

NHS workforce planning

The clinical workforce in secondary care



AUDITOR GENERAL 

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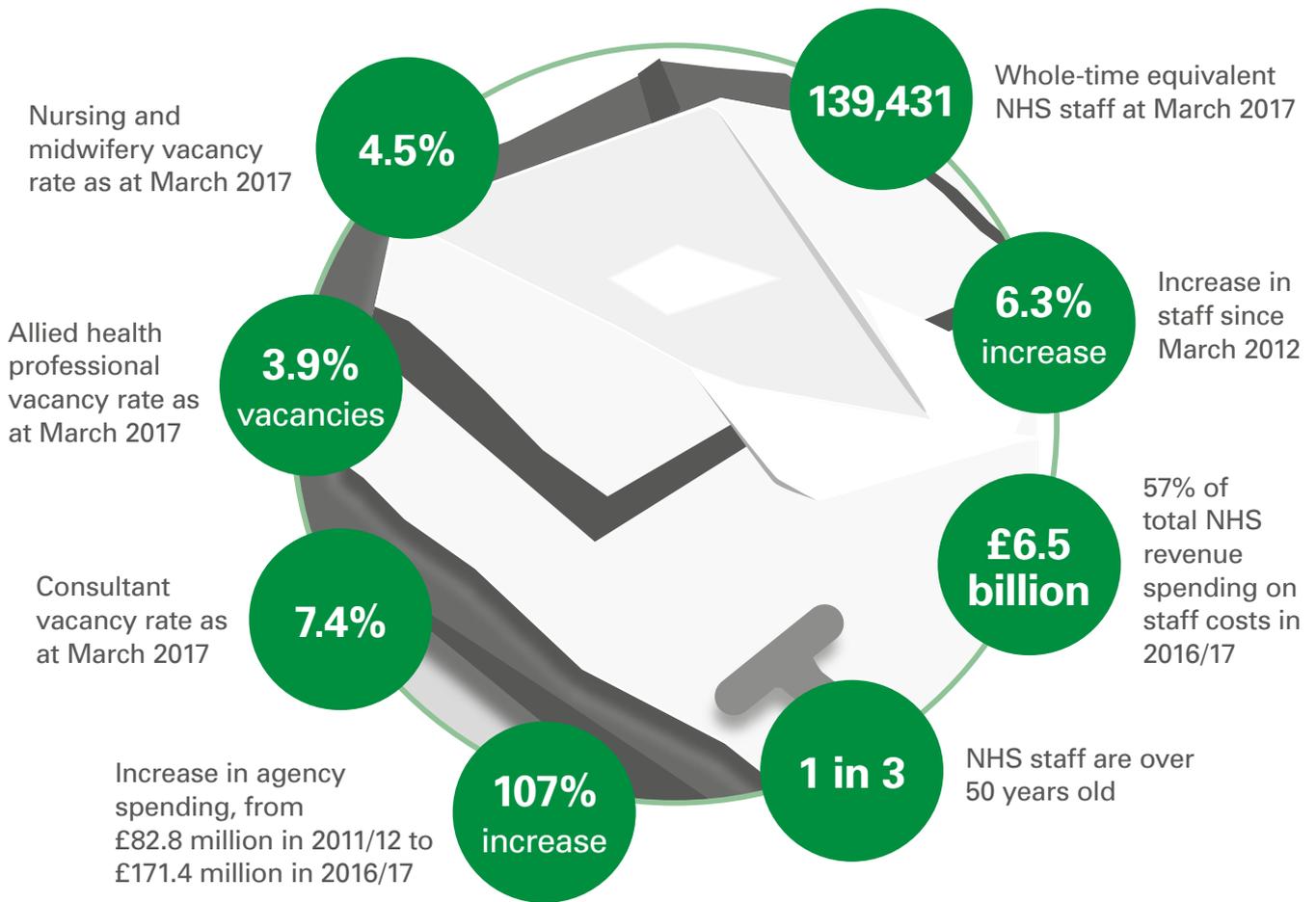
Links

-  PDF download
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Exhibit data

When viewing this report online, you can access background data by clicking on the graph icon. The data file will open in a new window.

Key facts



Summary



Key messages

- 1** Between 2011/12 and 2016/17, spending on NHS staff increased by 11 per cent to £6.5 billion. Overall staff levels in the NHS are at the highest level ever, with 139,431 whole-time equivalent (WTE) staff employed as at March 2017. The recently published *National Health and Social Care Workforce Plan – Part 1* acknowledges that the answer to future challenges cannot always be to grow its workforce, and that the workforce will need to work differently. In reaching current staffing levels, most NHS territorial boards overspent against their pay budget in 2016/17, with agency staff costs increasing in real terms by 107 per cent in six years, from £82.8 million in 2011/12 to £171.4 million in 2016/17. Overall, patients give positive feedback about their NHS experience and the staff they meet, although numbers of staff-related complaints are rising.
- 2** The Scottish Government and NHS boards have not planned their NHS workforce effectively for the long term. Responsibility for NHS workforce planning is confused, and is split between the Scottish Government, NHS boards, and three regional workforce groups. There is a risk that responsibilities will further fragment as health and social care integration authorities develop their own workforce planning arrangements and new specialist centres for certain medical procedures are established. There are separate planning processes for recruiting doctors, nurses and other professional groups. This makes it more difficult to consider how skills across different groups can complement each other. The Scottish Government is setting up a National Workforce Planning Group to improve joint working.
- 3** There are urgent workforce challenges facing the NHS and improving workforce planning is critical to addressing these pressures. The NHS in Scotland is undergoing major reform, in particular seeking to shift towards more community and home-based care. Dedicated funding to support NHS reform does not clearly identify associated workforce costs. Vacancies for certain consultant and nursing positions remain high and are proving difficult to fill. Upcoming retirements may increase vacancy levels in parts of the NHS where the age profile of the staff is older. This includes certain consultant specialties and locations, and the nursing workforce in general. NHS staff continue to raise concerns about their workload and there are signs that NHS services are under increasing stress.

despite record NHS staff numbers, long-term workforce planning has not been effective

- 4 The Scottish Government expects demand for health and social care to rise but it has not yet adequately projected how this will impact on the skills and workforce numbers needed to meet this demand. It has not looked at long-term scenarios for future patient demand when considering recruitment decisions and future workforce costs. This is a continuing challenge for medical recruitment, where consultants can take more than ten years to train. NHS Education for Scotland (NES) is working to improve NHS workforce projections, with a new approach due in early 2018.
- 5 The Scottish Government intended to publish a single workforce plan covering health and social care in spring 2017. It is now publishing it in three stages, with the first, covering the NHS workforce, published in June 2017. The second publication, covering the social care workforce, is due to be published in autumn 2017; and the third, covering primary care, due to be published by the end of 2017. The recently published *National Health and Social Care Workforce Plan - Part 1* is a broad framework to consider future workforce planning challenges and not a detailed plan to address immediate and future issues.

Recommendations

The Scottish Government should:

- improve understanding of future demand to inform workforce decisions, including:
 - collating, comparing and monitoring NHS boards assessments of demand and supply to help form a national picture and manage risks
 - carrying out scenario planning on the future population health demand and workforce supply changes (such as staff retiring), including how this will affect the types of treatments provided
 - considering and clarifying potential future skills mix with NHS boards and stakeholders to determine how a future team can work to meet this demand
- demonstrate how training and recruitment numbers will meet estimated demand for healthcare – if it does not, document and cost how the gap between demand and supply in the future will be covered
- provide a clear breakdown of the costs of meeting projected demand through additional recruitment across all healthcare staff groups
- demonstrate how policy initiatives, such as safe staffing levels and elective centres, are expected to affect staffing requirements in NHS boards

- set out the expected transitional workforce costs and expected savings associated with implementing NHS reform. This includes collating transitional costs attached to greater regional and national working, costs in relation to moving staff into elective centres and into the community, and savings through increased efficiencies
- determine the data required for decisions on the workforce. This will include data on the training pipeline for medical and allied health professional (AHP) staff, data on EU citizens working in the NHS in Scotland, and agency spending by professional group
- progress arrangements to create national and regional staff banks.

NHS boards should:

- produce future plans based on demand as well as supply criteria. This would include:
 - projecting their future workforce against estimated changes in population demography and health factors
 - producing plans which detail the expected workforce required, supported by analysis of workforce supply and demand trends
- fully cost the workforce changes needed to meet policy directives, such as the shift to community-based care, proposed elective centres, safe staffing levels and more regional working
- improve the accuracy of budgeting for agency spending.

Background

1. Overall staff levels in the NHS in Scotland are at the highest level ever, with 139,431 whole-time equivalent (WTE) staff employed as at March 2017, a 6.3 per cent increase since March 2012.¹ NHS Scotland is made up of 22 NHS boards. In 2016/17, staff costs across all NHS boards were £6.5 billion, accounting for around 57 per cent of total revenue, or day-to-day, spending.² There has been an 11 per cent real terms increase – that is, allowing for the effects of inflation – in staff costs, between 2011/12 and 2016/17. Of the 22 NHS boards, 14 territorial boards provide frontline healthcare services across the country. In February 2017, we presented data on the NHS workforce in Scotland highlighting key challenges facing the workforce. These included an ageing workforce, increasing agency staff costs and persistent vacancies in certain positions and specialties.³

2. We have previously recommended a coordinated, national approach to workforce planning, outlining what changes in health and social care mean for NHS staff.⁴ Since 2016, NHS boards and councils have collaborated as integration authorities (IAs) to provide health and social care services. These aim to deliver personal and practical help to enable people to live as independent a life as possible. Examples range from helping people with everyday tasks in their own homes, to helping them access supported accommodation. We have also highlighted the risk that NHS workforces are being organised in response to budget pressures rather than strategic needs.⁵

3. Planning the NHS workforce is complex because of the variety of skills, locations and experiences needed to meet the specific needs of patients. The pressures are felt throughout the four NHS health systems of the UK and several of the workforce issues included in this report also apply to other parts of the UK. For example, the National Audit Office has reported on pressures caused by agency costs, workforce planning arrangements and long-term planning in England.⁶

About the audit

4. There are significant challenges facing the health and social care workforce in both hospitals and in the community. This report is the first in a two-part audit on the NHS workforce. It focuses on the overall planning arrangements looking at how well placed the NHS workforce is to meet the current and future demands of the Scottish population. The scope covers NHS staff employed by NHS boards, including clinical staff working in hospitals. The second report, to be published in 2018/19, will look more closely at the community-based NHS workforce, including those employed by general practices.⁷ Our methodology is set out in [Appendix 1](#).

5. Our audits are informed by our wider programme of work on health and social care and the public sector workforce. These include recent reports such as [Changing models of health and social care](#) , [Health and social care integration](#)  (the first of three reports looking at this topic) and our annual *NHS in Scotland* overview publications.⁸

6. As some health and social care resources are delegated to IAs, workforce strategies and planning within these partnerships will become increasingly important to delivering healthcare. This will be considered as part of our subsequent reports on health and social care integration, as well as being considered in our second report on the NHS workforce. This report acknowledges the future importance of IA workforce arrangements, but focuses on those arrangements in NHS boards and within the Scottish Government.

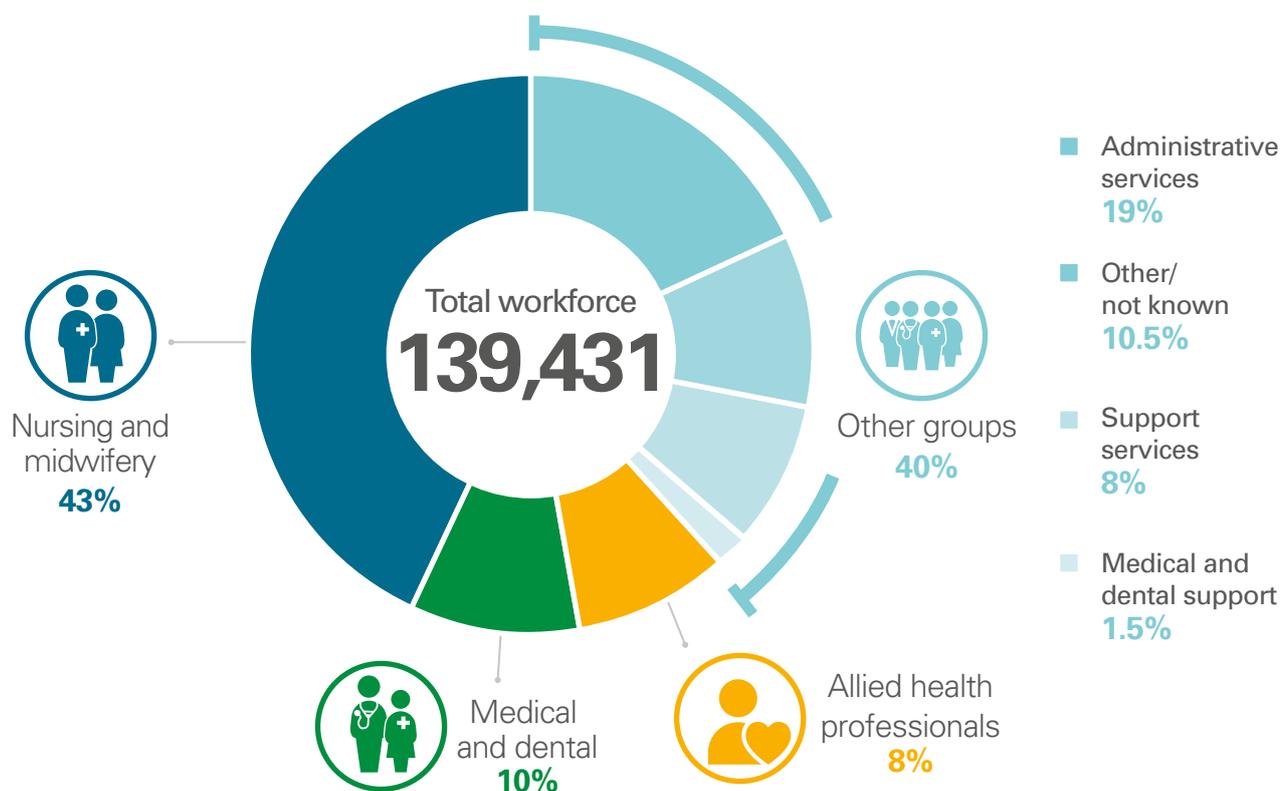
7. We focus on the three main clinical workforce groups, which account for 60 per cent of the NHS workforce ([Exhibit 1, page 9](#)). These are:

- the medical workforce, which includes doctors in all stages of training, and consultants, including those in dental specialties but excluding General Practitioners (GPs). GPs will be covered in our second NHS workforce report to be published in 2018/19
- the nursing and midwifery workforce, nearly three in four of whom are qualified nurses or midwives. This group also includes healthcare support workers who work under the supervision of qualified nurses and midwives or other registered professionals
- allied health professionals (AHPs), an umbrella term for a range of health professionals including paramedics, radiographers, occupational therapists and physiotherapists.

