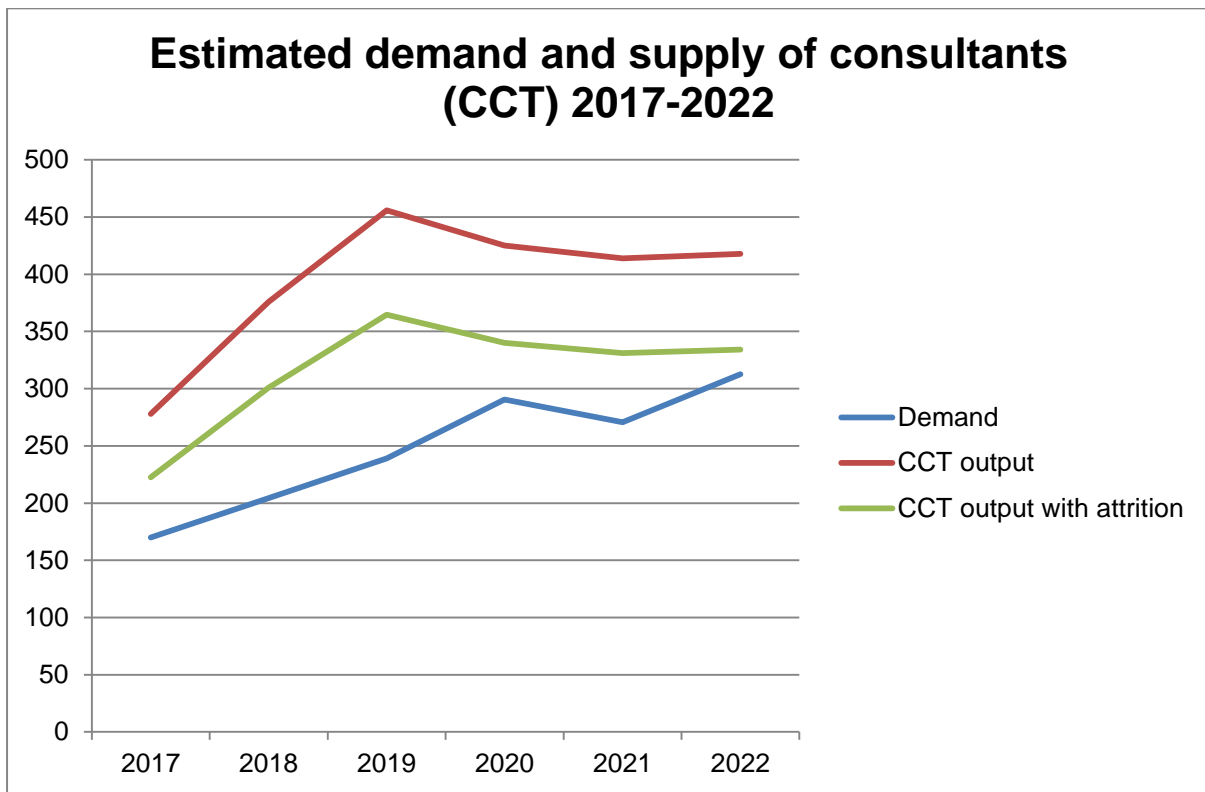


14. It is estimated that we will require around 600 more consultants by 2022. This projection takes account of anticipated annual retirement numbers over the period shown. These generate considerable additional annual demand on consultants which requires to be factored into supply adjustments, taking account of the long lead-time for training.

