NHS Education for Scotland

NES/18/39

AGENDA FOR THE ONE HUNDRED AND FORTIETH BOARD MEETING

Date: Monday 28th May 2018
Time: 1.30 p.m.
Venue: Meeting Room 6, Westport 102, Edinburgh

1. Chair's introductory remarks

2. Apologies for absence

3. Declarations of interest

4. Minutes of the One Hundred and Thirty-Ninth Board Meeting — NES/18/37
To approve the minutes of the meeting held on 14th April 2018. — (Enclosed)

5. Actions from previous Board Meetings — NES/18/38
For review. — (Enclosed)

6. Matters arising from the Minutes

7. Chair and Chief Executive updates

a. Chair's Report — Oral report

b. Chief Executive's Report — NES/18/40 (Enclosed)

8. Governance and Performance Items

a. Finance Report *(A. McColl)* — NES/18/41
For consideration. — (Enclosed)

b. Audit Committee: 12th April *(D. Steele)* — NES/18/42
To receive a report and the minutes. — (Enclosed)

c. Staff Governance Committee: 26th April *(S. Stewart)* — NES/18/43
To receive a report and the minutes. — (Enclosed)

9. Strategic Items

a.	Digital Development Entity (DDE) *(C. Lamb and L. Elliot)* To consider a proposition.	NES/18/44 (To Follow)
b.	Strategic Review 2019-24 *(D. Cameron)* For consideration and approval.	NES/18/45 (Enclosed)
c.	Children and Young People *(J. Thomson)* For consideration.	NES/18/46 (Enclosed)

10. Items for Noting

a.	National Health & Social Care Workforce Plan: Part 3 - Improving workforce planning for primary care in Scotland	(Enclosed)
b.	Training and Development Opportunities for Board Members For information.	NES/18/47 (Enclosed)

11. Any Other Business

12. Date and Time of Next Meeting

Thursday 28th June 2018 at 10.15 a.m. (N.B. followed by a Board development session)

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May 2018
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IN CONFIDENCE **NES/18/37**

NHS Education for Scotland

MINUTES OF THE ONE HUNDRED AND THIRTY-NINTH BOARD MEETING HELD ON THURSDAY 19th APRIL 2018 AT WESTPORT 102, EDINBURGH

Present: Mr David Garbutt (Chair)
Ms Susan Douglas-Scott, Non-executive member
Ms Liz Ford, Employee Director
Professor Stewart Irvine, Director of Medicine
Mr Douglas Hutchens, Non-executive member
Ms Caroline Lamb, Chief Executive
Mrs Audrey McColl, Director of Finance
Dr Doreen Steele, Non-executive member
Ms Susan Stewart, Non-executive member
Dr Andrew Tannahill, Non-executive member
Mrs Karen Wilson, Director of NMAHP

In attendance: Mr David Ferguson, Board Services Manager (Board Secretary)
Dr David Felix, Postgraduate Dental Dean
Ms Dorothy Wright, Director of Workforce
Mr Donald Cameron, Director of Planning and Corporate Resources
Mr Christopher Wroath, Director of Digital
Ms Sandra Walker, Non-executive member from June 2018
Dr Eleri Williams, Scottish Clinical Leadership Fellow
Mr Geoff Huggins, Scottish Government (particularly for agenda item 14)
Ms Liz Elliot, University of Edinburgh (particularly for agenda item 14)
Ms Mary-Jo O'Brien, Corporate Communications Manager
Mr James McCann, Executive Officer, Executive Office

Part One: Business Meeting

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Carole Wilkinson.

2. DECLARATIONS OF INTEREST

The following declarations of interest were made and noted:

- David Garbutt will remain as the Chair of the Scottish Ambulance Service Board until the end of May 2108.

- Susan Douglas-Scott has been appointed as the Chair of the Golden Jubilee Foundation Board from June 2018.

3. CHAIR'S INTRODUCTION

The Chair welcomed everyone to his first Board meeting since taking up appointment as Chair with effect from 1st April 2018.

Particular welcomes were extended to Sandra Walker, who will be joining the Board as a new non-executive in June 2018 and who was attending to observe for interest, and to Dr Eleri Williams, a Scottish Clinical Leadership Fellow, who was shadowing Professor Stewart Irvine (Medical Director) at this meeting.

The Board noted that Geoff Huggins, accompanied by Liz Elliot, would join the meeting to give a verbal report on the Digital Health and Care Strategy for Scotland, at agenda item 14.

The Chair advised that Susan Douglas-Scott and Carole Wilkinson will complete their terms of office as Board members at the end of May 2018 and thanked them both for their excellent contributions to the work of the Board and its committees since June 2010. It was noted that arrangements are in hand for an informal Board dinner to say farewell to Susan and Carole.

On behalf of the Board, the Chair congratulated Susan Douglas-Scott on her recent appointment as the new Chair of the Golden Jubilee Foundation Board.

4. CHIEF EXECUTIVE'S REPORT (NES/18/29)

The Chief Executive introduced her report, which provided information and updates on a wide range of NES activity, highlighting the following points:

- The NES Scottish Improvement Leader (ScIL) programme's receipt of the Annual Education Award from the Institute for Continuous Improvement in Public Services (ICiPS).
- The NES's Design Team's receipt of the NHSScotland 'Best Graphic Design' award for the second year running.
- The NES Cognitive Rehabilitation in Dementia resource has been shortlisted for two UK awards.
- An update on the forthcoming 8th Scottish Medical Education Conference, which will run alongside the NMAHP Conference for the first time.
- The successful recent launches of Turas Appraisal and Turas People. It was confirmed that Turas Appraisal is accessible to the IJBs. It was noted that Turas People will feature live links to other external record-keeping systems and has the potential to enable data-sharing across health and social care.
- The NES Digital team have been working closely with the Care Inspectorate, which has embarked on a digital transformation project.
- A successful National Dental Conference took place on 20th March.
- The welcome shift to a healthy excess of appointable dental trainers.

- The full reports of the recent GMC National Review of Scotland should be available in time for consideration at the May meeting of the Educational and Research Governance Committee.
- The GMC National Training Surveys are now live and it was noted that the issue of burnout has been addressed in the survey for the first time.
- Detailed information was provided on the background to the new GP Contract and the implications for NES. This issue will be brought back to the Board once further clarity is available.
- An update on the case of a junior doctor who was recently removed from the medical register and which has generated a great deal of interest in the medical profession and the media.
- A recent National Conference and Graduation Event for Cohort 8 Dementia Champions and Cohort 2 Dementia Specialist Leads.
- An update on NES's collaborative work with the Scottish Ambulance Service in relation to paramedic education.
- The launch of a new e-learning module entitled 'NES Older Adult Module – Promoting Positive Psychological Wellbeing', which will be widely available for staff working across health and social care.
- The Chief Executive's appearance before the Scottish Government Public Audit and Post-Legislative Scrutiny Committee, in her role as Chair of the NHS Tayside Transformation Group. Some discussion took place on significant subsequent developments, notably the recent appointments of a new Acting Chief Executive and Interim Chair at NHS Tayside.
- Attention was drawn to some recent updating of the Corporate Risk Register (which is routinely appended to the Chief Executive's Report).

The following points arose in discussion:

- It was noted that, in view of recent events in NHS Tayside, all NHS Board Chairs were asked to submit reports to the Chief Executive of NHSScotland on their treatment of endowment funds. It was noted that NES has no endowment funds as such but will submit a report in relation to its relationship with a charity associated with one of NES's predecessor bodies.
- Some discussion took place on the GP clusters which will drive and coordinate GP practice QI activity, in terms of the new GP Contract, and NES's key role in supporting training for QI activity in these clusters. It was understood that all GP clusters will require to have an identified QI Champion.

5. MINUTES OF THE ONE HUNDRED AND THIRTY-EIGHTH BOARD MEETING HELD ON 8TH MARCH 2018 (NES/18/26)

The minutes of the previous Board meeting were approved. **Action: DJF**

6. ACTIONS FROM PREVIOUS BOARD MEETINGS (NES/18/27)

The Board noted that all of the action points were completed or in hand.

7. MATTERS ARISING FROM THE MINUTES

There were no matters arising which did not feature elsewhere on the agenda.

8. GOVERNANCE AND PERFORMANCE ITEMS

a. Finance Report **(NES/18/30)**

Audrey McColl introduced a paper which presented the financial results for the eleven months to 28th February 2018 and indicated the anticipated forecast outturn as at 31st March 2018. The following points were highlighted:

- The forecast underspend at the end of February 2018 is £99,000, compared to a forecast underspend in January of £258,000.
- There is some indication of slippage during March and it is anticipated ending the financial year with a small underspend of less than £500,000.
- The main focus now is on managing the year-end position as carefully as possible. Accounting adjustments have still to be made and some of these will be dependent on advice from Scottish Government on the treatment of any underspend which may be carried forward into 2018-19.

The following points arose in discussion:

- It was confirmed that extra checks will be carried out on medical training grades expenditure in future to ensure greater accuracy.
- Attention was drawn to the fact that final allocations required are currently being discussed with Scottish Government, with a final position likely to be agreed in mid-April. Audrey McColl confirmed that NES is in regular contact with Scottish Government Finance colleagues throughout the year and is appreciative of their pragmatic and helpful approach.
- It was advised that the slippage into 2018-19 of part of the cost of the new mobile clinical skills unit was due to the timescale and value of the tender. It had not been possible to deliver all of the component parts by the end of 2017-18.

Following discussion, the Board noted and was content with the information contained in the Finance Report.

b. Finance and Performance Committee: 16th February 2018 **(NES/18/31)**

The Board received and noted the unconfirmed minutes and a summary, which were introduced by the Chief Executive.

It was highlighted that the committee had been assured that NES has a programme of work in place to address the implementation of the new EU General Data Protection Regulations (GDPR).

c. Educational and Research Governance Committee: 22nd February 2018 **(NES/18/32)**

The Board received and noted the unconfirmed minutes and a summary, which were introduced by Andrew Tannahill. Andrew confirmed that this had been his last meeting as Chair of this committee and that he had held a handover meeting with Douglas Hutchens, the new committee Chair.

In response to a recommendation from the committee, the Board agreed to receive, at an appropriate time, an update on the corporate position regarding NES's communication with integrated joint boards (IJBs) and community planning partnerships.

In response to a question from the Chair, Professor Stewart Irvine explained that a training site may be subject to Enhanced Monitoring by the General medical Council (GMC) and NES where a training programme or NHS Board is experiencing difficulty in meeting GMC standards and/or curricular requirements.

9. ITEMS FOR NOTING

a. NES Medical Directorate Research & Innovation Report **(NES/18/33)**

The Board received and noted a report highlighting the scope of research activity within the Medical Directorate, which had been circulated largely for information. The Board was impressed by this comprehensive and useful report.

Professor Stewart Irvine commended this report to the Board as firm evidence that NES's educational activities are based on evidence and best practice. It was noted that the Scottish Government has welcomed this report as a source of support for a number of its policy objectives.

The Board noted that the report had been shared with Medical Directors and Directors of Medical Education in NHS Boards and agreed that it would also be useful to share it with NHS Board Chairs and Chief Executives. **Action: DSI**

b. Partnership Forum: 22nd March 2018 **(NES/18/34)**

The Board received and noted the unconfirmed minutes and a summary, which were introduced by Caroline Lamb.

c. Training and development opportunities for Board members **(NES/18/35)**

The Board noted a paper providing information on upcoming training and development opportunities for Board members.

10. ANY OTHER BUSINESS

There was no other business.

11. DATE AND TIME OF NEXT MEETING

The next Board meeting will take place on Thursday 28th June 2018 at 10.15 a.m.

(Post-meeting note: As a result of the discussion at item 14 in Part Two of the agenda, there is likely to be an additional Board business meeting towards the end of May 2018)

Part Two: Strategic Update

12. NES ROLE, HISTORY and DEVELOPMENT

The Chief Executive gave a presentation covering the following main areas:

- 2002: A National Special Health Board with responsibility for training, education and workforce development
- 2002- 2012: Extension across the NHS Workforce (increasing emphasis on multi-professional work too)
- Roles and Responsibilities (Undergraduate education; Postgraduate education; Professional development and training; Educational infrastructure)
- Delivered in Partnership (work with multiple stakeholders)
- 2012-2017: Extension of Scope (extension of core business and taking new initiatives on board)
- 2018 and beyond. What next? (Maintaining core business; Sustainable Workforce; Single Employer?; Digital solutions; Improved data and planning)
- NES Strategic Framework 2014-19
- NES Strategic Framework 2019-24? Do our existing Vision and Mission reflect our extended range and ambition?

The presentation gave rise to a brief discussion, resulting in the following main points:

- The Board welcomed the presentation, which will be very helpful for induction purposes, and it was agreed to circulate copies for information and reference.

  Action: DJF
- It may be useful to indicate in the slides that the Clinical Skills Units in Forth Valley and Tayside are both national facilities.
- It will be necessary to develop a new Strategic Framework during 2018-19 and a paper on this will be brought to the Board in due course.

13. NATIONAL BOARD COLLABORATIVE PLAN (NES/18/36)

The Chief Executive introduced the paper 'Changing to Deliver' – National Board Plan 2018-23 (National Boards Collaborative) and a cover paper advising the Board of its submission to the Scottish Government. It was noted that Sustainable Workforce and National Business Systems are strong themes within the National Boards Plan and that NES has been asked to make a key contribution in developing these areas. The briefings in the cover paper set out further detail on the investment proposals

contained in the National Board Collaborative Plan to transform NHS Scotland Business Systems and to help shape a more sustainable workforce.

The Chief Executive also gave a presentation, which covered the following main areas:

- National Board Collaboration: the challenges undertaken
- Two Crunch Questions - 1. Is Scotland's Health and Social Care system **sufficiently equipped** to undertake large scale system re-design?; and 2. What would **real value-add** from the National Boards look like in the light of answers to question 1. above?
- Three Missing Pieces (in responding to system pressures) – Improvement, Transformation and Evaluation; Digitally Enabled Service Re-design; and Sustainable Workforce
- Contributions to system pressures
- Current status/next steps
- The NES Contribution – Part 1: Sustainable Workforce (led by NES)
- The NES Contribution – Part 2: Business Systems and eRostering (led by the NES Chief Executive and Director of Digital)
- Questions and Comments?

The following points were highlighted during the presentation:

- The National Board Plan is not yet in the public domain.
- The Plan was submitted to Scottish Government on 4th April and it is hoped that there will be approvals/decisions from Scottish Government in June, setting out what is required from NES and the resources assigned for the delivery of the pieces of work identified.

Some discussion followed, from which the following main points emerged:

- The Chief Executive acknowledged Donald Cameron's significant contribution to the drafting of the Plan.
- It was noted that some NHS Boards are seeking further clarity in relation to the longer-term governance for the regional and national arrangements.
- The importance of cross-sectoral working in delivery of the Plan was recognised.
- The Board recognised that this is an iterative process and that the Plan will firm up once the specific areas of work and associated resourcing are clarified. In the meantime, it will be important to achieve as much buy-in as possible and begin to build the momentum required for transformational change.

Following discussion, the Board thanked the Chief Executive for her useful presentation, noted the papers with interest and was content with the present direction of travel.

14. DIGITAL HEALTH AND CARE STRATEGY FOR SCOTLAND

Geoff Huggins (Scottish Government Director for Digital Health and Social Care) and Liz Elliot (University of Edinburgh) were welcomed to the meeting for this item. Geoff gave a verbal report on the emerging Digital Health and Care Strategy for Scotland. He began by outlining the current challenges in relation to the digital position in health and social care, which include:

- Multiple systems across Scotland
- Quality issues
- Potential for harm to patients, arising from issues relating to access to or delay in treatment
- Need for 'work-arounds' to address bottle-necks
- High cost and low flexibility
- Lack of control over current technology

Geoff then highlighted that the drivers for change include:

- The need to do something different
- An expert panel has stressed the need for a paradigm shift
- Strong evidence obtained during a consultation exercise
- A range of information governance issues
- A need to own the capability

The essential features of the emerging Digital Health and Care Strategy for Scotland (which will be published soon) were outlined:

- The strategy will be relatively brief, covering six key areas: national governance and direction of system operation; information governance issues, including secondary use of data; clear approach to service transformation, with digital as part of the service; workforce development (specialist and general roles); creation of a national platform; and transition process
- Three key considerations: creation of data at point of care; compatibility with other architecture; development of data to enable innovation

Geoff Huggins concluded his presentation by outlining the principles and proposition in relation to taking matters forward:

- The new system will require to be embedded in the NHS and be capable of application across the wider public sector.
- Scottish Government is looking for a NHS host for this development, to ensure robust protection and governance.
- NES is seen as the most appropriate host, in view of its excellent track record on digital transformation and development.
- Resources are in place for 2018-19.

The Chair thanked Geoff Huggins for his interesting and thought-provoking presentation and invited comments and questions. The following are the main points raised in discussion:

- It was clarified that the Scottish Government will support the progress of the overarching strategy.
- The importance of a robust financial plan was emphasised.
- In terms of the proposed hosting of the new development, accountability would sit with the NES Board, with a sub-board perhaps having specific responsibility for taking matters forward.
- The new system will be cloud-based and so should reduce costs and improve security.
- Positive engagement from the territorial NHS Boards will be key and it was noted that there has been a generally positive response from them so far.
- There was endorsement of the intention for an early focus on the area of primary care.
- The proposed system was viewed as potentially very beneficial to both patients and clinicians.

Following discussion, the Board was very supportive in principle of NES taking on the hosting of this important new development work and recognised the need to articulate the associated governance and resource issues.

Geoff Huggins thanked the Board for their in principle support and undertook to produce a formal proposition to put to the Board in May, with a view to the new arrangements being put in place during June. A suitable date will be identified for a Board business meeting in late May. **Action: DJF**

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April 2018
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NHS Education for Scotland **NES** **NES/18/38**
Item 5 **(Enclosure)**

Actions arising from Board meetings: Rolling list **May 2018**

Minute	Title	Action	Responsibility	Date required	Status and date of completion
Actions agreed at Board meeting on 19th April 2018					
14	Digital Health and Care Strategy for Scotland	Identify a date in late May for a Board meeting to consider the Scottish Government's Digital Development Entity (DDE) proposition.	David Ferguson	May 2018	DDE proposition to be considered at a Board meeting on 28th May 2018
Actions agreed at Board meeting on 8th March 2018					
10d	Medical Revalidation	(i) Raise the possibility of diverting funding from HIS for the purposes of producing the Scottish annual overview report in future.	Stewart Irvine	Ongoing	The issue of resources for the production of the Scottish annual overview report has been referred to the next meeting of the Scottish Government-led Responsible Officer Network.
		(ii) Consider the suggestion that it may be useful for the Board to consider, at some point, the suggested questions for boards and other governing bodies set out on pages 46-47 of the Pearson review report.	Stewart Irvine	Ongoing	The GMC has advised that, following the Person Review, and in relation to the questions of governance, they are amending and updating the Governance Handbook and expecting to re-issue this in the Autumn.
Actions agreed at Board meeting on 24th January 2018					
8ci	Revised Risk Management Strategy	Take account of the discussion points in finalising the revised strategy	Audrey McColl	Ongoing	Ongoing
8d	Revised Audit Committee Remit	Take account of the discussion points when the Audit Committee next reviews its remit.	Audrey McColl	January 2019	Ongoing

CHIEF EXECUTIVE'S REPORT

Caroline Lamb, Chief Executive

May 2018

1 INTRODUCTION

The agenda for our Board meeting today contains substantive items on proposals for the new Digital Development Entity (as introduced at the April Board), our approach to developing the NES Strategic Framework for 2019-24 and a paper on the contribution NES is making to Children and Young People's health and wellbeing in Scotland.

2 ANNOUNCEMENTS

NHSScotland 70th Anniversary Celebrations

Thursday 5 July 2018 marks the 70th Anniversary of the National Health Service. NHSScotland and the Scottish Government will be working with a wide range of partners to celebrate 70 years of the NHS in Scotland and everyone is being encouraged to get involved.

In NES, we will be holding regional 'tea parties' during the week of 2 – 6 July to give our staff the opportunity to get together and look back and celebrate 70 years of achievement in Scotland and the difference the NHS has made to people's lives, the contributions that staff in NES have made and how we can continue to take forward the founding principles of the NHS in the future. We are also taking the opportunity to thank staff for their continued hard work and commitment whilst acknowledging the constantly changing landscape and challenges they face. We would like to encourage Non-Executives to attend these events and we will send further information once the tea party dates are finalised.

Changes to membership of the NES Board

In light of the amended schedule of 2018-19 Board meeting dates, this meeting is now the final one to be attended by Susan Douglas-Scott and Carole Wilkinson. We are holding a farewell for dinner for Susan and Carole on 30 May. Linda Dunion and Sandra Walker formally join the Board as our new Non-Executive members from 1 June.

3 STRATEGIC UPDATE

National Boards Delivery Plan

The National and Regional board delivery plans have been presented to both the Cabinet Secretary and First Minister and we are awaiting formal feedback. Donald Cameron is working with Phil Raines (Health Workforce & Strategic Change directorate at Scottish Government) to develop a 'Scotland Narrative' which will be used when consulting with stakeholders and in communications with the general public. The narrative will aim to present an overarching picture of the financial, workforce and performance challenges faced across NHSS and the proposals for transformation that have been developed at a National and Regional level.

Through the Director of Finance, and Director of Planning representatives from the Regions and the National Boards, we are now working through a process to discuss and agree the transformation proposals that should be prioritised and the level of investment that will be required against the total funding available.

NES is leading on the proposals around developing a more sustainable workforce and on the work to move to new generation business systems for NHSScotland, including eRostering. In these areas we are continuing to try to maintain momentum in the period before we have full agreement, including confirmed funding.

Scotland's Digital Health & Care Strategy

This strategy was formally launched by COSLA and Scottish Government on 25 April 2018 and is included in this meeting's Board papers as an appendix to item 9a. Liz Eliot from the University of Edinburgh will be joining the Board meeting to support any detailed questions around this item.

4 MEDIA INTEREST, COMMUNICATIONS AND EVENTS

April was a busy month in communications terms, with the NES events team organising our largest conference of the year - the combined Medical Education, Medical Appraisal, Practice Managers, Pharmacy, NMAHP and GP Nurses conference, with an attendance over two days of 1,500. Next up is the GP Trainers conference on 17 May with another 200 attendees.

In media terms, we issued news releases on the appointment of the new Chair, the 'Rethinking Remote' International Conference, NES Medical Awards, the positive GMC Scotland report and Community Pharmacist qualifications. We were involved in discussions with SG and other stakeholders around our responses to the ST3 recruitment issue, referred to in more detail at section 7; and were active both with two media statements and social media support for NES' position. In social media terms, among other things, we supported recruitment to the GP Rural Fellowship.

We have been preparing graphics and other materials such as animations and new consent forms to support both NES and the rest of the NHS comply with their responsibilities under GDPR (General Data Protection Regulation). We have also been supporting design aspects of the NES Annual Accounts and preparing for the NHS70th Anniversary with animations around the changing shape of NHS careers.

5 DIGITAL

Work continues to refine Turas People in relation to the staff engagement form and documentation functionality. NES Digital are also working up new functionality to support the e:ESS Programme Board.

The new General Data Protection Regulation (GDPR) becomes law on 25th May. This has highlighted concerns regarding Turas holding patient data information which are being worked through with information governance colleagues to provide reassurance to users and to ensure that all documentation is robust. Internally, a communications plan has encouraged staff engagement with GDPR in relation to current and future projects, requesting the imbedding of information governance procedures at the initiation stages of any given project.

Turas FNP (Family Nurse Partnership) has seen some revised and improved onboarding with the client transfer process and significant development work in relation to PowerBI reports. User experience testing continues on the reports that have been developed to date and the development team have prioritised changes that have arisen out of this exercise.

Turas Appraisal provides user friendly support to the KSF Personal Development Plan & Review process. The application also supports the new performance management arrangements for staff on Executive Cohort contracts Turas Appraisal successfully launched on 2 April for over 167,000 staff. User feedback for Appraisal has been very positive with the main areas of comment being:

- A clean, fresh, easy to use interface that is significantly easier to use that the system it superseded
- Delight at it being cross browser compatible, and mobile enabled
- Gratitude at it being part of a larger single sign-on platform that avoids the user having to remember multiple passwords.
- Turas Appraisal has been received very positively in my Board
- It helps to put the focus back on the discussion
- I like the positive language used in the Discussion Summary - helps to start the discussion with 'what went well this year

6 DENTAL

NES Dental's Dental Care Professions (DCP) workstream has created a new Unit for Scottish Qualification Authority (SQA), titled Oral Health Improvement Mentoring, at SCQF Level 5. This Unit is designed to enable individuals with no previous experience of oral health education to develop the knowledge and skills required to provide support to their peers around key oral health messages. This unit is to be delivered for the first time by Anne Crowe, Lead DCP Tutor in Dundee, at HMP Perth in May 2018; and then to be rolled out to other prisons within Scotland.

This is a very timely initiative as all Scottish prisons will be smoke-free by November 2018; and there is a significant requirement for both staff and prisoners to be educated on oral health and smoking cessation.

This is an example of multi-agency working to tackle health inequalities involving the Dental Health Services Research Unit, University of Dundee; Scottish Oral Health Improvement Prison Programme; Scottish Prison Service and NHS Health Scotland who had collaborated to produce a Mouth Matters Training Pack from which the unit has been developed.

7 MEDICINE

GMC National Review of Scotland

Following their national review of Scotland, completed during 2017, the GMC has now published their final visit reports, along with organisations' action plans. This exercise involved GMC team visits to all 5 of Scotland's medical schools (Aberdeen, Dundee, St Andrews, Edinburgh, Glasgow) to 8 of Scotland's NHS Boards (NHS Ayrshire and Arran, NHS Fife, NHS Grampian, NHS Greater Glasgow and Clyde, NHS Lothian, NHS Shetland, NHS Tayside, NHS Western Isles) and to the Scotland Deanery of NES. The GMC has now published reports relating to each organisation visited, as well as an overview report. These are available on the GMC web-site[1], and will be on the agenda for the NES E&RGC which meets before this Board meeting.

These reports paint a very positive picture of the state of medical education and training in Scotland. The GMC has noted areas of good practice where they have found 'exceptional or innovative examples of work or problem-solving' related to their standards – and they have drawn attention to the NES digital strategy, which works across different systems and disciplines to support learners and educators, and to the Inter-professional educational leadership demonstrated by the NES Executive team.

In addition, the GMC has identified 68 areas across all the organisations visited where they felt that education and training was working well. Inevitably, there were areas where the GMC felt that more work needs to be done to ensure that their standards continue to be met – and NES will be working with the GMC and with partners across Scotland to ensure that the areas of good practice are shared built upon, and the areas for concern are addressed. We particularly welcome the GMC's 'judgement that the deanery is aware of what is happening across Scotland and have robust systems in place for identifying and managing concerns over safety or quality.'

Education Conference 2018

The 8th Scottish National Medical Education Conference took place on 26 and 27 April 2018, in conjunction with the Medical Appraisal, Practice Managers, Pharmacy and NMAHP conferences. With over 1,500 registered delegates, this was the largest such event that NES has held. The mix of plenary, parallel and poster presentations was impressive and of a very high quality, and we were pleased that our new Chair was able to present the annual medical directorate awards. In association with this meeting, we have published our PGMET Annual Report for 2018[2].

Quality Management Visits

Board members will be aware that as part of our programme of Quality Management of Postgraduate Medical Education and Training, we undertake site visits to training

[1] https://www.gmc-uk.org/education/reports-and-reviews/regional-and-national-reviews#ScotlandNationalReview

[2] http://www.scotlanddeanery.nhs.scot/media/184588/pgtmedicalannualreport2018.pdf

environments where we have concerns about whether or not the Board are meeting GMC standards and delivering the relevant curricula. As part of this process, we have recently undertaken visits to mental health training sites in NHS Tayside, and Professor Irvine will be able to provide a verbal update to Board members.

Recruitment
On Thursday 3 May 2018, the Royal College of Physicians of London (which manages recruitment into higher training in the physicianly specialties on behalf of all four UK nations) became aware of an error in the ST3 medical specialty recruitment process which affected the final scores candidates received from the recruitment process. The error, which was a human error and not due to the IT systems used, meant that some candidates had been wrongly ranked. This meant that candidates may have received incorrect job offers. However, this error did not affect the decision taken on whether or not an applicant was appointable.

The RCP accepted full responsibility, apologised and after much work involving NES and partners across the UK, all affected applicants were contacted by email via RCP; and NES cascaded this information across our TPD and STB networks. Unfortunately, due to the complexity and interlinked nature of the offers process, it was necessary to reset the status of all candidates who were deemed appointable at interview and reissue the scores and ranks with new offers being issued on Thursday 10 May[3]. NES will be working with partners across the UK and in Scotland to ensure that trainees affected by this error are appropriately supported and will offer tailored support for trainees whose offers have changed as a result.

8 PSYCHOLOGY

Health Psychology
Health psychology have launched a MAP training programme in behaviour change for health and social care professionals in April 2018. The programme uses an evidence-based, practical approach on how to Motivate, put plans into Action, and how to support with environmental Prompts. The online module available on Turas is supported by face-to-face workshops and coaching[4].

Physical Health
On 10 May 2018, the Physical Health Workstream within the Psychology Directorate at NES published a series of five e-learning modules called PATH: Psychological Awareness Training for the Heart. The five modules (Communication, Cardiac Adjustment, Core Mental Health Skills, Anxiety and Depression) were designed for staff who wish to gain more knowledge and skills in taking a biospsychosocial approach in the cardiac setting. The modules were designed as part of a stepped care training pathway for cardiac staff, and they were reviewed by national experts.

9 WORKFORCE

Project Lift

[3] https://www.rcplondon.ac.uk/news/topic/st3-recruitment/news-type/news-article
[4] https://turasdashboard.nes.nhs.scot

NES is one of three Boards working directly with Scottish Government and contracted technical partners to deliver the different strands of Project Lift, the new approach for integrated values-based recruitment, performance appraisal, talent management and leadership development for executive and senior managers in NHS Scotland.

Following the introduction of Turas Appraisal for this group of staff in March 2018, and the provision of updated Good Practice Guidance in April, the new team based in O&LD have been working with technical partners, Silvermaple and Brigid Russell Consulting respectively, to develop and test the talent management process and leadership development model for aspiring directors. The talent management process will be delivered via a Turas linked App currently in development and due for release on 4 June 2018; complemented by career conversations during July and August with individuals identified as demonstrating high potential and readiness for their next move or for targeted leadership development. The leadership development for an initial cohort of 20 is expected to begin in October and be based around the “live work” of collaborative leadership projects. To ensure impact, the focus of these projects will be agreed with national and regional Implementation Lead Chief Executives.