Exhibit 1

The make-up of the NHS workforce

The largest staff group among the NHS workforce are nurses and midwives, followed by administrative services staff.



Note: The category of 'other/not known' includes smaller staff groups like healthcare science, ambulance services, and personal and social care. Other groups are not included within the scope of this report.

Source: Audit Scotland using ISD Scotland data as at March 2017



8. Unless otherwise stated, data on workforce numbers and costs refers to NHS Scotland employees, paid through NHS boards. This does not include staff working in GP surgeries, as the majority are employees of the practice and not the NHS board.

9. The report is in three parts:

- **Part 1** examines the current pressures facing the NHS workforce.
- **Part 2** considers how NHS boards, regions and the Scottish Government are currently planning the workforce.
- **Part 3** focuses on the future NHS workforce, including how the Scottish Government is supporting the NHS in recruiting and training to meet the future needs of the Scottish people.

Part 1

Pressures on the NHS workforce



Key messages

- 1** There are urgent workforce challenges facing the NHS caused by factors including an ageing population, an ageing workforce and recruitment difficulties. The Scottish Government intended to publish a single workforce plan covering health and social care. This is now being published in three parts, the first covering the NHS workforce published in June 2017; the second, due in autumn 2017, covering the social care workforce; and the third before the end of the year looking at the primary care workforce. The recently published NHS workforce plan provides a broad framework to consider future workforce planning challenges but is not a detailed plan to directly address these.
- 2** While patient feedback about experiences of NHS staff is generally positive, NHS staff continue to be concerned about their workload. To help meet their workload requirements, NHS boards are spending more on agency staff each year. Thirteen of the 14 territorial NHS boards overspent against their original pay budgets in 2015/16. NHS boards with a higher spend on agency staff tend to have a greater overall overspend against their pay budget. Agency costs have increased in real terms by 107 per cent in six years, from £82.8 million in 2011/12 to £171.4 million in 2016/17.
- 3** Despite recommendations that we made in 2010, a Managed Agency Staff Agency Network (MASNet) set up by the Scottish Government in 2015 found that not all NHS boards have medical staff banks. This meant that some NHS boards had to use more expensive commercial agencies or use neighbouring NHS boards to help fill temporary vacancies. The Scottish Government is setting up regional staff banks from 2017/18 to address this, although other plans to reduce levels of agency use will take longer to put in place.
- 4** Until now, there has been no national workforce plan to support the Scottish Government's strategy for NHS reform. There is a 2020 workforce vision, with supporting annual implementation plans, but these plans focus on specific areas for workforce development with no milestones or quantifiable success measures attached. The Scottish Government has not published a review of national progress of the NHS workforce since 2015.

pressures have yet to be addressed by national workforce planning, and NHS boards are overspending against pay budgets

The Scottish Government needs to urgently address workforce issues as part of its wider NHS reform agenda

10. The Scottish Government intended to publish a national workforce plan in spring 2017, covering the entire health and social care workforce. It has now revised its approach and timescales:

- Part 1 (referred to in this report as the *NHS National Workforce Plan 2017*) was published in June 2017 and covers the NHS workforce.
- Part 2 to be published in autumn 2017 and will cover the social care workforce.
- Part 3 to be published later in 2017 and will cover the primary care workforce.
- The first full national health and social care workforce plan will now be published in spring 2018.

11. The *NHS National Workforce Plan 2017* is not a detailed plan. It provides a broad framework to consider future workforce planning challenges, which should help in making more informed decisions in the future. The plan makes recommendations about a number of workforce challenges explored in this report, including:⁹

- the changing demands of an ageing population which is living longer
- continuing recruitment and retention difficulties
- an ageing NHS workforce
- greater use of agency staff
- the need for a better understanding of supply and demand
- the need for better workforce data to help with decision-making.

12. In November 2013, we published our report [Scotland's public sector workforce](#) . In it, we define workforce planning as 'the process that organisations use to make sure they have the right people with the right skills in the right place at the right time'. The Scottish Government used this definition when consulting on workforce planning.¹⁰ However, the *NHS National Workforce Plan 2017* does not set out actions to deliver a workforce with the required skills, in the areas where staff are needed most. Nor is it clear on how staff can work together effectively.

13. Despite the increasing number of people working in the NHS, and higher spending on the workforce, major issues still need to be addressed. More than a third of the nursing and midwifery workforce is over 50 years old, and the proportion of staff across the NHS that is over 50 years old is increasing. There are persistent vacancies among certain specialties in hospital care, together with a failure to fill all available medical graduate training posts, and to retain doctors in Scotland once qualified.

14. NHS staff report feeling under pressure due to workloads ([Exhibit 2, page 13](#)), though there have been slight improvements since 2013.¹¹ Around one in four allied health professional (AHP), nursing and medical staff felt there were enough staff to properly do their job, compared to one in three staff overall. One in three medical staff members said they could meet the conflicting demands on their time, with this figure being slightly higher among nurses and AHPs. While there is some variation between boards, we found no connection between the results and higher vacancy rates in 2016/17.

15. Almost nine in ten nurses and midwives responding to a Royal College of Nursing (RCN) survey in Scotland felt that their workload had got worse.¹² The same proportion said they had felt the impact of the increasing number of older people requiring care. Only 13 per cent felt that the NHS was able to meet demand or exceed expectations. Forty per cent said that the one thing they would ask for, for the future of nursing, would be time to care.

16. The General Medical Council (GMC) surveys doctors in training in Scotland about access to educational resources, supervision and teaching.¹³ Most areas have improved between 2012 and 2016, and overall satisfaction with training provision is relatively high. Responses to questions on workload remain the lowest scoring area. In 2016, 57 per cent of doctors in training surveyed felt that the intensity of their work was about right during the day, while 42 per cent felt this was the case at night. The majority of the rest felt their workloads were too heavy.

17. Sickness absence is an indicator of the health and wellbeing of the workforce. The national target for sickness absence for NHS boards is a maximum of four per cent. The national sickness absence figure in 2016/17 was 5.2 per cent, up from 4.6 per cent in 2011/12. In 2016/17, no territorial board met the four per cent target, and the majority were above five per cent ([Exhibit 2, page 13](#)). Like the Scottish population, the NHS workforce is ageing. However, we found no link between NHS boards with a higher proportion of older staff and those with higher sickness absence rates.

18. As at March 2017, NHS Scotland failed to meet seven out of eight key performance targets. The only target met nationally was the three-week waiting time for drug and alcohol treatment. The targets missed include A&E four-hour waiting time, 18-week referral to treatment and cancer treatment times. NHS boards have been finding it increasingly difficult to meet these targets over recent years.¹⁴ We found no direct link between boards with higher vacancy levels and those that performed less well against these indicators.

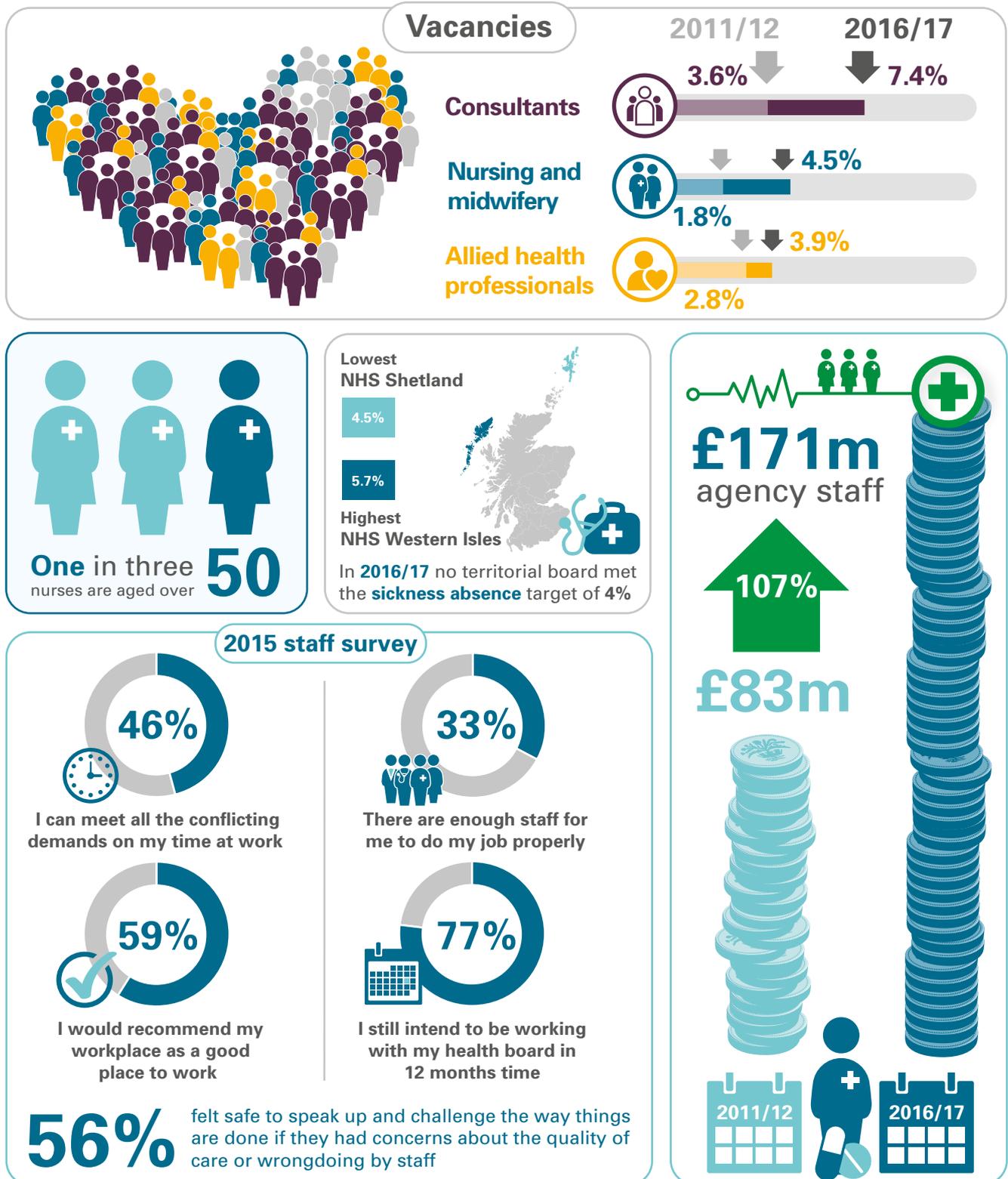
19. Concerns have been raised about the ability to deliver services due to staff shortages:

- The Royal College of Radiologists has expressed concerns that a shortage of radiologists in Scotland is resulting in a delay in diagnosis and treatment for patients.¹⁵ It found that nearly all radiology departments in Scotland were unable to meet their diagnostic reporting requirements in 2014/15.

Exhibit 2

Workforce pressures in the NHS

There are a number of areas of pressure for the NHS workforce, including vacancies, sickness absence, agency spending and the ageing workforce.



- Healthcare Improvement Scotland (HIS) inspects hospitals and clinical services in Scotland. Of the nine reviews of the care of older people published since our [NHS in Scotland 2016](#)  report, all note that staff treat patients with dignity and respect, and that the interactions between staff and patients that HIS witnessed are positive. HIS noted in two reports concerns that workforce issues are affecting the quality of service delivery. These included staff expressing frustration at not being able to deliver the quality of care they would like, and patients waiting up to ten days to see a dietician due to staff shortages.¹⁶
- While all NHS boards have whistleblowing procedures in place, just over half (56 per cent) of staff reported they felt safe to speak up and challenge the way things are done if they have concerns about quality, negligence or wrongdoing by staff ([Exhibit 2, page 13](#)). This suggests that the scale of staff concerns could be underestimated if those who do not feel safe to speak up do not do so.

Agency costs are putting pressure on pay budgets

20. We have previously noted that rising sickness absence, turnover and vacancy rates were contributing to an increase in NHS boards' spending on high-cost agency staff.¹⁷ We further noted that staff shortages and high use of temporary staff could affect quality of care. Agency costs for clinical and non-clinical staff have increased in real terms by 107 per cent in six years, from £83 million in 2011/12 to £171 million in 2016/17 ([Exhibit 2, page 13](#)).¹⁸ Agency costs fell slightly by three per cent between 2015/16 and 2016/17. Agency costs remain a relatively small percentage of the total spending on staff, at 2.6 per cent in 2016/17.

21. In 2015/16, 13 out of 14 territorial boards overspent against their pay budget. Auditors of 11 of the 14 territorial boards noted agency costs as a cost pressure in 2015/16. The amount NHS boards overspent ranged from 2.1 per cent of the pay budget at NHS Highland, to 9.6 per cent at NHS Orkney. NHS boards with higher agency costs are overspending by more on their pay budgets. There are two exceptions to this trend:

- NHS Dumfries and Galloway was the only NHS board to underspend against its pay budget. NHS Dumfries and Galloway explained that it included a realistic assessment of agency costs in its annual budget due to its historic reliance on agency staff in some areas.
- NHS Tayside overspent against its pay budget more significantly than other NHS boards with similar agency costs. This has contributed to its need for loan funding, known as brokerage, from the Scottish Government. We have recommended previously that NHS Tayside should review its annual budget-setting process to ensure it is achievable.¹⁹ We have also reported that the board has not budgeted for additional agency costs, which would help explain why its agency costs have a greater impact on its budget position.²⁰ NHS Tayside has made budgeting improvements in 2016/17 which will be reviewed as part of the 2016/17 audit of the NHS board.