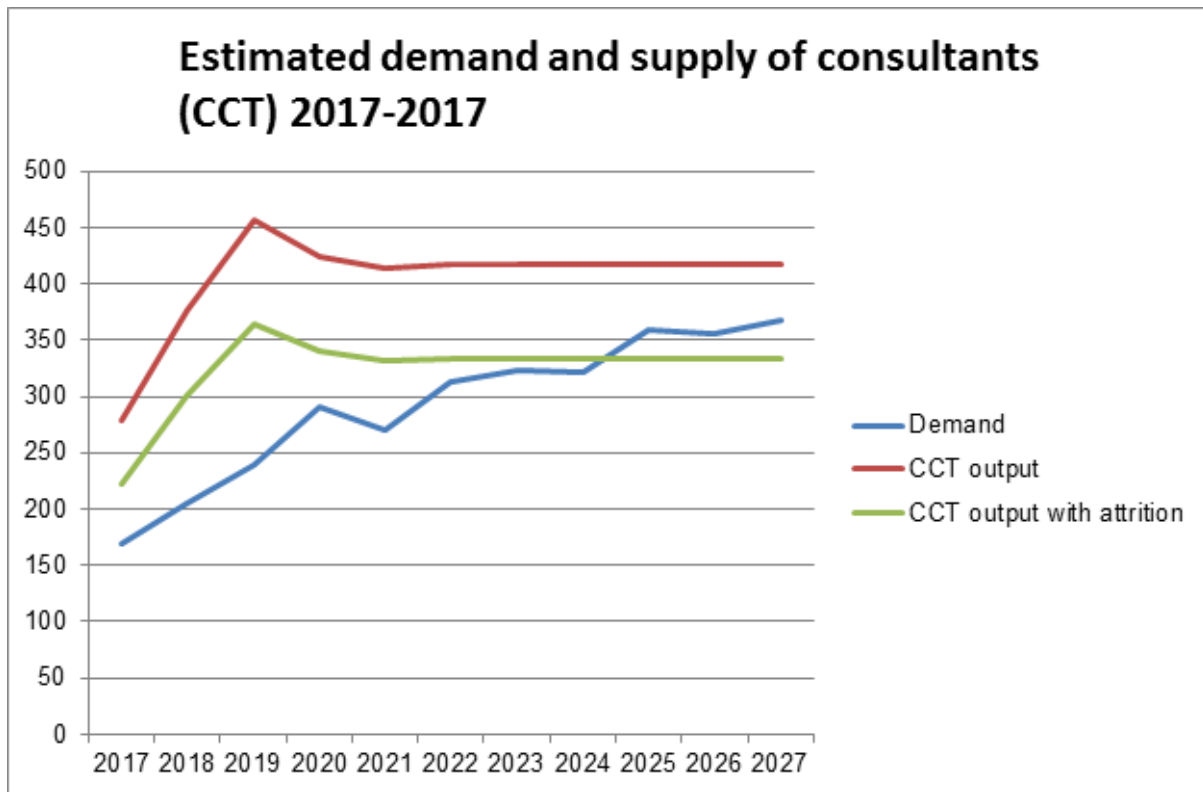
15. In terms of supply, the numbers of doctors exiting training at completion of clinical training (CCT) - especially those beyond the immediate horizon of five years - need to be treated with caution as these are based on estimates of CCT (end of training) output. There is also a high degree of variation between the medical specialties.

16. The graph below demonstrates estimated demand, as outlined above, against expected supply from 2017-2022. This is based on consultant output from training across all specialities. It is known that at least 20% upon CCT completion do not take a post in the medical workforce of Scotland. Although these numbers need to be

interpreted with caution, they show that the forecast increase in the supply of consultants will continue to meet estimated demand in the period up to and including 2022.



17. Further measures to reduce attrition and increase the overall medical training establishment will help ensure demand continues to be met over the period to 2022, combined with further work to profile the medical workforce being developed between Scottish Government and NHS Education for Scotland. These steps will give added confidence in projecting numbers ahead for the overall consultant workforce.



18. However, the long lead times involved in medical training require us to look further forward. Extending the projection for demand and supply of consultants to 2027, as in the graph above, shows that demand for consultants is likely to continue to grow post-2022. To address this trend, more concrete steps therefore need to be taken now. **We are therefore increasing the number of overall medical training places available in future years.** An additional 40 undergraduate places will derive from the ScotGem programme from September 2018; and between 50-100 additional undergraduate places will also be created across the wider system throughout the course of this Parliamentary term. Taken together, these increases of up to 140 in undergraduate numbers will help to widen access to medical careers; to ensure supply continues to be met, particularly at Foundation and Specialty stages, which are known pressure points; and to take account of the UK-wide approach to increasing numbers over the coming years. The increase is proportionate and logical in the wider UK context, and will be required to support the future consultant and GP workforce for the longer term beyond 2027.