NES is working closely on delivery planning with a Core Group Chaired by Dr Dave Caesar, National Clinical Adviser to the CMO, and involving representatives of the different collaborating organisations. Significant focus is currently being given to communications and engagement, with briefings and workshops for Chief Executives, Regional HR and OD Groups, and Medical Directors taking place in May, with a briefing for Chairs planned in June. These will be supplemented by two parallel sessions and a dedicated stand at the at the NHS Scotland Event in June. This engagement will include developing thinking about how best to establish and nurture a Scottish Leadership Community that will ensure support for both Project Lift participants and others with an interest in leadership moving forward. This will present an invaluable opportunity to market the significant range of programmes and resources that NES offers in respect of leadership development, management development and quality improvement.

CALENDAR

9 April

GPST Recruitment

I met with Stewart Irvine, Moya Kelly (Medicine) and David Bruce (Medicine) to discuss the disestablishment of GPST posts in the West region and the implications for future workforce development.

Meeting with EY

In relation to the NHSS Business Systems programme of work, I met with representatives from EY to discuss the work they have done in NHS England to modernise HR systems.

10 April

NES Executive Team
The Executive Team received a presentation from Anne Campbell (Workforce) on Turas Appraisal. We also reviewed and discussed our 2018-19 draft objectives which will be submitted to the Remuneration Committee on 31 May for approval.

National Boards Collaborative Programme Board
I attended this meeting where we discussed the National Board Delivery Plan with specific reference to the overall investment proposal and future communications/stakeholder engagement.

NHSS Chief Executives – Private Meeting
I attended this meeting where substantive agenda items included an update on the Scottish Trauma Network, a CHI business case and a finance and performance update from Christine McLaughlin (Director of Health Finance at Scottish Government). The Chief Executives also received a presentation on the NHSS Global Citizenship Programme, which was introduced by Catherine Calderwood (Chief Medical Officer).

11 April

NHSS Chief Executives Private Meeting with Paul Gray
I attended the monthly private meeting with Paul Gray.

NHSS Chief Executives – Strategy Meeting
Myself and the other Implementation Leads contributed to an item which focused on the National and Regional delivery plan submissions and planned next steps. Other substantive items included a discussion on the expansion of TAVI (Transcatheter Aortic Valve Implantation), a GDPR presentation given by the Information Commissioners Office and a paper/presentation regarding the improvement of services for victims of rape and sexual assault and healthcare in police custody.

Meeting with ERPaaS
In relation to the NHSS Business Systems programme of work, I met with representatives from ERPaaS to discuss how their technology platform enables the collection of automated HR data.

13 April

East Region Leads meeting
I attended this meeting where agenda items included a discussion on the East region delivery plan and an update on the regional capital investment programme.

Scottish Executive Nursing Directors (SEND)

I attended a meeting of the Scottish Executive Nursing Directors to present an update on the NHSS Business Systems programme of work, with particular reference to eRostering. As mentioned in the strategic update, improved rostering practice is a key area of focus for the Business Systems work going forward.

16 April

Health & Social Care Delivery Plan (HSCDP) National Programme Board
I attended this meeting where we discussed the National and Regional delivery plans, a progress update on the overall HSCDP implementation and papers on the Scottish Access Collaborative and the transformation of national planning processes. Christopher Wroath and Colin Tilley (NES) also gave a demonstration of the NES Workforce Planning platform which was positively received.

Meeting with Richard Foggo, Phil Raines and Isabella De Wit
Angiolina Foster and I met with colleagues from Scottish Government to discuss the implementation of the National Boards delivery plan.

19 April: Kate Burley

I met with Kate Burley (Associate Director, Scottish Trauma Network/STN) to discuss current and future developments in relation to the STN steering group, which I chair.

20 April: NHSS Implementation Leads

I attended this meeting at which Christine McLaughlin provided an update on the NHSS Financial Framework, with specific reference to the National and Regional delivery plans. Other substantive agenda items included an update on the Scottish Government timetable for reviewing the delivery plans and a paper on how delivery plan communications/media-related requests will be handled.

24 April

NES Executive Team
The Executive Team discussed their 2018-19 objectives, outcomes-focussed committee remits, the commissioning of paramedical education programmes and the NES People and OD Strategy.

Claire Sweeney
I met with Claire Sweeney (Audit Scotland) to discuss current issues.

25 April

Tom Power
I met with Tom Power (Head of Organisational Development, Leadership & Learning in NES) to discuss Project Lift developments and the current NHSS leadership landscape.

Annie Ingram and Susan Swan

I met with Annie Ingram (Director of Workforce, NHS Grampian) and Susan Swan (Deputy Director of Finance, NHS Borders) to discuss eRostering.

Geoff Huggins and Liz Elliot:
I met with Geoff Huggins and Liz Elliot to discuss the development of the Digital Development Entity and the plan to host this programme within NES. This will be discussed in detail at item 8a.

26 & 27 April

8th Scottish National Medical Education Conference, in conjunction with the Medical Appraisal, Practice Managers, Pharmacy and NMAHP conferences

I attended sessions on both days of these conferences and chaired a plenary session.

Scottish Medical Education Conference Dinner and Awards Ceremony

I attended an awards ceremony celebrating achievements in Scottish medical education during the last year. Professor Rowan Parks (Deputy Director of Medicine, NES) and David Garbutt presented the awards.

2 May: NHSS Business Systems – eRostering and Payroll

Christopher Wroath and I met with colleagues from PA Consulting and NSS to discuss the eRostering and Payroll workstreams and next steps for the overall Business Systems programme of work.

3 May: Sustainability & Value Programme Board

I am the Executive Lead for the workforce workstream of this programme board. I had a teleconference with Margaret Sherwood (National Elective Centre Programme Director) and Derek Lindsay (Director of Finance, NHS Ayrshire & Arran) to discuss 2017/18 year-end benefits and anticipated benefits for 2018/19.

4 May: NHSS Implementation Leads

I attended this meeting where we discussed the combined national and regional proposal for bids to the Scottish Government Transformation Fund. Other substantive agenda items included an approach to the overall 'Scotland Narrative' and associated public engagement activities.

8 May

National Boards Collaborative Programme Board
I chaired this meeting where substantive agenda items included papers on Lead Roles and Programme Resource processes and our Partnership Model. Updates were also provided on strategic communications and engagement, the overall National Boards Investment Proposal, a Target Operating Model for HR, and an

outline business case on the Advanced Life Support Monitor Defibrillator Unit Replacement Project.

NHSS Chief Executives - Private Meeting
I presented an update paper on eRostering and NHSS Business Systems at this meeting. The Chief Executives also received papers on Public Health Reform, the Oral Health Improvement Plan, Clinical Engineering, Finance & Performance, CHI and the British Sign Language (Scotland) Act and public body requirements for Local BSL Action Plans, which was developed by the NHSS E&D Lead Network.

9 May

NHSS Chief Executives - Strategy Meeting
The majority of this meeting was spent discussing Present and Future Financial Implications, which was introduced by a group of NHSS Directors of Finance. The Chief Executive also discussed an associated item entitled 'Our Strategy Going Forward – Our Message to Government'.

NHSS Chief Executives - Business Meeting
The main item of discussion at this meeting was Planned and Elective Care.

10 May: Dave Caesar

I met with Dave Caesar (National Clinical Advisor to the Chief Medical Officer) to discuss the Scottish Trauma Network and NHSS leadership developments, including Project Lift.

17 May: NES Partnership Forum

Myself, Dorothy Wright and Liz Ford attended the NES Partnership Forum in Inverness and met with regional staff beforehand. Substantive agenda items included an update on the National Boards delivery plan, workforce metrics and reporting, Turas Appraisal, Recruitment Shared Services and NES's role as the Lead Employer of GPSTs.

18 May

Aileen Keel
Angiolina Foster and I met with Aileen Keel (Director, Innovative Healthcare Delivery Programme at the Farr Institute) to discuss the Once for Scotland Digital Enablers workstream in relation to two cancer 'products' that the Innovative Healthcare Delivery Programme have produced.

NHSS Implementation Leads
I chaired this meeting where we received updates from Phil Raines on the Scotland Narrative, Scottish Government priorities in relation to the Transformational Change Fund Bids and clarity regarding available sources of funding and verbal feedback from the First Minister on the National and Regional delivery plans. We also discussed the content of a paper that will shortly be submitted to Paul Gray and reviewed the combined Transformation Fund proposal.

RISK REGISTER

In light of the move to capturing and reporting risk data using the MiTracker system, I have taken the opportunity to refresh the wording of risks on the Corporate Risk Register and have also updated the associated control measures. The updated register is presented on the following pages. Board members will note the updated register is similar to the format of previous risk registers, however it now also includes explicit reference to each risk's control measures and highlights the risk owner/lead Director.

The original numbering of the risks has been retained to facilitate comparison between this presentation and the previous register.

Risk 16 which relates to the pressures on Workforce across the system has been re-categorised as a strategic risk as this really relates to our ability to influence challenges in recruitment and retention in front line service rather than areas which would impact on our own operations.

Risk 17 has been combined with risk 3.

Risk 19 has been combined with risk 14.

Key Corporate Risks - April 2018

			Currrent Period						Last Period	
	Brief Description	I x L	Inherent Risk	I x L	Residual Risk		Notes	Appetite	I x L	Residual Risk
	Strategic/Policy Risks									
1	Retaining a strong focus on the importance of education, training and workforce development	4 x 4	**Primary 1**	**4 x 4**	**Primary 2**		Regional and National working has become well established over the course of 2017/18. It is clear that having a sustainable workforce is one of the key challenges across the Regional plans and a complete section of the National Plan focusses on ways in which this can be addressed. Our LDP for 2018/19 further articulates the 'core' NES contribution to this work.		**4 x 4**	**Primary 2**
2	Signifcant pressure on budgets for 2018/9 and beyond	5 x 5	**Primary 1**	**4 x 4**	**Primary 1**		The Scottish Government budget was published in Deember 2017 and included a flat cash settlement for NES. This has been extremely challenging to manage. Discussions continue with SG in relation to the impact on Training grade payments. The Board has approved a draft budget for 2018/19 which includes a relatively high level of unidentified savings to be delivered from programmes of work within NES, and also through collaboration across the National Special Health Boards.	**Open**	**4 x 4**	**Primary 1**
3	Lack of capacity and continuity at SGHD	4 x 4	**Primary 1**	**3 x 3**	**Contingency**		High inherent risk due to staffing reductions at SGHD which risks the loss of some corporate memory which is important in UK wide discussions. Increasingly NES is the repository for this level of expertise and experience. There is an opportunity for us to demonstrate this through joining up some of the data we hold, and through working with other organisations, such as NSS.		**3 x 3**	**Contingency**
17	Approach to workforce development is driven by HEE without due attention to requirements and views of the devolved nations	4 x 4	**Primary 1**	**3 x 4**	**Primary 2**		High inherent risk due to size of England as compared to other nations and extent of cross border flow. In response to this NES continues to work with the other devolved nations, with SG and to meet regularly with HEE. We have now established good relationships with the CE appointed to the new body (equivalent to HEE and NES) in Wales.		**3 x 4**	**Primary 2**
18	Challenges in managing changing relationships with partner organisations	4 x 4	**Primary 1**	**3 x 4**	**Primary 2**		Relationships are evolving as Regional and National working evolves. We continue to work hard to build collaborations, not just with the regions and other National Boards, but also into the care sector. We have a mature relationship with SSSC and are building a strong partnership with the Care Inspectorate, particularly in respect of our digital collaboration.		**3 x 4**	**Primary 2**
	Operational/Service Delivery Risks									
4	Ability to continue to support core business and respond to new demands in an agile and responsive manner.	5 x 5	**Primary 1**	**3 x 4**	**Primary 2**		We continue to experience pressures in maintaining core business in the face of increasing demands, and in the face of our Senior staff being asked to take on more national roles. We continue to review areas where we have the potential to release capacity and to use our workforce resource differently. Equally we will press SG for additonal resources where possible.		**3 x 4**	**Primary 2**
6	Dependency on key individuals	4 x 4	**Primary 1**	**3 x 3**	**Contingency**		Over the last year we have experienced some considerable turnover in senior roles and we have demonstrated our resilience in managing this. We are also now moving forwards with the development of our 'Potential and Career Management Strategy'.		**3 x 3**	**Contingency**
7	Turbulence and lack of cohesion due to internal organisational changes	4 x 4	**Primary 1**	**3 x 3**	**Contingency**		A number of significant organisational changes have been fully implemented. The budget paper that was considered by the Board in March highlighted areas that we will pursue with an enhanced focus.		**3 x 3**	**Contingency**

Key Corporate Risks - April 2018

	Brief Description	I x L	Currrent Period: Inherent Risk	I x L	Residual Risk		Notes	Appetite	Last Period: I x L	Residual Risk
16	Challenges in workforce supply in some areas	4 x 4	Primary 1	3 x 4	Primary 2		There are challenges in meeting the demand for workforce across Scotland. This is particularly acute in some geographies and some specialties. Improved workforce planning will be required to properly address this and the work that NES is leading on joining up data on workforce supply should assist in making data available to support this. In addition there are a number of proposals that we have developed as part of the National Boards Plan that are about attracting and recruiting into careers in health and care. In the immediate short term we have been working to disestablish unpopular placements, particularly in the 4 year GPST programmes in the West of Scotland and to establish more appropriate and attractive training opportunities.		3 x 4	Primary 2
19	We lose the integrity of some of our reporting systems as a result of the introduction of e:ESS						THIS RISK WILL BE REMOVED AS E:ESS HAS BEEN SUCESSFULLY IMPLEMENTED IN NES.NES is committed to the implementation of e:ESS and we have now implemented core e:ESS. We are continuing to experience some difficulties in replicating our reporting from the new system and this is causing some issues for us. We now have a direct influence on the review of NHS Business Systems which will help to drive developments in this area.		3 x 4	Primary 2
8	Major adverse incident - impacting on business continuity	4 x 4	Primary 1	2 x 4	Housekeeping		We have significantly improved our resilience in this area through roll out of more agile working. We are currently working through an updated process of impact assessment and should note that the nature of our business and the services that we provide means that disruption to NES would, in the main, not directly impact on services to patients.		2 x 4	Housekeeping
	Finance Risks									
9	Risk of underspends & resulting negative perception	4 x 5	Primary 1	3 x 3	Contingency		We anticipate a small underspend for 2017/18		3 x 3	Contingency
10	Reduction of resources puts NES into deficit	4 x 5	Primary 1	3 x 4	Primary 2		As above	Averse	3 x 4	Primary 2
	Reputational/Credibility Risks									
11	NES is unable to demonstrate that it makes a positive contribution to patient safety/patient experience	4 x 5	Primary 1	3 x 4	Primary 2		Our planning processes are now substantially focussed on outcomes. This remains a challenge given the well researched difficulties in demonstrating the impact of educational interventions.		3 x 4	Primary 2
12	NES does not deliver on key targets	4 x 5	Primary 1	3 x 2	Contingency		We have established processes in place to demonstrate performance against key targets and to identify and remedy areas where performance falls behind.	Cautious	3 x 2	Contingency
	Accountability/Governance									
13	Failure in Corporate Governance	5 x 5	Primary 1	2 x 2	Negligible		Very strong internal audit opinion relating to system of internal controls. Good quality reporting from all NES Committees to Audit Committee.	Averse	2 x 2	Negligible
14	Data security issue	4 x 5	Primary 1	3 x 2	Contingency		We have strong data security processes in place. Further information regarding preparation for the new General Data Protection Regulations is provided in Risk 19.		3 x 2	Contingency
19	Preparartion for GDPR	4 x 5	Primary 1	3 x 2	Contingency		We have a structured programme in place to address the new regulations and are engaging with all Directorates. Directorates are currently populating their information asset registers in preparation for GDPR coming into force from 31 May 2018. A full report was presented to the F&PM Committee at its February meeting.		N/A	N/A

NES Corporate Risk Register

Risk No.	Description	Risk Owner (Lead Director)	Current Period: I x L	Current Period: Inherent Risk	Current Period: I x L	Current Period: Residual Risk	Control measures	Appetite	Last Period (April 18): I x L	Last Period (April 18): Residual Risk
	Strategic Policy Risks									
1	Pressures on the system result in education and training being considered as less important	NES Executive Team (Caroline Lamb)	4 x 4	**Primary 1**	**4 x 4**	**Primary 2**	1. NES Board to advocate and promote the importance of education and training		**4 x 4**	**Primary 2**
2	Scottish Government budgetary decision results in an uplfit for NES that is less than cost pressures which in turn could mean NES Board are unable to balance expenditure	NES Executive Team (Audrey McColl)	5 x 5	**Primary 1**	**4 x 4**	**Primary 1**	1. Monthly management accounts show actual performance against budget projections ahead of year-end 2. Monthly management accounts are reviewed by Directors and the Director of Finance allowing mitigating action to be taken to manage any overspend/ underspend	**Open**	**4 x 4**	**Primary 1**
3	Policy development, UK-wide and within Scotland, may have negative impact on NES's capacity to support attraction, recruitment and retention of the workforce	NES Executive Team (Caroline Lamb)	4 x 4	**Primary 1**	**3 x 3**	**Contingency**	1. NES Directors maintain strong engagement with relevant leads at Scottish Government 2. NES to maintain an evidence bank to support ability to influence policy decisions 3. Chief Executive and NES Directors to maintain links with other UK organisations		**3 x 3**	**Contingency**
4	Challenges that Boards and other organisations have in meeting demand for staffing result in a negative perception of NES's involvement in the attraction, recruitment and retention of the workforce	NES Executive Team (Caroline Lamb)	4 x 4	**Primary 1**	**3 x 4**	**Primary 2**	1. Maintain clarity in relation to NES's role and influence 2. Work with Boards to ensure optimal deployment of staff		**3 x 4**	**Primary 2**
5	Changes in the landscape of health and social care and pressures in the system result in a risk that NES is unable to manage constructive relationships with key partners	NES Executive Team (Caroline Lamb)	4 x 4	**Primary 1**	**3 x 4**	**Primary 2**	1. Chief Executive and/or NES Directors maintain open and collaborative relationships/arrangements with counterparts in partner organisations 2. Ensure Chair is well briefed to management relationships with other Board/organisational Chairs		**3 x 4**	**Primary 2**
	Operational/Service Delivery Risks									
6	In the face of new and existing demands, NES is unable allocate resources to support priority activities in an agile and responsive manner	NES Executive Team (Caroline Lamb)	5 x 5	**Primary 1**	**3 x 4**	**Primary 2**	1. Resource allocation process to be driven by a prioritisation framework 2. Continued focus on improving processes to release capacity		**3 x 4**	**Primary 2**
7	Turnover in key roles leads to loss of expertise/corporate knowledge resulting in negative impact on performance	NES Executive Team (Caroline Lamb)	4 x 4	**Primary 1**	**3 x 3**	**Contingency**	1. Succession planning in place for key individuals 2. Talent management		**3 x 3**	**Contingency**
8	Organisational or other changes lead to dissatisfaction and disengagement of staff	NES Executive Team (Caroline Lamb)	4 x 4	**Primary 1**	**3 x 3**	**Contingency**	1. Strong partnership working arrangements in place and maintained through regular contact		**3 x 2**	**Contingency**
9	Major adverse incident impacting on business continuity	NES Executive Team (Christopher Wroath)	4 x 4	**Primary 1**	**2 x 4**	**Housekeeping**	1. Disaster Recovery Plan in place 2. Business Continuity Plans in place (Board and directorate level)		**2 x 4**	**Housekeeping**
	Finance Risks									
10	The complexity of the NES budget results in year-end underspend giving the impression that NES Is overfunded	NES Executive Team (Audrey McColl)	4 x 5	**Primary 1**	**3 x 3**	**Contingency**	1. Early engagement with Finance & Performance Management Committee and NES Board to give indication of likely financial position 2. Directorates given indicative budgets to plan own activities and expenditure 3. Ongoing programme of identifying efficiency savings 4. Final budget approved by NES Board by end of March each year		**3 x 3**	**Contingency**
11	NES is unable to identify in year savings required to balance budget and therefore has year-end overspend	NES Executive Team (Audrey McColl)	4 x 5	**Primary 1**	**3 x 4**	**Primary 2**	1. Early engagement with Finance & Performance Management Committee and NES Board to give indication of likely financial position 2. Directorates given indicative budgets to plan own activities and expenditure 3. Ongoing programme of identifying efficiency savings 4. Final budget approved by NES Board by end of March each year	**Averse**	**3 x 4**	**Primary 2**
	Reputational/Credibility Risks									
12	NES is not able to demonstrate the impact from the interventions that it has developed and delivered	NES Executive Team (Caroline Lamb)	4 x 5	**Primary 1**	**3 x 4**	**Primary 2**	1. Planning systems require all activities to include anticipated desired outcome 2. Desired outcome measured 3. Readiness to 'fail fast' rather than pursue initiatives that aren't working		**3 x 4**	**Primary 2**

NES Corporate Risk Register

Risk No.	Description	Risk Owner (Lead Director)	Current Period				Control measures	Appetite	Last Period (April 18)	
			I x L	Inherent Risk	I x L	Residual Risk			I x L	Residual Risk
13	NES does not deliver leading to a loss of reputation and confidence from stakeholders	NES Executive Team (Caroline Lamb)	4 x 5	**Primary 1**	**3 x 2**	**Contingency**	1. Ensure targets set are SMART and also have resources allocated to them to support delivery 2. Ensure Chief Executive, NES Directors, Board and standing committees have access to regular management reporting	**Cautious**	**3 x 2**	**Contingency**
	Accountability/Governance Risks									
14	Failures in Board processes lead to corporate governance non-compliance and loss of credibility with Scottish Government e.g. failure to comply with statutory and/or other requirements, failures in financial/audit/staff governance/educational quality procedures	NES Executive Team (Donald Cameron)	5 x 5	**Primary 1**	**2 x 2**	**Neglibible**	1. Standing committees responsible for each governance domain 2. Each committee provides annual report to Audit Committee 3. Comprehensive programme of internal audit	**Averse**	**2 x 2**	**Neglibible**
15	NES has a breach of Information Governance requirements resulting in loss of data and/or negative publicity	NES Executive Team (Christopher Wroath)	4 x 5	**Primary 1**	**3 x 2**	**Contingency**	1. Statutory and relevant data security processes in place, with specific reference to the new General Data Protection Regulation which becomes law on 25 May 2018		**2 x 2**	**Neglibible**

NES **NES/18/41**
Item 8a **(Enclosure)**
May 2018

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

Finance Report as at 31st March 2018

2. Author(s) of Paper

Audrey McColl – Director of Finance
Keith Douglas – Interim Head of Finance Business Partnering

3. Purpose of Paper

The purpose of this paper is to present the draft financial results for the year to 31 March 2018, which are still subject to final confirmation as part of the external audit process.

4. Key Items

The draft accounts currently reflect a £0.3m underspend for the 2017/18 financial year. This has increased from the £0.1m underspend reported in the last Board paper however, it is in line with the verbal update given at the Board meeting on 19th April. The outturn underspend is less than 0.07% of the overall revenue budget.

The previous forecast reflected known underspends in both Digital (£200k) and Workforce (£160k). Within Digital this related to the development of Turas People in support of the Lead Employer model to improve the employment experience of Doctors and Dentists in Training (DDiT)). In Workforce the underspend related to the Executive Leadership and Implementation Leads programmes. It had been agreed that these underspends would be returned to Scottish Government to carry forward into 18/19, therefore not impacting on the NES outturn position. The previous forecasts also reflected the unused element of funding related to the Medical Education Package (£465k) which, as this funding is ring fenced, was also required to be returned to Scottish Government. These returns have now been actioned and are reflected in the final allocation letter received on the 2nd May 2018.

Although the outturn is broadly in line with the previous forecast there have been some offsetting movements across directorates during March which are detailed in the main report.

It should be noted that the external audit process is not yet complete, and it is possible that some audit adjustments may change the outturn. A final update on the year-end outturn will be presented to the Board in the annual accounts.

5. Educational Implications

This report sets out the financial impact of the ongoing activity of the organisation in the delivery of its educational objectives. Areas where we see significant movements may also indicate issues with the delivery of targets.

6. Financial Implications

It is essential that we have effective mechanisms to ensure that appropriate financial information for decision making is available at all levels of our Governance structures.

7. Which NES Strategic Objective(s) does this align to?

An improved organisation.

8. Recommendation(s) for Decision

The Board is invited to note the information contained in this report.

1 Current financial position and context

We had a total revenue budget for 2017/18 of £445.2m, against which we have spent £444.9m, an underspend of £0.3m. The overall outturn underspend increased compared to the £99k reported in the Finance Paper presented to the Board in April, but is in line with the verbal update provided at the April meeting. In March 18, agreed carry forward and unused ring-fenced funds were returned to Scottish Government by means of a negative allocation. The table below reflects the impact of this negative allocation. The underspends are visible in the variance column for the Quality Management, Digital and Workforce lines, whilst the return to SG is reflected in the Net Provisions line.

2 Directorate Analysis

Table 1 – 2017/18 Final Outturn (subject to final Audit)

Directorate	Full Year				
	Current Budget	OUTTURN	Variance	Forecast Variance per last Board summary table	Movement in variance from last Board Meeting
Quality Management	78,333	77,825	**508**	26	482
Strategic Planning and Directorate Support	6,760	6,812	**-52**	46	-98
Training Programme Management	256,134	255,395	**739**	840	-101
Professional Development	6,369	6,280	**89**	26	63
Medical Total	**347,597**	**346,312**	**1,284**	**938**	**346**
Dental	44,677	44,518	**159**	233	-74
NMAHP	11,672	11,612	**60**	10	50
Psychology	17,395	17,310	**85**	69	16
Healthcare Sciences	2,404	2,387	**17**	3	14
Optometry	959	915	**44**	12	32
Digital	7,493	7,234	**259**	165	95
Workforce	4,647	4,322	**325**	107	218
Finance	2,120	2,118	**2**	-19	21
Properties	3,744	3,755	**-12**	-67	55
Facilities Management	640	613	**27**	20	7
Planning (incl OPIP)	1,131	1,124	**7**	3	4
Net Provisions	774	2,722	**-1,948**	-1,375	-573
NES Total (revenue)	**445,252**	**444,943**	**309**	**99**	**210**

All figures in £'000s

The Table above details the final outturn performance by Directorate, against the most recent forecast outturn reported to the Board in April 2018. Material variances are as follows.

2.1 Medical

The total spend in the Medical Directorate is £1,284k lower than budgeted for 2017/18, with the main underspends arising in Quality Management and Training Programme Management.

The most significant element of the underspend in Quality Management is related to the gap between income raised from the levy on overseas medical students, and the costs of the Medical Education Package (£465k). This arose because the budget was based on full costs for the 17/18 academic year (Aug '17 to Jul '18), rather than pro-rated to reflect the 8-month period August to March relating to the 17/18 Financial Year.

Training Programme Management's underspend of £739k is mainly related to Training Grade movements;

- GP Trainees are underspent by £458k, with lower volumes of trainees being offset by higher maternity leave, and some adverse price movements arising from higher than budgeted salaries paid to GP Trainees. This can arise to reflect the previous experience of the Trainees transferring into GP Training.
- GP Training Grants are underspent by £254k, due to the lower numbers of trainees (45 fewer ST1/ST3 trainees than budgeted), which impacts on the number of trainers receiving a grant.
- Hospital Trainees are showing an adverse movement of £104k largely due to lower than anticipated vacancies equivalent to 3 WTE.

In addition, E-Portfolio has generated higher income (£93k) than expected arising from an increased volume of chargeable change requests. Savings have also arisen from vacancies within the fellows' cohort of £84k, with the majority through a vacancy within Scottish Clinical Research Excellence Development Scheme (SCREDS).

The other two remaining Medical workstreams combined report a net underspend of £37k.

Since the previous Board report the Medical Directorate underspend has increased by £346k. This is the net impact of the additional underspend relating to the Medical Education Package of £465k offset primarily by adverse movements in Training Grades costs of £134k the main driver including higher GP Maternity Leave of £37k and £40k higher Hospital STR costs.

2.2 Dental

Dental are £159k underspent in the year against annual budget of £44.7m. The main variances arise from increased income from training courses being higher than anticipated of £60k, and £84k underspend in training support costs (Continuing Professional Development, Core & Specialty, Dental Care Professionals, Dental Vocational Training & Clinical Effectiveness).
The underspend has decreased by £74k since previous report, due to additional training grade costs following late notification of 2 starters (£38k) and £50k less allocation for Dental Outreach than anticipated.

2.3 NMAHP

NMAHP are £60k underspent in 2017/18 against annual budget of £11.7m. The year-end underspend is attributable to lower than anticipated training numbers in Post registration / postgraduate education & CPD workstream (£45k), and the Woman, Children and Young People and Family programmes (£15k).

The year-end underspend has increased by £50k against the forecast last reported to the Board, as a result of the lower numbers in programmes noted above.

2.4 Psychology

Psychology has an underspend of £85k in the year against annual budget of £17.4m. This arose from a combination of a delay in the recruitment of an Associate Director within Therapies (£128k) which impacted on the delivery of courses, and lower than anticipated cohort volumes within CBT Training (£120k). These have been offset by overspends in training expenses (£80k) and a number of smaller value overspends including Training Grade extensions (£39k), and additional CAMHS digital modules (£27k) driven my functionality modifications.

Previously we reported a forecast underspend of £69k in Psychology. The increased underspend of £16k is predominantly due to lower volumes within CBT Older Adult training numbers.

2.5 Digital

The underspend of £259k includes funding which will be carried forward into 18/19 of £200k. This return of funds has been reported through Net Provisions in Table 1. The underspend primarily arose from delays in recruitment of developers, net savings from in-year vacancies and appointments below budget or on reduced hours.

The expected underspend in Digital has increased by £95k since the previous Board paper, predominantly due to the vacancy movements noted above.

2.6 Workforce

Workforce are reporting an underspend of £325k in 17/18 against an annual budget of £4.6m. This includes £160k returned to SG at year end as noted earlier, to be carried forward into 18/19 which relates to Executive Leadership & Implementation Leads support. The balance is an underspend on Non-pay costs spread across several different projects, offset by an £90k overspend where a decision was made not to recharge Boards in respect of staff costs for delivering the PVG / Tier 2 service, reflecting a change in approach across NHSScotland.
The movement of £218k is largely due to a combination of the return of the £160k, underspends on eKSF (£48k), where savings made from system being made read only; various spends within Leadership & Management, including Silver Maple costs (£50k), and Tool 360, where works wore not able to be completed within the year (£18k). These underspends were offset by the non-recharge of costs related to PVG/Tier 2.