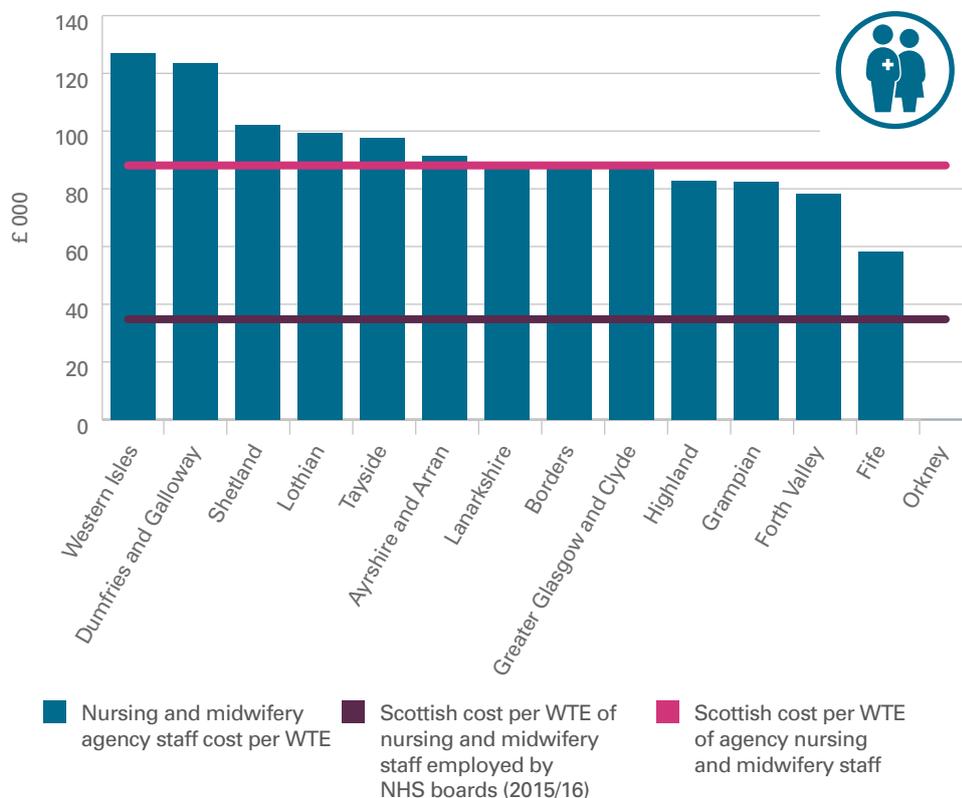
22. Information for 2016/17 indicates this pattern is continuing, with 12 boards overspending against their pay budgets, and boards with higher agency costs still overspending by more on pay budgets. The average annual cost per WTE of an agency nursing staff member in 2016/17 was £88,108, compared to around £38,000 for nursing staff employed directly by NHS boards ([Exhibit 3,](#)

page 15).²¹ Nursing agency costs have risen from £4.2 million in 2011/12 to £24.5 million in 2016/17, in real terms. While nursing staff working through an agency represent just 0.4 per cent of the total nursing workforce, this can result in relatively large increases in staff costs for NHS boards.

Exhibit 3

Average annual cost per WTE Agency nursing and midwifery staff in NHS boards, 2016/17

Agency nursing and midwifery WTE staff cost more than staff employed directly by NHS boards, and costs vary widely by board.



Note: NHS Orkney did not use any agency nursing staff in 2016/17.

Source: Audit Scotland using ISD workforce data as at March 2017 and Scottish Health Service costs data for 2015/16



23. In December 2015, the Scottish Government launched the Managed Agency Staff Network (MASNet). It aims to reduce agency spending and improve the arrangements NHS boards have for managing, monitoring and reviewing agency staff needs. The group includes representatives from the Scottish Government, NHS boards and the RCN. NHS board workforce plans for 2015/16 show that several NHS boards are aiming to reduce agency costs. Every NHS board has an executive lead for agency spending and is looking at local measures they can take to reduce agency costs.

24. One way of reducing agency use is to increase the availability and use of bank staff. A bank is an internal pool of NHS staff used to cover vacancies or gaps flexibly when required. This is different to agency staff, who are employed

through a commercial agency and are more expensive to use. In 2010, we reported that NHS boards could reduce costs and increase control by introducing medical staff banks.²² MASNet found that while all NHS boards had nursing banks, not all had a medical bank. NHS boards without a medical bank rely on commercial agencies or support from neighbouring NHS boards' banks to source additional medical staff. We also recommended that the Scottish Government should identify ways to reduce demand for agency doctors, for example by setting up regional medical banks. Three regional medical banks will, for the first time, be in place from 2017/18. Currently, regional banks covering the east and west have been set up, with MASNet expecting the third regional bank, covering the north to be operating from autumn 2017. Once all medical staff have access to a bank, NHS boards will seek to restrict their own staff from working through agencies, rather than joining the bank.

25. The *NHS National Workforce Plan 2017* states that priority is being given to reducing agency staff use and costs, by establishing regional and national staff banks and improving contract arrangements with agencies. MASNet intend to have a national bank for critical care nursing in place later this year. Following this, MASNet will look to identify other areas of the workforce where national banks could help with vacancy issues and reliance on agency staff.

Previous workforce strategies lacked the detail needed to address national workforce issues

26. A range of strategies and policies have affected the NHS workforce in recent years ([Exhibit 4, page 17](#)). One of the main strategic aims is to integrate health and social care services, moving more health services into the community and to increase the focus on prevention.

27. In 2013, the Scottish Government published *Everyone Matters: 2020 Workforce Vision*. It was a high-level vision, not a workforce plan. The Scottish Government prepared annual implementation plans to support this vision and help direct workforce planning activities in NHS boards. The annual implementation plans lacked quantifiable measures and milestones. This made it difficult to get a national picture of how the NHS was improving its workforce and addressing its priorities ([Exhibit 4, page 17](#)). The Scottish Government assesses progress against *Everyone Matters: 2020 Workforce Vision* by reviewing overall performance information given in individual NHS boards' Local Delivery Plans (LDPs) and good practice examples, which are published on the Scottish Government website.

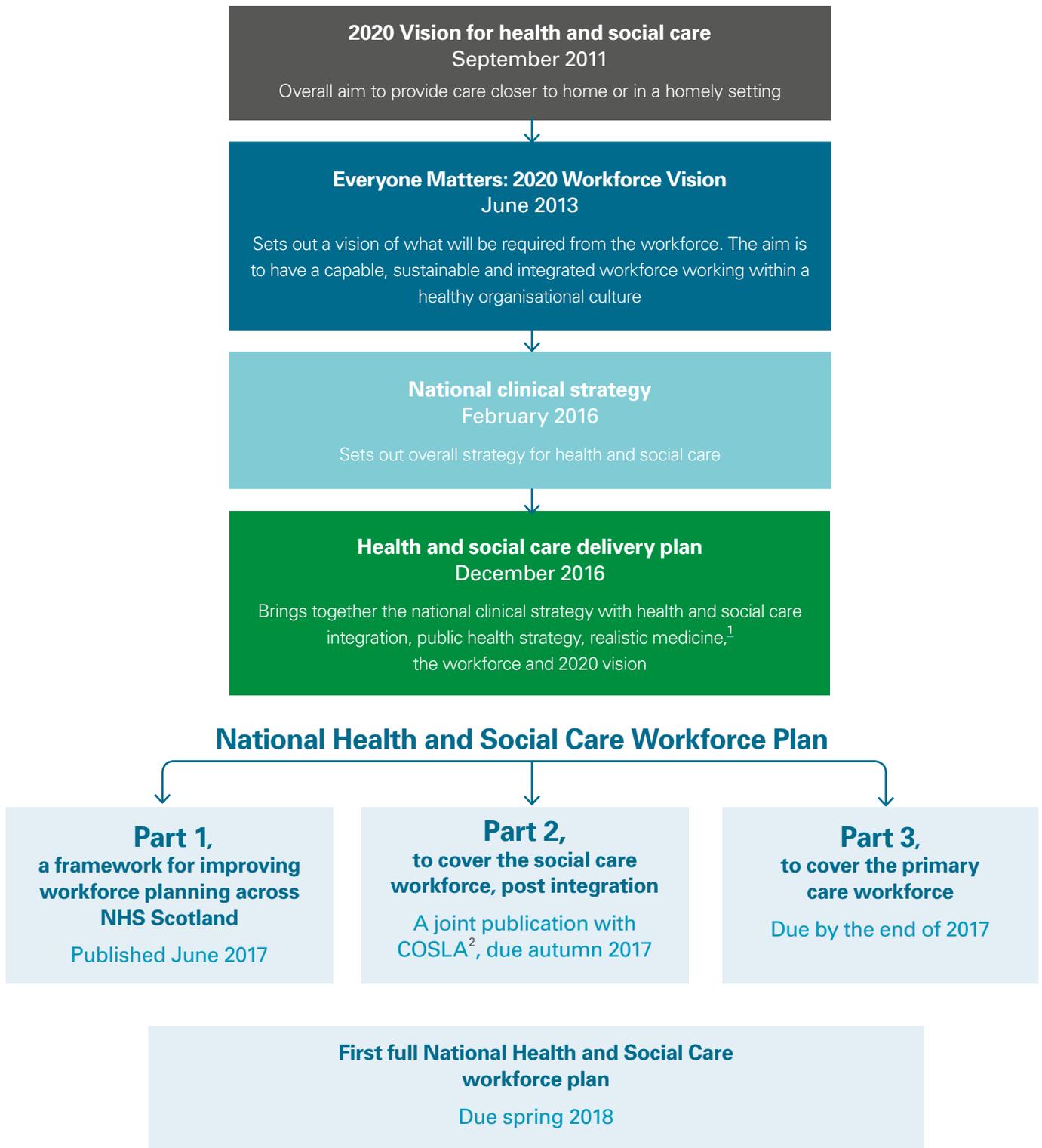
Patients give positive feedback about the care they receive, but complaints are rising

28. Despite increasing workload pressures ([Exhibit 2, page 13](#)), patient surveys suggest no negative impact on patient care. Patients are positive about their overall experience and about the staff they have been in contact with. In 2016, 84 per cent of respondents to the NHS Scotland inpatient survey rated their experience between seven and ten (most positive). Ninety-one per cent of respondents were positive when asked how the overall experience of the staff they came into contact with was. This is an increase from 87 per cent in 2010. At an individual board level, positive feedback about staff ranges from 81 per cent at NHS Ayrshire and Arran to 98 per cent at NHS Shetland and NHS Western Isles. We found no link between boards with higher vacancy levels and those with more negative responses to questions about staff.

Exhibit 4

Strategies and policies affecting the NHS workforce

There are a number of key strategies and plans affecting the NHS workforce.



Note:

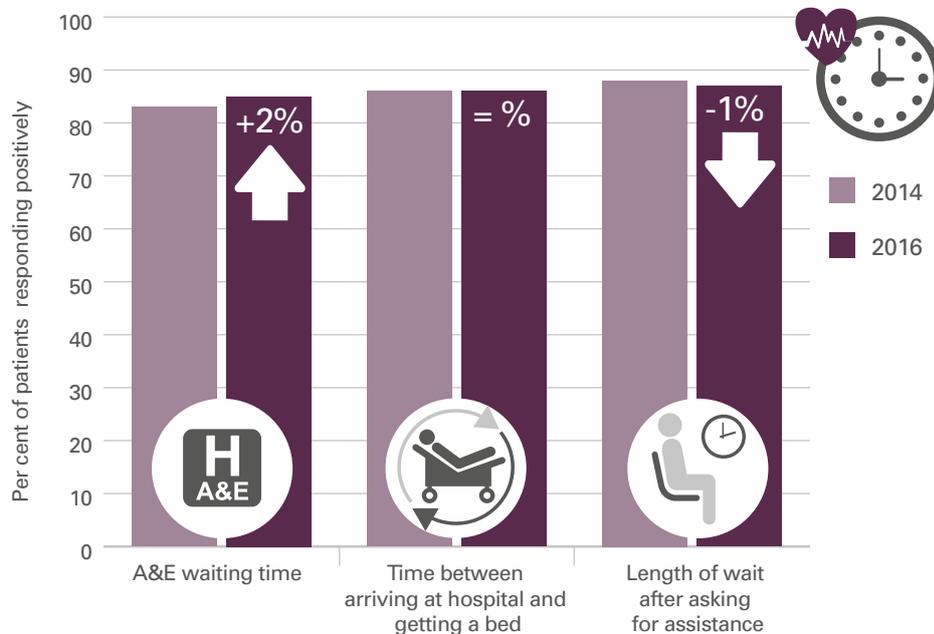
1. *Realistic Medicine* was a report by the Chief Medical Officer in 2016, focusing on reducing waste, harm and variation in treatment.

2. The Convention of Scottish Local Authorities (COSLA) is a national association of councils.

Exhibit 5

NHS Scotland inpatient survey, 2014 and 2016

Patients responded positively to questions about the length of time they had to wait.



Note: 2014 used for comparison as this was the first year all three questions were used.

Source: Audit Scotland using data from NHS Scotland inpatient survey



29. Patients were asked whether they thought there were enough nurses on duty during their stay: 63 per cent felt there were, while nine per cent felt there were rarely or never enough nurses. This is very similar to the results in 2014. In 2016, the percentage who felt there were enough nurses ranged from between 52 per cent at NHS Borders to 82 per cent at NHS Western Isles. Responses to questions relating to the length of time patients had to wait were also generally positive ([Exhibit 5, page 18](#)).

30. Although the vast majority of patients are satisfied with their care, complaints to NHS boards have been rising, with 53,876 complaints in 2015/16, an increase of 62 per cent since 2011/12.²³ We found no link between boards with higher complaint levels and those with higher vacancies. NHS boards have worked to raise awareness of the complaints process, and make it easier for patients to make a complaint. This may account for at least some of this increase in complaint levels.

Part 2

Current NHS workforce planning



Key messages

- 1 NHS boards have to produce annual workforce plans. While workforce plans describe pressures on the workforce and information on how demand for services could change, NHS boards' workforce projections do not truly reflect future demand for NHS services, or expected workforce numbers. Plans are restricted by what is affordable and achievable with the staff available. It is not clear what long-term impact health and social care integration, including the role of integration authorities, will have on the NHS workforce.
- 2 NHS boards make three-year projections for nurses and AHPs but only project a year ahead for medical staff. The Scottish Government makes projections of expected medical numbers coming through training centrally. Historically NHS boards have underestimated the size of the workforce they will have in future years.
- 3 The new *NHS National Workforce Plan 2017* considers what workforce planning decisions should be made at NHS board level, regional level, and nationally. Local-level arrangements will be determined in partnership with the Convention of Scottish Local Authorities (COSLA) and other stakeholders. This is welcome, as the current lines of responsibility and decision-making are unclear, and regional workforce planning is not working as originally expected. None of the regions currently have regional-level workforce plans in place, and there has been no requirement placed upon them to do so. The *NHS National Workforce Plan 2017* states that regional delivery plans will include workforce planning from September 2017. Regional arrangements are often used by NHS boards to help with immediate workforce issues, rather than part of longer-term workforce planning. Data to improve workforce planning decisions could be better collected and shared.