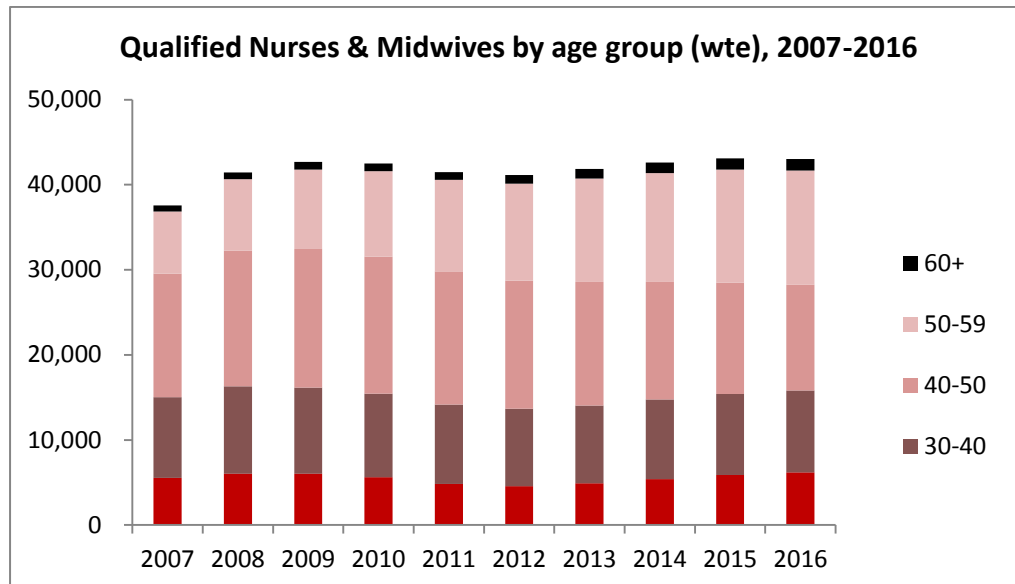
### Projecting the Registered Nursing and Midwifery Workforce to 2021/22

19. Nurses and midwives play a vital role in achieving the vision for health and social care, and maximising their role and contribution is the key aim of the *Transforming Roles* programme of work. There is constant change to the way nurses and midwives work, the work they do, where they work and the people they work with – particularly in taking on new or extended roles, or working as part of multi-disciplinary teams. All of these factors have an impact on the numbers of Nurses and Midwives that will be required in future.

20. The current model for setting annual student intake numbers is being developed to forecast future supply and demand for registered nurses. The model is



informed by known demographics for the Nursing and Midwifery workforce, particularly the age profile set out below. A high proportion of nurses and midwives falls within the current retiral band of 55 to 60 years. The model uses recent retiral rates (over four years) to demonstrate the impact of retireals on both supply and demand.



However the Nursing and Midwifery workforce continues to change: while nursing and midwifery is currently perceived as an 'older workforce', longer term demographic trends showing continued growth in the under 30 workforce indicate that supply will eventually need to be adjusted to match demand, should fewer staff retire and work later into life.

21. The model of demand for nurses and midwives is informed by NHS Board workforce projections, and available non-NHS demand data from social care, independent healthcare providers and GP independent contractors. ISD Scotland collects data on current staffing demographics, and NHS Education for Scotland collects data on enrolled student intake/completion rates.

22. The model produces a series of scenarios of required student supply which are shared and discussed with stakeholders in the Student Intake Planning Process (SIPP) group. In projecting forward to 2020-21, stakeholders' discussion have, for example, focused on the effects on the nursing and midwifery workforce of remoteness and rurality, social care (in particular, care homes) and the potential effects of Brexit. Professional judgement plays a significant role in this process, and recommendations on numbers of commissioned places for pre-registration nursing and midwifery education and training are presented annually to Scottish Ministers.

23. In 2015, recognising some limitations in planning intakes on an annual cycle, Scottish Ministers approved a 3 year cycle for student planning purposes. This longer planning cycle helps to avoid 'boom and bust' scenarios, and helps employers and higher education institutions to consider and indicate their financial requirements over the longer term. The 3 year cycle sets out a 3.5% baseline increase rate,

adjustable by +/-2% to take account of the SIPP group’s professional judgement and recommendations.