2.7 Properties

Properties reported a small overspend of £12k against 17/18 budget. Overspends in rent and service charges at Westport triggered by a rent review during the year (£46k), and increased service charges of £75k following the loss of legal dispute with landlord in 17/18, have been offset by reduced rates at Westport (£54k) and 2CQ (55k) following revaluations as at 1st April 2017.

The overspend decreased by £55k since previous report, due to lower than anticipated maintenance works being completed in March, across all of NES' properties.

2.8 Net Provisions

Net Provisions is made up of the following:

- central corporate charges for depreciation, amortisation and the Apprenticeship Levy;
- savings targets to be met by Directorates, e.g. vacancy savings,
- top-slicing of external income to cover overheads, and
  other provisions (such as those for redeployment and Fixed Term Contract (FTC) termination payments and potential claims through CNORIS - Clinical Negligence and other risks and indemnities scheme).

The net provisions budget shows a net revenue expenditure £1,948k higher than budget.

The main activities in the year are as follows:

- During the financial year we were advised by HMRC that we were incorrect to recover VAT on the eLibrary services. The accounts currently reflect the full anticipated liability of £1,966k.
- Vacancy savings of £1,897k were achieved against the savings target of £1,700k set at the beginning of the year. These savings relate to posts remaining vacant whilst the recruitment process takes place. The budget is transferred from directorates to provisions to cover the savings as they arise.
- We received additional allocations from Scottish Government in the year (£545k) relating to the 2016/17 underspend which were not anticipated in the 17/18 budget as it had not been confirmed when the 17/18 budget was finalised.

- An additional £1,000k was returned to Scottish Government during the year, as an additional contribution to the National Boards savings targets. This was funded from the underspends across the other directorates.
- £825k was returned to Scottish Government in March, in respect of agreed carry forward and the return of ring-fenced funding as noted earlier in this report.
- The Capital Expenditure budget is generated by a transfer from revenue. The Digital directorate held £1.9m of the annual capital budget. The remaining £0.3m has been transferred from provisions to capital to make up the full budget of £2,254k, resulting in a revenue overspend of £0.3m being reported within provisions.
- In addition to the above, non-budgeted costs have been approved and charged to provisions, notably for e-rostering work (£163k), and legal costs related to the dispute with Westport's landlords (£66k).

2.8 Capital Expenditure

The sum of £2,254k was allocated to Capital Expenditure during 2017/18, with a final outturn spend of £2,002k, an underspend of £252k. The main driver for this underspend has been the slippage in the procurement of the Mobile Clinical Skills Unit, where £90k was spent against a budget of £330k. The chassis (£62k) and the Scotia Medical Observation and Training System (SMOTS) equipment (£28k) have been received by the end of March. £1,640k was spent on software development (relating largely to the Turas Platform and associated applications) and £257k on the Digital Data Centre. We have requested that the capital underspend is carried forward into 2018/19 to cover the delayed spend on the Mobile Clinical Skills Unit.

NHS Education for Scotland

Board Paper Summary: Audit Committee Minutes

1. Title of Paper

Draft minutes of Audit Committee meeting held on 12 April 2018: copy attached.

2. Author(s) of Paper

Jenn Allison, Admin Officer (Planning & Corporate Governance)

3. Purpose of Paper

To receive the minutes of the Audit Committee meeting held on 12 April 2018.

Please note these minutes have been approved by the Lead Officer (Audrey McColl), but have not yet been approved by the Committee Chair (Doreen Steele). The Chair has confirmed the minutes can be submitted to the Board meeting in draft form.

4. Items for Noting

a) Item 4 – Any Other Business

Janice Sinclair informed the committee that considering recent events at NHS Tayside the Scottish Government has requested all NHS Scotland Boards provide information regarding how endowment funds are managed and reviewed by external auditors.

Members were assured that the Board and Executive team have sight of management of budgets, including Scottish Government funding and were content with the discussed response to Scottish Government.

b) Item 8 – Internal Audit Reports

i) 8a- Follow up Audit Recommendations 2017/18 Q4
This report provided information relating to outstanding internal audit recommendations.

The committee noted the report and were satisfied that NES continues to make good progress in implementing outstanding actions.

ii) 8b- Budget Management
This report reviewed NES's organisational change processes over the area of Pharmacy, which was most recently in progress.

The committee noted the report and the assurance provided.

iii) 8c- Budget Management
This report reviewed arrangements for setting and monitoring budgets, including variance analysis and financial reporting.

The committee noted the report and the assurance provided.

iv) 8d- Progress Report
This report summarised internal audit activity during the year to date and confirmed the reviews planned for the coming year.

The committee noted the report and approved the plan for the next quarter.

v) 8e- Draft Internal Audit Plan 2018/19
The draft internal audit 2018/19 plan was submitted for review and discussion.

The committee noted that a final version of the plan will be submitted to the Audit Committee for approval in June 2018.

a) Item 9 – External Audit Reports

i) 9a- Follow up Audit Recommendations 2017/18 Q4
The committee noted the report and were satisfied that NES continues to make good progress in implementing outstanding actions.

b) Item 10 – Counter Fraud Update

This report highlighted activities underway in NES aimed at supporting the Strategy to Combat Financial Crime in NHS Scotland.

The committee noted the report and progress of actions.

c) Item 11 – Annual Accounts Update

This report introduced changes to the annual accounts format for 2017-18 and draft accounting policies for 2017-18 for approval.

Members noted and were satisfied with the reporting requirements for the Annual Report and Accounts and approved the accounting policies for 2017-18, subject to a final review in June 2018.

d) Item 12 – Self-Assessment: Theme3 – Meetings

The committee carried out a self-assessment of how effectively it is operating and agreed with the comments and scoring subject to minor amendments

discussed.

e) Item 14 – Audit Scotland Report

The committee noted the following reports: NHS in Scotland 2017 and the 2016/17 audit of NHS Tayside: Financial sustainability.

5. Recommendations

Board members are asked to note the Audit Committee minutes.

NES
May 2018
JA

IN CONFIDENCE – DRAFT **NES/AUD/18/14**

AUDIT COMMITTEE

Minutes of the Sixty-Fifth meeting of the Audit Committee held on Thursday 12 April 2018 at Westport 102, Edinburgh, Room 8.

Present: Doreen Steele (Chair)
Susan Douglas-Scott
Susan Stewart

In attendance: David Garbutt, Board Chair
Caroline Lamb, Chief Executive
Audrey McColl, Director of Finance
Janice Sinclair, Head of Finance
Matt Swann, Scott-Moncrieff
Paul Kelly, Scott-Moncrieff
Angelo Gustinelli, Grant Thornton
Christopher Wroath, Director of Digital, for Item 8c
Sandra O'Brien, Executive Assistant
Jenn Allison, Committee Administrator

1. Welcome and introductions

The Chair of the Audit Committee, Doreen Steele, welcomed everyone to the meeting, which was her first meeting as Chair of the committee.

The Chair particularly welcomed David Garbutt, who was attending his first Audit Committee as NES Board Chair, Angelo Gustinelli from Grant Thornton who was also attending his first NES Audit Committee, Matt Swann and Paul Kelly from Scott-Moncrieff and Sandra O'Brien, Executive Assistant to the Director of Finance. Christopher Wroath, Director of Digital who was attending for the Internal Audit Business Continuity and Disaster Recovery Plan, was also welcomed to the meeting. It was agreed that this item would be taken at the start of the meeting.

2. Apologies for absence

Apologies were received from Carole Wilkinson, Non-Executive Director, Joanne Baker from Grant Thornton and Helen Berry from Scott-Moncrieff.

3. Declarations of interest

There were no declarations of interest in relation to items on the agenda.

4. Any other business

Janice Sinclair informed the committee that the Scottish Government has requested all NHS Scotland Boards provide information regarding how endowment funds are managed and reviewed by external auditors.

- The committee noted that the NES response will inform the Scottish Government that NES does not have any formal endowment funds created under the Health Scotland Act however NES is associated with the General Nursing Council for Scotland Educational Fund (1983) which is a registered charity whose Trustees include Non-Executive members of NES. The Charity accounts are separate from NES and are subject to external audit by Scott Moncrieff. The reply to Scottish Government will also confirm that its funds have not been used for any NES purpose.

Members were content with the discussed response to Scottish Government. Janice Sinclair would draft a response from the Chair to meet the deadline.

Action: JS

5. Minutes of the Audit Committee, 11 January 2018 (NES/AUD/18/07)

The minutes of the Audit Committee 11 January 2018 were approved as a correct record, following agreed minor amendments. **Action: JA**

6. Action list of the Audit Committee, 11 January 2018 (NES/AUD/18/08)

Members noted that the actions from the previous meeting were completed or in hand.

7. Matters arising

There were no matters arising from the previous minutes.

8. Internal Audit Reports

a) Follow up Audit Recommendations 2017/18 Q4

Matt Swann introduced the report, which provides senior management and the Audit Committee with assurance that agreed internal audit recommendation for Q4 2017/18 have been implemented satisfactorily or are in progress.

- Management has made good progress in completing actions during the fourth quarter of 2017/18. Seven outstanding actions have been completed and four actions have been added to the tracker in the last quarter, resulting in 14 open actions.

- 67% of outstanding actions are from 2016/17. These are being progressed and are expected to be completed shortly.

- Discussion took place regarding extensions to due dates. The committee agreed that it is important to be realistic with timelines so that due dates do not need to be extended however noted that evidence is sometimes required to be supplied throughout the cycle of a process, depending on the nature of recommendations.

- Internal Audit agreed to include details of the original recommendation as well as the title to assist members in reviewing the extent of progress and appropriateness of the response provided. **Action: MS**

The committee noted the report and were satisfied that NES continues to make good progress in implementing outstanding actions.

b) **Budget Management**

Matt Swann introduced the annual budget management report, which reviewed arrangements for setting and monitoring budgets, including variance analysis and financial reporting.

- The committee noted that a previous version of the report had been submitted to the January meeting, where it had been agreed that further discussions were required between NES Management and internal audit to reframe the initial recommendations more specifically to the NES operating environment.

- The Report concluded that the NES budget management framework is well defined and supports the achievement of strategic objectives, which is reflected by a number of areas of good practice.

- The report recommended that Management consider the need to complete virement forms for virements between different lines of a Directorate budget.

The Audit Committee noted the report and the assurance provided.

c) **Business Continuity Planning & Disaster Recovery**

Paul Kelly introduced the report, which assessed whether NES Business Continuity Planning (BCP) and disaster recovery plans are up to date, adequately communicated and regularly tested. This included a review of progress against previous audit recommendations.

- The Report concluded that NES has recognised the importance of having effective Business Continuity arrangements in place and noted that NES has conducted a Business Impact Analysis (BIA) for its key services and activities and is currently drafting an BCP and Incident Management Plan (IMP).

- The report highlighted a number of areas for improvement including; a formal programme of BCP testing; raise general awareness of BCP; development of a formal Business Continuity Management Policy; completion of relevant Business Impact Assessments; completion of risk assessment of NES' critical services and activities; and documentation of recovery measures.

- The report also noted that neither the BCP or IMP had been fully developed or approved at the time of audit.

- Christopher Wroath noted that the BCP and disaster recovery developments are closely aligned with work to achieve compliance with new General Data Protection Regulations (GDPR) and ISO 27001 accreditation. Christopher explained that the Digital move to cloud based data storage has helped NES to be more resilient in relation to short term incidents, such as the recent bad weather conditions, however noted that plans regarding long term incidents, such as loss of a building, need to be developed further.

- A member noted the importance of mitigation from the potential loss of key members and/or groups of staff and Christopher Wroath noted that colleagues in workforce are working on a Succession Planning document alongside the BCP.

- A query was raised regarding an outstanding action relating to an initial Internal Audit disaster recovery report in 2014/15 relating to collation of documentation. Christopher Wroath provided assurance that the relevant documentation is already in place and is regularly tested, however the documents are currently being pulled together to form one document, which is on track for closure before the next Audit Committee.

The Audit Committee noted the report and the assurance provided.

d) **Progress Report**

Matt Swann introduced the report, which summarised internal audit activity during the year to date and confirmed the reviews planned for the coming year.

- At the end of March 2018, nine out of fifteen audits have been completed; Procurement, Organisational Change, Budget Management, Expenditure and Payables, Business Continuity Plan and Q1, Q2, Q3 and Q4 follow up reports.

- Reviews for the next Audit Committee in June 2018 are in progress or in planning: Educational and Research Governance, Health & Social Care Integration Governance, Directorate Review, Talent Management Framework, Governance of e-ESS roll-out, Property Transaction Monitoring. The internal audit Annual Report (2017/18) will also be presented at the June meeting.

- The committee noted the information in appendix 3 of the report which summarised results of a review of the risk registers of all NHS Scotland Health Boards and noted that the most commonly occurring risks were relating to: workforce sustainability; financial sustainability; partnership working; ICT; and targets.

- NES has identified at least one risk related to each of the above 5 areas in the corporate risk register and the report noted that this aligns well with the role that NES has in the support of the NHS in Scotland. The report also noted that consideration should continue to be given to the resources dedicated to managing these risks and continuing to be aware of emerging risks both within the organisation and those across the sector.

The committee noted the report and approved the plan for the next quarter.

e) **Draft Internal Audit Plan 2018/19**

Matt Swann introduced the draft internal audit 2018/19 plan for review and discussion and noted that a final version of the plan will be submitted to the Audit Committee for approval in June 2018.

- The detailed plan for 2018/19 is set out in the context of a three-year cycle which uses the period of 2015/16 to 2017/18, as its basis.

The Audit Committee noted and were satisfied with the draft internal audit plan for financial year 2018/19.

9. External Audit Reports

a) Follow up of External Recommendations (NES/AUD/18/10)

Audrey McColl introduced the follow up report and provided the Audit Committee with updates on the progress of External Audit recommendations.

The committee noted the report and were satisfied that NES continues to make good progress in implementing outstanding actions.

10. Counter Fraud Update (NES/AUD/18/11)

Janice Sinclair presented the report which updated the Audit Committee on activities underway in NES aimed at supporting the Strategy to Combat Financial Crime in NHS Scotland.

- Satisfactory progress against the actions in the 2017-18 workplan is being made, with plans to roll out Anti Bribery training to the Senior Operational Leadership Group underway. There has been an increase in the uptake of the Counter Fraud eLearning modules, with 91% of staff completed the eLearning and 62% of line mangers completed WebEx session.

- The review of the Gifts and Hospitality Registers have revealed no new declarations for the 3-month period to end of December 2017. There have been two declarations of hospitality received from the former Chair of the Board.

The committee noted the report and progress of actions.

11. Annual Accounts Update (NES/AC/18/12)

Janice Sinclair presented a paper to inform the Audit Committee of changes to the annual accounts format for 2017-18 and present the draft accounting policies for 2017-18 for approval.

- Janice Sinclair informed the committee there have been changes to the layout of the annual accounts format, which impacts on notes 4-6 requiring pay and non-pay to be separated. NES Management are scheduled to meet with the external auditors to ensure that the proposed layout of the annual accounts is consistent with the new requirements but also remains relevant to the NES context, aiding the understanding of users of the accounts.

- The Chair noted that as there will be two new members to the Audit Committee starting in June it will be helpful for them and other members of the Board to attend the annual accounts session held by Finance for non-Executive Board members.

Members noted and were satisfied with the proposed changes to the accounts layout for the Annual Report and Accounts and approved the accounting policies for 2017-18, subject to a final review in June 2018.

12. Self-Assessment: Theme 3 – Meetings (NES/AUD/18/13)

Audrey McColl introduced theme 3 of the Self-Assessment Tool which the committee has been using to assess to how effectively it is operating and identify any areas for improvement.

The committee agreed with the comments and scoring noted for theme 2 (Internal Control, finance reporting and regulatory matters) which had been reviewed at the January meeting. Theme 3 was reviewed and evidence agreed against each heading. The committee agreed that Self-Assessment should be reviewed again on an annual basis and that NES management review the Audit Committee workplan to identify which quarter this should begin .

Action: AMC

13. Items for information

The following Audit Reports were noted by the committee:

a) NHS in Scotland 2017 (Audit Scotland)

b) Public Audit & Post-Legislative Scrutiny Committee paper on Tayside

During discussion of this paper Audrey McColl highlighted where the items raised may have relevance for NES. The key areas discussed were; conditions attached to specific funding streams, pass through monies and changes to revenue allocations. Audrey reassured the committee that all allocations are subject to the same monthly budget review process and if allocations are ring fenced they are recorded separately.

The committee noted these comments.

14. Date and time of next meeting

The next meeting of the Audit Committee will be held on Thursday 14th June at 10:15am in Westport Room 8.

The Chair extended her thanks to Carole Wilkinson and Susan Douglas-Scott, for their time as Chair and member of the Audit Committee and wished them well for the future. Carole and Susan's appointments to the NES Board are due to end in May 2018. Susan Douglas-Scott thanked members and NES management for their support during her time on the committee. It was noted that new members will be appointed to the Audit Committee in due course.

NES
April 2018
JA/JS/AMcC

NES **NES/18/43**
Item 8c **(Enclosure)**
May 2018

NHS Education for Scotland

Board Paper Summary: Staff Governance Committee Minutes

1. Title of Paper

Minutes of Staff Governance Committee meeting held on 26th April 2018: copy attached.

2. Author(s) of Paper

David Ferguson, Board Services Manager

3. Purpose of Paper

To receive the unconfirmed minutes of the Staff Governance Committee meeting held on 26th April 2018.

4. Items for Noting

Item 7 – People & OD Strategy

The Staff Governance Committee noted that the draft strategy was being revised in the light of useful comments received from the Executive Team and that the revised draft will be re-submitted to the Executive Team before being circulated to members for comment and featuring on the committee's next agenda for consideration.

Item 8 – Annual Report of Staff Governance Committee (including Remuneration Committee) to Audit Committee

The Staff Governance Committee made some comments on the draft report and agreed that a revised draft should be submitted to the Remuneration Committee meeting on 31st May, en route to the June meeting of the Audit Committee.

Item 9 – Doctors and Dentists in Training: Lead Employer Model

The Staff Governance Committee received an update paper and commended the excellent progress being made with this complex piece of work.

Item 10 – Turas Appraisal

The Staff Governance Committee received an update paper and was impressed by the progress made to date in relation to implementation.

Item 11 – Staff Experience Report 2017

The Staff Governance Committee received and commented on a paper

describing the key findings from the national staff experience report and the dignity at work survey and outlining the associated actions in relation to delivering continuous improvement in staff experience.

The committee was assured that the actions will ensure that staff governance standards will continue to be met for all NES employees.

Item 13– Workforce Metrics, Reporting and Performance Management

The Staff Governance Committee received a very interesting and useful presentation on the first iteration of the People & OD Dashboard.

The committee commended the excellent work to date on this ground-breaking development and welcomed the potential to apply this approach to other areas of governance and performance monitoring in NES.

5. Recommendations

None.

NES
April 2018
DJF

Unconfirmed

NHS Education for Scotland **NES/SGC/18/16**

Minutes of the Sixtieth Meeting of the Staff Governance Committee held on Thursday 26th April 2018 at Westport 102, Edinburgh

Present: Susan Stewart, non-executive Board member (Chair)
Andrew Tannahill, non-executive Board member
David Cunningham, BMA representative

In attendance: Dorothy Wright, Director of Workforce/Executive Secretary
David Garbutt, NES Board Chair
(agenda items 13 to 18 only)
Christine McCole, Head of Service, HR
Ameet Bellad, Senior Specialist Lead (Workforce)
(particularly for agenda item 13)
Morag McElhinney, Senior Specialist Lead (Workforce)
(particularly for agenda item 9)
Kristi Long, Senior Specialist Manager (Workforce)
(particularly for agenda item 11)
Jen Calder, Business Partner (O&LD) (particularly for agenda item 11)
David Ferguson, Board Services Manager

1. Chair's welcome and introduction

The Chair welcomed everyone to her first meeting in the Chair of the Staff Governance Committee.

Susan thanked Susan Douglas-Scott, the former Chair of the Committee, for her excellent contribution and wished her well in her forthcoming new role as the new Chair of the Golden Jubilee Foundation Board.

2. Apologies for absence

Apologies were received from Liz Ford, Employee Director, and Susan Douglas-Scott, non-executive Board member (who will complete her term of office on the Board at the end of May 2018).

3. Declaration of interests

There were no declarations of interest in relation to the items on the agenda.

4. Minutes of meeting held on 8th February 2018 (NES/SGC/18/07)

The minutes of the previous meeting were approved. **Action: DJF**

5. Action list from meeting held on 8th February 2018 (NES/SGC/18/08)

It was noted that all of the action points had been completed or were in hand.

It was agreed to follow up the question of members being provided with a link to the Learning and Management Zone on Turas Learn. **Action: DJF**

6. Matters arising from the minutes

There were no matters arising which did not appear elsewhere on the agenda.

7. People and OD Strategy (NES/SGC/18/10)

Dorothy Wright advised that this draft paper will be revised in the light of useful comments received at the Executive Team meeting on 24th April and re-submitted to the Executive Team before being circulated to members for comment and featuring on the next agenda for consideration.

Action: DW and CMcC

It was noted that the updated draft strategy will focus on the strategic context for the next five years and reflect the National Board Collaborative Plan material on the Sustainable Workforce workstream.

Members confirmed that they are content with this direction of travel.

8. Annual Report of the Staff Governance Committee (including the Remuneration Committee) To the Audit Committee (NES/SGC/18/11)

Dorothy Wright introduced a paper inviting the committee to review and comment on the section of this report which sets out the work of the Staff Governance Committee in 2017/18. It was highlighted that the Remuneration Committee (which reports to the Staff Governance Committee) will review its section of this report at its next meeting on 31st May.

It was noted that the annual reports of the Board's committees form part of the Statement of Internal Control for the Annual Accounts.

The following points arose in discussion:

- Members commended the inclusion of an 'Impact Achieved' column in the review table.
- It was agreed that care should be taken not to over-state impacts or to include impacts of little significance.

- It was agreed to re-word the last 'Impact Achieved' noted on page 5 of the main paper.
- It was agreed to re-order the names of the committee members in the table on page 3 of the report (Chair, then alphabetical by surname).
- Members were pleased to note the low rates of sickness absence and staff turnover in NES.
- It was agreed to amend the commentary in relation to one of the Remuneration Committee items on page 11 of the report. Two other minor corrections were noted on page 10.

Subject to taking the above points on board, the committee was content with its Annual Report for 2017-18, which will be amended and submitted to the Remuneration Committee for the opportunity to comment before the report is forwarded to the June meeting of the Audit Committee. **Action: DW and CMcC**

9. Doctors and Dentists in Training: Lead Employer Model - Update (NES/SGC/18/12)

Morag McElhinney introduced a paper updating the committee on the early implementer work being delivered by NES with early adopter NHS Boards, in order to further test the new employment model for Doctors in Training. The following points were highlighted:

- In the new model, NES will be the lead employer for all General Practice Specialty Trainees (GPSTs) as the Doctors in Training rotate through placement NHS Boards and general practice attachments as part of their training programme. This will increase the number of NES employees by around 600.
- In addition to NES, there are three other regional lead employers, which will employ trainees on a regional basis across all the other training programmes on a regional basis. National programmes will be assigned across the four employing Boards.
- The new model will be implemented fully in August 2018, resulting in a reduction of employment contracts and on-boarding activity for doctors in training.
- An Employment Responsibilities Agreement (ERA) details the responsibilities of employing boards and placement boards in the lead employer model.
- There will be a need for a 'once for Scotland' consistency of approach and common standard operating procedures.

Discussion of the paper produced the following main points:

- Members recognised the complexity of this project and commended the clarity of the paper.
- It was acknowledged that this substantial increase in the number of NES employees from August 2018 will impact on processing capacity, particularly in relation to payroll. A Payroll Services Group has been established to monitor the implementation of the new arrangements closely.

- The Turas People application will be particularly helpful in enabling the completion of datasets online.

Following discussion, the committee noted the paper, commended the excellent progress to date with the implementation of the new lead employer model, taken forward with a very positive approach, and was assured that robust arrangements for staff governance are in place for all employee groups.

10. Turas Appraisal: Update (NES/SGC/18/13)

Dorothy Wright introduced a paper providing an update on the implementation of Turas Appraisal. The following points were highlighted:

- Turas Appraisal was successfully launched across all NHS Boards on 2nd April 2018, as planned. To date, 35,000 NHSScotland staff have logged in to the application.
- NES has assumed responsibility for the Information Governance/General Data Protection Regulations (GDPR) aspects of Turas Appraisal. This also applies to the Turas People application.

It was anticipated that staff engagement with the system will increase sharply once it begins to be used for performance reviews, objective-setting and PDPs.

The committee noted the paper and was impressed by the progress made to date in relation to implementing Turas Appraisal.

11. Staff Experience Report 2017 (NES/SGC/18/14)

Jen Calder was introduced as the new iMatter lead for NES.

Kristi Long introduced a paper describing the key findings from the national staff experience report (iMatter) and the dignity at work survey and outlining the actions ongoing or proposed to deliver continuous improvement in staff experience. The following points were highlighted:

- The dignity at work survey includes a number of the questions which featured in the former national staff surveys.
- Overall, the pattern of results is consistent with past staff survey results.
- The Scottish results on racial discrimination are not consistent with the results in the most recent NHS England staff survey.
- When analysing staff data, NES typically disaggregates GP trainee data to inform more focussed and targeted action planning. Unfortunately, the design of the survey does not allow for disaggregation in this dataset. This point has been raised with Scottish Government, and the issue is likely to be relevant for other lead employers of trainees.
- Attention was drawn to the actions ongoing or proposed moving forward, which all align to existing action plans in a range of contexts.

The following points emerged in discussion:

- It was confirmed that a communications plan has been discussed with the Head of Corporate Communications. The Chair proposed that references to communications plans should be include in all cover papers coming to the committee in future, where appropriate.
- It was agreed to clarify the last sentence in the fifth paragraph on age 2 of the cover paper. **Action: KL**
- In relation to the dignity at work survey, some concern was expressed in relation to the non-reporting of incidents of physical abuse, particularly as it appeared that positive responses were received when such incidents are reported. Again, the issue of the aggregation of the results for GP trainees and other NES employees was highlighted and it was agreed to seek to engage with other organisations (e.g. the BMA) to enable triangulation of data from different sources. This will be raised with the Training Programme Managers, in the first instance. **Action: JC**
- Attention was drawn to AXA-ICAS, NES's free and confidential employee support and counselling service, which offers support to employees and their families. \although it can be accessed via the NES intranet and website, it was suggested that the availability of this service might be publicised more widely.

Following discussion, the committee noted the paper and was assured by NES's approach to continuous improvement of staff experience.

12. Primary 1 Inherent Priority Risk Review

Dorothy Wright advised that none of the risks identified in this review are relevant to the Staff Governance Committee's remit. The committee noted the position.

13. Workforce Metrics, Reporting and Performance Management (NES/SGC/18/15)

Members noted a paper drawing the committee's attention to the first iteration of the People & OD Dashboard, which would be presented by Ameet Bellad.

Ameet Bellad gave a presentation, 'Management Information: Workforce Data – April 2018', which provided an overview of the journey of this project to date and some illustration of the capabilities and functionality of the new People & OD dashboard. The presentation covered the following main areas:

- The solution developed
- Usage (10 core dashboards for use by HR Business Managers)
- The story so far: Building analytical capability; Training HR Business Managers; Focus on specialty areas; Moving from reporting to forecasting (storytelling; predictive analytics)

- People & OD Dashboard in a live environment (N.B. illustrative only, as the data is not yet live)
- Key metrics, including Staff Governance Standards
- Quadrants of a balanced scorecard mechanism
- Summary dashboard

The presentation prompted discussion, resulting in the following main points:

- The committee thanked Ameet for his excellent presentation of this ground-breaking development and warmly congratulated Ameet and his team for their hard work in bringing this work to fruition.
- The People & OD Dashboard will be particularly useful in the context of moving towards a single system approach for NHSScotland, enhancing the potential for NES to be regarded as a centre of excellence in relation to workforce data.
- It may be useful to present this work to the NHS Board Chairs and Chief Executives in due course.
- It was agreed that it would be useful to develop a governance model around the dashboard and it was suggested that some of the non-executive Board members may be interested in championing quadrants within the dashboard.
- David Garbutt wondered if the People & OD Dashboard approach might be applicable to other areas of governance and performance monitoring in NES.

Following discussion, it was agreed that it would be useful to highlight some key indicators from the live data at the committee's next meeting in August.

Action: AB

14. Policy Tracker

Members reviewed the Policy Tracker as at April 2018.

Christine McCole advised that policies are updated routinely and not just when PIN Guidelines are updated.

The considerable delay in updating the Hospitality Policy was highlighted. Although members accepted that the delay has been a result of staffing challenges in the Directorate concerned and noted that the updated policy is due to come to the committee's next meeting in August, it was agreed that the importance of carrying out policy updates timeously should be raised with the Director concerned and with the Executive Team. **Action: DW**

15. Managing Health, Safety and Wellbeing Committee minutes

Members noted the minutes of this committee's meeting held on 29th January 2018.

Concern was expressed regarding the 67% completion rate for mandatory health and safety training modules, although it was pointed out that this figure is perhaps artificially low due to the current lack of an 'Amber' performance rating. It was however agreed that completion rates for mandatory training should be at or as near as possible to 100%.

16. Change Management Programme Board (CMPB) minutes

Members noted the minutes of the CMPB meeting held on 5th February 2018.

It was confirmed that this meeting had been chaired by Caroline Lamb and that this should be noted in these minutes. **Action: DJF**

17. Any other business

a. Chairing of Remuneration Committee

David Garbutt advised that he has decided that it will be more appropriate for a non-executive Board member other than the Board Chair to chair the Remuneration Committee.

18. Date and time of next meeting

It was confirmed that the committee's next meeting will take place on Thursday 9th August 2018 at 10.00 a.m.

NES
April 2018
DJF/dw/kl/ss

NES **NES/18/45**
Item 9b **(Enclosure)**
May 2018

NHS Education for Scotland

Board Paper Summary

1. Title of Paper

NHS Education for Scotland strategic framework 2019-24

2. Author(s) of Paper

Donald Cameron (Director of Planning and Corporate Resources)

3. Purpose of Paper

To set out the approach to developing the NES strategy for 2019-24.