NHS boards' workforce plans describe workforce pressures, but workforce projections do not reflect future demand

NHS boards consider pressures on the workforce, but this is not reflected in their workforce projections

31. Workforce planning in the NHS has been a statutory requirement since 2005.²⁴ Since 2011, the Scottish Government has required NHS boards use the *Six Steps Methodology to Integrated Workforce Planning*.²⁵ This sets out a process for all NHS boards to follow when forming an annual workforce plan ([Exhibit 6, page 20](#)). The *NHS National Workforce Plan 2017* states that workforce planning guidance will be refreshed by the end of 2017, following the publication of the second part of the plan in autumn 2017.

Exhibit 6

An overview of the six-step approach to workforce planning

NHS boards' workforce plans have to follow an agreed format to consider service change and the workforce needed.

Steps	Task
1 Defining the plan	Identify why a workforce plan is needed and for whom it is intended
2 Mapping service change	Identify the purpose and shape of any proposed service change that will impact on future workforce requirements
3 Defining the required workforce	Identify the skills required and the type/ number of staff to deliver the new service model (workforce demand)
4 Understanding workforce availability	Identify current and future staff availability based on current profile and deployment (workforce supply)
5 Developing an action plan	Plan to deliver the required workforce (new skills in new locations) and manage the change
6 Implementing, monitoring and refreshing	Implement the plan, measure progress and refresh the plan as required.

Source: Scottish Government

32. NHS boards must have workforce plans in place by 30 June each year. All boards have workforce plans in place, except for NHS Orkney. In many cases, NHS boards' plans show detailed consideration of pressures facing their staff and services. Examples include the pressures of an ageing population, the risks associated with an ageing workforce and recruitment difficulties.

33. Several plans give examples of local initiatives to reduce sickness absence and the use of agency staff as well as using new roles such as advanced nurse practitioners (ANPs), and developing the skills of the current workforce. For example, NHS Lothian's workforce plan states that if it wishes to maintain the same level of staffing, it will need to rebalance its skills mix by developing and providing a career structure for unregistered staff.²⁶ Scottish Government guidance states that NHS boards should apply the three tests of affordability, availability and adaptability to their workforce planning. This means that workforce plans rightly reflect what can be afforded in the short term, but risk presenting unrealistic projections of the workforce needed for the future. The need to make changes, such as developing the skills of existing staff to control costs, is referred to in workforce plans.

34. NHS boards also submit workforce projections to the Scottish Government, detailing how they expect their workforce to change. These projections cover a three-year period for nursing and AHP staff groups, but only a year for medical

staff. The Scottish Government does not require NHS boards to give three-year projections for medical and dental staff. This is because these groups are already subject to separate longer-term planning processes to determine the number of first-year places for medical and dental students at Scottish universities ([paragraph 67](#)). Our review of the Scottish projections shows:

- two NHS boards (Ayrshire and Arran, and Lanarkshire) have only projected their workforce for one year rather than the required three
- five NHS boards have reported a no-change position for pay bandings of staff for years two and three
- other NHS boards project changes, but these appear to be minor, and are in line with year-one projections.

35. Many NHS boards are redesigning their services, such as how patients access unscheduled care, and are developing clinical strategies which align with the National Clinical Strategy published in 2016. NHS boards are also aware of expected changes through the new national health and social care workforce plan expected in 2018. Other developments include the workforce needs of six planned elective centres for Scotland, which will enable boards to refer patients for procedures such as joint replacement and cataract treatment. Given the scale and range of reform affecting the NHS, we would expect NHS boards' workforce plans to show greater projected change in their workforce. It is clear that NHS board projections are not achieving the intended goals for workforce planning.

36. The long-term impact on the NHS workforce of health and social care integration, including the role of integration authorities, is also still to be determined.²⁷ Within this environment, NHS boards are projecting against existing supply or do not make projections at all. Of the two NHS boards where only a single year projection is made, both state that this is due to ongoing service redesign. NHS boards receive a one-year budget, and given the affordability test previously mentioned ([paragraph 33](#)), it is more difficult to plan for future years without knowing what the funding will be. We have highlighted the need for better long-term planning in our annual NHS overview reports, which would include the workforce as well as overall financial planning. As such, we have previously recommended having three-year rolling budgets to allow better long-term planning.²⁸ The *NHS National Workforce Plan 2017* sets out that from summer 2017, NHS Education for Scotland (NES) and others will begin work to improve NHS workforce projections, to better link future demand for healthcare to national decisions on student intakes. A new approach is due in early 2018.

37. Historically, NHS board projections consistently underestimate the numbers of staff they need, particularly when they are making their three-year projections for nursing and midwifery staff and AHPs. This may help explain NHS boards' overspend against budget costs. The Scottish Government should consider this when using board projections as an indicator of future recruitment needs as part of its wider nursing and midwifery and AHP recruitment planning ([Part 3](#)). Projections alone could understate recruitment need for the future.

NHS boards are struggling to recruit to certain medical positions

38. The Health and Sport Committee of the Scottish Parliament held three evidence sessions in 2016 on recruitment and retention in the NHS.²⁹ The committee identified a number of risks that could prevent the NHS from recruiting the skilled staff needed to meet demand. These included the impact of Brexit, pay and contract issues, and geographical barriers, such as employment opportunities for families of medical staff in rural areas of Scotland.

39. The Scottish Government has looked at some ways to try to recruit and retain doctors in Scotland, including the following:

- Clinical Development Fellowships (CDF): these are one-year non-training posts taken up by doctors not ready to choose a specialty or who want to be in a specific location. In 2016, there were 59.5 WTE CDF posts spread across six NHS boards.
- International Medical Training Fellowships (IMTF): despite some problems regarding visas and other processes for some posts, ten posts were appointed to in 2016, and a number of others have had applications. These are one or two-year posts aimed at overseas doctors who have completed specialty training.
- Scottish Graduate Entry Medicine (ScotGEM): this is a four-year medical programme for graduates of any discipline, run between the Universities of St Andrews and Dundee and in partnership with the University of the Highlands and Islands and NHS Scotland. The first 40 students will start in September 2018. It is geared towards those looking for a generalist career and offers experience of working in remote and rural areas.

40. NHS boards are also trying local initiatives to attract staff:

- NHS Lanarkshire ran two international recruitment campaigns for emergency medicine medical staff, although this resulted in little success.
- NHS Highland is involved in an international project, working with other countries with rural recruitment and retention issues.
- NHS Borders had some success in recruiting consultants to shortage specialties. This followed actions like revamping job descriptions, highlighting the attraction of the new Borders railway, a consultant development programme and mentoring.

41. In some cases the recruitment difficulties might be caused, or made worse, by the numbers of training places going unfilled in some specialties. Some of the highest percentages of unfilled places in 2016 included old age psychiatry, clinical oncology and general psychiatry. In old age psychiatry, around one in three training places were not filled. In both other fields, around one in five training places were unfilled.

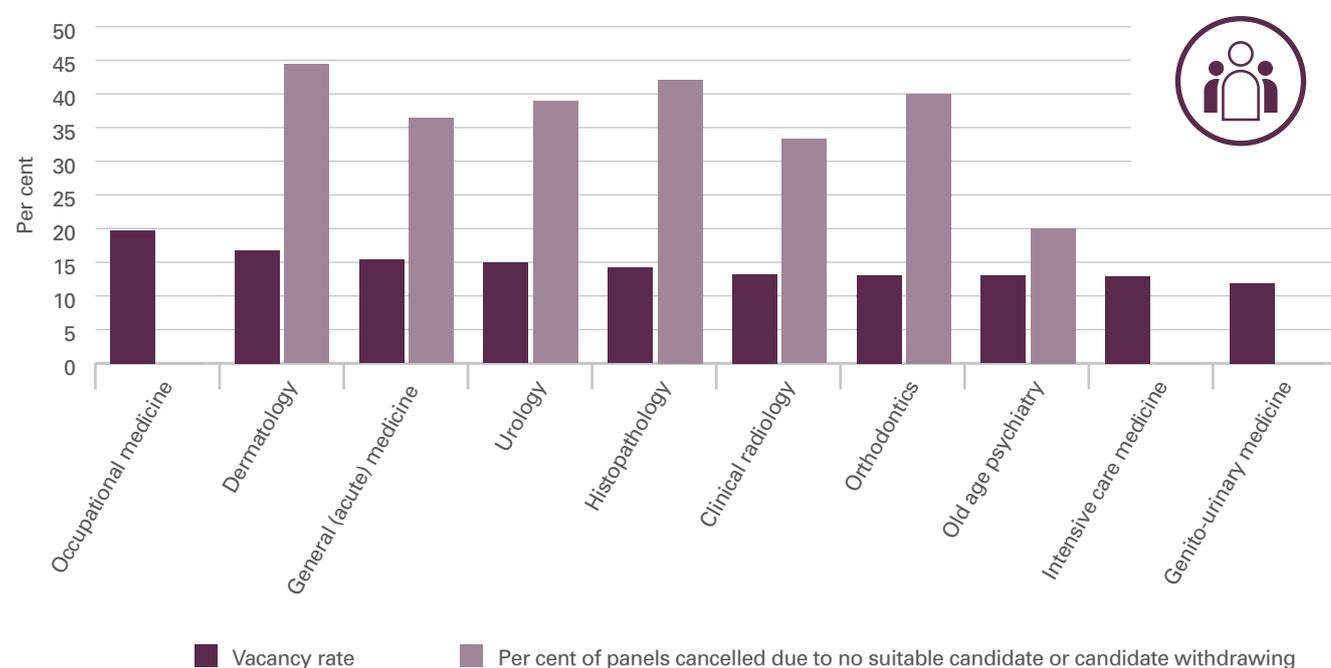
42. Levels of consultant vacancies are not evenly spread across medical specialties. Twenty-seven of the 75 specialties had vacancy rates higher than the 7.4 per cent total rate for consultants. [Exhibit 7 \(page 23\)](#) shows the consultant specialties with some of the highest vacancy rates. In seven of these

specialties, at least half of the vacancies have been open for six months or more. NHS boards are attempting to recruit to these vacancies, but with varying rates of success. Across all specialties in 2016, 30 per cent of interview panels for consultants had to be cancelled as either the candidate withdrew, or there were no suitable applicants. This is a slight increase from 28 per cent of panels cancelled two years earlier.

Exhibit 7

Vacancy rates and cancelled interview panels for the ten specialties with the highest consultant vacancy rates, 2016

The specialties with the highest vacancy rates in 2016/17 also tended to have high rates of interview panels that were cancelled due to candidates withdrawing, or no suitable candidates.



Note: Genito-urinary and had no panels cancelled due to no suitable candidates or candidates withdrawing. No information is available on panels for intensive care medicine. Only specialties with an establishment of at least 10 WTE are included.

Source: Audit Scotland using data from ISD Scotland and the Academy of Medical Royal Colleges and Faculties in Scotland (the Scottish Academy)

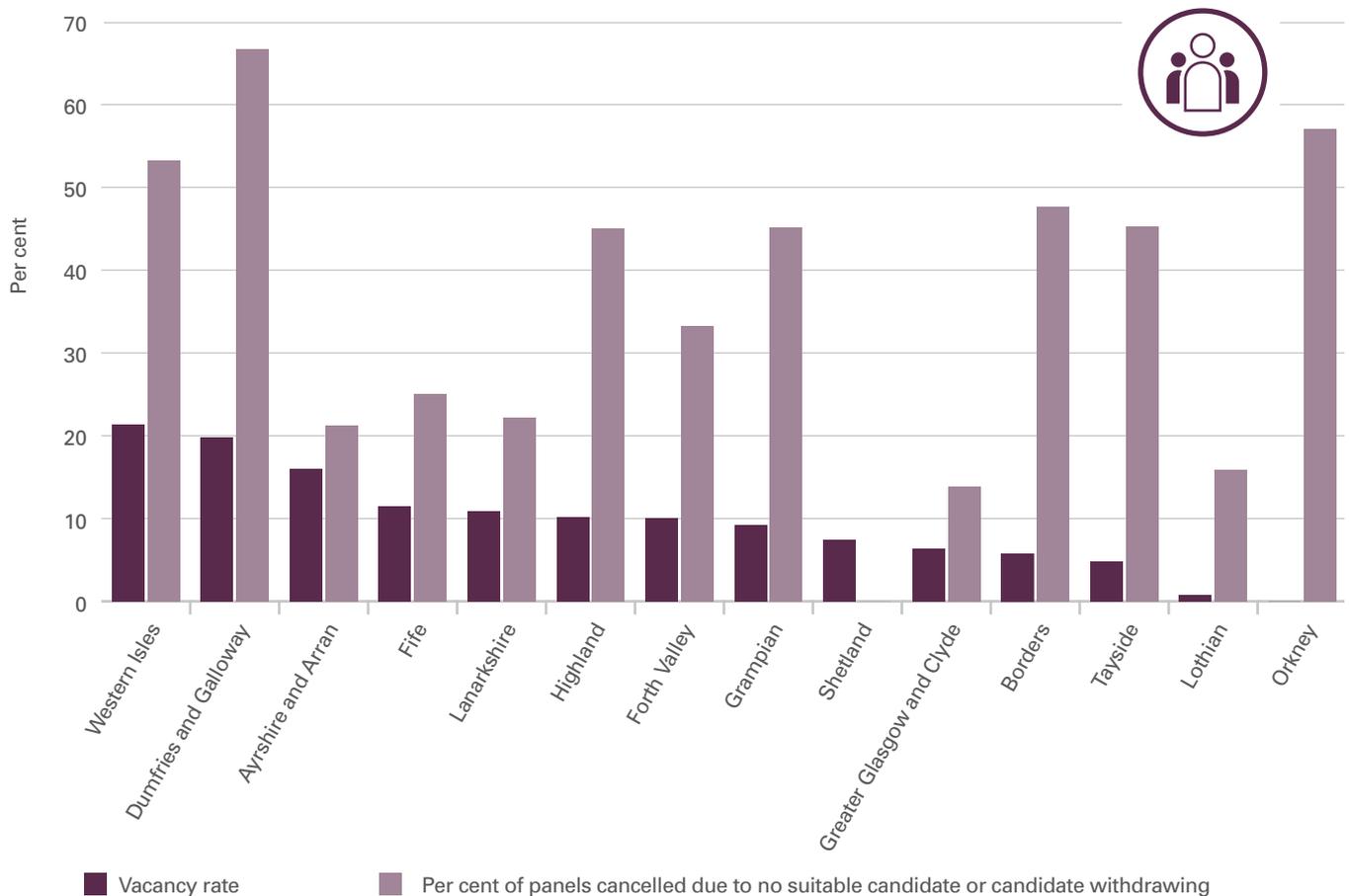


43. The highest rates of consultant vacancies, and consultant vacancies that had been open for at least six months were at NHS Western Isles which has a 21 per cent vacancy rate, with all those posts having been vacant for at least six months; in NHS Dumfries and Galloway, the figures were 19.8 per cent and 13.4 per cent [Exhibit 8 \(page 24\)](#).