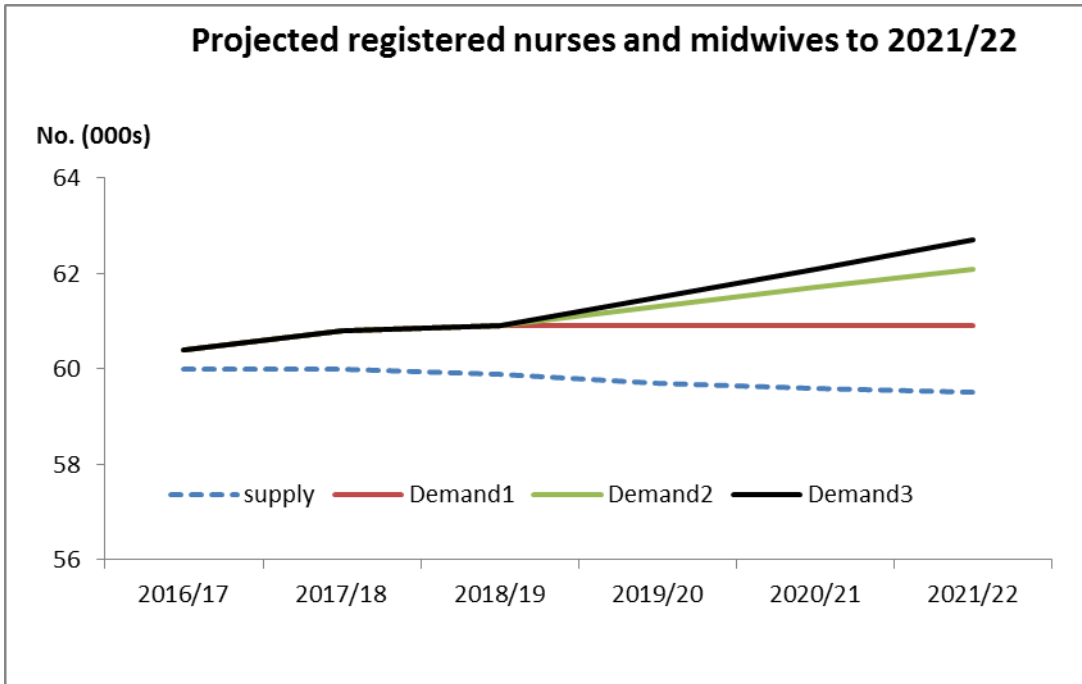
24. For 2017/18 intakes, an overall 4.7% increase was recommended, with effects on each of the main staff categories within Nursing and Midwifery, as follows:

- Adult 5% increase to 2,326 training places
- Mental Health 5% increase to 465 places
- Learning Disabilities status quo at 110 places
- Children’s Nursing 3.9% increase to 268 places
- Midwifery 4.9% increase to 191 places

25. The diagram below demonstrates the model projections for 2017 intakes for each of the categories, derived from projected workforce demand in 2020-21. The recommended 4.7% increase is towards the higher end of the model, and is the fifth consecutive increase in student intakes.



26. The following diagram sets out the *total* forecast supply (in 000s) of Nurses and Midwives in the workforce (including NHS, social care and care homes, and Primary Care), projected against three demand scenarios for each year to 2021/22.



Data source: Scottish Government Health and Social Care Analytics

- **Supply** – assumed 5% annual increase in student intake
- **Demand 1** – NHS Board projections to 2018, thereafter assumed to be constant
- **Demand 2** – NHS Board projections to 2018, thereafter assumed to grow by 0.6%
- **Demand 3** – NHS Board projections to 2018, thereafter assumed to grow by 1%

27. Current modelling projects that supply<sup>23</sup>, with a 5% annual increase in student intakes, will be sufficient to broadly sustain the current level of total staff establishment in a workforce of around 60,000. The critical years for projected shortfall are **2017-2020** where student intakes cannot be increased in time to balance supply and demand and other measures are required. **From 2018-2021**, the demand projected can be met by increasing student intakes alongside other actions. **From 2021** onwards, we will continue to review the position; supply is expected to increase and demand to decrease.

28. The most likely projection for Scotland’s nursing requirement is that demand will increase according to the “Demand 3” line in the diagram above and that 62,400 nurses and midwives (around 2,600 additional nurses and midwives) will be required in the workforce by 2021/22, unless enhanced measures are taken to address demand and increase supply.

29. While some uncertainties remain about ongoing changes to NHS Scotland services and their consequential impact on the Nursing and Midwifery workforce, there is flexibility to increase numbers, and **we will therefore take steps to ensure that our supply of nurses and midwives meets anticipated future demand in two ways:**

- To reflect the likely increased demand, further measures will be taken, informed by on-going evidence of demand and supply. The current estimate

<sup>23</sup> leavers and joiners, including newly qualified nurses.

is that an additional 2,600 nurse and midwifery training places will be created over the next four years. These will include a further expansion of training places during the lifetime of this Parliament to provide an additional 1,600 places, in addition to the 1,000 extra places already anticipated as part of our workforce planning and committed to as part of our Programme for Government 2016-17. This will bring the total number of training places to over 12,000, a historical high.

ii. A further package of measures will extend and increase funding for Return to Practice programmes, enhance access programmes for support workers; improve recruitment, retention and completion rates particularly targeted at remote and rural areas; and support measures to retain and attract nurses and midwives to work in Scotland. These enhanced initiatives are expected to result in a further 1,300 nurses and midwives working in Scotland.