4. Key Issues

This paper outlines the plan for developing our strategic framework for 2019-24 to ensure our activities align with national policy and service priorities. We will review our vision and mission and consider which of our existing strategic themes and outcomes need to be continued/developed and what needs to be added.

5. Educational Implications

Our strategic framework will align our educational activity over the next five years.

6. Financial Implications

The strategy will be delivered within the financial plan agreed by the Board.

7. Which NES Strategic Objective(s) does this align to?

The strategy will build on all the existing strategic themes and outcomes.

8. Key Risks and Proposals to Mitigate the Risks

The key risk is that our strategy does not align with current policy, plans and service priorities. To mitigate the risk, we will consult with key service partners and staff and ensure there is close alignment with national policy and plans.

9. Equality and Diversity Impact Assessment

Equality and diversity and the equalities duty will be reflected within the strategic framework.

11. Communications Plan

A communications plan will be developed and implemented.

12. Recommendation(s) for Decision

To comment on and approve the outline plan.

Developing the NES Strategic Framework for 2019-24

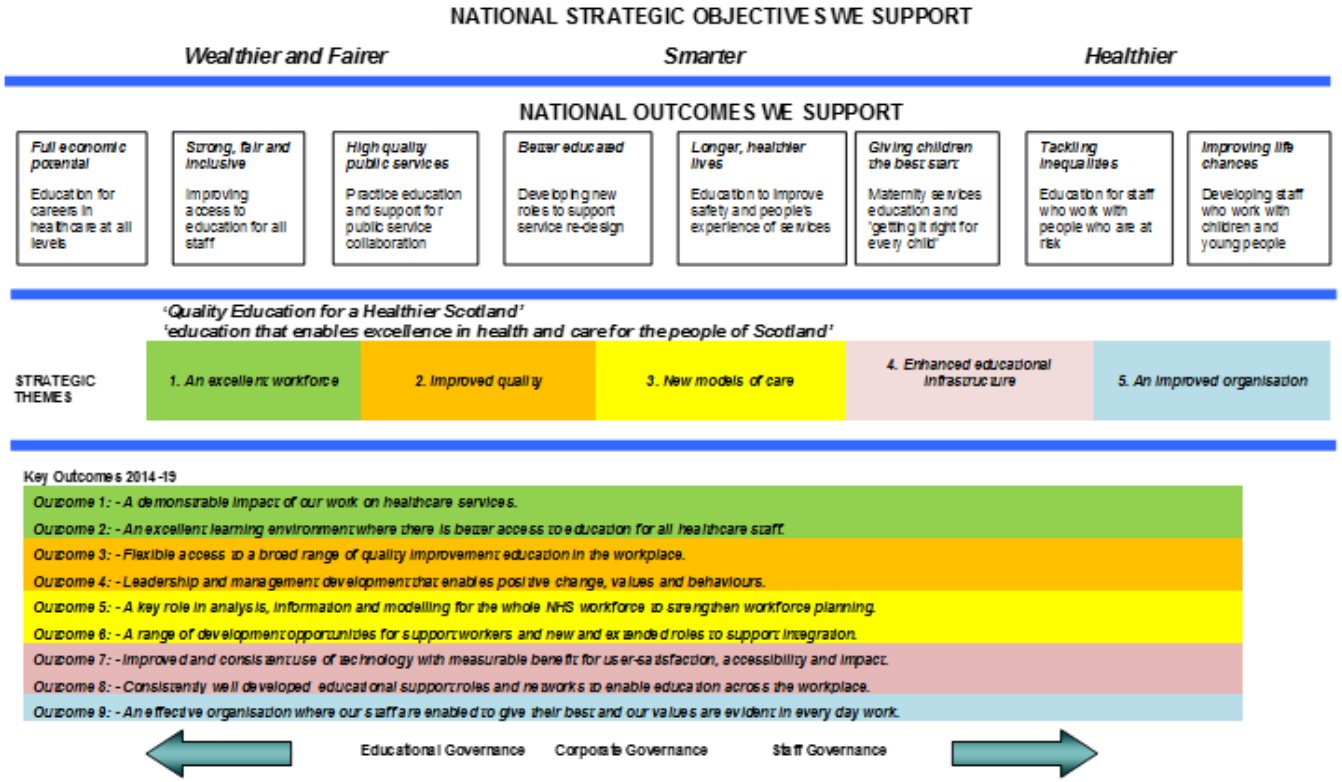
1. Purpose of this Paper

This paper sets out the approach to developing NHS Education for Scotland's (NES) strategic framework for the period 2019-24. Our new strategy will:

- build on the themes and outcomes in our 2014-19 strategic framework
- clearly state our values and ways of working
- integrate strategic vision, mission, themes and outcomes
- support efficiency and integration through organisational improvement
- reflect national policy and service priorities

2. Background

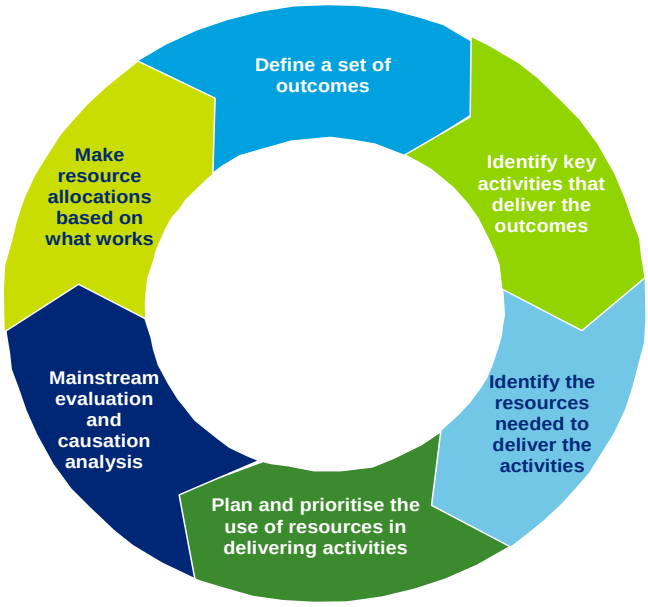
We are approaching the end of our current strategic framework; *Quality Education for a Healthier Scotland*; which has aligned our annual operational planning activities, outcomes and targets to five themes and nine strategic outcomes as follows:



Publication of the *Health and Social Care Delivery Plan* (the H&SCDP) in December 2016 signalled a requirement for organisations to work more collaboratively and to

focus on how we best use our collective resources to support better health, better care and better value; at a local, regional and national level. This strategic review will consider how our strategy will support the H&SCDP while acknowledging and reviewing the progress we have made over the last five years. The review will consider the collaborative national board and regional proposals ('plans') and Scottish Government policy including the *Digital Health and Care Strategy, the National Clinical Strategy*, *Realistic Medicine* and the *Everyone Matters: 2020 Workforce Vision*.

The review will consider our current vision and mission as well as which of our strategic outcomes need to be continued and further developed and which need to be replaced or changed. In addition, we will examine the extent to which our values and ways of working are being applied in our day to day work. It is proposed that the new strategic framework continues to take an *Outcome Planning Framework* approach as recommended by external audit - see below;



Our strategic framework for 2019-24 will be delivered within a continuing context of tight budgets, integration and public service reform; and will include a commitment to working closely with the new national and regional collaboratives as well as performance improvement to make our organisation more efficient, streamlined and agile. Underpinning this review will be the principle of further developing our digital capacity and capability and the provision of data and intelligence across health and

social care to better inform planning and decision making. In addition, the review will consider *The Fairer Scotland Duty*, which requires NHS Boards to take steps to reduce inequalities of outcome caused by socio-economic disadvantage when making strategic decisions. We will need to consider the relevance and application of this duty throughout the strategic review and to report on how we have done this.

The new *Digital Health and Care Strategy* and the national board and regional proposals to Scottish Government will be important going forward and we will have a key role in the workforce and digital elements covering areas such as: workforce planning; health and care careers; youth employment; education and training; online learning management; a digitally enabled workforce; leadership and talent management and; flexible models of employment.

The strategic review will consider our core business preparing professionals for practice in medicine, dentistry, psychology, pharmacy, optometry and healthcare science and providing education for the nursing, midwifery and allied health professions, healthcare chaplains, support workers and managers. We will also take into account education for: improving quality; patient safety; role development; leadership and management; mental health; dementia; older people and; children and young people.

3. Governance

The timetable for completing the strategic review is outlined in appendix 1 and the key governance principles are summarised as follows:

- the Board leads strategy development to deliver organisational purpose
- responsibility is allocated, and authority delegated
- there is a requirement for each directorate to contribute
- governance groups are identified, and their role and remit defined
- we will consult with our key stakeholders in health and social care

We will establish a small project team to which authority is formally delegated by the Board. The project team will co-ordinate and manage the review with existing

committees and groups providing the oversight, governance and key input as outlined below and in appendix 2;

- **NES Board** – The Board will have a lead oversight role to review and approve the draft strategic framework for consultation and the final document for launch. This will be supported by a planning workshop to review progress and shape the vision, mission, strategic themes and outcomes.
- **Executive Team** – The Executive Team will have a participative and sponsorship role with responsibility allocated to each director for ensuring they and their teams participate in developing the strategy plus input to drafts and the final document.
- **Project Team** – The Project Team will have a co-ordinating role with authority delegated by the Board. The Project Team will develop drafts and final versions based on workshop outputs and external stakeholder feedback.
- **Communications Team** – The Communications Team will have a communication and stakeholder engagement role to support consultation with our staff and key stakeholders.

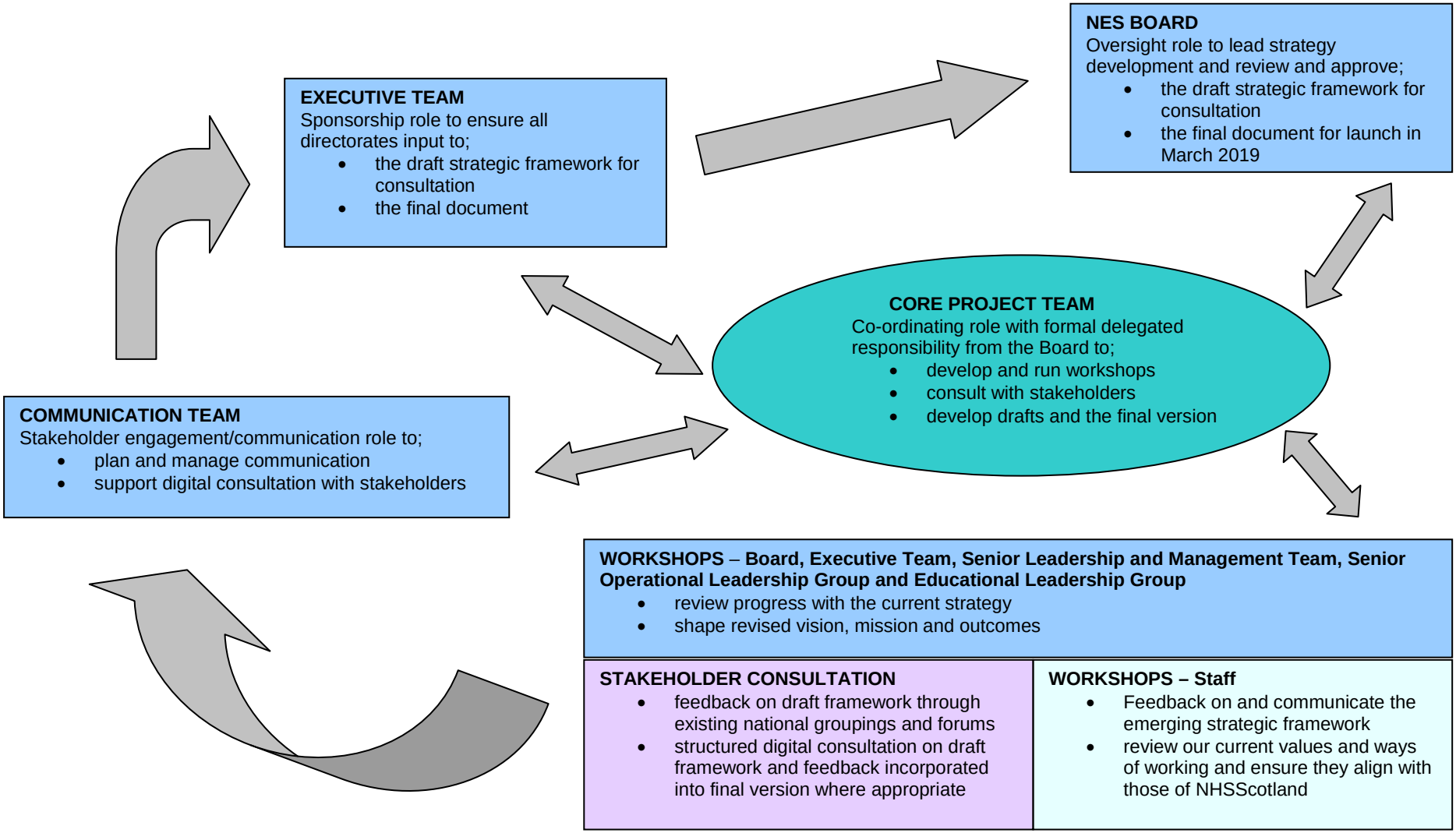
Development of the draft strategic framework will be informed by workshops with the Board, Executive Team, Senior Leadership and Management Team, Educational Leadership Group and the Senior Operational Leadership Group. Events will also be run with our staff to feedback and input to the emerging framework and to consider our values and ways of working. These events will review progress and consider the current vision, mission and outcomes to develop a refreshed strategy for the next five years. The draft that is produced from these events will be subject to a structured consultation with our key external stakeholders to obtain feedback which will inform the final version. Events and stakeholder consultation will be designed around an improvement cycle as outlined below;

- review the strategic vision, mission and outcomes
- what's working well, what needs continued and where the weaknesses lie
- identify the improvement and development priorities for the future
- include the changes within a refreshed outcome based strategic framework

Appendix 1 – Strategic Review Timetable

	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Strategic review plan agreed by the Board.												
Communication plan developed.												
Workshops - Board, ET, SLMT, ELG, SOLG and staff.												
Draft framework developed and approved by the Board.												
Formal internal and external consultation with key stakeholders.												
Consultation feedback incorporated into final version.												
Final strategic framework approved by the board and launched.												

Appendix 2 – Strategic Review Governance



NHS Education for Scotland

Board Paper Summary

1. Title of Paper

Children and Young People's Health in Scotland – update and future direction for NES

2. Author(s) of Paper

Judy Thomson (co-ordinating author), Susan Key, Elaine Figgins, Sarah Doyle, Jose Marshall, Jean Allan, Janice Turner, Leon Zlotos, David Bruce, Peter MacDonald, Pam Nicoll, Sandra Ferguson.

3. Purpose of Paper

To update Board members on the contribution NES is making to Children &Young Peoples health and wellbeing in Scotland and to outline future directions

4. Key Issues

- Improving the health and life chances of Scottish children is a very high priority for Scottish Government and all public-sector agencies
- A whole system collaborative approach to support early intervention and prevention and reduce inequalities is being promoted. NES needs to strengthen internal and external collaboration to delivery high quality education in this complex system.

5. Educational Implications

- NES is already making a very significant contribution to the health and wellbeing of Scotland's children through educating and training the healthcare disciplines and a growing contribution to multi sector education through digital and blended learning programmes
- Flexible training pathways to support flexible careers as roles change and new roles develop are required

6. Financial Implications

- Funding arrangements for the education and training of healthcare disciplines vary significantly with high proportions of NES permanent recurrent funding dedicated to this with additional non-recurring allocations from Scottish Government

- Recently SG has invested significant funding in Health Visitor education and additional Health Visitor posts in NHS Scotland, as well as workforce development for Child and Adolescent Mental Health Services and implementation of the CYP Act 2014

7. Which of the 9 Strategic Outcome(s) does this align to?

- A demonstrable impact of our work on healthcare services
- An excellent learning environment
- Flexible access to a broad range of quality improvement education in the workplace
- Leadership and management development that enables positive change, values and behaviours
- A key role in analysis, information and modelling for the NHS Scotland workforce to strengthen workforce planning
- A range of development opportunities for support workers and new extended roles to support integration
- Improved and consistent use of technology with measurable benefits for user satisfaction, accessibility and impact
- Consistently well-developed educational support roles and networks to enable education across the workplace
- An effective organisation where staff are enabled to give their best and our values are evident in every day work

8. Impact on the Quality Ambitions

NES's work has implications for all the Quality Ambitions – safe, effective, and person centred care.

9. Key Risks and Proposals to Mitigate the Risks

The key risk for NES is the breadth and scope of the workforce development needed to promote the wellbeing of infants, children and young people. A strengthened leadership and reporting structure will be developed in 2018 to ensure high quality, efficient delivery of education and training.

10. Equality and Diversity

NES has a duty to consider equality and diversity issues and take relevant and proportionate action to eliminate discrimination and harassment, advance equality of opportunity and foster good relations between people who share a protected characteristic and those who do not in the delivery of our functions.

Please summarise any key equality and diversity findings related to the duty or equality and diversity risks relevant to the work described in the paper. If you have identified any risks of negative impact, indicate what actions you propose to mitigate that impact.

[This section is required when a decision is requested to: approve new work; approve work which will result in significant change; disinvest in programmes of work].

11. Health Inequalities

Briefly describe opportunities the work offers to reduce health inequalities and proposed actions.

[See guidance if further information is required].

12. Communications Plan

A Communications Plan has been produced and a copy sent to the Head of Communications for information and retention:

Yes		No	X

A Communications Plan format template is available in the 'Meetings' and 'Communications' sections of the NES Intranet.

13. Actions to be taken forward

Board members are invited to note the information contained in this report and the following actions that will be taken forward;

1. Strengthen partnership working across internal and external boundaries to enable education and training to support holistic and flexible care where children young people and families "ask once get help fast".

2. Where possible, coordinate and align the education and training of the specialist and general healthcare disciplines serving children young people and families with opportunities to support multidisciplinary and multi sector workforce development.

3. Ensure all staff for whom NES has a training or employment remit are aware of their responsibilities to protect the safety and promote the wellbeing of children and young people.

4. To continue to explore methods to attract and retain staff into training pathways for the children's services workforce.

NES
March 2018
JT

Board Paper May 2018

Children and Young People's Health and Wellbeing in Scotland – update and future directions for NES

Authors; Judy Thomson (co-ordinating author), Susan Key, Elaine Figgins, Sarah Doyle, Jose Marshall, Jean Allan, Janice Turner, Leon Zlotos, David Bruce, Peter MacDonald, Pam Nicoll, Sandra Ferguson.

1. Introduction

The purpose of this paper is to update Board members on the contribution NES is making to Children and Young People's health and wellbeing and to outline future directions. The strategic and policy context is described followed by some examples of current work drawn from across the organisation. A summary of the key issues and future directions along with actions to be taken forward is provided.

Regarding the scope of this paper, Corporate Parenting was the subject of a recent Board paper therefore will not be covered in detail. In contrast, although mental health was discussed by the Board in October 2017 the current paper provides more detail on NES mental health work in relation to children and young people. Also, a future Board paper will be prepared on the review of maternity and neonatal services and NES's contribution to "Best Start" will be covered in that paper.

2. Background

Improving the health and wellbeing and life chances for Scotland' s children continues to be a high priority for government and all public-sector agencies, including NES. There is a strong focus on early intervention and prevention, and reducing inequalities, with an aim for a whole system collaborative approach to improve outcomes for children, young people and families.

Scottish Government plans to launch an action plan for child and adolescent health and wellbeing later in 2018, which is also the Year of Young People. It has been clearly indicated that a holistic approach will be adopted. The plan will include physical and mental health with the child's needs at the centre with an ambition for all services to be trauma informed and to reduce the impact of adverse childhood experiences by promoting resilience.

The Children and Young People Improvement Collaborative (CYPIC) has been established to help early years health family services and schools improve outcomes by using Quality Improvement (QI) methods. NES is supporting this work.

There will be further educational implications for how services are supported to work together from the resolution of the information sharing issues arising from the Children and Young People's Act 2014 which we expect later this year.

NES is already making a significant contribution to the education and training of healthcare staff to equip them with the knowledge and skills for working with children, young people and families. Most of the resources are focussed on preparing the healthcare disciplines for their specific roles, although there has been significant growth in the multidisciplinary and multi-sector education and training that NES delivers.

It is anticipated that this trend for multidisciplinary and multi-sector education and training will continue. This will require strengthening of our cross-organisational planning and co-ordination.

3. Examples of NES Contributions

3.1 Nursing

NES performance manages the nursing pre-registration programmes, including children's health, and is working with government and universities to improve retention rates in this field of practice. Opportunities to develop a community children's nursing training route for Scotland are currently being explored. NES also provides local educational infrastructure to support practice based education via a network of practice education coordinators and facilitators.

NES has a central role in the Transforming Roles programme, in designing, commissioning and delivering education to support the new roles for health visitors and school nurses. This includes the commissioning of an additional 500 health visitor training places. In addition, NES is continuing to support new and existing education to assist staff with the new universal health visiting pathway and named person responsibilities. The new school nursing pathway for vulnerable children has required a strong educational focus on developmental needs, communication and emotional wellbeing. Health visitors and school nurses have a central role in child protection. Support for practitioners adopting new roles is being enhanced by education for clinical supervisors.

The Family Nurse Partnership (FNP) has been delivered in Scotland since 2010 and NES continues to support the education required to ensure that Family nurses have the competences to work with teenage mothers from early pregnancy until the child is two. Through the relationship between nurse and parent and regular home visiting, FNP aims to improve: pregnancy and birth outcomes; child health and development; and parent's economic self-sufficiency. NES is involved in the preparation of Family Nurses and their supervisors and has extended the training remit to support FNP colleagues in Northern Ireland and Norway. Recently the programme has developed some in-programme targeting for the most vulnerable families and NES has provided continuous professional development (CPD) to support these developments.

Protecting children is a key component of nursing training and is also embedded within FNPs educational programme.

3.2 Allied Health Professionals (AHPs)

3.2.1 Intergenerational cycle

A model known as the intergenerational cycle of deprivation has been developed as the foundation of a collaborative framework to achieve increased resilience and improved wellbeing outcomes for children and young people (CYP) in Scotland.

AHPs are centrally involved in taking this forward and NES's has representation on this working group. This will include considering learning resources to support speech and language needs in the criminal justice system and young offending, as well as reducing the impact of adverse childhood experiences, understanding demographic and incidence data, addressing poverty and relationship building.

Supporting children and young people with communication needs is a key role for speech and language therapists who work alongside families, health visitors, early years and school staff to deliver this. AHPs also make a central contribution to addressing diet, physical activity and executive motor functions. NES supports this through education and training across several programmes of work.

3.2.2 Children with disability/physical health issues

Allied Health Professionals (e.g. physiotherapists, occupational therapists, orthoptists, orthotists and dietitians) make a significant contribution as members of multi-disciplinary health and social care teams to promoting child development and life skills, as well as addressing specific difficulties. An example of this would be around the Diet and Obesity Strategy (addressing the obesity epidemic in 0-5-year olds) where work by paediatric public health dietitians has highlighted other clinicians' lack of confidence in discussing obesity and portion size etc with families. NES is ideally placed to support improvement through the education and training of the wider workforce.

NES has a key role in education and CPD for this staff group and has been central to developing the advanced practice framework. Currently a framework for disabled CYP is out for consultation and this will have further implications for training and education of staff across Scotland. Collaborative work has also begun to develop a national postural care strategy and NES is scoping education and training to support this.

3.2.3 Transforming AHP roles

There is an increasing demand for community paediatric AHP services and the opportunity for the development of advance AHP practice roles. NES will be involved in supporting AHP CYP access clinical reasoning modules in advanced practice and clinical academic roles. NES has a pivotal role in the design and uptake of this education within the NHS and across sectors. There is an opportunity for further collaboration in education for health visitors, children's nursing and AHPs.

There is also an opportunity for NES to strengthen its contribution to the children and young people improvement collaborative (CYP-IC) in relation to language and literacy.

3.3 Medicine

3.3.1 General Practice Training

The Royal College of General Practitioners sets out the capabilities required for those training to be a General Practitioners (GP) through a UK curriculum which is approved by the GMC[1]. GPs have an important role in the care of children and young people, with most healthcare for children and young people delivered outside the hospital setting. Patients under 15 years of age comprise around 20% of the average GP list and account for one in four GP consultations.

GPs have the opportunity to promote health in all contact with children, young people and families, and ideally this should be targeted particularly at the vulnerable and socially excluded. All GPs need to be competent in dealing with safeguarding matters concerning children. GPs must be able to recognise and respond to the needs of children and young people in special circumstances, through referral and joint working.

As the effective care of children and young people is a multiprofessional activity with different health professionals working in teams, often across the historical primary and secondary care divide, it is essential that learning takes place as often as possible with other health professionals. During training, trainees gain experience of working in a collaborative way with other professionals in the team.

Interprofessional case-based learning is promoted as an effective way to learn about child protection (safeguarding children), and to remove some of the barriers to collaboration. GP Specialty Trainees need to demonstrate that they are competent in Safeguarding Children and Young People at Level 3 by completion of GP training.
http://www.rcgp.org.uk/training-exams/training/gp-curriculum-overview/online-curriculum/caring-for-the-whole-person/3-04-children-and-young-people/3-04-learning-activities.aspx

3.3.2 Paediatric Training

Again, The Royal College of Paediatrics and Child Health sets out the capabilities required for those training to be paediatricians through one UK curriculum[2] and 17 sub-specialty curricula which are approved by the GMC. Paediatrics is a specialty that relies on multidisciplinary team working and trainees are taught this from the beginning of their training. In addition, many clinical presentations in Paediatrics involve a combination of physical, emotional and psychological contributing factors.

The Royal College of Paediatrics & Child Health has in the past used the “Child in Mind” programme to encourage trainees to think about the emotional and psychological factors behind clinical presentations and more recently has collaborated in the MindEd project – see link below.
https://www.rcpch.ac.uk/training-examinations-professional-development/continuing-professional-development-cpd/education--15

[1] https://www.gmc-uk.org/education/standards-guidance-and-curricula/curricula/general-practice-curriculum
[2] https://www.gmc-uk.org/education/standards-guidance-and-curricula/curricula/paediatrics-curriculum

The mental health consequences of emotional neglect and abuse are recognised as key issues within the formal child protection training undertaken by all Paediatric trainees in order to demonstrate mandatory competency progression. There is a routine annual requirement to complete a safeguarding case based discussion as a regular workplace based assessment (WBA). This is a minimum; many trainees address the issue of emotional and mental health factors in their other WBAs.

The inter-dependence of physical and mental health is recognised by involvement of psychological support within many paediatric teams caring for children & young people with chronic conditions. All trainees undertake a specific placement in Community Child Health during the middle years of their training. It is in this post that they have greatest exposure to multidisciplinary team working involving professionals from a very broad range of backgrounds including mental health services. Some trainees will go on to specialise in Community Child Health and will follow a subspecialty curriculum for three years before spending their careers working entirely in this area.

3.3.3 Other Disciplines

In addition to the key training programmes detailed above, a number of disciplines support full CCT specialty or sub-specialty training of direct relevance to the care of children. The detailed curricula are similarly approved and published by the regulator.

Specialty Group	**Training Programme**
Royal College of Psychiatrists	Child and Adolescent Psychiatry
	Psychiatry of learning disability
Royal Colleges of Surgeons (JCST)	Paediatric surgery
	Congenital cardiac surgery
Royal College of Emergency Medicine	Paediatric emergency medicine
Royal Colleges of Physicians (JRCPTB)	Paediatric cardiology
Royal College of Pathologists	Paediatric and perinatal pathology

We currently manage 1403 postgraduate medical training places across the programmes outlined above (General Practice = 1104, Paediatrics = 240, Mental Health = 41, Others = 19).

3.3.3 Supporting Scottish Grief and Bereavement Care

NES was commissioned by the Scottish Government to produce educational resources to support health and social care practitioners (initially primarily medics) to communicate effectively around the time of an individual's death. These include an educational framework for bereavement care and clinical care after a death and a toolkit of training resources to support implementation. Some of these resources are particularly pertinent to professionals who encounter children and young people for example:

- Animated videos (http://www.sad.scot.nhs.uk/video-wall/) including Talking to Children who are Bereaved, Dealing with Unsuccessful Neonatal Resuscitation, Discussing Post Mortem Examination after Stillbirth or Neonatal Death, Understanding the Processes Following a Sudden or Unexplained Death. A further

video Supporting Families Around the Resuscitation of a Baby or Child is currently in production
- Practice Based Small Group Learning module on bereavement includes a scenario on the death of a child
- Mobile app to support decision making/ communication – includes child focussed scenarios/ topics
- NES Support Around Death website (www.sad.scot.nhs.uk) includes information regarding cardiopulmonary resuscitation of children and young people, death of a child, supporting children who are bereaved, stillbirth and neonatal death

3.4 The Dental Team

NES delivers several full-day CPD courses to members of the dental team highlighting professional responsibilities to children and young people in relation to the Children and Young People Act and outlining the principles of 'getting it right for every child' (GIRFEC). Core to these training events is encouragement to collaborate with other health professionals, social care and local authorities, adopting a holistic approach to welfare and wellbeing and the development of individual practice protocols. Feedback from these courses has been extremely positive, and the delivery of the course has evolved in response to the changing legislative background.

Child protection/ wellbeing is delivered as a core topic to all Dental Vocational Trainees.

Child protection/ wellbeing is included in the training and development for those delivering the Childsmile Programme to Extended Duty Dental Nurses (EDDNs) and Dental Health Support Workers(DHSWs) who have a role in supporting families with young children to access oral care.

Also included is:
- principles of GIRFEC
- breastfeeding, weaning and nutrition
- communication and behavioural change
- motivational interviewing
- compassionate connections

It is also worth noting that child protection /wellbeing is embedded in the dental undergraduate curriculum.'

3.5 Pharmacy Team

NES Pharmacy have a number of resources relevant for members of the pharmacy team working with C&YP. These include;
- Child Protection - a pharmacy specific resource relating to current legislation in terms of the pharmacy team knowledge and awareness in relation to child protection issues. This is currently being reviewed and updated by the child protection Board national leads.

- Introduction to paediatric pharmaceutical care - this is a clinical resource aimed at pharmacists.
- Consulting with children and young people - this is a CPPE course aimed at pharmacists and technicians when talking with a young person.