Exhibit 8

Vacancy rates and cancelled interview panels for consultants, by board, 2016

Higher vacancy rates in 2016/17, and higher rates of consultant interview panel cancellations, are often among the more rural boards.



Source: Audit Scotland using data from ISD Scotland and the Academy of Medical Royal Colleges and Faculties in Scotland (the Scottish Academy)



44. NHS boards in more rural areas also tended to have higher cancellation rates for interview panels ([Exhibit 8](#)) although higher rates are not exclusive to such boards. There is a risk that in the future some NHS boards may find it more difficult to recruit to positions as they become vacant. Of the eight NHS boards with a cancellation rate higher than the Scotland average in 2016, the highest were:

- NHS Dumfries and Galloway (67 per cent cancelled)
- NHS Orkney (57 per cent cancelled)
- NHS Western Isles (53 per cent cancelled).

45. NHS boards can employ consultants on different types of contracts, which can have an impact on how much time they have to train their colleagues. Contracts with less training time built in could lead to bottlenecks in the training process, and reduce the number of trainee doctors that could be taken on.

Of the types of contract used, a 9:1 contract has the least time set aside (one session out of every ten) for training, mentoring, continuous professional development and research. Of consultants appointed in 2016, 43 per cent were on 9:1 contracts, a fall from 46 per cent the year before. Some of the specialties with the highest vacancy rates ([Exhibit 7, page 23](#)) also had high levels of consultants being employed on a 9:1 basis. For example, 64 per cent in histopathology (nine of 14) and 46 per cent in clinical radiology (12 of 26).

The Scottish Government, regional groups, NHS boards and partners need to clarify their respective roles

46. The Scottish Government's Health and Social Care Delivery Plan aims to improve workforce planning practice to make it clearer what is planned nationally, regionally and locally ([Exhibit 9, page 26](#)).³⁰ We recommended in our *Changing models of health and social care*  report in 2016 that the Scottish Government should set out clearly how organisations will work together, including changing job roles and responsibilities.

47. The Scottish Government needs to clarify workforce planning responsibilities to make the new national, regional and local arrangements work. Several national organisations are involved in national workforce information, planning and monitoring. They include NHS National Education for Scotland (NES) and NHS National Services Scotland (NSS) as well as the NHS boards providing healthcare to the Scottish population and the Scottish Government Health and Workforce Directorate. There are no formalised roles and responsibilities around workforce planning which would show how these organisations work best together. This has led to misunderstandings. For example, some NHS boards believe that their three-year workforce projections are used nationally to plan future workforce numbers, and are being monitored by the Scottish Government. In practice, while these projections are considered in the round, they are not in themselves the basis of training and recruitment decisions.

48. Regional arrangements were intended to improve strategic workforce planning between NHS boards, including being responsible for integrated workforce planning for cross-board services.³¹ In practice, regional workforce activity is decided through regional planning groups, which include the chief executives of the NHS boards within the regions. Chief executives are accountable for the performance of their own NHS board. None of the three regions has a regional workforce plan, and only South East and Tayside has a regional director for workforce planning. In the north and west regions, when the post holders moved on to employment elsewhere in the NHS, the roles were not replaced. There are examples of where regional working has been successful in helping NHS boards to solve workforce problems ([Case study 1, page 27](#)).

49. The Scottish Government intends to strengthen regional workforce planning arrangements.³² Currently no region has mapped out the skills its regional workforce has available. Nor have any regions mapped out the future health demands of the population living in the region. This means that no region can see at a high level how current available skills within their workforce fit against what they will need for the future. This lack of a strategic view hinders the ability to make effective and coordinated regional planning decisions. It is encouraging that the *NHS National Workforce Plan 2017* intends for a National Workforce Planning Group to be set up, and for regional delivery plans which include workforce planning to be in place by September 2017.

Exhibit 9

NHS workforce planning responsibility levels

There are three levels of responsibility for workforce planning, though not all have workforce plans, and arrangements are not always clear.

National planning



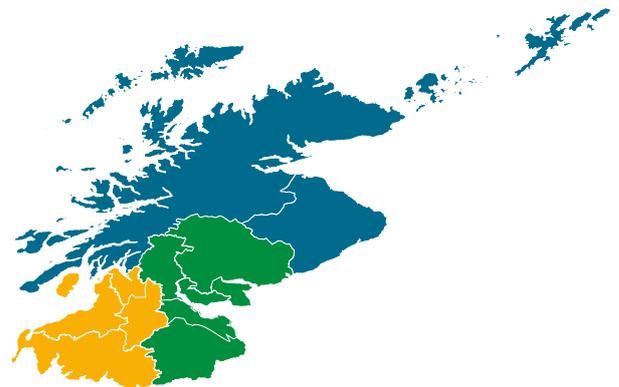
- The Scottish Government has a health workforce directorate. There are also nine national boards, including NES and NSS working at a national level
- The Scottish Government produces national plans, including the Health and Social Care Delivery Plan and the *NHS National Workforce Plan 2017*
- The Scottish Government is responsible for monitoring the NHS workforce, issuing planning guidance, and setting training numbers for medical staff and nurses and midwives



Regional planning



- Three regional planning groups covering the North of Scotland, the West of Scotland, and South East and Tayside
- None has regional workforce plans and have not been required to produce these. Instead, they focus on targeted workforce issues as directed by regional planning groups
- Work mainly on specific initiatives, rather than strategically over the whole region



Local planning



- 14 territorial NHS boards 31 and integration authorities
- All NHS boards (except NHS Orkney) have workforce plans and submit workforce projections to the Scottish Government
- Responsible for the performance of the workforce in their NHS board.



Case study 1



North of Scotland regional workforce planning to help with workforce shortages

In the North of Scotland, regional workforce arrangements are in place for elements of paediatric services. The region had a shortage of clinicians working within certain sub-specialties and was concerned about being able to meet people's needs.

Multidisciplinary teams of doctors, nurses, dieticians, psychologists and other AHPs work across all five NHS boards in the region, both in hospitals and in network clinics. This has helped alleviate pressures across the North. This was part of a national planning initiative, the National Delivery Plan for Specialist Children's Services, which each of the regions considered.

Paediatric clinicians working in northern NHS boards led the initiative to work regionally and initial funding was secured over 12 years ago from the National Delivery Plan.¹

Note: 1. *Better Health, Better Care: National Delivery Plan for Children and Young People's Specialist Services in Scotland*, Scottish Government, January 2009. This was set up in 2009 providing funding to help regional and national programmes.

Source: North of Scotland Regional Planning Group

50. There is a risk that the sheer number of workforce plans and the number of different workforce groups involved may itself become a barrier to effective working. As well as the current NHS board workforce plans, there will be:

- further national workforce plans ([paragraph 10](#))
- regional workforce plans
- workforce plans within integration authorities, and potentially
- workforce plans for other cross-board networks such as elective centres.

51. The Scottish Government investigated, by specialty, whether services are best delivered for patients locally, regionally or nationally.³³ However, it has not set out which professions and skills are best suited to a hospital or a community setting. There are over 70 medical and dental specialties. Some will always be delivered in a hospital setting, for example emergency medicine. Others may be more transferable, such as geriatric medicine. Such specialties need to be identified and the opportunities and barriers in moving the workforce from a hospital setting need to be set out. This may include considering the specialty group's own ability and willingness to do so and effects on the ability to recruit.

Data needed for reliable and accurate workforce planning is not joined up

52. Not all data that would help the Scottish Government to identify specific workforce pressures is being collected and used nationally. Examples include:

- Published data collected on agency spending does not give a breakdown by different staff groups. Nursing and midwifery staff are the only group for whom this information is separately identified and published. In addition, no information is published on other non-standard staff costs such as additional hours worked.
- Published data about vacancies covers consultants, nursing and midwifery and AHPs, but does not track vacancy pressures among medical trainees. Alongside this, sickness absence data is not split by the different staff groups.
- Data on nurses with special class status, which entitles some nurses to retire at an earlier age of 55, is not held. The Scottish Public Pensions Agency cannot separate nurses from others in the public sector with special class status.
- The Scottish Government recognises the potential impact of Brexit on recruitment and retention in health and social care.³⁴ No information is held on how many NHS medical staff are non-UK EU citizens. The Scottish Government has used other figures to assess the impact on staff numbers of leaving the EU. These include looking at where people studied, data from the Office of National Statistics and national survey data.³⁵ A total of 10.5 per cent of NHS Scotland medical trainees and 22.7 per cent of consultants attended a medical school outside the UK; and 3.5 per cent and 9.2 per cent respectively qualified in other countries in the EU. The GMC has looked at the relationship between where medical students qualified, and their nationality. It concluded that using the place of medical qualification underestimates the number of EU nationals.³⁶

53. Data and information held by different organisations are not used to their full potential to help with decision-making. NES has looked to improve how it uses data in making better workforce decisions ([Case study 2, page 29](#)). In the case of medical and AHP data in particular, inconsistent or incomplete data is preventing good workforce information being used in decision-making.

54. For the medical profession, NES has been working to understand the paths people take from university, to junior doctor to consultant level. The Scottish Funding Council holds data on the numbers of Scottish medical students, while the GMC holds data on doctors in the workforce ([Exhibit 10, page 30](#)). It is difficult to link up these two sets of data as no consistent unique identifier is given to medical students, unlike the nursing data. Without this data, the Scottish Government will struggle to quantify the effect of increasing the student intake on the take-up of places in NHS boards. The *NHS National Workforce Plan 2017* sets out that from summer 2017, NES will be looking at the data required to inform workforce decisions, including how data on the workforce, demand for healthcare, and NHS training fit together. This will include improving the consistency of data gathered across Scotland.

55. Not all medical students studying in Scotland stay in Scotland after their studies. In addition, not all trainee doctors will choose a career as a consultant, and some may take time out of the pipeline altogether. The Scottish Shape of Training Transitional Group (SSoTTG) considers future training numbers. The SSoTTG includes representatives from the Scottish Government, NHS boards, the Academy of Medical Royal Colleges and Faculties and regional planning groups. When the SSoTTG analyses the number of training places needed it does not fully consider all the potential inflows and outflows of doctors in the training pipeline, in part due data not being readily available. Without a full picture

of doctors' movements in the training pipeline it is difficult to plan the training numbers required. The SSoTTG has been drafting a framework to improve the retention of medical trainees in Scottish medical training, including looking at the medical training pipeline in more detail. NES, the GMC and other interested groups are working to bring together undergraduate and postgraduate medical education data held by different organisations. This should allow better tracking of doctors at different stages of training, as well as understanding doctors' geographical movements and medical activities. This should help the Scottish Government to improve the accuracy of its workforce planning. For AHPs, the Scottish Government commissioned NES to produce workforce reports for each of the individual professions under this umbrella. NES had previously produced workforce reports for dentistry, updated annually, which were used as a monitoring tool by the Scottish Government. NES found it difficult to gather information on AHPs, as they work widely across healthcare and are employed in local government and the private sector as well as in the NHS. NES is aware of inconsistent data recording of the AHP workforce by NHS boards, including AHP staff contracted by NHS boards not always being recorded. Of the nine AHP workforce reports NES intended to publish, six workforce reports have been published, between 2013 and 2015. Two reports were completed but not externally published because of data concerns, and a further report is yet to be published. Due to inconsistencies in data and competing priorities, none of these reports has been updated since being produced.

Case study 2

NHS Education for Scotland is using data to understand the nursing workforce



NES has been analysing workforce data to better understand the movements of pre-registration nursing students and those who are registered and are working in the NHS. This information would help workforce planning by understanding better the route that those in training take through education and into the workforce.

For the nursing profession, all students are assigned an ID number when they begin study at university. This ID number remains with them through university and into post-registration work as a nurse. NES tracks a number of factors that could help in future workforce planning such as:

- where nurses take up employment in relation to where they studied
- how long nurses spend in study and in employment in the workforce
- what proportion of university students complete their training and then work in Scotland.

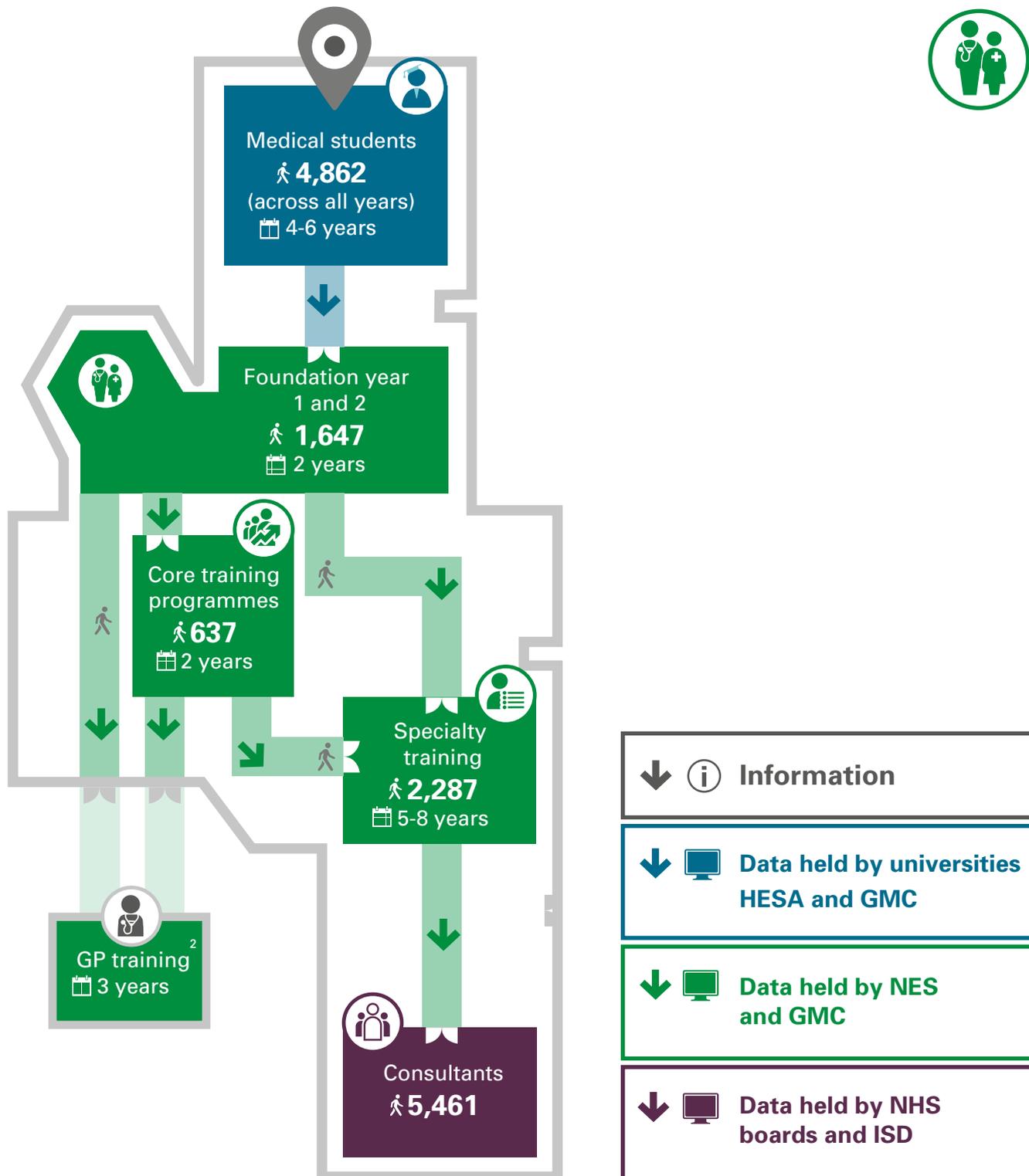
The Scottish Government is working with NES to determine how this information can be better used in future decision-making and projections.