30. The package of measures will be targeted towards those practice and geographical areas where particular needs are identified, including primary care, mental health, midwifery, maternal and child health and more remote and rural areas, particularly the North of Scotland. It will be closely aligned to the Chief Nursing Officer's commission into widening access to nursing and midwifery education and careers and will help deliver its recommendations. The report - which will be produced later in 2017 - will identify best practice and current barriers to nursing and midwifery careers, both in terms of ambition and access, and make recommendations to support and enhance access across the education and employment sectors.

31. This additional supply will give sufficient flexibility for the nursing and midwifery workforce - who will be working longer - to reduce hours of work as they near retirement. It will also enable the workforce to be boosted by younger staff, allowing the additional maternity or parental leave and flexible working they will need to support work/life balance.

32. We are committed to reviewing the model that is designed to estimate the required nursing intake, and further analytical work will be carried out into Autumn 2017. This will help to further refine these projections, and will be an important part of future annual editions of the Plan.

### **Next steps in understanding the workforce required in future**

33. It is important that the right processes are in place to manage workforce supply and demand on an ongoing basis. We will continue to develop our understanding of these projections, reviewing how identified needs are being met through the National Workforce Planning Group.

34. The recent publication of the Mental Health Strategy: 2017-2027 highlighted improved access to CAMHS and other mental health services across Scotland. The publication of this Plan will provide opportunities to develop services further, increasing the mental health workforce by 800 additional mental health workers in our hospitals, GP surgeries, prisons and police stations.

35. The recommendations in this plan will provide a new framework for workforce planning which will help to predict the numbers of staff we will need for the future. This will require further work at local, regional and national levels, via NES and other NHS Scotland bodies, to get a better understanding of future workforce demands, and to introduce a more sophisticated methodological approach to modelling all of this.

36. As well as continuing to refine the student intake modelling process for Nursing and Midwifery, the Scottish Government is developing a more integrated model to scenario plan and carry out workforce projections across the GP workforce, qualified Nursing and Midwifery and the medical workforce, with potential to extend this approach to Allied Health Professionals, who are a key part of the vision for health and social care in the future and are critical to multi-disciplinary team working.

## CHAPTER 5 - MAIN RECOMMENDATIONS AND NEXT STEPS

1. This section brings together the recommendations set out in this document in the following table:

Category	Aim	Recommendations
<p><b>1. Governance</b></p>	<p>A clearer authorising environment securing greater parity for workforce issues alongside service and financial planning, supporting NHS Boards to design future workforce plans, respond to IJBs' needs and resolve capacity issues nationally, regionally and locally.</p>	<ul style="list-style-type: none"> <li>• <u>Nationally</u>, a new National Workforce Planning Group will be established with broad representation from across health and social care – including NHS Scotland, local authorities, IJBs and third and independent sector and their staff side and trade union representatives.</li> <li>• Terms of reference for the National Workforce Planning Group, including its membership, role and remit, will be finalised in discussion with stakeholders following the publication of this Plan. We expect that the Group will work across boundaries to support implementation of the Plan by health and social care providers; and to act collectively to advocate the Plan, raising its profile and promoting the understanding of its requirements within respective workplaces.</li> <li>• The National Workforce Planning Group will meet from Summer 2017 to review the Plan's recommendations and proposals for future work. Initially the Group will focus on the NHS workforce, but will take on a broader role which reflects Parts 2 and 3 of the Plan published later this year. The Group will strengthen a "Once For Scotland" approach, improving consistency and use of workload tools across Scotland.</li> <li>• <u>Regionally</u>, Health Board Regional Delivery Plans arising from the Delivery Plan for Health and Social Care will include workforce planning from September 2017. Successful regional workforce planning will depend upon the further development of a clear and sustainable workforce planning infrastructure to progress regional issues.</li> <li>• <u>Locally</u>, work will begin to share development of existing workforce tools and resources with employers, reflecting governance arrangements as they develop, by end 2017. This work, including the roles expected for NHS Boards, IJBs, local authorities and third and independent sector</li> </ul>