3.6 Carers

The Carers (Scotland) Act 2016 came into force from April 2018. Local authorities and health boards have a range of duties to involve and support carers and young carers. NES was commissioned by Scottish Government to produce a digital resource aimed at supporting the acute sector workforce meet the duty to involve carers and young carers in hospital discharge. The resource focuses on identifying, involving and informing carers and young carers, including parents of children where the parents are considered carers for the purposes of the Act.

3.7 Palliative and End of Life Care

NES and Scottish Social Services Council were commissioned by Scottish Government to develop a framework describing the knowledge and skills required for palliative and end of life care, for all health and social care staff including the children's workforce. More information is available at: https://learn.nes.nhs.scot/2452/palliative-and-end-of-life-care/palliative-and-end-of-life-care-a-framework-to-support-the-learning-and-development-needs-of-the-health-and-social-service-workforce-in-scotland

In response to learning needs identified through implementation of the framework, NES has produced an associated digital resource to support health and social care workers at Informed Level of the framework, including the children's workforce.

3.8 Protecting Children

The educational leadership (ELG) organised a session on protecting children in the light of the findings and recommendations from the Significant Case Review into a child protection case in Fife, which was published in June 2017.
Jane Scott (Senior Research Fellow at the Centre for Child Wellbeing and Protection, University of Stirling) led a discussion on issues arising from Significant Case Reviews, with specific reference to implications for health care staff.

Representation from Medicine, NMAHP, Psychology and Dental discussed current practice within the educational programmes across NES and agreed that sharing best practice on a multi-disciplinary basis was helpful and would continue via the Educational Leadership Group.

3.9 Corporate Parenting

Along with other public agencies NES acts as a Corporate Parent and has a statutory duty to promote the interests and welfare of children and young people who are care experienced. This important topic was recently the subject of a Board paper and NES's action plan was recently published online at http://www.nes.scot.nhs.uk/publications-and-resources/corporate-publications/corporate-parenting-plan-2017-18.aspx

3.10 Supporting Remote and Rural Practitioners

Remote, rural and island practitioners carry a wide breadth of caseload responsibilities including care for children, young people and families. They are unlikely to have specialist skills in these areas and access to specialist support may be via "at distance" methods. As a result, accessing and developing appropriate professional and educational programmes that support this aspect of rural practice continues to be a high priority for NHS Boards, Remote and Rural Healthcare Education Alliance (RRHEAL) and NES.

RRHEAL have developed a range of specific programmes and resources to support these needs and they can be accessed via TURAS Learn https://learn.nes.nhs.scot/792/rrheal/child-health. RRHEAL VC Education monthly sessions also focus on topics relating to children, young people and families in response to priority workforce needs and these are delivered in collaboration with NES colleagues from a range of disciplines.

RRHEAL has 'rural proofed' a wide range of paediatric programmes in conjunction with NES Child Health, NMAHP and other NES colleagues such as the Core Level Paediatric Emergency Care Programme. This programme has been taken up by over 2500 healthcare staff across Scotland. RRHEAL also worked with NES Child Health colleagues to develop the Assessment of The Acutely Ill and Injured Child; Skills Maintenance Resource.[2] RRHEAL have also worked extensively with the ScotsSTAR Paediatric Retrieval Service and the Children's Hospice Association Scotland (CHAS) to develop a range of specialist resources to support remote and rural practice in these key areas.

3.11 C&YP with Health Conditions – Psychological Interventions

Children and young people with health conditions experience four times more psychological distress than their healthy peers. Good psychologically informed care delivered by the whole paediatric workforce can improve adherence, capacity to adjust and manage conditions. Ultimately this could improve quality of life, reduce healthcare contacts and reduce admissions.

The NES Paediatric Psychology workstream focuses on upskilling multidisciplinary paediatric healthcare staff by developing and delivering training in low level psychosocial interventions and skills. We currently offer 9 skills based face to face modules (TIPS-PH) and 5 e-learning modules. In the past 7 years, a total of 2568 training places have been taken up on the TIPS-PH modules by multidisciplinary staff across all health boards: 34% from nursing, 25% AHPs, 14% doctors and 27% from other backgrounds (which includes social workers, health visitors, school nurses and 3rd sector/voluntary staff). Modules are delivered by NES Principal Educators and a network of trainers: Paediatric Psychologists are trained to deliver

[2] https://learn.nes.nhs.scot/793/rrheal/child-health/early-recognition-and-assessment-of-the-sick-child

the modules, with a total of 56 trained and 24 actively delivering modules each year. Evaluation has consistently demonstrated significant increases in both knowledge and confidence across all modules and qualitative analysis demonstrates high levels of satisfaction with the training.

3.12 Psychological Trauma and Adverse Childhood Experiences (ACEs)

The Scottish Government has identified adverse childhood experiences (ACEs), their prevention and mitigation of the range of possible sequalae including developing resilience as one of the goals in their recently published Programme For Government (2017-2018)

'We will embed a focus on preventing ACEs and supporting the resilience of children and adults in overcoming early life adversity across all areas of public service, including education, health, justice and social work.' (pg. 73)

NES has been able to take a leading role in the workforce development, training and implementation in relation to this through the leadership of the National Trauma Training Strategy (due to be published summer 2018) and the underpinning NES/SG (2017) 'Transforming Psychological Trauma: A knowledge and Skills Framework for the Scottish Workforce.

3.13 Multisystemic Therapy

Multisystemic Therapy (MST) is an internationally recognised intensive form of therapy that provides a preventative intensive family and community based intervention that targets the multiple sources of antisocial behaviour in Young Persons aged 11-17, who, without intervention, could be at risk of being placed into Local Authority Care.

There are currently four MST teams in Scotland. In November 2017 a Scottish Consultant and Programme Lead was successfully appointed by NES on a cost neutral basis via a service level agreement with MST UK.

In addition to providing consultation and quality assurance to the current four teams, support for other NHS Boards and Local Authority partnerships on a 'Once for Scotland' basis that wish to improve outcomes for young people is available. The UK Network Partnership offers the advantage of integration into Scottish policy and national planning whilst also being part of the MST quality assurance system within the UK Network Partnership. There are several areas in Scotland that have expressed interest in MST and development work in conjunction with NHS Boards, Scottish Government and Local Authorities to progress this interest will be undertaken. More information is available at: http://www.mstuk.org/ and http://www.mstservices.com/

3.14 Mental Health Scottish Government Funded Workforce Development Programme for Child and Adolescent Mental Health

In March 2016 NES was awarded funding of £24.6 million to deliver a four-year workforce development programme to enhance the supply and training of the mental health workforce to deliver evidence based therapies in support of the Local Delivery Plan (LDP). Access Standards for CAMHS and Psychological Therapies (i.e. 18-week referral to treatment). Within this package of funding £12,178,134, 50% is dedicated to the children's services workforce including specialist child and adolescent services (CAMHS). This additional funding has been added to core NES funding to deliver the programmes below.

3.14.1 Infant Mental Health

The Solihull Approach helps early years practitioners think psychologically about development in the early years of life. Since 2014 approximately 870 early years staff (nursery staff, health visitors, midwives) have been trained in the approach along with 90 trainers and this is continuing.

Some new infant mental health initiatives have been developed as part of a systematic training pathway for practitioners working with families of children up to 18 months. These staff will already have undertaken Solihull training and the NES infant mental health online module. The new pathway includes further online training followed by additional in-depth training in two specific interventions suitable for work with parents and infants where the relationship is subject to high levels of stress.

NES is also involved in work to update the Perinatal Mental Health curriculum framework as well as contributing to Perinatal Mental Health Managed Clinical Network. The mental health component of the revised health visitor training pathway has also been developed.

3.14.2 Early Years Early Intervention Framework

Funding is also being utilised to develop an inventory of evidence based early years psychological interventions with key implementation information which is contextualised for Scotland. This resource will be useful for individual practitioners, communities, organisations and policy leads. This project is in the early stages of development, including the establishment of an Executive Group, a Design Team and Advisory Group. The first phase of the framework will focus on 0-3 years of age.

3.14.3 Pre-school children

Approximately 10% of pre-school children display atypical and persisting high levels of behaviour problems. Fortunately, evidence based parenting programmes are available that are successful, cost effective and valued by parents. Since 2013 the Psychology of Parenting Project (PoPP) has been working with Community Planning Partnerships (CPPs) across Scotland to equip staff to deliver these programmes to the families of 3 and 4-year olds with elevated behaviour problems. To date 20 CPPs have been working with PoPP with 668 PoPP

groups having been delivered to 4036 families. The 665 who have been trained to deliver these interventions have mainly been local authority employees. 81% of children (for whom we have full data) have demonstrated an improvement with 61% moving out of the high-risk range in standardised measures. Further work is planned to extend this work.

In order to increase the reach of PoPP within communities a strength based communication skills training has been implemented to support staff in engaging parents. Over 900 practitioners have participated in this.

3.14.4 School-age Children

TIPS-EIC (Training in Psychological Skills-Early Intervention Children)

Between 10% and 23% of school-aged children and young people have distress or mental ill health that could benefit from a psychological intervention. Without such early intervention these difficulties can escalate and become entrenched. CAMHS can only address the needs of a fraction of these children and young people.

The TIPS-EIC project employs Implementation Science principles to select, train and coach individuals across professional groups in the Scottish child workforce (e.g. school nurses, guidance teachers, educational psychologists, social workers and pupil support workers) to deliver evidence-based / informed psychological interventions to children and young people who may not otherwise be able to access such support. Locally based Clinical psychologists are supported to deliver training, coaching supervision and practice support across Scotland in schools and other universal settings.

The programme is skills focussed including topics such as communication, distress, trauma informed practice and supporting anxious children. To date this has reached about 300 staff and has received positive feedback.

Contributions have also been made to the mental health component of the revised school nurse training pathway.

3.14.5 Support for Specialist CAMHS

Since 2015, CAMHS training has aimed to build supervision and therapeutic delivery capacity across major evidence-based psychological interventions, with the aim of supporting the quality and future sustainability of psychological intervention delivery in the long term. Just under half of current CAMHS training funding has been allocated to health boards in the form of backfill funding to help release staff for training. Assessment of local training needs and plans has been encouraged through funding local CAMHS learning co-ordinator sessions in each health board.

CAMHS clinicians have been offered training to different levels in Cognitive Behavioural Therapy (CBT) to support children and young people with anxiety, depression and other mental health difficulties.

Family therapy training has been completed by a range of CAMHS clinicians to a variety of levels since 2015. Training in Family Based Treatment (FBT) for anorexia is underway with the aim of developing them to practitioner and then supervisor level. Training in specialist cognitive behavioural therapy for eating disorders is being offered to CAMHS clinicians. Training in Interpersonal therapy (IPT) for depression, and eating disorders has been undertaken and the plan is to develop them to increase IPT supervision capacity.

CAMHS clinicians have also been trained in trauma and resilience to different levels including: accessing a newly developed NES trauma in child online module, training in assessment and formulation, and training in trauma focussed CBT. Clinicians working with children with a learning disability have received training in applied behavioural analysis. A redevelopment of the Essential CAMHS training resource which aims to facilitate the development of new CAMHS clinicians is currently being undertaken.

3.14.6 Professional Training Posts for CAMHS

This funding is also being used to increase workforce supply for CAMHS through investment in professional training posts as below. These trainees deliver clinical services under supervision while training.

Child and Adolescent Psychotherapy Training

This 4-year training offers an in depth and intensive training to enable practitioners to provide psychotherapy suitable for children and adolescents:

- Supporting 4 training places for Child and Adolescent Psychotherapists in Training over 4 years- 3 trainees from the 2013 cohort completed at the end of September, with 2 completed in November and December 2017. 5 new trainees commenced in September 2017.

MSc Applied Psychology Children and Young People

This one-year Masters training equips psychology graduates to deliver interventions for anxiety and depression as well as in parenting and mental health promotion:

- Increase number of MSc APCYP trainees by 5 to 18 per intake- 18 commenced training February 2017 and 19 commenced in February 2018.

CAMHS aligned Clinical Psychology Training

This is a three-year post-graduate training in clinical psychology with a particular focus on CAMHS. This enables staff to intervene across a range of mental health disorders and conditions across the lifespan:

Support 30 CAMHS aligned clinical psychology trainees per year- there were 30 CAMHS aligned trainees in 2016/17 and 29 in 2017/18. It is expected that there will be 30 CAMHS aligned trainees in 2018/19.

4. Workforce Supply Issues

The workforce serving children, young people and families is subject to many of the general workforce pressures (the aging trend of the Scottish population, concerns about post Brexit impact on the availability of workers from outside the UK) but there are also some particular pressures.

Recruitment to medical training posts in Scotland is broadly similar to the other UK nations. General Practice and Psychiatry training posts have for some years now not completely filled, while Paediatric training posts have a 100% fill. Scottish Government has increased the number of GP training programmes from 300 to 400, and there has been a gradual increase in the number of doctors choosing to train for general practice. The lengthy training pipeline in medicine means that rapid improvement in supply is difficult. The situation is different in healthcare disciplines with shorter training pathways where further expansion in training places could increase workforce capacity. Recruitment into training for nursing roles in health visiting, school nursing and general children's nursing is strong. Retirals, maternity leave and part-time working however, create high vacancy in some areas. Allied Health Professionals and psychology roles in children's services remain attractive careers with a ready supply of applicants for training.

Scottish Government is currently developing a 10-year child and adolescent health and wellbeing action plan to be launched later in 2018 and it is likely to have significant workforce development implications that NES will need to take account of.

Scottish Government has indicated that a whole system collaborative approach to support early intervention and prevention and to reduce inequalities will be promoted in the action plan.

5. Summary of Key Issues and Future Directions

As health and social care integration progresses NES will need to continue helping prepare staff for working across traditional organisational boundaries and our partnerships with Scottish Social Services Council (SSSC), Education, Justice, Integrated Joint Boards, national and territorial health boards will be critical in this. In order to improve our working with external partners and general efficiency NES needs to strengthen and deepen internal collaboration and co-ordination. As part of "Once for NES" an improvement programme will be developed later in 2018 to address this while learning from the experience of other improvement programmes.

Flexible training pathways to support flexible careers will be required as roles change and adapt to new service requirements.

Our education and training will need to be informed by the views of children, young people and families from design to delivery, and we have some useful experience in doing this.

The production of this board paper has been a useful first step in sharing information about the volume and breath of education that NES is providing. It is likely that there will be scope for further standardising and alignment of core learning across disciplines and sectors with supplementary materials for specific audiences. There will be many opportunities to realise this through NES TURAS Learn.

6. Actions to be taken forward

Board members are invited to note the information contained in this report and the following actions to be taken forward;

1. Strengthen partnership working across internal and external boundaries to enable education and training to support holistic and flexible care where children young people and families “ask once get help fast”.

2. Where possible, coordinate and align the education and training of the specialist and general healthcare disciplines serving children young people and families with opportunities to support multidisciplinary and multi sector workforce development.

3. Ensure all staff for whom NES has a training or employment remit are aware of their responsibilities to protect the safety and promote the wellbeing of children and young people.

4. To continue to explore methods to attract and retain staff into training pathways for the children’s services workforce.

NHS SCOTLAND

National Health and Social Care Workforce Plan

Part 3 – Improving workforce planning for primary care in Scotland

April 2018

Healthier Scotland
Scottish Government

CONTENTS

FOREWORD

I am delighted to publish the *National Health and Social Care Workforce Plan: Part 3 – Improving workforce planning for primary care in Scotland*, which sits alongside the workforce plan parts one and two published last year. We are embarked on a long-term journey to reform primary care in Scotland to better serve the needs of our people, promote prevention and self-management, and put services on a sustainable footing. This plan is an important further step on that journey.

The plan focusses on developing, building and expanding Multidisciplinary Teams (MDTs), made up of professionals each contributing their unique skills to managing care and improving outcomes. This government has previously set out a series of ambitious commitments to significantly expand and strengthen the primary care workforce, backed by a historic increase in investment in primary care. The plan outlines how we intend to deliver these pledges. What is clear however, is that we are already seeing considerable benefits from enhanced MDT working and new models of care across Scotland, and I am confident this will gather pace in the coming years through the initiatives we and our partners are taking forward.

The Chief Nursing Officer, together with Scottish Executive Nurse Directors and partners, is leading an important piece of work to maximise the contribution of the nursing, midwifery and health professionals (NMaHP) workforce. The *Transforming Roles* programme is ensuring nationally consistent, sustainable and progressive roles, education and career pathways to meet the current and future needs of our population, and will inform and support local workforce planning. We will invest £6.9 million over three years for the training and education of General Practice Nurses and District Nurses to help support a sustainable 24/7 community nursing workforce.

In addition, recognising the importance of the District Nursing workforce in shifting the balance of care from hospitals to community settings, we will work alongside partners, including the Royal College of Nursing, to understand the requirements for sustaining and expanding this workforce. We are committed to undertaking this work at pace and will be in a position by September 2018 to better understand the requirements and investment necessary to grow the workforce. Integration Authorities and NHS Boards retain responsibility for planning and funding District Nurse vacancies and projected retirals from existing budgets.

The new GP contract, which I was delighted to see strongly endorsed by Scotland's GPs in January, will be crucial in making general practice a more attractive career choice. I recently announced our commitment to increase the number of GPs in Scotland by at least 800 over the next 10 years. This is challenging, requiring action across a number of fronts and with the input and support of many individuals and organisations. We can deliver, and the initiatives we set out in this plan move us along that road.

However, I fully recognise the considerable pressure our health services are under to meet the increasing demands of our ageing population. I hear the concerns expressed around our ageing primary care workforce and the need for bold action to address current vacancies across professions. The actions set out in this plan, alongside our wider programme of reform of primary care, will accelerate the pace of

change but I acknowledge we will continue to face significant challenges and tough decisions along the way.

Finally, I'd like to take this opportunity to thank the Royal College of Nursing, the British Medical Association, the Royal College of General Practitioners, Chief Officers, Allied Health Professions Federation Scotland, Optometry Scotland, Community Pharmacy Scotland, British Dental Association and other stakeholders who have helped shape the plan. I am aware the plan doesn't address all concerns raised by our partners but it is an important starting point. It sets a marker for further developments needed to improve workforce planning in Scotland, and we will continue to work closely with partners in developing an integrated workforce plan to be published by the end of this year.

Looking ahead, there is still much to be done but we have already come far in realising our ambition of a modernised primary care service. That is down to the skill and dedication of the many individuals – both clinical and non-clinical – that make up our workforce.

SHONA ROBISON
Cabinet Secretary for Health and Sport

SUMMARY OF KEY RECOMMENDATIONS AND NEXT STEPS

This Plan sets out recommendations and the next steps that will improve primary care workforce planning in Scotland. These complement the recommendations in parts one and two and, taken together, will form the basis of the integrated workforce plan in 2018. The recommendations below set out how we will enable the expansion and up-skilling of our primary care workforce, the national facilitators to enable this, and how this will complement local workforce planning.

Facilitating primary care reform

Recommendations and commitments:

1. Reform of primary care is driven by developing multidisciplinary capacity across Scotland. Workforce planners including NHS Boards, Integration Authorities and General Practices will need to consider the configuration of local multidisciplinary teams that offer high quality, person-centred care.

2. In recognition of an ageing workforce, local planners have responsibility for workforce planning and managing anticipated levels of staff turnover.

3. The implementation of the new GP contract will require services to be reconfigured to maximise workforce competencies and capabilities, and ensure people see the right person, at the right time and in the right place.

4. The National Workforce Planning Group will play a strategic role in implementing the recommendations of part three of the plan, and strengthen the development of approaches for the primary care workforce.

5. An integrated workforce plan to be published later in 2018 will move towards a better articulated joint vision for health and social care workforce planning.

Building primary care workforce capacity

Recommendations and commitments:

6. Significant investment will be made available over the next 3-5 years, as part of the First Minister's commitment to an additional £500 million for community health services, to plan for, recruit and support a workforce in general practice, primary care and wider community health, including community nursing.

7. Scotland’s multidisciplinary primary care workforce will become more fully developed and equipped, building capacity and extending roles for a range of professionals, enabling those professionals to address communities’ primary healthcare needs.

8. As part of national, regional and local activity to support leadership and talent management development, planners will need to continuously consider staff training needs in their workforce planning exercises; invest appropriately so that leaders in primary care are fully equipped to drive change; and enhance

opportunities for the primary care workforce to further develop rewarding and attractive careers.

Improving data, intelligence and infrastructure in primary care

Recommendations and commitments:

9. More integrated workforce data for primary care is required, in the context of the workforce data platform being developed by NHS Education for Scotland.

10. Local planners should consider workforce planning tools (such as the six step methodology) in developing their workforce strategies to address local population needs.

11. Planning for future staffing in primary care should identify and make use of available guidance and intelligence on local recruitment and retention issues, and of wider developments in workforce data and scenario planning.

12. The Scottish Government will publish the Primary Care Monitoring and Evaluation Strategy 2018-2028 by summer 2018.

INTRODUCTION

As set out in the *Health and Social Care Delivery Plan*[1], the Scottish Government's vision for the future of primary care is for enhanced and expanded multi-disciplinary community care teams, made up of a variety of professionals each contributing their unique skills towards delivering person-centred care and improving outcomes for individuals and local communities. This vision closely reflects the 21 underpinning principles on the future of primary care set out by Scotland's health professional groups in 2016[2].

We have established six long-term outcomes that support the delivery of our vision:

- We are more informed and empowered when using primary care
- Our primary care services better contribute to improving population health
- Our experience of primary care is enhanced
- Our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care
- Our primary care infrastructure – physical and digital – is improved
- Primary care better addresses health inequalities

Delivering these outcomes, and the wider aspirations set out in the *Delivery Plan*, will take time and will involve significant challenges. Nevertheless, we are committed to investing in primary care and focusing on new models of prevention and self-management. Getting primary and community care right is an essential component of ensuring the whole healthcare system is sustainable. It will deliver the best outcomes for patients, in line with our vision of care being provided at home or in a homely setting, and help ensure rewarding, well-supported careers for our community healthcare workforce.

Committing to the future of primary care

With our local and national partners we have already embarked on an ambitious programme to support and build primary and community care. The First Minister announced in October 2016 an increase in funding in primary care of £500 million by the end of this Parliament. This investment will see at least half of frontline NHS spending going to community health services, and will enable us to significantly expand the primary care multidisciplinary workforce. This includes training an additional 500 advanced nurse practitioners across acute and primary care, 250 more community links workers in practices by the end of the parliamentary period to address patients' wider needs, training an additional 1,000 paramedics to work in

[1] Scottish Government (2016), *Health and Social Care Delivery Plan* http://www.gov.scot/Resource/0051/00511950.pdf

[2] *The Future of Primary Care: a view from the professions* (2017), https://www.rcn.org.uk/about-us/policy-briefings/sco-pol-future-of-primary-care-1-sept

support of general practice, the expansion of mental health workforce, and enhanced roles for Allied Health Professionals (AHPs) in delivering person-centred care. General Practice will further be supported by ensuring all practices are given access to a pharmacist by the end of this parliamentary period.

The new General Medical Services (GMS) contract, jointly negotiated by the BMA and the Scottish Government, sets out a refocused role for GPs as Expert Medical Generalists (EMGs) and recognises the GP as the senior clinical decision maker in the community. This role for all GPs will be supported through service redesign and the expansion of the multi-disciplinary workforce. The Cabinet Secretary for Health and Sport recently committed to increasing the number of GPs by at least 800 (headcount) in the next 10 years through an ambitious training, recruitment and retention programme.

NHS Boards are responsible for allocating resources to ensure that people are able to access quality healthcare services both in and out of hours. We recognise the particular challenges faced by out of hours services and remain committed to having a high-quality service which fully meets patient needs. That is why we invested £10 million in 2016-7 and provided further investment as part of the £23 million Primary Care Transformation Fund (PCTF) in 2017-8, to deliver the recommendations in Sir Lewis Ritchie's report *Pulling together*[3]. Going forward, we expect Boards to maintain and develop a resilient out of hours service that builds on the recommendations in Sir Lewis's report, ensuring effective links and interface between in and out of hours GP services. This is also reflected in further work undertaken by Sir Lewis through *Improving Health and Social Care Service Resilience over Public Holidays*, published in December 2017[4].

Alongside the expansion of the multidisciplinary workforce, we are currently implementing significant changes in how primary care will be organised. Our historic *Memorandum of Understanding* (MoU)[5] with Integration Authorities, the British Medical Association, NHS Boards and the Scottish Government sets out the principles underpinning primary care in Scotland, including respective roles and responsibilities. It provides the basis for the development by Integration Authorities (IAs), as part of their statutory strategic planning responsibilities, of Primary Care Improvement Plans (PCIPs), clearly setting out how additional funding will be used and the timescales for the reconfiguration of services currently delivered under GMS contracts.

Workforce planning

The publication of *National Health and Social Care Workforce Plan: Part 1 – a framework for improving workforce planning across NHS Scotland*[6] last June signalled the beginning of a process to further improve workforce planning across health and social care. It set out new approaches to workforce planning across Scotland, within a framework for wider reform of our health and care systems. Part 2

[3] http://www.gov.scot/Resource/0048/00489938.pdf
[4] http://www.gov.scot/Publications/2017/12/2391
[5] *Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards* http://www.gov.scot/Resource/0052/00527517.pdf
[6] http://www.gov.scot/Resource/0052/00521803.pdf

of the Workforce Plan – *A framework for improving workforce planning for social care in Scotland*[7] – published jointly by the Scottish Government and COSLA – sets out a whole system, complementary approach to local and national social care workforce planning, recognising our new integrated landscape. The publication of this primary care workforce plan marks an important further step in that journey.

Part 3 does not restate the range of actions already underway to improve workforce planning as set out in parts 1 and 2, but focuses on how we will support the primary care workforce deliver improved outcomes for Scotland's people. It is recognised however, that to deliver integrated services and continuity of care for patients across community-based health and social care services and acute services, good interfaces based on shared understanding and trust, and supported by robust data and intelligence, are essential. Effective workforce planning needs to acknowledge interdependencies across the different parts of the system and take an iterative approach to planning across the wide range of skilled professionals involved in its delivery. The next stage in this process therefore builds on the actions taken to deliver the recommendations across the three parts of the workforce plan, with publication of a single, integrated national Workforce Plan later in 2018.

This plan is split into seven chapters. Chapter one sets out the role of primary care services in effectively responding to the changing and growing needs of our population, alongside the evidence of the significant benefits that will be delivered through focusing our workforce on prevention and supporting self-management. We set out the shape of the existing primary care workforce, including recent trends in workforce numbers, in Chapter two, before describing the anticipated changes in the way services will be developed to meet population need in Chapter three. Chapters four to six set out how the MDT will be strengthened to deliver an enhanced and sustainable workforce to improve patient outcomes. Chapter seven outlines how we will work with partners to ensure that better quality and more timely data is developed to drive effective local and national workforce planning.

[7] http://www.gov.scot/Resource/0052/00529319.pdf

CHAPTER ONE: SETTING THE CONTEXT

Introduction

Primary Care in Scotland: A definition from the professionals[8]

Most of the time, people use their own personal and community assets to manage their health and wellbeing and achieve the outcomes that matter to them. Primary care professionals enhance this by providing accessible health care and support to individuals and families in the community, when it is needed, at whatever stage of life.

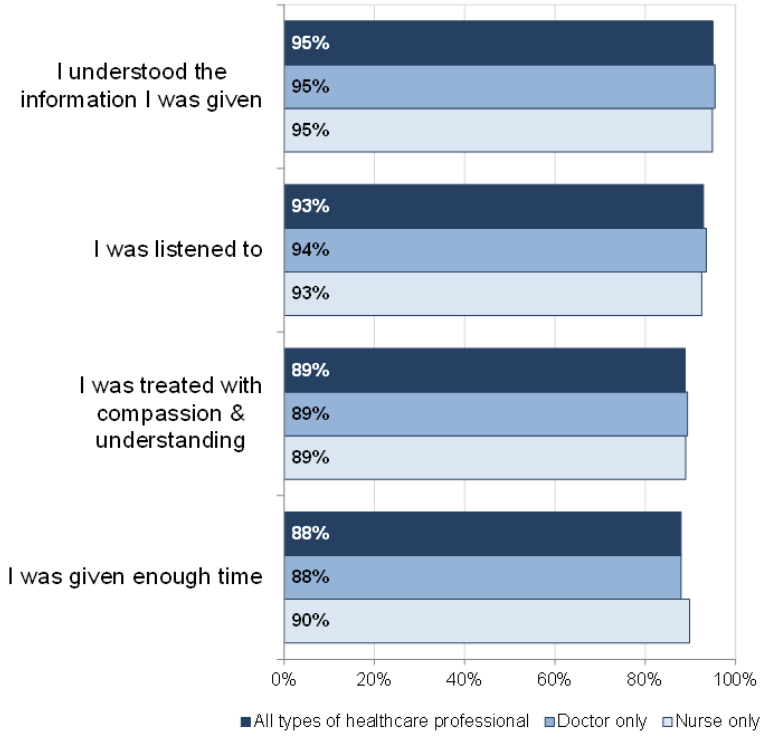
Primary care is provided by generalist health professionals, working together in multidisciplinary and multiagency networks across sectors, with access to the expertise of specialist colleagues. All primary care professionals work flexibly using local knowledge, clinical expertise and a continuously supportive and enabling relationship with the person to make shared decisions about their care and help them to manage their own health and wellbeing. Primary care is delivered 24 hours a day, 7 days a week. When people need urgent care out of core service hours, generalist primary care professionals provide support and advice which connects people to the services they need, in a crisis, in a timely way.

Scotland's health is improving, driven by the skill and dedication of the NHS workforce and the bold measures taken on public health since the establishment of the Scottish Parliament in 1999. We are now living longer, healthier lives with a marked reduction (by over a third) in premature mortality between 1994 and 2015 (including significant falls in premature deaths caused by cancer, coronary heart disease, and cerebrovascular disease)[9].

Despite pressure on services, patients are highly positive of their experience of the health service, with 83% of people rating the overall care provided by their GP practice as good or excellent in 2017-18[10]. Of those who needed an urgent appointment, 93% were offered one within 48 hours, an increase from 91% in 2015-16. As figure 1 shows, people were also highly positive about their experiences of person-centred care at their GP practice, with positive ratings typically around or over 90%. Overall ratings for care from out of hours services were similar to those for the GP practice at 83%. These are achievements of which the primary care workforce should be rightly proud.