Source: NHS Education for Scotland

Exhibit 10

Numbers in the medical training path in 2016

Data on the medical workforce is held by different organisations and training times are lengthy.



Notes:

1. HESA is the Higher Education Statistics Agency.
2. GP planning and training will be covered in more detail in our next audit.
3. The numbers in the boxes refer to the number of people at any stage in that process, for example there are 4,862 medical students in total, from those in their first year to those in their last.

Source: GMC, and ISD

Part 3

The future NHS workforce



Key messages

- 1 The NHS workforce is a key component to the delivery of the Scottish Government's long-term reforms, as set out in the Health and Social Care Delivery Plan and National Clinical Strategy. Despite this, committed funding to support NHS reform does not clearly separate out the expected workforce costs associated with the changes. The *NHS National Workforce Plan 2017* does not include details on expected workforce costs associated with NHS reform.
- 2 The Scottish Government has not looked at scenarios for how future demand for healthcare might look, and what this means for the NHS workforce. Long-term recruitment decisions do not consider how future healthcare needs will influence the skills the NHS workforce needs.
- 3 Processes for determining training numbers risk not training enough doctors, nurses and midwives, with the right skills for the future. Medical recruitment numbers are based on replacing current numbers rather than looking at the impact of changing demand. Decisions on nursing and midwifery intake numbers do take account of previous growth in the nursing and midwifery workforce, although again they are not based on meeting the long-term needs of a changing population. Nursing is included on the Shortage Occupation List for Scotland and for the rest of the UK.
- 4 The Scottish Government has not fully considered the risk that retirement from the NHS in coming years may lead to increased vacancies. Certain consultant specialties and certain areas in Scotland are relying on an ageing consultant workforce who may retire in the next five years. Similarly, over a third of the nursing and midwifery workforce is over 50 and the number of newly qualified nurses in Scotland available to enter the workforce to replace them fell by 15 per cent between 2013/14 and 2014/15, and a further seven per cent in the following year.
- 5 The Scottish Government aims to have a workforce with the right mix of skills to deliver different types of healthcare for the future. The current systems for making recruitment decisions are not sufficiently coordinated to help make this happen. There are separate processes for doctors, nurses and midwives and other professional groups. This makes it more difficult to consider the crossovers between groups and how their skills complement each other.

a lack of long-term planning risks failing to train the right numbers with the right skills

The total costs associated with reforming the workforce and meeting future demand are unclear

56. The Scottish Government's *Health and Social Care Delivery Plan* states: 'Health funding is expected to grow in resource terms by the end of this Parliament, with significant planned investment in areas such as primary care, mental health, social care, cancer and new elective capacity. Spending on primary care services is set to increase by £500 million so that it accounts for 11 per cent of the frontline NHS Scotland budget by May 2021.'³⁷

57. Specific initiatives with committed funding include:

- An investment of £200 million in new elective treatment capacity, including new elective centres, and expanding the Golden Jubilee National Hospital.
- New models of primary care in every NHS board, such as changing how GP surgeries operate. £23 million will be invested in this.

58. The Scottish Government has not quantified how much of this additional funding for the NHS in Scotland will be spent meeting additional NHS workforce costs. Some, such as money spent on primary care funding and mental health, will be incorporated within NHS boards' annual funding allocations. NHS boards will therefore be responsible for deciding how this money is spent, and what proportion will relate to workforce cost. The Scottish Government intends to look at NHS board workforce costs to deliver these initiatives in more detail in 2017/18. The *NHS national workforce plan 2017* does not include details on expected workforce costs associated with NHS reform.

59. The Scottish Government needs to clarify how the *Health and social care delivery plan* and *Everyone Matters* will affect workforce planning and costs. It has yet to set out how new models of care will have an impact on workforce costs. These models include moving services to the community, new elective centres, health and social care integration, and more regional working. Without this, the NHS in Scotland risks further difficulties in organising the workforce in the most cost-effective and efficient way.

The Scottish Government does not plan the NHS workforce against long-term demand for healthcare

60. The future health needs of the Scottish population will determine the future services the NHS workforce will need to provide. The Scottish Government does not adequately consider long-term future health demands through its workforce planning process.

61. In 2014, the Scottish Government assessed its workforce planning arrangements for the NHS.³⁸ The report highlighted that understanding the current and future population is 'key to understanding workforce supply need and education requirements'. The report recommended that the Scottish Government and NHS boards should conduct scenario planning, and noted different ways of doing this, based on information from the Organisation for Economic Cooperation and Development (OECD). Scenario planning involves looking at current trends such as the effects of an ageing population, current lifestyles and future medical advances. It then uses this analysis to anticipate potential changes in future demand for services. This helps to identify the skills that a future NHS workforce will need to develop.³⁹

62. It is now over three years since this recommendation was made. The Scottish Government does not carry out scenario planning of this type to anticipate the quantity and make-up of the future workforce required nationally. The *NHS national workforce plan 2017* acknowledges the need to better forecast the demand for, and supply of, health and social care workers. The plan states that current work on projections is in development. We are aware that work is under way to produce a Scottish burden of disease report in autumn 2017.⁴⁰ This will include overall scenario planning against certain diseases and health conditions. This is an opportunity for the Scottish Government to consider how the future workforce will meet the health needs the report explores.

63. An example of using scenario planning to better understand future workforce numbers came from the South East and Tayside regional group, although this type of planning is uncommon in the NHS in Scotland ([Case study 3](#)).

Case study 3



Scenario planning to estimate the future workforce in the South East and Tayside region

In 2012, the South East Scotland Cancer Network looked at radiotherapy capacity, including the current workforce and the available facilities. The South East and Tayside regional workforce planning group fed the outcomes of the review to NES and the Scottish Shape of Training Transitional Group ([paragraph 55](#)), which then looked at the service and its workforce in more detail in 2013.

As well as considering current workforce difficulties, the review considered changes in demand for radiotherapy and how this would affect the workforce needed. The review considered:

- how the population in the region was likely to grow up to 2025, including the percentage increase in the population over 75 years old
- advances in radiotherapy treatment, including increasing complexity of treatment
- increasing numbers of patients with cancer, including patients living longer with cancer.

The review then ran scenarios against the data to predict how the current workforce and facilities could cope with this increased demand. The scenarios considered the amount of medical machinery available, skills balance within teams, and hours spent per treatment.

The review concluded that, alongside additional equipment required, the workforce would need to expand in the future to meet demand.

The evidence was presented to the Scottish Government, resulting in an increase of five clinical oncologist training positions being approved for the region, alongside additional therapeutic radiographer and medical physics training positions.

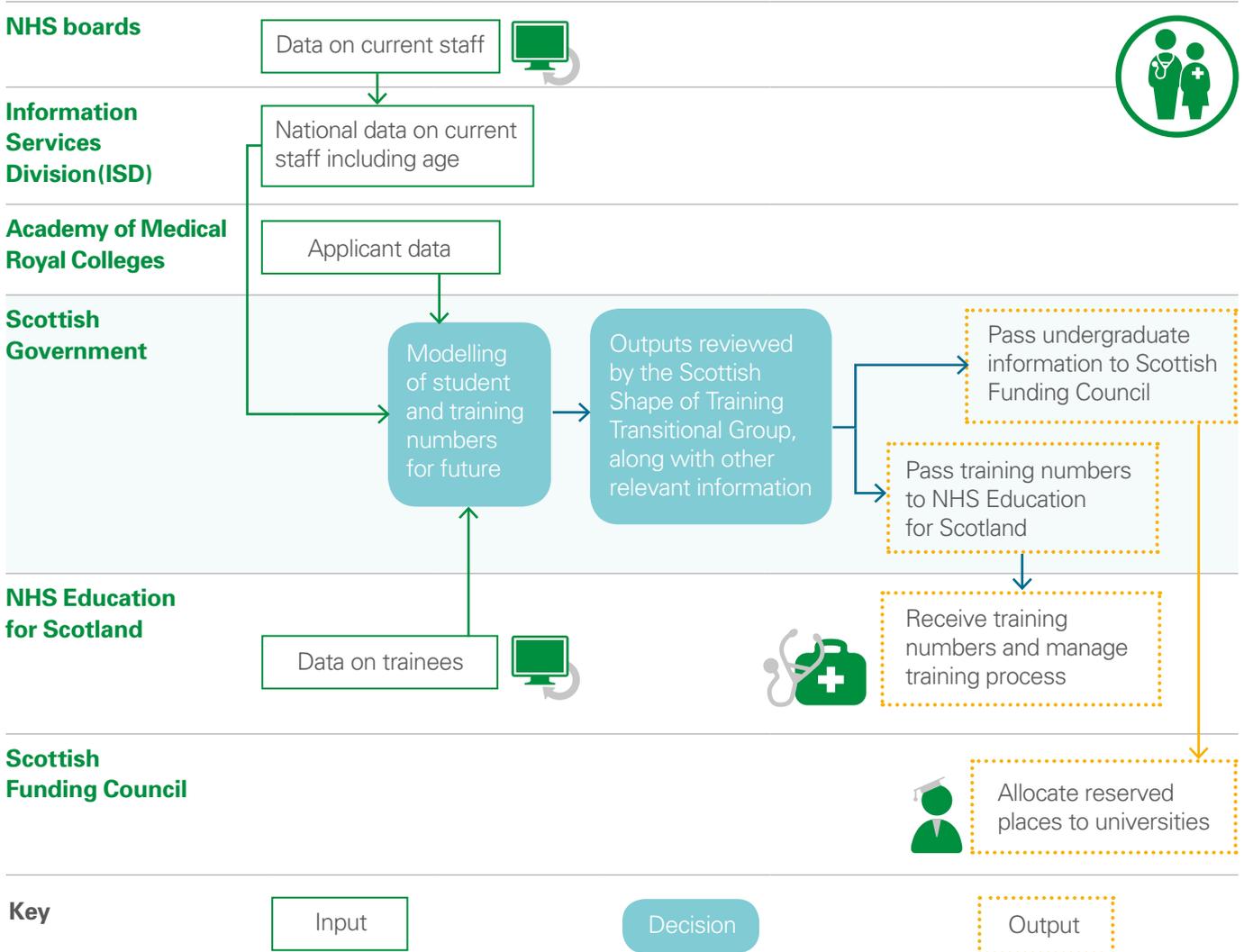
The way the Scottish Government plans medical training places does not sufficiently consider future demand for healthcare

64. The Scottish Government decides how many medical training places there will be in Scottish universities ([Exhibit 11](#)). Scottish Government decisions on training numbers have a delayed effect on the numbers of doctors entering the NHS workforce. In determining the future need for consultants in the medical workforce, the delay between the decisions on training numbers and the effect on the workforce is much greater than other clinical professions. It takes at least 11 years from entering university to becoming a consultant ([Exhibit 10, page 30](#)). This means that the training places set in 2017 affect the number of consultants joining the workforce in 2028 or later.

Exhibit 11

The process used by the Scottish Government to set medical training numbers

The current processes for deciding student and training numbers involve a number of different bodies and sources of data.



65. In 2009, the Scottish Government issued guidance for hospitals and community health service medical workforce projections.⁴¹ Up to this point, medical training numbers were based on locally determined predictions from NHS board returns. The guidance states that previous projections were hampered by uncertainty over future numbers of medical trainees, as well as 'the need to consider affordability before planning any increases in future numbers of career grade doctors'. It predicted that a 'bulge' of medical graduates would result in 'oversupply in nearly all specialties'. Reductions in future training places were planned on the basis of this view. The Scottish Government believed that the Scottish position as a net exporter of doctors would come into balance as supply similarly outstripped demand in other parts of the UK. In reality, supply did not outstrip demand, and the bulge of medical graduates did not result in an oversupply of consultants.

66. Given the length of time needed to become a consultant, doctors in training include those who began training before 2009 guidance was issued. Current consultant vacancies may therefore in part be a result of pre-2009 recruitment decisions, which were based on the perception of affordability at that point, and were supported by less sophisticated analysis.

67. The Scottish Government has since developed modelling tools to estimate future workforce numbers needed, using the data sources shown in [Exhibit 11](#). It uses the information that these models provide in its discussions with stakeholders, and in reaching its decisions on training numbers. This process does not fundamentally consider future demand for each of the consultant specialties, nor the transformational change expected through NHS service reform. While the Scottish Government has improved the basis of its recruitment decisions, the current default position for workforce recruitment decisions is to replace anticipated future vacancies on a like-for-like basis. The workforce modelling tool produces an estimate of the expected joiners and leavers by specialty and uses this to estimate future need for training. For each consultant specialty in Scotland, the model considers:

- consultants' dates of birth (to determine potential time until retirement)
- consultants in post and vacancies at NHS board level
- numbers expected to gain a Certificate of Completion of Training (CCT) in the next five years⁴²
- numbers expected to leave Scotland after gaining CCT status.

68. The exception to the default position is where the SSoTTG considers there is a pressing case for change. In 2017, this led to an increase in posts across Scotland in radiology, intensive care medicine and pathology. For 2016, there was a similar increase across the same specialties.