		employers, will flow from the establishment of the National Workforce Planning Group.
<b>2. Workforce Planning roles</b>	Greater clarity about who does what to ensure NHS Scotland workforce planning is more effectively co-ordinated nationally, regionally and locally.	<ul style="list-style-type: none"> <li>• <u>Nationally:</u> The National Workforce Planning Group will support implementation of this Plan, helping to define where workforce planning sits within the strategic direction and vision for NHS Scotland, and with strategic priorities for social care. It will identify good practice in national workforce planning – for example, how this should apply to the new elective centres - in line with main Delivery Plan and National Clinical Strategy themes.</li> <li>• Work will begin to reconstitute the National Forum for NHS Workforce Planners from Summer 2017 with a new, clearer remit and reporting structure to ensure Board level links are visible nationally, and to further develop links with IJBs using practical approaches to workforce planning which can apply in an integrated context.</li> <li>• <u>Regionally:</u> Linking to NHS Board Regional Delivery Plans, NHS Boards will undertake joint regional workforce planning (also through the refocused National Forum for NHS Workforce Planners), to ensure patients’ needs are met and resources allocated effectively, responding to and meeting the needs of IJBs and others as required.</li> <li>• <u>Locally:</u> This will be determined over Summer 2017 in partnership with COSLA and other relevant stakeholders.</li> </ul>
<b>3. Workforce Data</b>	Integrating statistical, demographic and labour market information on the NHS Scotland workforce to build the evidence Boards will require in future.	<ul style="list-style-type: none"> <li>• NHS Education for Scotland (NES) will provide proposals to bring together existing data sources in a new supply side “platform” by Autumn this year. This will consider the NHS Scotland workforce and how this fits wider social care and local authority needs in the context of integration.</li> <li>• NES will work alongside stakeholders to bring together relevant data sources; analyse and align them to better inform workforce planning; and work to determine the data required for effective decisions on workforce and improving analysis of future demand and supply and the “pipeline”</li> </ul>

		<p>between education and employment. This work will be delivered in Autumn 2017, while being responsive to Parts 2 and 3 of this Plan and the wider, whole system approach required for the future.</p> <ul style="list-style-type: none"> <li>• NES will lead development of a minimum standardised dataset with potential to use across different sectors, with agreed data collection and collation parameters. It is important that this work aligns with the rollout of e:ESS across NHS Boards, where much work has already been undertaken to ensure a consistent dataset on the NHS workforce. This will require a phased approach.</li> </ul>
<p><b>4. Recruiting and retaining staff</b></p>	<p>Tackling persistent recruitment challenges to provide sustainable national, regional and local solutions, ensuring an NHS workforce fully fit for purpose and in the right numbers now and in future.</p>	<ul style="list-style-type: none"> <li>• The Scottish Government will work with NHS Boards and NES on a strategic approach to recruitment and retention, including GP recruitment and retention challenges. Actions developed over Summer 2017 will be reported to the new National Workforce Planning Group, with clear recommendations for action by NHS Boards to be drawn up by early 2018. Consideration will be given to: <ul style="list-style-type: none"> <li>○ existing work (for example work being taken forward in a Shared Services context within NHS Boards);</li> <li>○ testing out new approaches, focussing on promoting and attracting applicants and making health and social care careers more attractive to young people through improved marketing and advertising;</li> <li>○ exploring the interface between health and social care and further and higher education to maximise opportunities to recruit and retain staff;</li> <li>○ exploring whether the regionalisation of colleges and the development of regional curricula may provide further opportunities to collaborate on recruiting and retaining the future NHS Scotland workforce; and</li> <li>○ promoting better retention, ensuring the workforce has access to CPD support and structured, transparent career progression opportunities.</li> </ul> </li> </ul>