[8] *The Future of Primary Care: a view from the professions* (2017), https://www.rcn.org.uk/about-us/policy-briefings/sco-pol-future-of-primary-care-1-sept
[9] Scottish Government (2017), *Realising Realistic Medicine* http://www.gov.scot/Resource/0051/00514513.pdf
[10] Scottish Government (2018), *Health and Care Experience Survey 2017/18 - National Results* http://www.gov.scot/Publications/2018/04/2112

Figure 1: Patient experience, 2017-8



Challenges facing primary care

We are aware however, that as across the UK and internationally, demand on our primary care and social care services is steadily increasing due to a combination of an ageing population and rising levels of multi-morbidity[11]. The number of people aged 65 and over is estimated to increase by around 60% from 0.93 million to 1.48 million by 2039[12], leading to substantial rises in a range of long-term conditions[13]. Patients are also demanding more from their healthcare professionals: they rightly expect higher standards of care, more information about their treatment, more involvement in decisions about their care and improved access to the latest treatments[14].

People with long-term conditions already account for about 50% of GP appointments[15], placing significant and increasing strain on services. Evidence also demonstrates that people with co-existing physical and mental health problems often have longer hospitalisations, treatment failure, poor quality of life and premature mortality. As we said in the *Mental Health Strategy for 2017-2027*[16], our guiding ambition is that we must prevent and treat mental health problems with the same commitment, passion and drive as we do with physical health problems.

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[11] Multi-morbidity is commonly defined as the presence of two or more chronic medical conditions in an individual.
[12] https://www.nrscotland.gov.uk/files//statistics/population-projections/2014-based/pp14-fig4.xlsx
[13] Information Services Division (ISD) estimate an additional 243,000 individuals living with hypertension, diabetes, heart failure or COPD by 2029.
[14] Baird, B. et al (2016), *Understanding pressures in general practice*, The Kings Fund
[15] Department of Health (2012), *Long Term Conditions Compendium of Information: Third Edition* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf
[16] Scottish Government (2017), *Mental Health Strategy 2017-2027* http://www.gov.scot/Publications/2017/03/1750

The benefits of a strong and integrated primary care system

Whilst our workforce has continually adapted and innovated to meet an increasing and more complex workload, maintaining consistently high standards of care and treatment has become more difficult to sustain. There is growing consensus that the NHS needs to focus more on the development of preventative models of care (including self-management), rather than reactive management of patients with long term conditions to be financially sustainable, tackle persistent health inequalities, improve long-term outcomes and to reduce pressure on the workforce. This calls for a modernised healthcare system as set out in the Chief Medical Officer's ground-breaking reports *Realistic Medicine* and *Realising Realistic Medicine*[17]. Realistic Medicine puts the person at the centre of decision-making and creates a personalised approach to their care.

Primary care is at the heart of this vision. The primary care workforce is uniquely placed to influence the level of demand for other care settings, acting as a 'navigator' or 'gatekeeper' to secondary care, developing anticipatory care plans, and co-ordinating care, screening and health promotion. It is best placed to support self-management by helping patients to fully understand and manage their own conditions, as well as promoting a focus on both primary and secondary prevention.

This is supported by greater integration of health and social care services to develop stronger care pathways between primary and social care focused on the need of the individual. The ambition set out in Part 2 of the National Workforce Plan[18] that social care supports people at all stages of their lives to live as independently as possible closely aligns with and supports the vision for a strengthened primary care system. The potential benefits in further strengthening primary care system, built on enhanced and expanded multi-disciplinary teams, are set out below.

Figure 2: Strengthening primary care: the benefits

[17] Scottish Government (2016), *Realistic Medicine* http://www.gov.scot/Resource/0049/00492520.pdf; Scottish Government (2017), *Realising Realistic Medicine* http://www.gov.scot/Publications/2017/02/3336/downloads#res-1

[18] http://www.gov.scot/Resource/0052/00529319.pdf

The key benefits of a strong and integrated primary care system

- Half of cancers, three-quarters of cardiovascular disease and 80% of strokes are preventable. More systematic primary prevention in primary care therefore has the potential to improve population health outcomes and has been shown to be cost effective[19].
- Lifestyle behaviours (such as smoking, diet, obesity and alcohol consumption) are driving non-communicable disease clusters, particularly in our most deprived communities, contributing to a legacy of health inequalities.
- Systematic and scaled-up secondary prevention – for example, prescribing statins to reduce cholesterol and taking measures to reduce high blood pressure – has been found to be cost-effective, clinically significant and an important way to tackle inequalities in health[20].
- Improved access to primary and social care services could lead to a reduction in 'social admissions' – admissions based not on the severity of a patient's clinical condition but on their inability to cope without appropriate support unless admitted, or if discharged. Social admissions and delayed discharges pose significant issues for hospitals, with up to 40% of admissions of elderly patients who have attended A&E shown to be avoidable[21].
- Improved access to in and out of hours primary care has the potential to reduce demand for A&E attendances and unnecessary ambulance call outs.
- In the medium term, an enhanced primary care workforce could support patients to take a more pro-active approach to managing their conditions, leading to an estimated 8% to 11% reduction in avoidable admissions (that is, admissions for ambulatory care sensitive conditions)[22].

Citizen engagement

It is vital that we engage our citizens at every step of the journey to successfully reform primary care services. They must play a key role in helping to shape the services they need now and in the future. In 2015 the Scottish Government launched a National Conversation *Creating a Healthier Scotland*[23] and through this and the subsequent engagement via the Scottish Health Council's *Our Voice Framework*[24], we heard that people want more flexible primary care services, with appointments that fit in with their lives, including work and caring commitments. Engagement via *Our Voice* has produced a range of innovative suggestions on how to develop services, including highlighting ways to take the pressure off primary care, reduce physical access issues and support self-management.

[19] Health England (2009). *Intervention Reports: Report no 5*.
[20] *Ibid*
[21] Deloitte (2014) *Spend to save: The economic case for improving access to general practice* http://www.rcgp.org.uk/~/media/Files/PPF/2014-RCGP-Spend-to-Save-Deloitte-report.ashx, Royal College of General Practitioners
[22] *Ibid*
[23] Scottish Government (2016) *Creating a healthier Scotland - What matters to you* http://www.gov.scot/Publications/2016/03/9693
[24] https://www.ourvoice.scot/

In addition, the Scottish Government has recently commissioned a series of workshops across Scotland inviting people to give their views on changes to primary care, to hear how general practice teams are changing, and how the development of these teams might impact on them and how they can work for them. The findings from this engagement exercise will help inform the implementation of the new GP contract and the reform of primary care more generally.

As set out in Chapter seven, we are developing a 10 year monitoring and evaluation strategy to capture learning from the reform of primary care. We will ensure that people's views help inform that work as it is taken forward.

Conclusion

We are aware of the significant challenges currently facing the primary care workforce as demand on services continues to increase. Our commitment to reform and invest in primary care services – continuing to shift the balance of care from hospital settings to community health and social care services – is founded on robust evidence that demonstrates that health systems based on strong primary care infrastructure have better outcomes in terms of population health, access, co-ordination experiences and a lower and more appropriate use of resources[25].

[25] See, for example, Starfield B, Shi L, Macinko J. Co*ntribution of primary care to health systems and health*. Milbank Q. 2005;83(3):457–502.

CHAPTER TWO: THE SHAPE OF THE PRIMARY CARE WORKFORCE

Introduction

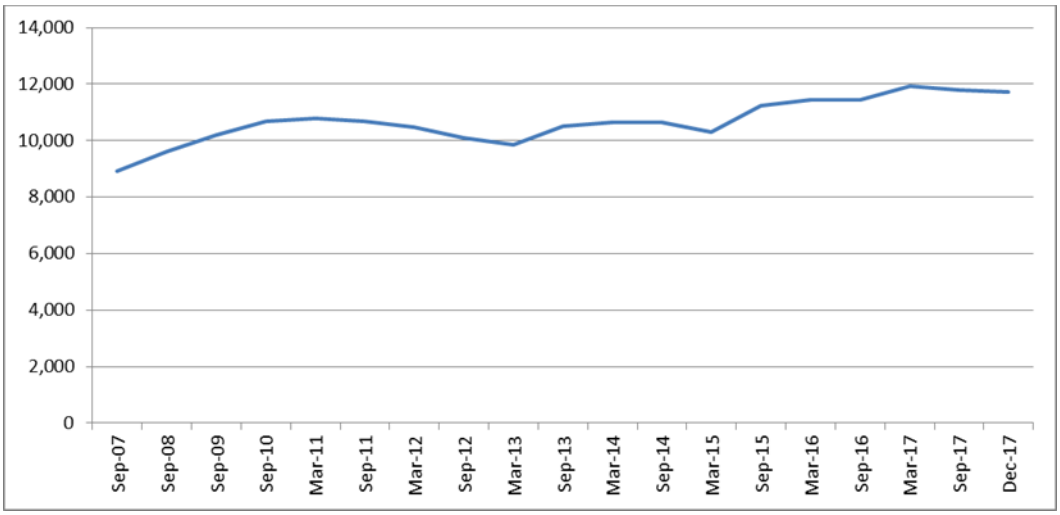
The first step in good workforce planning is to have good quality, consistent data on the shape of the current workforce, including recent and predicted future trends in workforce numbers. For the primary care workforce, much has still to be done to improve existing data to provide a more comprehensive and robust evidence base to inform workforce planning. Our approaches to enhancing the data available to planners and clinicians are set out in Chapter seven.

While current workforce data requires further development, it provides useful context on the profile of the existing workforce and potential effects of future pressures. Our understanding of trends will improve as fuller and more integrated data becomes available, informing subsequent iterations of the health and social care workforce plan.

Community and primary care nursing

There are approximately 60,000 nursing and midwifery staff (WTE) currently employed within NHS Scotland. Of those, around 12,000 (WTE) work in community settings, almost 3,000 more than in 2007. The increase in nurses working in the community reflects our strategic goal of moving care out of hospital settings to home or a homely setting wherever possible.

Figure 3: Nursing and midwifery (qualified and support) in community settings, WTE, 2007-2017[26]



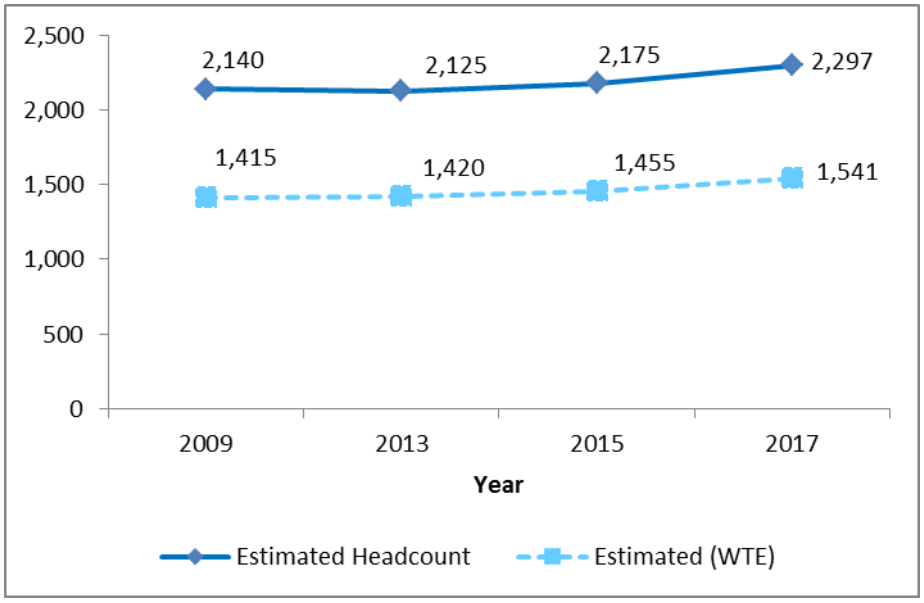
Note: Excludes nurses working in general practice.

[26] The graph shows the number of nursing and midwifery staff working in community settings; these data are consistent over time. Data on community nurses are not comparable prior to 2015 due to changes in coding following the review of nursing and midwifery 'job families'. Source: https://www.isdscotland.org/Health-Topics/Workforce/Publications/2018-03-06/Nursing_and_Midwifery_SIP_D2017.xls

General Practice Nursing

At present data on the number of nurses working in general practice (and not employed by NHS Boards) relies on biennial surveys of practices. As set out in Chapter seven our knowledge about the workforce will improve significantly as part of the workforce data that will be collected as part of the new GMS contract. The *Primary Care Workforce Survey 2017* suggested that there were around 2,300 General Practice Nurses (GPNs) working in general practice; approximately 1,540 WTE. These numbers have increased by approximately 160 (headcount) and 125 (WTE) since 2009.

Figure 4: Estimated registered nurse headcount and WTE, Scotland; 2009 - 2017[27]



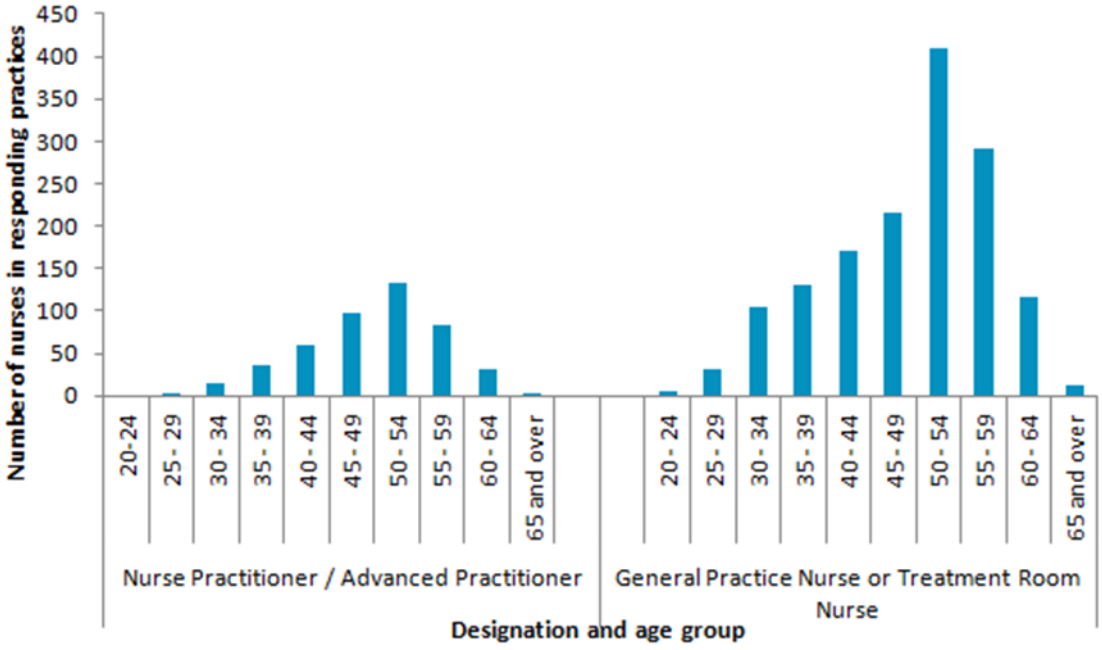
Of the 2,300 registered nurses (headcount) working in general practice, a quarter (544) are Nurse Practitioners or Advanced Nurse Practitioners (i.e. have acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice). The estimated headcount for General Practice/Treatment Room nurses was 1,754. We have seen a rise of 5% (from 520 to 544) in the number of Nurse Practitioners/Advanced Nurse Practitioners between 2013 and 2017, a positive indication of the enhanced role nurses are playing in general practice across Scotland[28].

The majority (98%) of registered nurses working in general practice are female. Over half (55%) of all nurses are aged 50 years and over, and this needs to be considered in planning for the workforce of the future.

[27] NHS National Services Scotland (2018), *National Primary Care Workforce Survey 2017* http://www.isdscotland.org/Health-Topics/General-Practice/Publications/2018-03-06/2018-03-06-PCWS2017-Report.pdf

[28] *Ibid*

Figure 5: Age profile of General Practice Nurses, 2017[29]



District Nursing and Health Visitors

Due to changes in classifications, longer term time series data on District Nursing and Health Visitors is unavailable. In December 2017 there were approximately 3,400 (WTE) staff working in District Nursing in Scotland (a slight fall from December 2015), and almost 1,450 (WTE) Health Visitors (an increase of approximately 270 since December 2015)[30]. Of the 3,400 working in District Nursing, around 1,000 are band 6 and 7 District Nurses (WTE)[31]. The number of District Nurses has fallen by about 50 since December 2015.

Table 1: District Nursing and Health Visitors[32] (WTE), Dec 2015 – Dec 2017

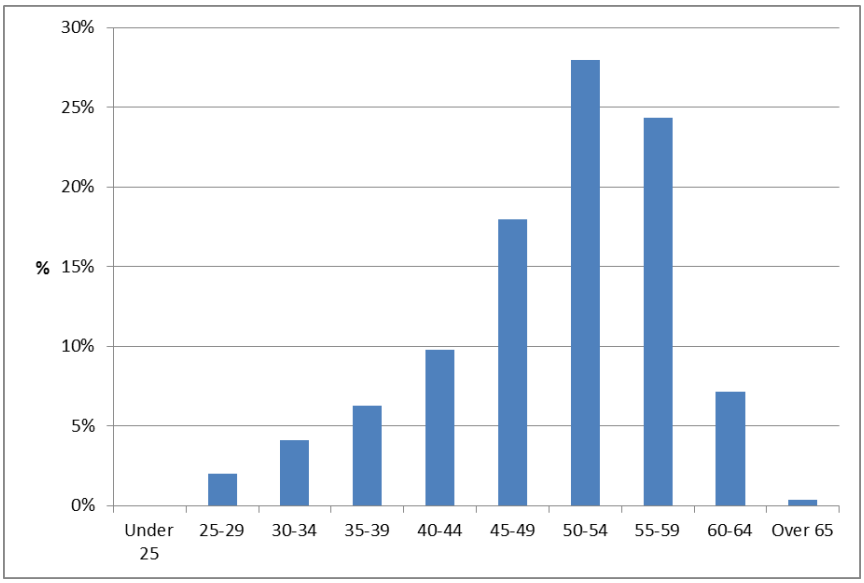
	Dec-15	Dec-16	Dec-17
District nursing	3,504	3,514	3,443
- of which District Nurses	1,056	1,055	1,002
Health visitors	1,180	1,292	1,448

The age profile of District Nurses (band 6 and 7) are shown below. Approximately 60% are aged 50 years and over. This is likely to partly reflect career pathways, with District Nurses tending to be experienced practitioners. Planning for routine staff turnover in light of local workforce data is the responsibility of NHS boards, but

[29] *Ibid*
[30] Qualified Health Visitors classed as Agenda for Change (AfC) Band 6 and above; qualified District Nurses are Band 6; with Band 7 usually either DN Team leaders, DN ANPs or DN Practice
[31] Qualified District Nurses are Band 6; with Band 7 are usually either DN Team leaders, DN ANPs or DN Practice Teachers.
[32] *ISD Workforce Statistics:* http://www.isdscotland.org/Health-Topics/Workforce/Publications/data-tables2017.asp?id=2115#2115

clearly such a sizeable proportion of the workforce being aged over 50 also has important implications for workforce planning in ensuring a sustainable service.

Figure 6: Age profile of District Nurses (band 6 and 7), 2017[33]



Care Home Nursing

There are approximately 4,600 nurses (headcount) working in care homes, the vast majority (around 4,250) in private care homes[34]. Further information on the numbers and trends in numbers of nurses in the social care sector is contained in Part 2 of the National Workforce Plan[35].

Health Care Assistants[36] (HCAs)

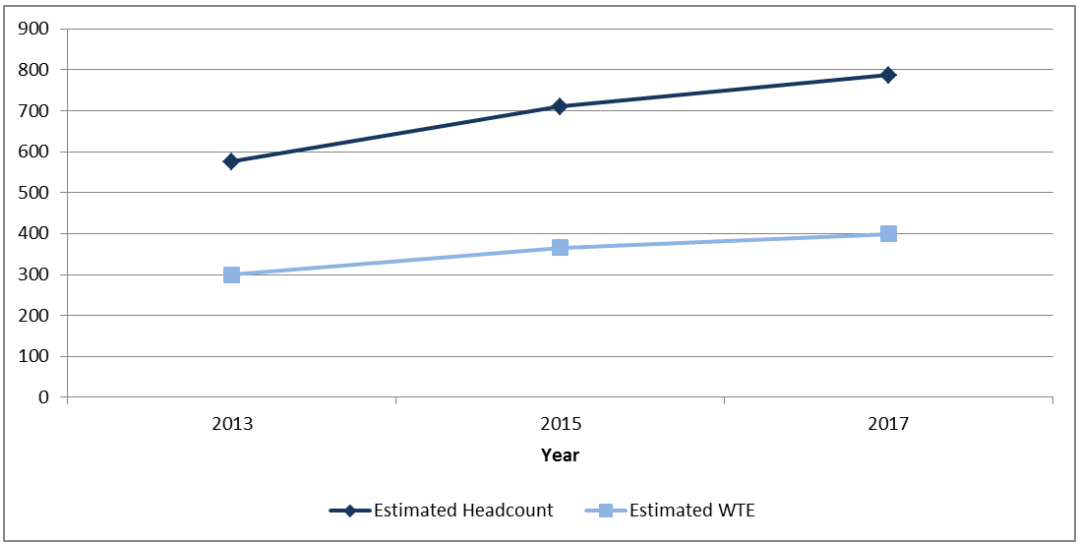
Health Care Assistants are a vital part of the community team, working across healthcare disciplines under the direction and professional accountability of registered practitioners, such as nurses, physiotherapists and pharmacists. For example, the *Transforming Roles*[37] review of district nursing roles in integrated nursing teams set out how support workers can work most effectively in a range of settings and activities.

Data on the number of HCAs working in general practice is available from the biennial *Primary Care Workforce Survey*. In 2017 it was estimated that there were

[33] Data from ISD Workforce statistics; analysis by Scottish Government
[34] Scottish Social Services Council (2017) *Scottish Social Service Sector: Report on 2016 Workforce Data* http://data.sssc.uk.com/images/WDR/WDR2016.pdf
[35] http://www.gov.scot/Publications/2017/12/2984
[36] Also referred to as 'Health Care Support Workers'.
[37] Scottish Government (2017), *Transforming Nursing, Midwifery and Health Professionals Roles - The district nursing role in integrated community nursing teams* http://www.gov.scot/Publications/2017/12/6658

around 787 (399 WTE) HCAs, an increase of approximately 210 headcount and 100 WTE from 2013[38].

Figure 7: Health Care Assistants (estimated headcount and WTE), 2013-17[39]



Allied Health Professions

Allied Health Professionals are a distinct group of health professionals[40] who apply their expertise to prevent illness, diagnose, treat and rehabilitate people of all ages. They deliver direct patient care, rehabilitation, treatment, diagnostics and health improvement interventions to restore and maintain optimal physical, sensory, psychological, cognitive and social functions. There are many developing AHP roles where practitioners are taking on extended generic skills and functions.

As shown in figure 8, the number of physiotherapists, occupational therapists, dieticians, and paramedics employed by NHS Scotland has increased since 2007, although there has been a slight fall in staff employed in podiatry. More comprehensive data on the AHP workforce is available at: http://www.isdscotland.org/Health-Topics/Workforce/Publications/data-tables2017.asp?id=2115#2115

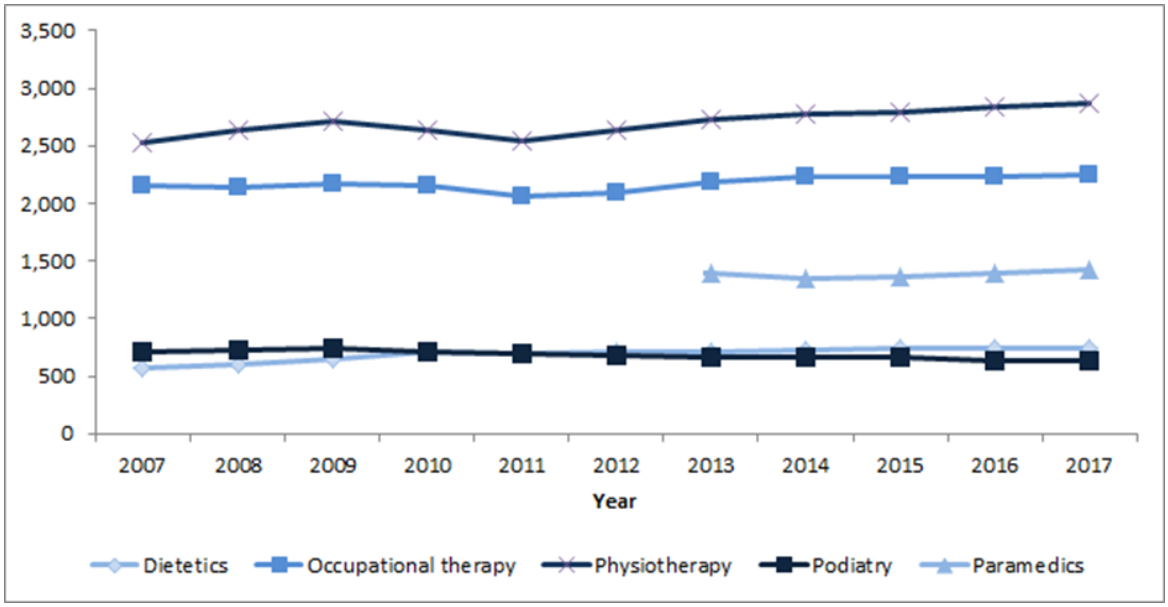
We know the number of AHPs working in the community is substantial but data is currently not available at a national level on location of practice. We are aware of the significant gaps in AHP workforce data and outline approaches to improving these data in Chapter seven.

[38] NHS National Services Scotland (2018), *Primary Care Workforce Survey 2017* http://www.isdscotland.org/Health-Topics/General-Practice/Publications/2018-03-06/2018-03-06-PCWS2017-Report.pdf

[39] Data from ISD Workforce statistics; analysis by Scottish Government

[40] Art Therapists; Dietitians; Drama Therapists; Music Therapists; Occupational Therapists; Orthoptists; Orthotists; Paramedics; Physiotherapists; Podiatrists; Prosthotists; Radiographers (diagnostics) Radiographers (therapeutic); Speech and Language Therapists

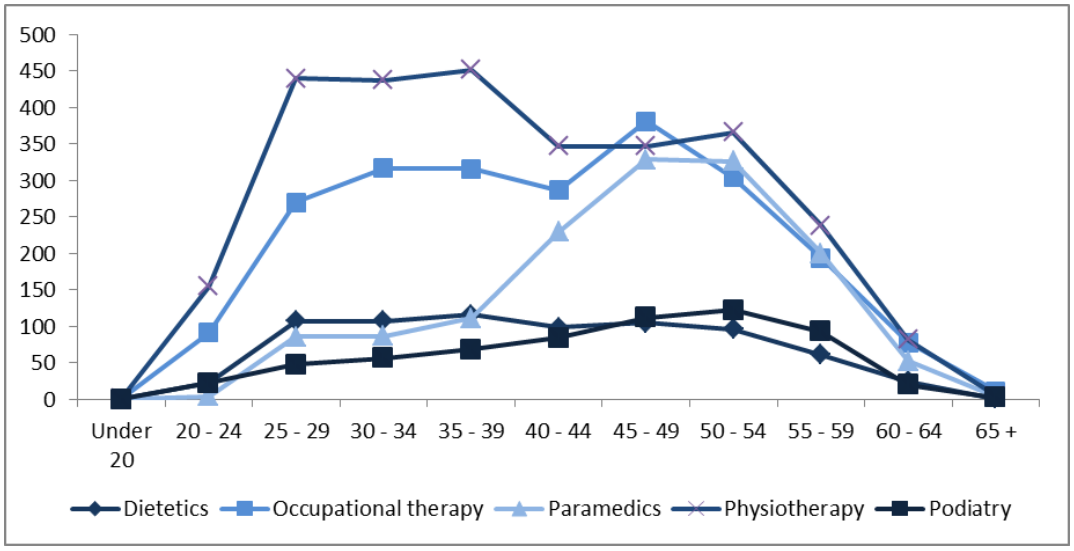
Figure 8: Selected Allied Health Professions groupings (WTE), 2007-2017[41]



Note: Paramedics were reclassified as allied health professions from 1st April 2013.

The age profile of the AHP workforce is provided below. The physiotherapist workforce is notable for having a relatively young age profile, with a significant proportion below the age of 40.

Figure 9: Selected AHP groupings, age profile, December 2017[42]



General Practitioners

The number of patients registered with GP practices continues to rise slowly year on year and has increased by 5% since 2007, however the number of patients aged 65+

[41] ISD Workforce Statistics: http://www.isdscotland.org/Health-Topics/Workforce/Publications/data-tables2017.asp?id=2115#2115
[42] *Ibid*

has increased by 20% since 2007. The number of practices in Scotland decreased by 7% since 2007, reflecting a trend towards larger practices[43].

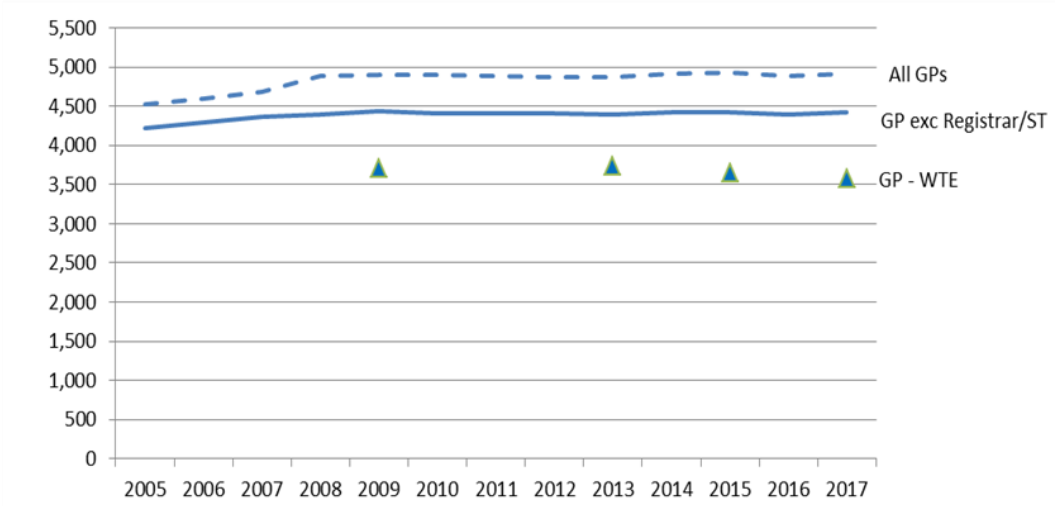
There were approximately 4,900 GPs working in around 960 practices in Scotland as of end of September 2017. The majority (3,500) of GPs are GP partners, with about 850 salaried GPs, 100 retainees[44] and 500 GP Registrars / specialist trainees. The number of salaried GPs (Board-employed and GP partner employed) has doubled over the last decade with falling numbers of GP partners and GP retainees. Around 60% of the GP workforce is female, up from half a decade ago.