69. The *NHS National Workforce Plan 2017* includes estimates that 600 more consultants will be required by 2022. On this basis, it suggests that the total number of consultants will exceed demand. However, there are marked differences across different NHS boards and medical specialties which are masked by the overall projection. The projections of future demand for consultants reflect existing numbers rather than an assessment of future health needs of the population. The *NHS National Workforce Plan 2017* does not state the additional costs associated with this increase in consultant numbers.

70. The Scottish Government should identify those areas of the medical workforce more vulnerable to higher vacancy rates in the near future, not just those with an immediate pressing need. The Scottish Government does not systematically look at expected retirements from the workforce in coming years for all specialties to determine how this will affect workforce numbers. Initiatives and discussions through the SSoTTG often focus on those specialties with current high vacancy rates that are struggling to cope with immediate demand. Across all specialties, 30 per cent of medical staff are trainees and 38 per cent are aged over 50. Specialties which may be more vulnerable to increased vacancies through retirements in coming years include:

- public health medicine (16 per cent trainees and 64 per cent of consultants over 50)
- rehabilitation medicine (20 per cent trainees and 65 per cent of consultants over 50)
- cardiothoracic surgery (22 per cent trainees and 59 per cent of consultants over 50).⁴³

71. It is not clear to what extent possible declining numbers within these specialties could affect services because other factors, such as the impact of medical advances, flexible working, longer working lives, pension changes and expected future demand increases or decreases, also need to be considered. Not all trainees within these specialties will go on to replace retiring consultants in Scotland. Over the past five years, 79 per cent of doctors completing training in Scotland are now working in Scotland. The Scottish Government, by completing a systematic review of specialties in this way, would be better positioned to identify those specialties where the numbers of doctors in training are insufficient and where other recruitment routes, such as from outside Scotland, will be needed.

72. Specialties with the higher number of cancelled interview panels for consultant appointments do not match in all cases to those specialties where there are current high levels of vacancies. In 2016, all three panels for psychiatry of learning disability posts were cancelled due to a lack of suitable applicants or candidates withdrawing. In child and adolescent psychiatry, 57 per cent of panels were cancelled (12 of 21). Again, this may indicate that there are certain specialties that are particularly vulnerable to workforce shortages in future years.

73. Looking at this at an NHS board level, those with a higher number of older consultants and lower percentage of trainees are the three island boards:

- NHS Orkney (32 per cent trainees and 100 per cent of consultants over 50)
- NHS Shetland (no trainees and 80 per cent of consultants over 50)
- NHS Western Isles (21 per cent trainees and 91 per cent on consultants over 50).⁴⁴

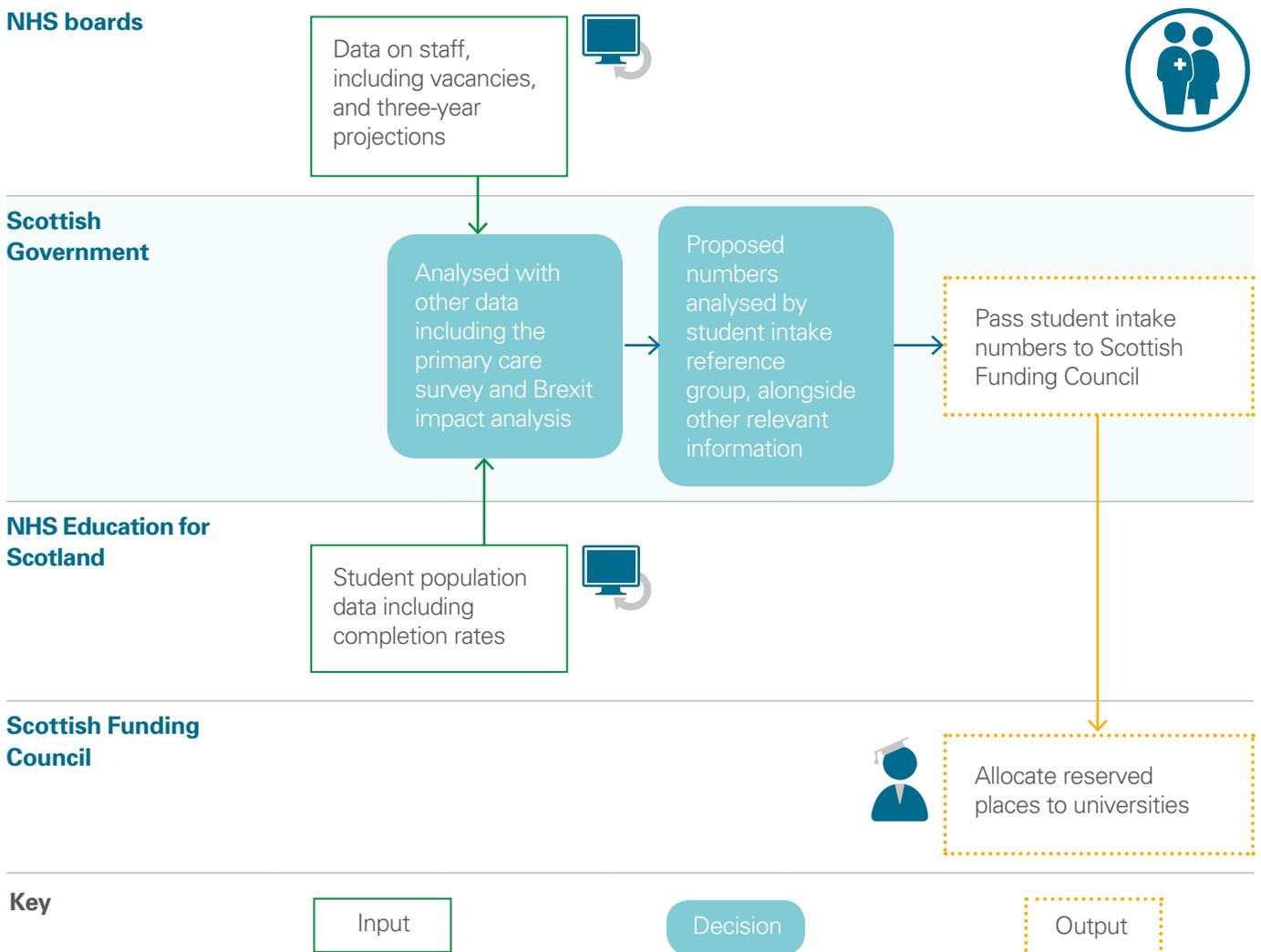
The process for nursing and midwifery training numbers includes demand assumptions based on previous years' growth

74. Similar to the medical projection process, the process for arriving at student nursing and midwifery intake numbers focuses predominantly on supply. It considers the age and working patterns of the existing workforce, as well as completion rates for those in training and average numbers leaving and entering the workforce each year ([Exhibit 12](#)).

Exhibit 12

Workforce planning process for nursing and midwifery student numbers

Information on the current nursing and midwifery workforce, along with student information and other analysis, is used to model future training places.



Note: The student intake reference group includes members from the Royal College of Nursing, NHS boards and representatives from social care and universities.

Source: Audit Scotland

75. Unlike the medical model, the nursing and midwifery model does attempt to factor in future demand for healthcare. The nursing and midwifery model uses NHS board workforce outturn numbers for the last three years to estimate the population demand for the future. The Scottish Government then estimates years four and five by taking the trend of years one to three. Again, similar to the medical process, this does not consider any changes to what the future population's health needs will be. However, given that it takes significantly less time to train a nurse or midwife than a consultant, the impact is likely to be less pronounced.

76. All nurses are included on the UK Shortage Occupation List. This is a list of professions where there are not enough EU resident workers to fill the vacancies, and so non-EU residents can be sought for recruitment. This is on a UK-wide basis and not specific to Scotland. In March 2016, the Migration Advisory Committee published a review of nursing.⁴⁵ This stated that until recently workforce planning across the UK had not taken account of the demand for nurses in the care and independent sector, such as nurses working in care homes. This created a 'structural undersupply of nurses'. The Scottish Government had recognised this and updated its processes to take account of the care and independent sector. However, including nurses on the Shortage Occupational List is, in part at least, a result of this failure to factor demand from non-NHS employers into workforce planning. The report also noted the effect reductions in training places had on numbers of new nurses entering the profession, which we have considered in [paragraph 80](#).

The Scottish Government has not fully considered the impact of the ageing nursing and midwifery workforce

77. Nurses and midwives are the largest staffing group in the NHS. All NHS boards use nursing and midwifery workforce planning tools. These currently cover 98 per cent of the entire nursing and midwifery workforce and allow boards to understand short-term staffing need. The workforce tools also consider the balance of skills required among teams of nurses. This evidence is used alongside professional judgement to make local level workforce planning decisions. The Scottish Government has pledged to make safe staffing levels of nurses a legal requirement, and using such tools will help boards administer the staffing levels needed.⁴⁶

78. The Scottish Government has not fully considered whether nurses and midwives already in training, alongside other routes of nursing and midwifery recruitment, are enough to fill the gap left by those retiring. Over a third of nursing and midwifery staff in NHS Scotland are over 50 years old.⁴⁷ This is higher than the other NHS workforce groups we looked at and higher than the average for the Scottish population. A larger proportion of the nursing and midwifery workforce will be eligible to retire in the coming years. If this element of the workforce is not replaced, there are potential knock-on effects for delivering healthcare.

79. Nurses and midwives in pensionable employment before 1 April 1995 with 20 years' continuous service are classified as special class members by the Scottish Public Pensions Agency. This entitles qualifying nurses and midwives to retire at a normal retirement age of 55 years. The Scottish Government does not know how many of the existing workforce has special class status.

Exhibit 13

Number of students completing nursing and midwifery courses and vacancy rates for nurses and midwives

While the vacancy rate for nurses and midwives has been increasing, the number of students completing nursing and midwifery courses dropped in 2014/15 and 2015/16, then rose in 2016/17.



Source: Audit Scotland based on data from ISD Scotland and NHS Education for Scotland



80. In 2011/12, the Scottish Government reduced the training intake targets for nurses and midwives by 12 per cent, and a further ten per cent the following year. This was in response to lower projections from NHS boards and concerns about an oversupply of nurses and midwives. It takes around three to five years to become a qualified nurse or midwife. The effects of these prior cuts to the nursing and midwifery intake are now showing up as reduced numbers of qualified nurses and midwives available to enter the NHS workforce in Scotland. The number of newly qualified nurses and midwives in 2015/16 was 2,132, down from 2,284 (or seven per cent) the previous year ([Exhibit 13](#)). Since 2012/13, the Scottish Government has increased their target student intake each year for five years.

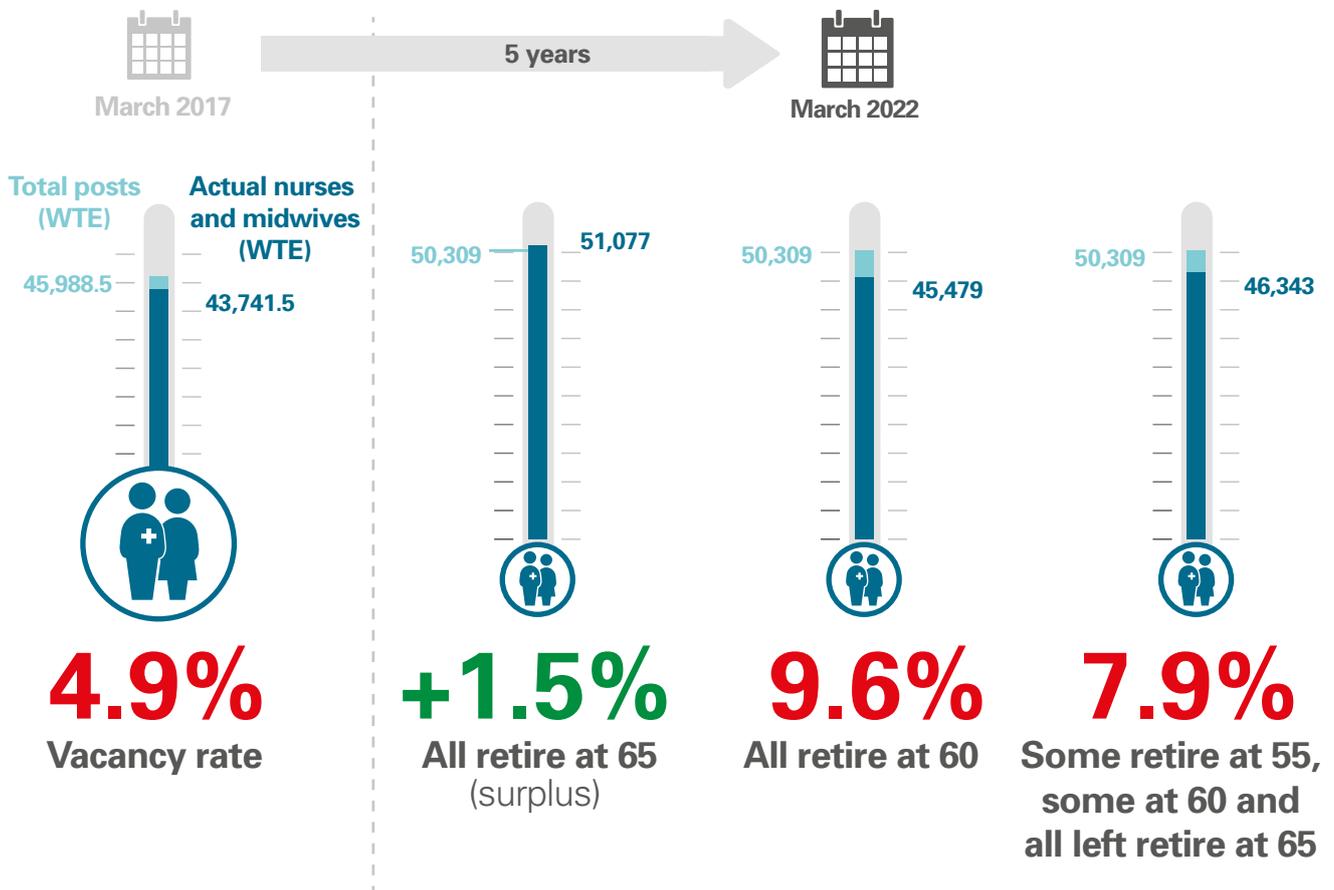
81. We have analysed the potential impact on the nursing and midwifery workforce of three possible retirement ages ([Exhibit 14, page 40](#)). Our analysis also assumes that the posts that the NHS needs to fill will continue to follow the same trend as in previous years, though this could be affected by changing demand and changes to service delivery. The data and assumptions used are in [Appendix 1](#).