		<ul style="list-style-type: none"> <li>• This work will involve reviewing current learner and student support across the health and social care workforce to maximise the attractiveness of careers in health and social care, and work to promote them in schools; assessing how access to training and developmental opportunities can promote better retention of existing staff; and how this can help ensure the future sustainability of the remote and rural workforce.</li> <li>• This work will also consider international flows, including the impact of Brexit, on recruitment and retention, and how to make more effective use of international recruitment opportunities. These will take account of developing research across the wider public sector in Scotland of the potential effects of Brexit on international recruitment.</li> <li>• Recruitment also needs to be considered as part of regional service and workforce plans, including the development of further ways to fill vacancies and address recruitment issues. We expect regional workforce plans to give consideration to regional and national recruitment initiatives. These may include the following: <ul style="list-style-type: none"> <li>○ Examine extension of bursary approach, other training/developmental incentives to retain staff; increased roles working across regions; co-ordinated regional recruitment activity;</li> <li>○ Work with employers on careers, liaison with FE/HE, campaigns, social media, including youth groups eg Young Scot etc;</li> <li>○ Youth employment initiatives to increase supply across the NHS workforce – recognising that work with NES should help to identify new frameworks and approaches;</li> <li>○ Work to consider retention initiatives, including potential for employers to outline Regional Retention Strategies including e.g. “bonding”, and increasing returners.</li> </ul> </li> </ul>
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		<ul style="list-style-type: none"> <li>Progress made in this area must take account of contributions already being made by COSLA and local authorities, the Improvement Service, Scottish Care, Scottish Social Services Council, Care Inspectorate, CCPS and others. Further discussion on recruitment and retention issues between all relevant health and social care stakeholders will be required following publication of this document, and in advance of the publication of Part 2 of the Plan later this year.</li> </ul>
<b>5. Clear and consistent guidance</b>	<p>Providing high quality workforce planning support to NHS Boards throughout a period of change, building on clear principles to provide and further develop better data, intelligence and tools to predict future needs.</p>	<ul style="list-style-type: none"> <li>Scottish Government will work with NHS Scotland stakeholders to refresh workforce planning guidance for NHS Scotland by end of 2017, with potential to link to other sectors as appropriate, taking account of Part 2 of this Plan, to be published later this year.</li> <li>The refreshed guidance will need to fully reflect the post-integration environment, complementing and supporting workforce planning undertaken within Primary Care, Integrated Joint Boards, local authorities and other health and social care providers.</li> <li>NHS Education for Scotland will work together with other organisations to develop training resources to assist adoption of the workforce planning guidance in NHS Boards.</li> </ul>
<b>6. Student Intakes</b>	<p>Designing and developing an improved process so that national decisions on student intakes are more clearly linked to addressing future demand, with closer ties to NHS Board workforce planning.</p>	<ul style="list-style-type: none"> <li>Nationally, NES will work together with other organisations to use specialty profiles and other data sources across professions to design a “pipeline” approach demonstrating how supply via training and recruitment numbers will meet estimated demand. This work will help to achieve better alignment between training providers and services and will begin in Summer 2017, leading to a shadow process in 2018 and then full implementation in 2019. These timescales recognise that many organisations are involved, with long training lead-in times and resource implications.</li> <li>The current workforce projections process in NHS Scotland is limited in its ability to project forward nursing and medical staff intakes in the longer term. The impact of</li> </ul>

		<p>local demographics – for example retirements in 3 years due to an ageing workforce - should be more consistently factored in to national intake projections. The new National Workforce Planning Group will consider, in consultation with other organisations, how this process should be adjusted.</p> <ul style="list-style-type: none"><li>• NES should also assess how the nationally controlled student intake process might extend to other professions beyond nursing, medical and dental staff. This will be beneficial if it is closely linked to recruitment, retention, youth employment and potentially bonding, taking account of current trends in supply and demand. This work should also link to career paths and opportunities across the health and social care sector.</li></ul>
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## APPENDIX

### Programme for Government (PfG) and other strategic commitments

#### **PfG Commitments relating to planning:**

- To make sure our NHS has the right skills mix, we will introduce national and regional workforce planning. This will include an increase in the number of consultants and greater use of clinical generalists;
- We will enshrine the proposal for safe staffing in law – we will put our innovative nursing and midwifery planning tools on a statutory footing, and explore how this model can be extended to cover other parts of the health and social care workforce.

#### **PfG Commitments to maintain/increase/improve staffing capacity:**

- We will continue the policy of no compulsory redundancies in the NHS;
- Increase number of GPs and Nurses working in Communities;
- We will invest £3 million to train an additional 500 advanced nurse practitioners;
- Commitment to create 1000 additional training places for nurses and midwives;
- We will recruit an extra 500 health visitors by 2018 so that every child benefits from a health development check at 30 months;
- We will increase the number of GP training places from 300 to 400 a year;
- We will invest over £23 million to increase the number of medical school places;
- We will work to improve recruitment and retention;
- Scotland's most deprived communities need additional support, so we will recruit at least 250 Community Link Workers to work in GP surgeries and direct people to local services and support;
- Over the next five years another 1,000 paramedics will be trained to work in the community, helping to reduce pressure on A&E services.