Table 2: GP Designation by gender, Scotland, September 2017 (headcount)[45]

Designation	Females	Males	All
GP Partners	1,868	1,631	3,499
Salaried GPs	625	221	846
GP Retainee	91	0	91
GP Registrar/ST	360	140	500
All GPs	**2,935**	**1,985**	**4,920**

The headcount number of qualified GPs working in NHS Scotland has increased by around 200 since 2005 to around 4,400. There has been a larger increase (of 400 to 4,900) in all GPs, including registrars and those in speciality training. However there has been a fall in the estimated whole time equivalent[46] in recent years (figure 10).

Figure 10: GP headcount and whole time equivalent, 2005-2017[47]



[43] All figures in this section from ISD *GP Workforce and Practice Populations*: http://www.isdscotland.org/Health-Topics/General-Practice/Workforce-and-Practice-Populations/

[44] The GP Retainer Scheme enables qualified GPs who are unable to commit to a full-time post to continue working in general practice in order to maintain and develop their skills. Up to four sessions per week are available for a period not exceeding five years.

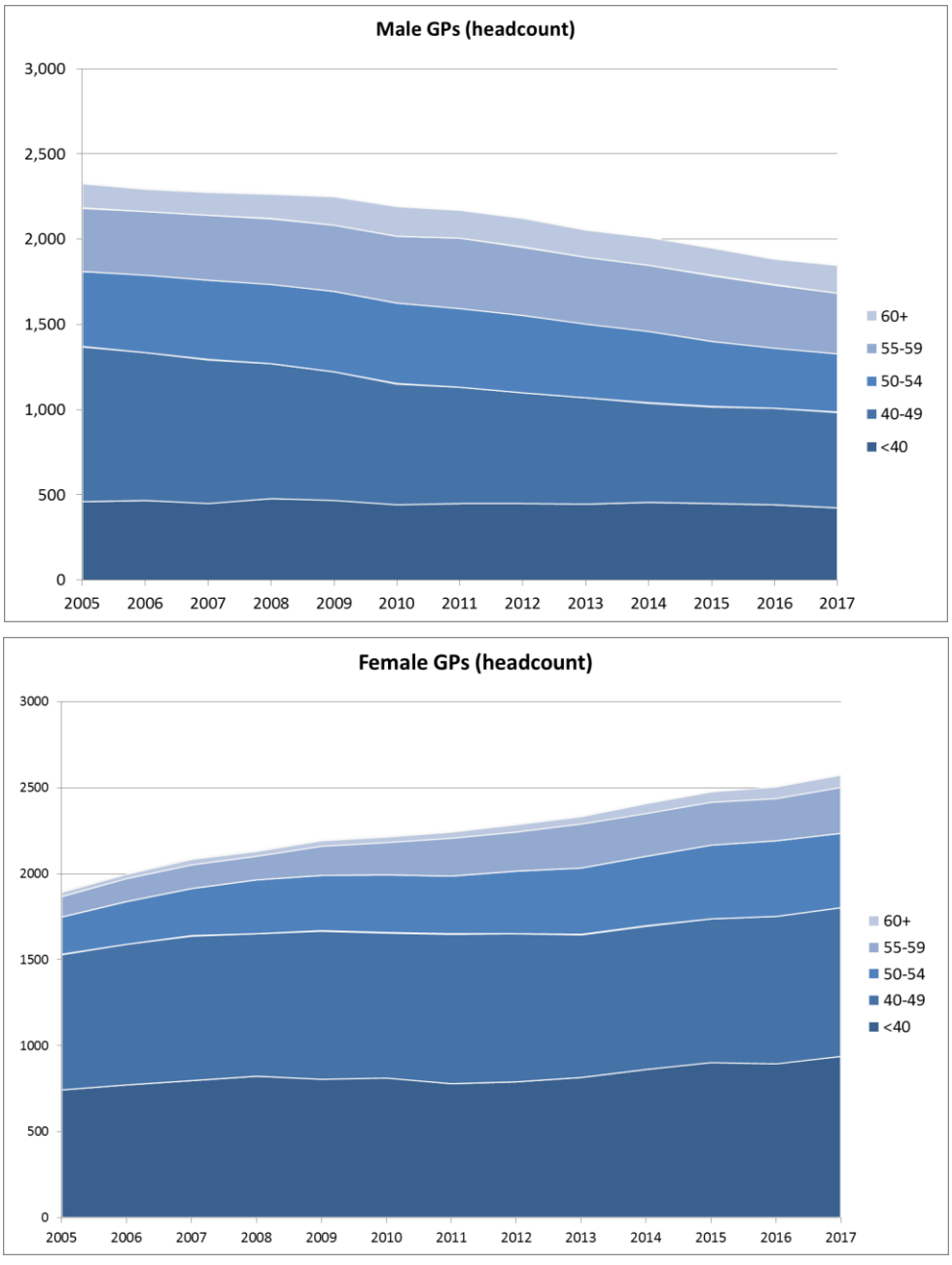
[45] NHS National Services Scotland (2017), *GP Workforce and practice list sizes 2007–2017* https://www.isdscotland.org/Health-Topics/General-Practice/Publications/2017-12-12/2017-12-12-GPWorkforce2017-Report.pdf

[46] The GP whole time equivalent figures are estimated based on data from the biennial *Primary Care Workforce Survey* and therefore are indicative.

[47] Data from *GP Workforce and practice list sizes 2007–2017; Primary Care Workforce Survey 2017*

The fall in WTE shown in figure 10 is largely driven by falling numbers of male GPs (particularly those in middle-age), who have traditionally worked more sessions than their female colleagues. The number of female GPs (headcount) has increased by almost a third since 2005 (Figure 11) and this trend is expected to continue.

Figure 11: GPs (headcount) by gender and age, Scotland 2005-2017[48]

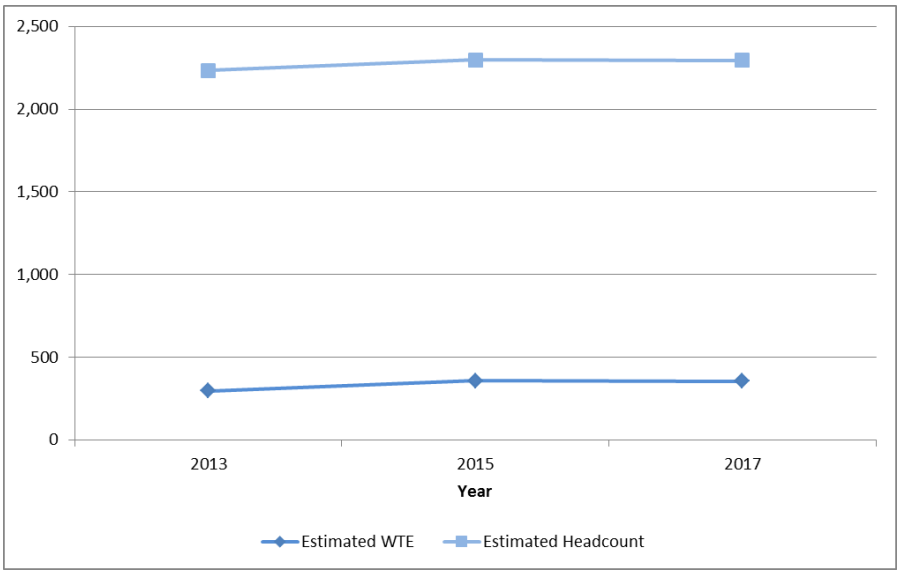


Out of hours services are vital in ensuring people with urgent care needs get the right advice at the right time. The number of GPs working out of hours has increased

[48] Data from General Practice Central Database (GPCD); analysis Scottish Government.

slightly since 2013[49]. There approximately 2,300 GPs (including registrars/ST) providing Out of Hours in the year ending 31 August 2017.

Figure 12: Number of GPs (headcount and WTE) working Out of Hours, 2013-2017



Locums constitute an important part of our workforce offering flexibility and temporary support. Over four fifths of practices (83%) reported requiring to recruit locums for planned events, and approximately half (47%) for unplanned absences. There has been a slight fall in the use of locum sessions (per 10,000 patients) between 2013 and 2017[50].

While general practice workforce data currently relies on a biennial survey, submission of workforce and other practice data will become a requirement under the new GP contract (Chapter seven). This will improve the completeness and scope of the data available to planners.

Pharmacists

Pharmacists are located throughout our hospitals, GP practices and communities, from rural areas to deprived inner-city areas, providing pharmaceutical care on behalf of NHS Scotland. As well as dispensing around 100 million prescription items annually[51], NHS pharmaceutical care services delivered in our community pharmacies include minor ailment, public health, and acute and chronic medication services. These services involve pharmacists in the community providing direct person-centred care as part of the wider primary care team.

[49] The OoH element of the survey was introduced as a pilot in 2013 and the survey coverage between then and 2017 has varied. Conclusions drawn from trend analysis should be treated with caution.
[50] NHS National Services Scotland (2017), *GP Workforce and practice list sizes 2007–2017* https://www.isdscotland.org/Health-Topics/General-Practice/Publications/2017-12-12/2017-12-12-GPWorkforce2017-Report.pdf
[51] Information Services Division (2017), *Prescribing & Medicines: Dispenser Payments and Prescription Cost Analysis*

Pharmacy workforce data is one of the areas that we are working to strengthen, particularly in community pharmacies where, as independent contractors, pharmacy owners and managers determine staffing levels needed to provide safe and effective services in line with the General Pharmaceutical Council standards and guidelines.

As a proxy measure of overall pharmacy workforce numbers, figure 13 below shows the number of registered pharmacists and technicians in Scotland by age as at January 2018. In total, there are currently approximately 4,800 registrant pharmacists and 2,100 pharmacy technicians in Scotland.

Figure 13: Age profile of Registrant Pharmacists and Pharmacist Technicians, Scotland, January 2018[52]

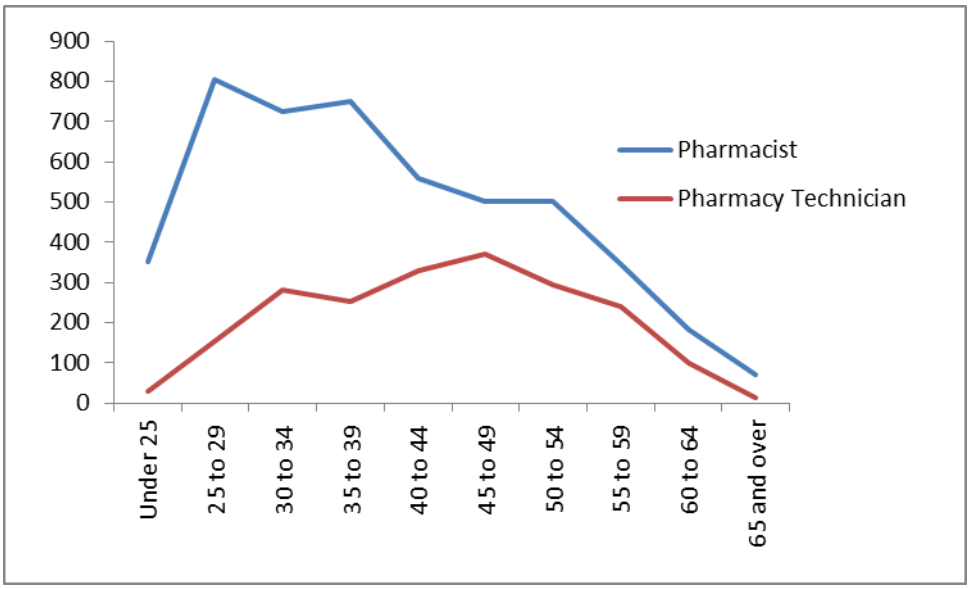


Table 3 represents the total number of pharmacy staff directly employed by NHS Scotland. As indicated above, it does not include those employed in community pharmacy as this is the responsibility of individual community pharmacy contractors.

Table 3: Age profile of Pharmacy Staff (WTE) directly employed by NHS Scotland, December 2017[53]

WTE 31st December 2017	**Age Group (years)**										
	Under 25	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64	≥ 65	**TOTAL**
Pharmacy Staff	198.9	375.2	372.8	385.7	349.9	347.0	341.9	260.5	86.7	4.1	**2,722.6**

[52] General Pharmaceutical Council of Great Britain. Data is based on registrants with a registered home address in Scotland. Data on registrants place of work or working in Scotland is not captured.
[53] Information Services Division workforce statistics

NHS Boards across Scotland directly employ approximately 2,700 whole time equivalent pharmacy staff working in hospital and providing support to community health services working within or with GP practices.

These figures are made up of pharmacists, pharmacy technicians, trainee pharmacy technicians, pharmacy assistants and pharmacy administration and clerical staff. In broad terms over half (approximately 55%) are registered pharmacists, with the remainder employed in increasingly important roles such as pharmacy technicians and assistants.

While the current age profile at a national level suggests a steady supply of pharmacists and pharmacy technicians aged under 50, it is acknowledged that there are greater challenges in some areas around recruitment and retention for both hospital and community sectors.

Dentists

In relation to oral health the dental workforce consists of dentists working alongside dental care professionals, i.e. dental nurses, hygienists, therapists, dental technicians, clinical dental technicians and orthodontic therapists. As oral health improves particularly amongst the younger generation, the dental needs of patients will change, focussing more on prevention. This will take several generations to work through and the dental workforce will require to be sufficiently flexible to meet the differing requirements. At the other end of the age spectrum with an increase in the number of frail, elderly patients retaining their natural teeth other challenges are emerging for clinicians in providing care for frail people, often in the patient's place of residence.

The number of dentists in primary care continues to increase. The majority of Primary Care dental services are provided by independent General Dental Practitioners (GDPs) with the remainder being provided by Public Dental Service dentists.

Table 4: Primary Care Dentists (headcount), Scotland, 2014-17[54]

2014	2015	2016	2017	% change
3,332	3,348	3,397	3,407	2.3%

The increase in the independent GDP workforce (from 2,261 in 2007 to 3,004 in 2017) means that there are 55.6 dentists per 100,000 of the population providing NHS dental care and treatment, compared to 44.0 in 2007[55].

Optometrists

Community eyecare is a contractor service provided by optometrists and ophthalmic medical practitioners (OMPs). This has developed since the introduction of free eye

[54] Source: Combined non-GDS dentists and Public Dental Service dentists as at September 2017 (ISD Workforce Statistics)".
[55] ISD Scotland, *NHS Scotland Workforce Statistics* http://www.isdscotland.org/Health-Topics/workforce/ 2017 figure uses 2016 population estimates.

examinations in 2006, to the service being the first port of call for people with eye problems, helping to detect eye diseases early.

Based on the most recent workforce data available, in 2016 there were approximately 1,453 optometrists and three OMPs (headcount) providing a community eyecare service in Scotland. In addition, there were approximately 410 dispensing opticians who advise and help with the supply of spectacles and contact lenses, as well as dispensing low vision aids and fitting spectacles for children[56]. Historically, the number of optometrists in Scotland has increased on average by approximately three per cent per annum. This is due to more optometrists qualifying than retiring, with only a small number entering Scotland from elsewhere.

Optometrists can become independent prescribers on completion of an additional professional qualification, which is part funded by NHS Education Scotland (NES). Independent prescribing optometrists are able to prescribe licensed medicine for conditions affecting the eye, and the tissues surrounding the eye, within their recognised area of expertise and competence. To date, 214 community optometrists have qualified to become independent prescribers in Scotland – a third of the total UK figure.

Local variation

We have presented data at a national level to provide broad context on the shape of the current primary care workforce. We are aware that there is considerable variation across Scotland both in the size of the workforce and the pressures being experienced in retaining and recruiting staff. Data at Health Board level is available from Information Services Division: http://www.isdscotland.org/Health-Topics/Workforce/ and is used to informed local workforce planning. However, as noted, we fully recognise the need to improve the information available to both local and national planners.

Conclusion

This overview of the primary care workforce in Scotland is a starting point. We recognise that some gaps remain in the data currently available and Chapter seven outlines the improvements underway to data quality and completeness that will aid national, regional and local understanding and planning of the workforce.

We have already acknowledged in Parts 1 and 2 the need over the longer-term to develop more sophisticated workforce modelling, including the design of a 'pipeline' approach indicating how supply via training and recruitment numbers will meet estimated demand for services and take account of, for example, the changing demographic profile of the workforce. NHS Education for Scotland is currently developing a workforce data platform which will help drive more informed, comprehensive and integrated workforce planning. We recognise that it is important for this work to extend in order to encompass the primary care workforce, and good progress is already being taken to ensure this.

[56] Data provided by National Services Scotland.

CHAPTER THREE: THE CHANGING SHAPE OF PRIMARY CARE

- We have a vision of a primary care workforce that supports everyone to live longer healthier lives at home, or in a homely setting.
- Developing multidisciplinary capacity at the heart of transformed and sustainable primary care services. Multidisciplinary teams will deliver care in communities and be involved in the strategic planning of services.
- The *Transforming Roles* Programme is ensuring nationally consistent, sustainable and progressive roles, education and career pathways for nurses, supported by investment in additional training and continuous professional development.
- Transformed Nursing, Midwifery and Allied Health Professional community roles, will inform and support local workforce planning.
- Reform of primary care gathering pace through the transformation programme and significant investment in new models of care.
- We have made a commitment to increase funding in direct support of general practice by £250 million by 2021.
- A new GP contract has been agreed, and a co-produced Memorandum of Understanding between the Scottish Government, the Scottish General Practitioners Committee of the British Medical Association, Integration Authorities and NHS Boards will support its delivery.
- Priorities areas are being taken forward to enable service change in general practice over the next three years, to ensure that patients receive the right service at the right time from the right profession.
- The six step methodology offers an evidence based approach to workforce planning which takes into account local need.
- Reconfiguring services will bring challenges – there is a need for local flexibility in how this is done.

Introduction

The previous chapter broadly set out the shape and size of our primary care workforce, acknowledging that there are gaps in the available data. This chapter describes the shared principles underpinning our approaches to developing a sustainable and safe primary care service for Scotland's people. Improving MDT capacity in primary care, with enhanced pathways to wider health and social care services including third sector service provision, is crucial for the development of new ways of delivering continued high quality services to patients. This is in the wider context of health and social care integration and the role of Integration Authorities in planning and commissioning primary care services.

Primary care is provided by generalist health professionals, working together in multidisciplinary and multiagency networks across sectors, with access to the

expertise of specialist colleagues. All primary care professionals work flexibly using local knowledge, clinical expertise and a continuously supportive and enabling relationship with the person receiving care, to make shared decisions about their care and help them to manage their own health and wellbeing every day, seven days a week.

Enabling change

The context for the reform of primary care in Scotland is Health and Social Care Integration. Integration is the most significant change to health and social care services in Scotland since the creation of the NHS in 1948. With a greater emphasis on joining up services and focussing on anticipatory and preventative care, integration aims to improve care and support for people who use services, their carers and their families. Since April 2016, Integration Authorities have been responsible for the commissioning, planning and delivery of all community and primary care services in their localities – including general practice.

The *2020 Vision*[57] for health emphasised the drive to provide more care at home or in a homely setting, and this was further underlined in *A National Clinical Strategy for Scotland*[58] and the *Health and Social Care Delivery Plan*[59], which embeds primary care at the heart of reform.

The vision for primary care is for enhanced and expanded multi-disciplinary community care teams delivering person-centred care and improving outcomes for individuals and local communities. The principles that underline this vision closely align with those set out by Scotland's health professional groups in *The Future of Primary Care: a view from the professions*[60].

The principles underpinning the approach to general practice in Scotland were set out in *General Practice: Contract and Context – Principles of the Scottish Approach*[61] published by the Scottish General Practitioners Committee of the British Medical Association and the Scottish Government in October 2016. These provide a vision for general practice where:

- General practice and primary care at the heart of the healthcare system;
- People who need care are more informed and empowered than ever, with access to the right person at the right time, and remaining at or near home wherever possible;
- Multi-disciplinary teams in every locality, both in and out of hours, are involved in the strategic planning and delivery of services.

[57] Scottish Government (2011), *2020 Vision* http://www.gov.scot/Topics/Health/Policy/2020-Vision
[58] Scottish Government (2016), *A National Clinical Strategy for Scotland* http://www.gov.scot/Publications/2016/02/8699
[59] Scottish Government (2016), *Health and Social Care Delivery Plan* http://www.gov.scot/Resource/0051/00511950.pdf
[60] *The Future of Primary Care: a view from the professions* (2017), https://www.rcn.org.uk/about-us/policy-briefings/sco-pol-future-of-primary-care-1-sept
[61] http://www.gov.scot/Publications/2016/11/7258

Following the agreement by GPs to the new contract, and as set out in the landmark Letter of Intent published in November 2017[62], Chief Officers and Chief Executives are recommending to their respective Boards the approach set out in the co-produced Memorandum of Understanding.

The Memorandum of Understanding[63] between the Scottish Government, Integration Authorities, the British Medical Association, and NHS Boards, sets out respective roles and responsibilities including the development of Primary Care Improvement Plans. The Plans will set out how additional funding will be used and the timescales for the reconfiguration of the services set out in the MOU and the new GMS contract (see below). Health and Social Care Partnerships will ensure that local stakeholders are appropriately informed and involved in the process and in the development (and where appropriate, the approval) of the plans.

Leadership

The need for good collaborative leadership is essential in promoting and driving change, with leadership in primary care being the responsibility of all professions. The continued development of the skills and attributes of leadership should be supported and visible across all organisations. The Scottish Government recently funded the *Leadership for Integration* development programme delivered in partnership by NHS Education for Scotland, RCGP and the Scottish Social Services Council (SSSC). The aim of the programme was to build capacity and capabilities of primary care and social care professionals to work effectively at locality level and within integrated partnerships to deliver integrated models of care. The principal target audience was those with leadership roles in health and social care contexts, including GPs and other health professionals, and social care leaders from local authority, third sector and independent care organisations.

Leadership capability and capacity amongst our workforce needs to be developed and grown in tandem with service development. As part of the development of the primary care multidisciplinary workforce, NES will support GP practices to provide the necessary clinical leadership and supervision to the wider team of professionals as required. NES will work with Integration Authorities to align this support with the priority areas as set out in the GMS contract.

Investment

As part of its commitment to increase funding in direct support of general practice by £250 million by 2021, the Scottish Government is investing £110 million in 2018-19 to support implementation of the new GP contract and wider primary care development, in line with the priorities set out in *The 2018 General Medical Services Contract in Scotland* ("the Contract offer")[64]. There will be new investment in expanded teams of health professionals in practices and communities, which may include pharmacists, nurses, physiotherapists, paramedics, community mental health workers and non- clinical support workers such as community links workers.

[62] http://www.gov.scot/Resource/0052/00527515.pdf
[63] *Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards* http://www.gov.scot/Resource/0052/00527517.pdf
[64] http://www.gov.scot/Topics/Health/Services/Primary-Care/GP-Contract

We outline our approaches to developing MDT capacity across primary care in Chapters four to six. Shifting the balance of care will require investment to grow the community nursing workforce, which includes District Nurses, General Practice Nurses, ANPs and others over the next three to five year period. A total investment of £6.9 million over three years will be allocated between general practice nurses and district nurses to help meet the training and education needs of a sustainable 24/7 community nursing workforce.

A modernised General Practice

General Practice has a long history of innovation to meet the changing need of its patient population. The new Scottish GMS contract will help accelerate the pace of change, with an enhanced opportunity for GPs to work as Expert Medical Generalists and senior clinical decision makers within multidisciplinary teams (described in Chapter five). To enable GPs to more fully deliver this role, strong and well-connected multidisciplinary teams are needed with workload appropriately redistributed to ensure that patients have the benefit of the range of expert advice needed and available for the delivery of high quality care.

As set out in the MoU, we have agreed to focus on a number of specific priorities for service change at scale over a three year period. Table 5 briefly describes these services and the associated workforce.

Table 5: Workforce needed to deliver service reconfiguration in Primary Care

Service	Description of service	Workforce
Pharmacotherapy	By April 2021, every practice will benefit from the pharmacotherapy service delivering the core elements of the service including acute and repeat prescribing, medicines reconciliation and monitoring of high risk medicines. Additional elements of the service include medication and poly pharmacy reviews and specialist clinics. This will form part of a three-tiered approach to developing pharmacy services to support GP practices.	Pharmacists and pharmacy technicians
Vaccinations	Responsibility for vaccination and immunisation services will move from general practices to IAs and NHS Boards through the transforming vaccination programme.	Nurses, other appropriate clinical professionals and healthcare assistants

Urgent care services (advance practitioner)	Providing sustainable advanced practitioner support for unscheduled care, based on appropriate local service design. Advance practitioners such as a nurse or paramedic for GP clusters and practices as first response for home visits, and responding to urgent call outs for patients, working with practices to provide appropriate care to patients.	Paramedics, nurses where appropriate
Community Treatment and Care Service	These services include, but are not limited to: - basic disease data collection and biometrics (such as blood pressure) - chronic disease monitoring - the management of minor injuries and dressings - phlebotomy - ear syringing - suture removal; and some types of minor surgery as locally determined as being appropriate. Phlebotomy will be delivered as a priority	Nurses, and healthcare assistants
Additional Professional Roles	Additional professional roles will provide services for groups of patients with specific needs that can be delivered by other professionals as first point of contact in the practice and/or community setting. For example, but not limited to: - Musculoskeletal focused physiotherapy services - Community clinical mental health professionals (e.g. nurses, occupational therapists psychologists) directly working in general practice	Musculoskeletal Physiotherapists and community mental health practitioners.

Community links workers	A generalist practitioner based in or aligned to a GP practice or cluster who works directly with patients to help them navigate and engage with wider services, often serving a socio-economically deprived community or assisting patients who need support because of (for example) the complexity of their conditions or rurality. As part of the Primary Care Improvement Plans, IAs will develop CLW roles in line with the Scottish Government's manifesto commitment to deliver 250 CLWs over the life of the Parliament. The roles of the CLWs will be consistent with assessed local need and priorities and function as part of the local models/systems of care and support.	Non-clinical staff providing support and connection, based in practices or groups of practices

Further detail on the new GP contract and reconfiguration of services can be found at: http://www.gov.scot/Topics/Health/Services/Primary-Care/GP-Contract

Safe and Effective Staffing in Health and Social Care

Taking a rigorous, evidence based approach to workload and workforce planning is important to ensure safe and effective staffing in primary care that reflects patients' care needs and promotes a safe environment for service users and staff. The Scottish Government's *Programme for Government 2017-18*[65] includes a commitment to introduce a Safe Staffing Bill to enshrine NHS staffing in law, starting with nursing and midwifery.

The Nursing and Midwifery Workload and Workforce Planning Programme has been in use since 2004. In October 2012 the application of the tools was mandated by the Scottish Government to be used as part of NHS Boards' annual nursing and midwifery workforce projections from April 2013. This is referenced in Local Delivery Plans and Workforce plans[66]. There is now a suite of 12 tools covering 98% of all service areas, including a Community Nursing Tool.

In summary, the overarching intention is for the legislation to:

- Be a further enabler of high quality care and improved outcomes for individuals by helping ensure appropriate staffing for high quality care.

[65] Scottish Government (2017), *A Nation With Ambition: The Government's Programme for Scotland 2017-18* http://www.gov.scot/Publications/2017/09/8468

[66] http://www.isdscotland.org/Health-Topics/Workforce/Nursing-and-Midwifery/NMWWP/_docs/CEL2011_32.pdf

- Strengthen and enhance arrangements already in place to support continuous improvements and transparency in workforce planning and employment practice across Scotland.
- Support consideration of service delivery models and service redesign.
- Actively foster an open and honest culture where all staff feel safe to raise concerns regarding safe and effective staffing.
- Provide assurance – including for service users and staff – that appropriate staffing is in place to enable the provision of high quality care.

Given the importance of ensuring the right people, in the right place at the right time to deliver sustainable and high quality services with improved outcomes for service users, irrespective of setting, and of enabling integrated workforce planning, the intention is that the legislation will – in an appropriate and proportionate way – span the health and social care landscape. However, in taking this broader approach, the legislation will not be restrictive or prescriptive. Rather it will seek to be appropriate and enabling for the social care sector, and in particular support the recommendations in the co-produced Part 2 of the National Health and Social Care Workforce Plan to develop multidisciplinary workload and workforce planning tools where this is considered appropriate.

We consulted on initial proposals for safe staffing in 2017, and published a discussion document in January 2018 setting out refreshed legislative proposals, taking account of further engagement with stakeholders. Currently, the intention is that this legislation will:

- place a duty on Health Boards and care service providers to ensure appropriate numbers of suitably qualified staff, similar to and learning from the current requirement for care service providers set out in existing regulations
- enshrine overarching principles which will apply to NHS Boards and care service providers who will be required to take them into account in carrying out their general duty
- include more specific requirements where a validated workload planning tool and methodology exists – in the first instance this will only be applicable to nursing and midwifery services and to medical services in emergency medicine settings.

We continue to work closely with stakeholders to refine proposals and will introduce legislation later this year.

National Oversight Group

New oversight arrangements for the implementation of the GMS contract in the context of wider primary care transformation in Scotland have been developed including:

- A national oversight group with representatives from the Scottish Government, the SGPC, IAs and NHS Boards which will oversee implementation of the GMS contract in Scotland and the Integration Authorities' Primary Care Improvement Plans, including clear milestones for

the redistribution of GP workload and the development of effective MDT working.

- National issue specific groups – a range of national issue specific groups with members drawn from a range of stakeholders will support and provide policy and professional advice to the national oversight group on a range of national policy areas relevant to the delivery of primary care transformation.

Implementing the changes described in Table 5 relies on robust workforce planning, appropriate utilisation of the workforce, expansion where necessary or appropriate of MDTs and effective MDT working. This will be determined locally and set out in local improvement plans but in practice this will include a mix of the nursing, pharmacy, mental health, allied health professional, paramedic and non-clinical workforces. Delivering this change will require investment at national level to ensure workforce supply in future years. This is discussed further below.