82. The *NHS National Workforce Plan 2017* estimates that around 2,600 additional nurses and midwives will be needed by 2021/22 to meet demand. The plan acknowledges that between 2017 and 2020 the number of existing students entering the workforce will not be enough to meet demand. From 2018, the plan suggests student intakes and other actions will meet demand. After 2021, the supply of nurses and midwives is expected to increase and the demand for nurses and midwives is expected to decrease.

Exhibit 14

Projection of the potential future nursing and midwifery staff posts against actual staff, taking into account retirements and newly qualified nurses

Projecting the impact of different potential retirement ages shows the large differences in the impact this could have on the nursing workforce.



Notes:

- 1. The data refers to registered nurses and midwives, and does not include other nursing and midwifery staff.
- 2. See [Appendix 1 methodology](#)

Source: Audit Scotland using previous years' data from ISD Scotland and NES Education for Scotland

83. This estimate of the number of additional nurses and midwives needed by 2021/22 may be an underestimate. The Scottish Government has not fully incorporated future demand for healthcare and the impact of retirements from an ageing workforce:

- The estimated shortfall of nurses and midwives is based on NHS board projections up to 2018 and one per cent annual growth beyond this. We have previously noted that NHS board projections do not fully reflect existing workforce pressures. Also, it is not clear why a one per cent annual growth is a realistic assessment of demand after 2018. As noted elsewhere in this report, there has been no exercise to map future demand for healthcare across Scotland.
- The *NHS National Workforce Plan 2017* recognises that a high proportion of nurses and midwives are between 55 and 60 years old. Using past data on leavers may understate the impact of an increased number of retirements.
- The *NHS National Workforce Plan 2017* does not explain why demand for nurses and midwives is expected to decrease after 2021.

84. The *NHS National Workforce Plan 2017* plans to address the estimated shortfall in nursing and midwifery numbers in two ways:

- Adding 2,600 nursing and midwifery places over the next four years, 1,600 additional places on top of the 1,000 places already committed. The plan does not state the training and additional workforce costs associated with this increase in numbers. These measures will increase the NHS nursing and midwifery workforce, but not in time to address the critical shortfall period between 2017 and 2020.
- Increasing funding for Return to Practice programmes, alongside improved recruitment targeted at remote and rural areas, and attracting nurses and midwives from outside Scotland to join the workforce. The Scottish Government expects this to result in 1,300 additional nurses and midwives. No further details are given, although we note that in 2014/15 and 2015/16, 86 and 92 people respectively completed Return to Practice courses.

Future workforce planning should better consider the impact of different professions working together

85. The *NHS National Workforce Plan 2017* recognises that managing increased pressures is not purely about increasing overall staff numbers. Part of dealing with workload pressures is ensuring that the workforce has the correct balance (skills mix) between doctors, nurses and midwives and other healthcare professionals. It is also about assessing whether the NHS staff have the skills they need.

86. The Scottish Government's delivery plan for AHPs in 2012 identified areas where AHPs could maximise their skills, including:

- radiography reporting – by using radiographers for reporting on X-rays, easing pressures on radiologists within the medical team
- working in A&E departments – AHPs working with doctors and nurses to identify avoidable admissions to hospitals and patients who are ready to be discharged.⁴⁸

87. Certain AHPs are included on the UK Tier 2 Shortage Occupation List. Medical radiographers and paramedics who could potentially be used to progress the earlier examples, are included on the list. While shortages exist within these professions, the AHP delivery plan may struggle to deliver its goals. There is little national evidence from the Scottish Government's review of the delivery plan in 2015 of the changing impact AHPs made in this period, as the plan did not set out the government's expected outcomes to measure success against. The AHP strategy ran up until 2015. Currently no new strategy is in place although we are informed this is being developed.

88. The Scottish Government does not set the number of university places for AHPs.⁴⁹ Planning training numbers for doctors, nurses and midwives involves specific modelling to help arrive at future projections, but the AHP process does not. Training agreements between NHS boards and universities tend to be based on supplying work placements for minimum agreed numbers, based on what NHS boards have provided historically. It is not clear whether the number of AHPs being recruited by universities is enough to meet the future needs of the NHS in Scotland. The *NHS National Workforce Plan 2017* predicts that the demand for AHPs is likely to increase. The Scottish Government is exploring whether to control numbers for larger AHP groups, in particular radiography, physiotherapy and occupational therapy.

89. As well as AHPs, advanced nurse practitioners (ANPs) are contributing to the skills mix by undertaking more complex clinical roles traditionally carried out by doctors. For example, NHS Borders and NHS Tayside employ neonatal ANPs and paediatric ANPs to work alongside consultant paediatricians. The Scottish Government intends to increase the number of ANPs by 500 by 2021. A standard definition of ANPs has only recently been agreed. Historically, the term ANP has not been applied consistently between NHS boards, and as such it is unknown at a national level how many ANPs fitting the definition currently exist, and what they currently do. It is not clear if the 500 ANPs will be new nurses or will be trained from the existing nursing staff.

90. There are different arrangements for recruiting to different professions in the NHS. Each of the professions within the NHS can demonstrate that they consider the mix of skills required within their own profession. Nursing and midwifery, medical and dental professions have their own student intake processes; however, the individual recruitment processes do not adequately consider the skills required of the NHS as a whole when making decisions about future numbers within each group of professions. Each recruitment process is separate and does not consider collectively the distribution of work across professional groups.

Endnotes



- ◀ 1 *Overall NHS Scotland workforce summary by staff grouping*, ISD Scotland, June 2017.
- ◀ 2 *NHS consolidated accounts*, Scottish Government, June 2017.
- ◀ 3 [Scotland's NHS workforce](#) , Audit Scotland, February 2017.
- ◀ 4 [NHS in Scotland](#) , Audit Scotland, October 2015.
- ◀ 5 [Health and social care integration](#) , Audit Scotland, December 2015.
- ◀ 6 *Managing the supply of NHS clinical staff in England*, National Audit Office, February 2017.
- ◀ 7 A small number of staff working in GP surgeries may be employed by NHS boards, and are included in the data, where they cannot be separated.
- ◀ 8 <http://www.audit-scotland.gov.uk/reports/e-hubs/transforming-health-and-social-care-in-scotland>
- ◀ 9 *National Health and Social Care Workforce Plan – Part 1*, Scottish Government, June 2017.
- ◀ 10 *National Health and Social Care Workforce Planning: Discussion Document*, Scottish Government, February 2017.
- ◀ 11 *NHS Scotland staff survey 2015 national report*, Scottish Government, December 2015. 160,635 NHS Scotland employees were invited to take part and there was a 38 per cent response rate.
- ◀ 12 RCN survey, 2016. The RCN is a union and professional body representing nursing. It surveyed nursing staff across the UK, and almost 1,000 responded in Scotland.
- ◀ 13 The GMC is an independent body that oversees the registration and education of doctors in the UK. It runs an annual survey of all doctors in postgraduate training in the UK. In 2016, 5,124 were surveyed in Scotland, and there was a response rate of 98.7 per cent.
- ◀ 14 *Waiting times data*, ISD Scotland, June 2017.
- ◀ 15 *The clinical radiology workforce in Scotland: 2015 census report*, Royal College of Radiologists, September 2016.
- ◀ 16 *University Hospital Crosshouse - care of older people inspection report*, HIS, January 2017; *Queen Elizabeth University Hospital - care of older people inspection report*, HIS, October 2016.
- ◀ 17 [NHS in Scotland 2016](#) , Audit Scotland, October 2016. Agency staff are staff employed by a commercial organisation and supplied to the NHS as temporary staff. Agency workers can be clinical or non-clinical.
- ◀ 18 Audit Scotland analysis based on review of NHS boards' annual accounts. Spending on agency staff includes both clinical staff, who provide patient care and treatment, and non-clinical staff.
- ◀ 19 [The 2014/15 audit of NHS Tayside: financial management](#) , Audit Scotland, October 2015.
- ◀ 20 [The 2015/16 audit of NHS Tayside](#) , Audit Scotland, October 2016.
- ◀ 21 *Bank and agency nursing and midwifery comparison*, ISD Scotland, June 2017 and *Scottish Health Service Costs year ended 31 March 2015*, ISD Scotland – for NHS employee costs.
- ◀ 22 [Using locum doctors in hospitals](#) , Audit Scotland, June 2010.
- ◀ 23 *NHS Scotland complaints statistics 2015/16*, ISD Scotland, October 2016. Complaints data includes territorial boards, but not national boards, as this data is only available from 2013/14, and is not broken down by staff group.

- ◀ 24 *National Workforce Planning Framework 2005 guidance (HDL 52)*, Scottish Government, November 2005.
- ◀ 25 *Revised Workforce Planning guidance 2011 (CEL 32)*, Scottish Government, December 2011.
- ◀ 26 The nursing workforce consists of registered nurses and non-registered health care assistants and assistant practitioners.
- ◀ 27 [Health and social care integration](#) , Audit Scotland, December 2015.
- ◀ 28 [NHS in Scotland 2016](#) , Audit Scotland, October 2016.
- ◀ 29 Evidence sessions were held in October and November 2016. The findings of the Health and Sports Committee were set out in a letter to the Cabinet Secretary for Health and Sport on 9 December 2016.
- ◀ 30 *Health and Social Care Delivery Plan*, Scottish Government, December 2016.
- ◀ 31 *NHS Scotland: Guidance on Regional Planning for Health Care Services, NHS HDL (2002) 10*, Scottish Government, 2002.
- ◀ 32 *Health and Social Care Delivery Plan*, Scottish Government, December 2016.
- ◀ 33 *Creating a World Class NHS*, NHS Scotland, August 2015.
- ◀ 34 Motion S5M-02355: Scotland values its EU workforce and their contribution to health and social care, date lodged 7 November 2016.
- ◀ 35 From the annual population survey, a Scotland-wide survey that covers topics including employment, education and health.
- ◀ 36 *The relationship between the primary medical qualification region and nationality at the time of registration*, General Medical Council working paper, March 2017.
- ◀ 37 *Health and Social Care Delivery Plan*, Scottish Government, December 2016.
- ◀ 38 *Pan Scotland Workforce Planning Assessment and Recommendations*, Debbie Donald, Programme Director Pan Scotland Workforce Planning, March 2014.
- ◀ 39 [Scotland's public sector workforce](#) , Audit Scotland, November 2013.
- ◀ 40 The National Burden of Disease, Injuries and Risk Factors Study is being conducted by the Scottish Public Health Observatory teams in NHS National Services Scotland and NHS Health Scotland.
- ◀ 41 *Reshaping the Medical Workforce Guidance on Projecting Future Medical Requirements within Clinical Workforce 2009-2014 (CEL 28 2009)*, Scottish Government, June 2009.
- ◀ 42 A Certificate of Completion Training confirms that a doctor has completed approved training and is eligible for the Specialist Register.
- ◀ 43 Based on analysis of data provided to Audit Scotland by ISD Scotland as at March 2017, and 2016 trainee data provided by GMC. See Appendix 1 for further information.
- ◀ 44 Data provided to Audit Scotland by ISD Scotland, as at March 2017.
- ◀ 45 *Partial Review of the Shortage Occupation List: Review of Nursing*, Migration Advisory Committee (MAC), March 2016. The MAC provides advice to the UK Government on migration issues, including which occupations should be included on the Shortage Occupation List.
- ◀ 46 *A Plan for Scotland: The Scottish Government's programme for Scotland 2016/17* sets out that safe staffing will be enshrined in law starting with the nursing and midwifery workforce planning tools.
- ◀ 47 *Overall NHS Scotland workforce summary by staff grouping*, ISD Scotland, June 2017.
- ◀ 48 *AHPs as agents of change in health and social care: the National Delivery Plan for the Allied Health Professions in Scotland 2012-15*, Scottish Government, 2012.
- ◀ 49 The exception to this is orthotics and prosthetics, where numbers are planned by the Scottish Government.

Appendix 1

Audit methodology



We gathered evidence for the audit by:

- reviewing documents including NHS board-level workforce plans, strategic plans, internal audit work and reports published by other organisations such as the National Audit Office
- analysing workforce data for trends, and existing surveys carried out with patients and members of the NHS workforce
- interviewing a range of stakeholders, including a sample of NHS boards and bodies representing the NHS workforce, such as the British Medical Association, the Royal College of Nursing and the Allied Health Professions Federation Scotland
- liaising with stakeholders in the Scottish Government, NHS Education for Scotland and NHS National Services Scotland among others.

Data in the report refers to both territorial and national boards such as NHS Education for Scotland. Territorial boards are referred to when giving examples of highest or lowest, as the small numbers of staff in the national boards can skew the numbers.

Methodology for nursing and midwifery workforce projections (Exhibit 14)

- Assumes that the nursing and midwifery posts required will continue to increase at the same rate as the last five years.
- Assumes nursing and midwifery student completion figures will continue to increase at the same rate as intakes have done in previous years.
- Uses information on current nursing and midwifery workforce working patterns, and assumes new nurses and midwives will follow a similar pattern.
- Takes into account the approximate percentage of nursing and midwifery graduates who will go on to employment in NHS Scotland.
- Does not include information on nurses working in GP surgeries as there is a lack of complete information on this staff group.
- From published leaver and joiner information it is not possible to identify who is leaving due to retirement, as opposed to seeking employment elsewhere, or which new starts are newly qualified nurses and midwives.

Therefore this information has not been used, and the model does not take into account those who started or left for other reasons.

- The third scenario assumes a third of nurses and midwives currently between 50 and 55, a third of nurses and midwives between 55 and 60, and all those over 60 will retire in the next five years.

Methodology for consultant specialty shortages

- For this exercise we assume that consultants retire at 60 years and that new consultants continue to work the same working pattern as the current consultants do.
- Uses ISD and GMC data, using specialties that could be matched. Excludes those indicated in ISD as new categories that had disproportionately high numbers of trainees to consultants, and core and foundation trainees.

Appendix 2

Advisory group members



Audit Scotland would like to thank members of the advisory group for their input and advice throughout the audit.

Member	Organisation
Jean Allan	NHS Education for Scotland
Sushee Dunn	Royal College of Physicians Edinburgh
Sean Gallimore	British Medical Association
Paul Hawkins	NHS Fife
Grant Hughes	Scottish Government
Sian Kiely	Royal College of Nursing Scotland
Robert Peat	Allied Health Professions Federation for Scotland

Note: Members sat in an advisory capacity only. The content and conclusions of this report are the sole responsibility of Audit Scotland.

NHS workforce planning

The clinical workforce in secondary care

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