#### **PfG Commitments that will impact on the workforce:**

- The number, structure and regulation of health boards – and their relationships with local councils – will be reviewed, with a view to reducing unnecessary backroom duplication and removing structural impediments to better care;
- Thirty-one new local integration bodies have been created to deliver adult health and social care. Scotland also has 22 health boards – 14 territorial and 8 special boards. In implementing the National Clinical Strategy, we will make sure the existing boundaries between health and integration bodies do not act as barriers to planning local services effectively;
- We will put in place a new ten year plan to transform mental health and invest an additional £150 million to improve mental health services (part of this will mean we recruit mental health link workers in GP practices);
- We will invest £100 million to improve the prevention, early diagnosis and treatment of cancer (part of this will be recruitment of more radiographers);
- Our reforms will bring together a range of professionals in GP surgeries, including practice nurses, district nurses, mental health professionals, pharmacists, and allied health professionals. All GP practices will have access to an enhanced pharmacist, allowing GPs to focus more on the patients who require their assessment;

- We will implement the recommendations from The Best Start Review of Maternity and Neonatal Services which describes a new model of care which puts mothers and babies at the centre of safe and high quality care.

## Strategic Commitments

1. Employers in health and social care are being asked to deliver on a number of fronts, linked to the Programme for Government commitments set out above, and to the **Health and Social Care Delivery Plan** published in December 2016, which set out an ambitious programme of change for the NHS and wider health and social care services in Scotland. The Delivery Plan's key components are health and social care integration; the National Clinical Strategy (including Realistic Medicine, the Cancer Strategy and the investment in Elective Centres); public health improvement (including the mental health strategy); and NHS Board reform. These will be supported by cross-cutting activity including the review of health and social care targets and innovation and digital health, as well as this Plan.

2. **Health and Social Care Integration** requires whole system planning. IJBs are required to deliver workforce plans but cannot do this in isolation. A national framework will help to draw out whole system planning and also identify which elements are for local resolution. There is an opportunity for joint planning between Integration Authorities, NHS Boards and local authorities as authorities (at the end of their first year of operation) are clearer about their strategic plans and delivery objectives and the workforce needed to deliver on it.

3. The **National Clinical Strategy** is the framework for a range of activity to create more high quality sustainable health care. Within that framework is included strengthened primary and community care, improvements to secondary and acute care and a focus on realistic medicine. It sets the direction of travel within which Boards can work effectively with Integration Joint Boards and others. This will require workforce models and scenarios that are more generalist, and flexible enough to cope with the uncertainty of future demands.

4. **Realistic Medicine** describes how the workforce can provide care and treatment more innovatively, intuitively and flexibly. For example, hospital-based clinicians are now operating in the community along with other health and social care professionals to provide more tailored care to people in their homes.

5. The **Cancer Strategy**<sup>24</sup> takes a wide look at the range of services provided and considers how the vital roles that staff play in delivering high quality services can be clearer, more targeted and better prepared for and planned.

6. The **Elective Strategy** aims to deliver an integrated approach to the effective delivery of elective care. A key objective of this work is to deliver the commitment of £200 million of new investment in Diagnostic and Treatment Centres capacity within the timeframe of the current Parliament.

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<sup>24</sup> <http://www.gov.scot/Publications/2016/03/9784/1>

7. The **Mental Health Strategy 2017-2027**<sup>25</sup> underlines the principle of “ask once, get help fast” by ensuring the right workforce is in place at local and national levels, As well as increasing the supply of the mental health workforce with different skill mixes across different services, the Strategy emphasises the need to make careers in mental health more attractive with clearer career pathways. It includes the following actions: *“Increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. Over the next five years increasing additional investment to £35 million for 800 additional mental health workers in those key settings.”*

8. The Active and Independent Living Improvement Programme in Scotland (AILP) focuses on wellbeing, prevention and targeted early interventions for children, young people and adults of all ages and abilities, supporting them to live well; be physically active; self-manage their health conditions; remain in, or return to employment; and live independently at home or in a homely setting. Through AILP, the Allied Health Professional (AHP) workforce will support the delivery of key elements of the Health and Social Care Delivery Plan.

## **Technology**

9. Technology is already being used differently to monitor care, with effects on the roles played by different workforces and changes in the patterns of demand and supply. Those effects will continue to expand, with an increasing impact on the demand for and supply of care. In some circumstances, this may mean less direct care is needed, with training and education ensuring staff are fully able to use what technology can deliver, while being fully aware of its limitations. An integrated Digital Health and Social Care Strategy<sup>26</sup> is being developed which can aid staff in using data and evidence as a routine part of decision-making – particularly in the community and in primary care settings. This will give health and social care staff access to data and evidence to inform safe and effective decisions about the services they provide. Workforce development in digital skills is already captured in the *Everyone Matters 2020 Workforce Vision* actions.

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<sup>25</sup> <http://www.gov.scot/Publications/2017/03/1750>

<sup>26</sup> <http://www.ehealth.nhs.scot/strategies/the-person-centred-ehealth-strategy-and-delivery-plan-stage-one/>



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