The extent and pace of change over the next three years will be determined locally but will be affected by a number of factors including workforce availability, degree of skills enhancement and the needs of individual practices or practice clusters. In a small number of cases it may be locally determined that GPs and their staff continue to provide some of these services, for example in some very small remote and rural practices. Patient safety will also be a determining factor in local implementation in that the changes will only be made when it is safe to do so. These changes will require investment in the skills of the workforce so that these match the service needs.

Planning Multidisciplinary Teams

A clear and consistent approach to effective workforce planning at national, regional and local levels that involves appropriate engagement between service commissioners and employers is key to high quality service provision.

There is recognition that the multidisciplinary approach needs to grow. To develop an understanding of future requirements and how this approach should be taken forward, Scottish Executive Nurse Directors are leading work, together with the Chief Nursing Officer and partners, with the aim of profiling what an integrated Nursing, Midwifery and Allied Health Professional (NMaHP) community team for adults would look like in a cluster context. This will support local workforce planning and inform the need for national undergraduate and postgraduate education provision to support a growing workforce.

To manage and plan the workforce effectively, local workforce planning agencies need up to date information on:

- The healthcare needs of the population both now and in the future
- The number of people employed and what they do
- Current deployment of staff, past trends and anticipated changes
- What skills the workforce has and where there are gaps
- What skills and staff will be needed to deliver future services and priorities.

In the future, primary care services will increasingly be delivered through multidisciplinary teams including General Practitioners (partners and salaried), other health professionals and social care partners working across clusters of practices, integrated into Health and Social Care Partnerships.

MDTs can be organised at different levels – typically at practice level, but potentially also at cluster or wider primary care level depending on local circumstances. They can therefore be small or large in size and can vary in the composition of their membership. There is no fixed or defined structure for an MDT but instead a significant degree of flexibility to ensure that the services provided meet local needs.

Integration Authorities working with NHS Boards have, over the course of the last two years, identified priorities for local improvement. In 2015 a £20.5 million Primary Care Transformation Fund was announced aimed at supporting the redesign of primary care services across Scotland. A further £10 million was invested in primary care mental health services to encourage the development of new models of care. With investment from the fund, 24 tests of change in 10 NHS Boards focussed on the expansion of the multidisciplinary clinical team and these tests of change have supported the direction of travel set out in the GP contract. As an example, in Inverclyde, Advanced Practice Physiotherapists (APP) have been embedded in three general practices resulting in over 1,000 consultations being provided by APPs which would have otherwise been GP appointments.

Already we are seeing significant change happening through the primary care transformation programme. In particular, there is growing evidence to demonstrate that a sizeable proportion of current GP consultations can be safely and appropriately delivered by other professionals, freeing up GP time for the more focused Expert Medical Generalist (EMG) role. The Scottish School of Primary Care has been commissioned by the Scottish Government to capture key learning from the transformation fund tests of change and we anticipate a final report in late 2018.

GP Clusters

In January 2017, the Scottish Government published *Improving Together, a National Framework for Quality and GP Clusters in Scotland*[67]. GP clusters are typically groups of between 5 to 8 GP practices in a close geographical location. The purpose of clusters is to encourage GPs to engage in quality improvement activity with their peers, and to contribute to the oversight and development of their local healthcare system. Each GP practice has a nominated Practice Quality Lead (PQL) and each cluster will have a Cluster Quality Lead (CQL). Healthcare Improvement Scotland (HIS) is developing the required educational and quality improvement support to embed continuous quality improvement in primary care. The aim of this work is to:

- Support GPs to care for their patients and to better address the health needs of their local communities;
- Reduce primary care health inequalities and contribute to improving people's health;

[67] http://www.gov.scot/Resource/0051/00512739.pdf

- Improve patient experience of primary care through the local delivery of care by a range of health professionals (e.g. GPs, nurses, AHPs, pharmacists, dentists);
- To develop a network of Quality Improvement leads to support and embed continuous quality improvement in primary care.

Where appropriate it is expected that integrated multidisciplinary teams will support and be shared across GP clusters, depending on priorities identified by local planners including cluster leads. The role of Local Intelligence Support Team (LIST) analysts has been expanded to support GP Clusters with the data, evidence and intelligence required to drive quality improvement (more detail on LIST is provided in Chapter seven). Public health professionals also have a clear role to play in advising on approaches to addressing local need and providing evidence on effective population health initiatives.

Approaches to planning the primary care workforce

There are a variety of approaches to identifying local population need and planning the primary care workforce to best address local circumstances. This requires good communication between planners and health and social care professionals. Employers across different sectors frequently use a variety of approaches in undertaking their workforce planning, including case management tools, *Indicator of Relative Need (IORN)*, and the NHS Scotland 6-step workforce planning methodology[68].

Applying the six step methodology provides the opportunity to take into account local population needs and assess potential impact on other services. Using the guide across workforce planning will assist in ensuring that decisions made around service design and recruitment of staff and MDTs are sustainable, realistic and support the delivery of high quality patient care.

[68] http://www.sehd.scot.nhs.uk/mels/CEL2011_32.pdf

The six steps in this tool are briefly outlined:

1. **Defining the plan** – This could include measures to improve practice sustainability, improve integration of health and social care services, develop MDT capacity and strengthen workforce planning.

2. **Mapping service change** – This step is about being clear on what services need re-configured to meet the aim(s) of the workforce plan. A strong vision of what an expanded and / or enhanced service can look like sets the appropriate parameters for workforce planning.

3. **Establishing workforce needed to meet service demand** – Population needs analysis, as well as additional information on the current number and types of services provided is an important first step here. When assessing population need, consideration should be given the specific circumstances in terms of rural, remote or island communities (further detailed below), an increasing elderly population in many areas and/or the needs of areas of high socio-economic deprivation. The expansion of LIST analysts into primary care is an important facilitator in this respect, as is the role of Public Health professionals.

4. **Mapping workforce skills and competencies** – Competency-based planning to help distribute work more efficiently, and skill mix initiatives should be utilised to determine the most appropriate use and redeployment of available workforce. Determining what type of skill mix is needed to meet future demand will help support succession planning. In order to support enhanced MDT roles in primary care it is critical that there are agreed roles supported by defined competencies and a robust career / educational and support framework irrespective of employer.

5. **Understanding workforce availability** – The next step is to profile the existing primary care workforce, including vacancies, and the demographic profile of the workforce. Workforce demographics for certain staff groups may pose particular challenges which should be considered and addressed. We have already highlighted, for example, the older profile of our General Practice and District Nurses. These demographics may of course vary across local areas. This enables an understanding on whether current resources are in the right place, are being utilised effectively and whether the workforce has the right skills to deliver safe and effective patient care. Regional as well as local planning will help in the appropriate distribution of the workforce across Scotland.

6. **Implementing, monitoring and refreshing** –It is essential to measure the impact of any change including outcomes for patients, services and the wider organisation or local community. Scotland is fortunate to have a range of national organisations whose role it is to provide data, improvement support and evaluation advice to local partners. We set our approaches to monitoring and evaluation in Chapter seven.

Additional factors that should be considered when planning MDTs, include:

The employment of staff will be an important consideration when redesigning services. The expectation is that there will be a mixed model of employment, with Practice Managers, administrative staff and General Practice Nurses generally remaining directly employed by the practice as independent contractors, and the new expanded workforce typically being employed outwith the practice by the Health Board or Scottish Ambulance Service but embedded within practice teams. This provides continuity of care to people, whilst supporting practice sustainability and professional governance.

One area which faces particular challenges is the sustainability of GP Out of Hours (OoH) services. Sir Lewis Ritchie's report – *Pulling together – transforming urgent care for the people of Scotland*[69] identified a number of key recommendations for service redesign, including workforce planning focussing on the development of MDTs, and the need for robust inter-relationships between daytime and OoH care to ensure a sustainable service for the future. Whilst OoH and in-hours will remain GP-led services, it may increasingly be the case that some patients' needs are best met by another member of the MDT, whether that be an advanced nurse practitioner, a pharmacist or a paramedical practitioner. *Improving Health and Social Care Service Resilience over Public Holidays*[70] focused on what can be done to ensure that good working practices and processes are rapidly put in place to ensure that appropriate levels of service are available throughout public holiday periods.

Where patients have high levels of non-clinical need, this may lead to consideration of whether provision of non-clinical support such as community links workers or welfare rights advisers would be a suitable intervention.

Local Examples of MDT approaches

Govan 'SHIP' was launched in 2015 by four practices working in Govan Health Centre who are within the top 100 most deprived practices in Scotland ('Deep End'). The practices are increasingly working with expanded and integrated network of partners from statutory and third sector agencies, which includes attached physiotherapy, pharmacy, housing, link workers, social work, education and are currently developing teamwork with secondary care. In a short period of time for a project of this complexity, it has managed to innovate, change patient behaviour and reduce use of health services across all patient groups[71].

In Ayrshire and Arran some physiotherapists have been redeployed from acute into community settings to offer a better 'first point of contact' service for patients and fewer avoidable referrals into secondary care.

The *Headroom* initiative involved 23 GP practices across South East Edinburgh in areas with concentrated economic disadvantage. It recognised

[69] http://www.gov.scot/Resource/0048/00489938.pdf
[70] Scottish Government (2017), *Improving Health and Social Care Service Resilience over Public Holidays* http://www.gov.scot/Publications/2017/12/2391/0
[71] Further information on Govan SHIP is included within the Deep End website: https://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/reports/

the distinct challenge and opportunities for more effective intervention by primary care through working in partnership, including with the local authority, voluntary and other community organisations. In particular *Headroom* delivered improvements aimed at the critical `life-wrecking` dimensions of inequality; mental health, alcohol, drugs, severe parenting problems, housing, employability, chronic disease and social isolation. While *Headroom* came to an end March 2017, a number of strands of learning have gone on to inform and/or support general practice including the implementation of a Community Link Worker Network across Edinburgh and the continuation of small 'Total Place' groups delivering responsive, local outcomes through collaborative working.

Remote and Rural

There can be particular challenges in recruiting and retaining GPs, nurses, pharmacists, AHPs (particularly paramedics) and other clinical staff in remote and rural areas. Working in rural areas, especially very remote areas or islands, can be significantly different from working in more urban areas – e.g. relatively limited options to develop careers, access to updating professional skills, difficulty in meeting employment needs of spouses and partners, etc. This is coupled with the often dispersed nature of the practice population, the potential difficulty in recruiting locum cover, wider expectations of the role of health and social care professionals, and the (lack of) availability of other support services such as Care Homes, palliative care, etc.

Clinical staff working in these remote areas often need to have a wider or different range of skills to meet the needs of the local population. We must therefore ensure that we develop a workforce that has the appropriate skills and experience to work in our remote and rural areas. This includes supporting professionals working in these areas and ensuring such roles are attractive and rewarding.

These recruitment and retention challenges should be reflected in the Primary Care Improvement Plans of rural Health Boards/ Integration Authorities, as the role of the MDT and the skills required of the team will be different in each area depending on local need.

In addition, the Scottish Government and BMA have committed to setting up a Rural Short Life Working Group which will support the implementation of the new GP Contract in rural areas, both in the short and longer term, and support the sustainability of remote and rural practices, in particular for very small practices in remote areas.

This will work alongside a Dispensing Short Life Working Group which will look at the needs of dispensing practices in Scotland, including workforce development and training needs especially for non-clinical dispensing staff, and the role of Pharmacists to support dispensing practices.

The Scottish Government will also continue to fund the Scottish Rural Medical Collaborative to take forward work looking at the recruitment, retention and training

needs of primary care staff working in rural Scotland (further details are provided in Chapter five).

The Chief Nursing Officer's *Commission on Widening Participation in Nursing and Midwifery, Education and Careers*[72], published in December 2017, sets out a number of recommendations and will provide a platform for further targeted work to attract and retain individuals into careers in nursing and midwifery, including remote and rural areas.

Health Inequalities

Health inequalities are linked to a range of factors that are complex and interrelated. For example, genetic factors and poor housing can have a major effect on an individual's health over time, and issues can be exacerbated by behaviours such as poor diet, smoking, sedentary behaviour and alcohol misuse. Public services in Scotland can address some of these factors, for example by improving social housing or access to sports and community facilities. Broader UK and global factors, such as levels of economic growth also play a significant role.

Better addressing health inequalities therefore requires continued action beyond primary care but, as set out in Chapter one, the primary care workforce also has a significant role in focusing activity on prevention, anticipatory care planning, and managing complex care to improve patient outcomes. A key aim of the new GMS contract is to focus GP time on complex care as an Expert Medical Generalist, whilst we continue to build capacity in the wider MDT. As patients living in our most deprived areas experience higher levels of ill health earlier in their lives, enabling GPs to address complex care will benefit those patients with greatest clinical need. All Integration Authorities will develop Primary Care Improvement Plans which will show how they intend to address inequalities locally.

The new Scottish Allocation Formula (SAF) is a methodological improvement on the previous formula. It more accurately captures the determinants of the workload of GPs, giving greater weight to older patients and to deprivation. It uses smaller geographies than the previous formula, ensuring that both deprivation in urban areas and isolated pockets of rural deprivation are better addressed by the new formula. The formula provides about 25% more funding to support the care of patients living in the most deprived areas compared to the least deprived. With the introduction of the new formula, no GP practices in Scotland will be protected from any potential funding losses. To this end, the Scottish Government has committed to invest an additional £23 million to fund the additional care needs recognised by the new formula. This additional investment has been provided to practices to improve services for patients in areas where workload is highest.

A significant proportion of consultations with GPs in areas of very high deprivation are due to experiences of social adversity, especially poverty and financial problems. This can place additional pressures on practices, whose primary aim is to address the clinical needs of their patient population. We have therefore committed to recruiting 250 community links workers by the end of this Parliament. CLWs are one

[72] http://www.gov.scot/Publications/2017/12/5568

of six key services that, in future, will be provided to patients in GP practices by Health Boards under the new GP contract. The roles of the CLWs will be consistent with assessed local need and priorities. CLWs are one of the ways in which local systems can tackle health inequalities, and therefore our expectation is that the first priority for CLWs will be more deprived areas.

Promoting workforce health and wellbeing

The health and social care workforce is our greatest asset, they have a vital role in delivering *Everyone Matters - the 2020 vision*[73], to drive improvements in health, patient care and reducing inequalities. It has been recognised that improvements to staff health and wellbeing have major benefits to the economy, society as a whole, and to reducing disease and illness[74], with staff themselves benefiting from improved morale, job satisfaction and improved health and wellbeing[75]. Crucially, a workforce that is healthy, valued and treated well improves patient care and overall performance[76]. The Boorman Review found that over 85% of staff reported their health and wellbeing impacts upon patient care, while a recent influential study found a direct relationship between staff health and wellbeing and staff reported performance[77].

There are key challenges in this area. The workforce is ageing; some staff require support with management of their weight; musculoskeletal disorders and mental health problems can lead to staff absences; and issues with working cultures and shift patterns can also cause staff ill-health. Some of the issues are already being addressed through current policies and programmes including: *Workforce 2020 Vision*, *Healthy Working Lives*, *iMatters*, *Partnership Information Network* (PIN) policies, and our public health policies. The *Nursing Vision 2030: Promoting Confident, Competent and Collaborative Nursing for Scotland's Future* recognises the need to put in place measures to protect and promote nurses' physical and mental health and wellbeing. *The Nursing Vision 2030* recognises that all environments in which nurses work, whether in communities, hospitals, care homes or elsewhere, are hugely influential in fostering – or inhibiting – professional practice and behaviours. A positive culture can help support the workforce to feel valued, and share their experiences and insights honestly and openly, leading to a healthier workforce that feels more valued.

In addition, in October 2016, the Scottish Government and the BMA launched the General Practice Occupational Health Service to provide a range of occupational

[73] Scottish Government (2013), *Everyone Matters: 2020 workforce vision* http://www.gov.scot/resource/0042/00424225.pdf)
[74] Waddell, G., and Burton, A. K. (2006). *Is work good for your health and wellbeing*? https://www.nice.org.uk/guidance/ng13/evidence/evidence-review-1-workplace-policy-and-management-practices-to-improve-the-health-of-employees-pdf-75821149
[75] The Point of Care Foundation (2014), *Staff care how to engage staff in the NHS and why it matters* https://16682-presscdn-0-1-pagely.netdna-ssl.com/wp-content/uploads/2014/01/POCF_FINAL-inc-references.pdf)
[76] Scottish Government (2013), *Everyone Matters*, 2020 vision http://www.gov.scot/Resource/0042/00424225.pdf
[77] Boorman, S (2009) *NHS Health and Well-being: Final Report* http://webarchive.nationalarchives.gov.uk/20130103004910/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108799 NA(M)

health services to GP's, GP Locums, Administration, nursing and other practice staff. This service can be accessed through local NHS Board Occupational Health Services, which is available to all NHS staff. The Occupational Health Service for General Practice provides a range of services including pre-placement assessments, management and self-referrals, Immunisation and BBV exposure follow up, Health Surveillance, Physiotherapy and Mental Health advice and support.

NHS Scotland has transformed its approach to measuring staff experience[78]. The national staff survey has been replaced by the *iMatter Continuous Improvement Model* complemented by a short additional *Dignity at Work Survey* to provide a full overview of national staff experience. The *iMatter Continuous Improvement Model*[79] was developed by NHSScotland staff for staff and provides a team-based tool offering individual teams and managers the facility to measure, understand, improve and evidence staff experience. The Dignity at Work Survey addresses questions about discrimination, bullying and harassment, violence and abuse from patients and members of the public, resourcing and whistleblowing.

These new arrangements have been developed in full partnership and through focussed engagement with the HR community and local and national staff side representatives. It comes with the full support of these communities and has been endorsed by the Scottish Workforce and Staff Governance Committee (SWAG), and approved by the Cabinet Secretary for Health and Sport. This has enabled NHS Scotland to obtain a comprehensive picture of staff experience indicating areas of success and those which require improvement both nationally and locally. A number of Integration Authorities have been involved in this new transformational approach, and more staff than ever before have used their employee voice to engage in the new approach across health and social care.

Conclusion

Primary care is embarked on a process of reform to place it on a more sustainable and resilient footing and to address the increasing and changing needs of Scotland's population. The Memorandum of Understanding sets out the principles underpinning primary care in Scotland, including respective roles and responsibilities going forward. We are investing significantly (including £250 million in direct support of general practice by 2021) to enable the reshaping of primary care to be delivered.

Shifting the balance of care from hospitals to community and primary care settings presents significant challenges and will require collaborative working across many partners. What is clear though is that to deliver our vision of a modernised and reformed primary care, we must develop multidisciplinary capacity across Scotland and the following chapters begin to set our approaches to increasing workforce capacity.

[78] *IMatters* covers staff employed in NHS Scotland and social care. It does not survey staff employed directly by GP practices.
[79] Scottish Government (2018), *Health and Social Care Staff Experience Report 2017* http://www.gov.scot/Publications/2018/03/5142

CHAPTER FOUR: PLANNING AND DEVELOPING THE MULTIDISCIPLINARY WORKFORCE – NURSING AND MIDWIFERY

- Integrated community nursing teams will play a key role in planning, providing, managing, monitoring and reviewing care, building on current roles and best practice to meet the requirements of people with more complex health and care needs in a range of community settings.
- Nationally consistent approaches to roles and educational preparation for advanced nursing practice, district nurses, general practice nurses, health visitors and school nurses are supporting the development of these integrated teams.
- Programme for Government 2016-17 commits to invest £3 million to train an additional 500 advanced nurse practitioners across primary and secondary care. This will enable nurses across Scotland to maximise their leading role in integrated health and social care of the future.
- We have committed to an investment of £3 million over three years into training and education needs of general practice nursing.
- We will invest an additional £3.9 million over three years into training and education needs of district nurses to help sustain a 24/7 community nursing workforce.
- By September 2018, we will work alongside partners, including the Royal College of Nursing, to understand the requirements and investment necessary to grow the District Nursing workforce.
- An additional 2,600 additional nurse and midwife training places will be created over the life of this Parliament, with a 10.8% increase (sixth increase in a row) in nursing and midwifery student intake places for academic year 2018/19, as a further step to ensure we can recruit and train the next generation of staff.
- We will increase the number of health visitors by 500. This is being supported by funding which has increased over four years to £20 million annually (recurring).
- A marketing campaign will be developed to attract individuals into nursing and midwifery careers and ensure a sustainable workforce is available to meet Scotland's future requirements.

Introduction

Nursing is the largest occupational group in community care, with approximately 12,000 nurses working in community settings (see Chapter two). As more people with increased complex needs receive care in their own homes and other community settings, the vital role of community nursing as expert nursing generalists is reinforced. Shifting the balance of care from hospital to community and primary care settings at or near people's homes aims to improve population health, increase quality and safety, and secure best value from health and social care services.

More Advanced Nurse Practitioners (ANPs), District Nurses, Community Pharmacists and AHPs will be required to meet the evolving needs of individual communities and localities. This is in keeping with the *National Clinical Strategy*[80] and national health and social care workforce planning. The recent *Improving health and social care service resilience over public holidays* report[81] showed that workforce planning and development of extended professional roles within primary care recommended by the *Primary Care OoH Review*[82] is underway.

All those responsible for workforce planning should consider the full range of options at their disposal to deal with recruitment and retention issues within their nursing workforce to ensure sustainable 24/7 services. This Chapter sets out the national activity taking place to strengthen the nursing workforce in primary and community care settings, whilst recognising local challenges. Chapters five and six cover general practitioners and the wider clinical and non-clinical workforce.

Maximising the contribution of the nursing and midwifery workforce

The nursing and midwifery workforce will be enabled to work to its maximum capability; to do more or to work differently, reflecting changing population needs or service models irrespective of whether these staff are GP or Health Board employees. Part 1 of the *National Health and Social Care Workforce Plan* outlined the steps that the Scottish Government is undertaking to ensure that our supply of nurses and midwives meets anticipated future demands.

An additional 2,600 nursing and midwifery training places will be created over the lifetime of this Parliament. These will include a further expansion of training places to provide an additional 1,600 places, to build on the 1,000 extra places already committed to as part of the *Programme for Government 2016/17*[83]. This is expected to bring the total number of training places to over 12,000, an historic high which will strengthen the supply of qualified nurses and midwives across health and social care settings.

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

The package of measures will be targeted towards those practice and geographical areas where particular needs are identified, including primary care, mental health, midwifery, maternal and child health, and more remote and rural areas, particularly the North of Scotland. It will be closely aligned to the Chief Nursing Officer's

[80] Scottish Government (2016), *A National Clinical Strategy for Scotland* http://www.gov.scot/Resource/0049/00494144.pdf
[81] https://beta.gov.scot/publications/improving-health-social-care-service-resilience-over-public-holidays-9781788514965/
[82] http://www.gov.scot/Publications/2015/11/9014
[83] Scottish Government (2017), *A Plan For Scotland: The Scottish Government's Programme For Scotland 2016-17* http://www.gov.scot/Publications/2016/09/2860

Commission into Widening Participation in Nursing and Midwifery Education and Careers[84] and will help deliver its recommendations. The report – published in December 2017 – identified best practice and current barriers to nursing and midwifery careers, both in terms of ambition and access, and made recommendations to support and enhance access across the education and employment sectors.

The Commission report also concluded that further action is needed to celebrate the impact and opportunities of nursing and midwifery education and careers and recommended a national campaign to promote career opportunities. We will take forward a campaign later this year with the aims of:

- emphasising the professions' flexibility and extensive opportunities for personal and professional development;
- recognising nursing and midwifery career opportunities beyond the traditional boundaries of NHS Scotland, with a particular focus on care home nursing given increased workforce challenges in those settings;
- tackling stereotypical images of nurses and midwives, creating a more positive professional role model.

As noted in Chapter six, we anticipate that the campaign will be broadened to cover health care careers notably in Allied Health Professions and Health Care Science, given on-going recruitment challenges in these professions.

Good quality primary care workforce data is vital in planning for the future nursing and midwifery workforce. We are aware of the need to strengthen the data we currently collect and our approaches to developing more robust, integrated workforce data are set out in Chapter seven.

Integrated Community Nursing teams

Community nursing can be broadly described as any nursing care provided outside of an acute hospital. This includes healthcare provided in the home or other homely settings, and also in other settings, for example, General Practice, a community hospital, the custody suite of a police station, a school or care home and we acknowledge that not all roles have been covered in this chapter but all make a valuable contribution to improving the health and wellbeing of the people of Scotland.

Integrated community nursing teams will play a key role in planning, providing, managing, monitoring and reviewing care, building on current roles and best practice to meet the requirements of people with more complex health and care needs in a range of community settings. Delivering our aim of shifting the balance of care from hospital to primary and community care settings requires a different approach that enables community nursing staff to develop new and innovative ways of working to provide safe, effective, person-centred care and clinical interventions tailored to meet the needs of the individual.

[84] http://www.gov.scot/Publications/2017/12/5568

District nurses, general practice nurses, ANPs and their wider teams working as an integrated community nursing team will provide a seamless interface and reduce any boundaries between their practice and place of care.

Integrated nursing teams are at the heart of the *Buurtzorg* model of neighbourhood care which has been so successful in the Netherlands. The model involves unhurried visits by community nurses who provide continuity of care and have freedom to work autonomously in small, self-organising teams to develop a flexible range of solutions to meet people's needs. A number of integrated community nursing and home care teams in Scotland are testing the Buurtzorg principles, using the learning to accelerate progress with integration as well as the development of the community health and social care workforce.

District nursing

Sir Lewis Ritchie's independent review of Out Of Hours emphasised the essential role of district nurses to support 24/7 community healthcare. The review sought to underpin a consistent district nursing role, where nurses have the capacity, capability, infrastructural support and access to resources, enabling them to meet patient need.

In response, the Chief Nursing Officer's *Transforming Roles* programme has outlined a nationally consistent role for district nurses within integrated community nursing teams[85]. This emphasises district nurses' leadership role in areas such as anticipatory, palliative and end-of-life care; balancing their role in managing complexity alongside promoting self-care, independence, prevention and community engagement.

District nurses will play a pivotal role in integrated community teams. They will be at senior practitioner level within the career pathway and will be supported by the wider community team, including healthcare support workers, registered nurses and advanced nurse practitioners, to promote health and wellness, enable self-care and deliver personalised health outcomes in people's own homes or communities. Services will be integrated appropriately with social care and other partners and properly signposted to ensure a full range of locally led, co-ordinated, high quality, accessible and well-understood services are in place.

Refocused and nationally consistent core education provision has been developed to support a future-facing district nursing role, with guidance on caseload and resource-allocation agreed to complement the triangulated approach within the nursing and midwifery workload and workforce planning tools.

NHS Education for Scotland is managing a range of activities on behalf of the Scottish Government to support the implementation of the refocused District Nursing role. For example, NHS Boards are being funded to train District Nurses in nonmedical prescribing and Advanced Clinical Assessment modules with 95 training

[85] Scottish Government (2017), *Transforming Nursing, Midwifery and Health Professionals Roles - The district nursing role in integrated community nursing teams* http://www.gov.scot/Resource/0052/00529738.pdf

places in 2017/18. A Continuous Professional Development (CPD) digital resource has also been developed which focuses on the skill required for the refreshed role. The resource has been developed in partnership with District Nurses to ensure the key areas for role development are addressed. In addition local projects within NHS Boards have been funded to support the implementation of the refocused role. For example, NHS Western Isles is testing implementation of the role in a remote and rural setting, and NHS Lothian has developed peer support groups to support roll out of the District Nursing CPD digital resource.

In total over £158,000 has been invested in District Nurse education and CPD in 2017/18. District Nurse education will continue to be a national priority and this is reflected in our investment of an additional £3.9 million over three years into training and education needs of district nurses to help sustain a 24/7 community nursing workforce.

In addition, recognising the importance of the District Nursing workforce in shifting the balance of care from hospitals to community settings, we will work alongside partners, including the Royal College of Nursing, to understand the requirements for sustaining and expanding this workforce. We are committed to undertaking this work at pace and will be in a position by September 2018 to better understand the requirements and investment necessary to grow the workforce. Integration Authorities and NHS Boards retain responsibility for planning and funding District Nurse vacancies and projected retirals from existing budgets.

General Practice Nursing

General Practice Nurses are essential to the future of general practice and are an integral part of the core practice team. They provide primary care services, mainly through direct employment by GPs, with general nursing skills and extended roles in health protection, urgent care and supporting people with long term conditions.

The numbers of consultations for GPNs relative to GPs increased from 28% in 2003/4 to 33% in 2013, illustrating the continued shift of chronic disease management from GPs to nurses[86]. With the growth in chronic disease prevalence, significant focus on the role of GPN is needed to reduce demand through more effective disease prevention and management including self-management and anticipatory care. The benefits of such an approach are set out in Chapter one.

With a dedicated Community Treatment and Care Service delivered through Integration Authorities, the 2018 GMS contract will support GPNs to focus on a refreshed role in general practice as expert nursing generalists providing acute and chronic disease management, enabling people to live safely and confidently at home and in their communities, supporting them and their carers to manage their own conditions whenever possible.

Over half (53%) of all nurses in general practice are aged 50 years and over. In order to support an enhanced role safely integrated into general practice and to grow the GPN workforce, making general practice an attractive career choice for nurses,

[86] Information Services Division (2013), *Practice Team Information (PTI) Annual Update*.

under the Chief Nursing Officer's *Transforming Roles* programme, a short life working group was established in 2017 to refresh the role and educational requirements of GPNs. The overall aim of the General Practice Nursing Group is to scope the current GPN role across NHSScotland Boards and identify areas for developing a refreshed GPN role.

We are investing a further £3 million over a three year period for additional training to enhance the skills of GPNs so that they are better equipped to meet the needs of patients with multiple health conditions, making it easier for patients to access the right person at the right time.

Advanced Nurse Practitioners

ANPs are qualified to Masters level and are competent to work at advanced level as part of multidisciplinary teams across all clinical settings, dependent on their area of expertise. They are clinical leaders with the freedom and authority to act, and accept responsibility and accountability for those actions. The role is characterised by high-level autonomous decision-making, including assessing, diagnosing and treating (including prescribing for) patients with complex multidimensional problems. ANPs have the authority to refer, admit and discharge within defined clinical areas.

To ensure consistency and sustainability ANP roles need to be developed in a systematic way. The Chief Nursing Officer's *Transforming Roles*[87] programme has set out a nationally consistent approach to advanced nursing practice. To underpin this, NHS Education for Scotland has produced a *Service and Education Needs Analysis Tool*[88] to support NHS Boards/employers to plan, and evaluate the implementation of ANP roles and the education required to support them. NHS Boards/employers have been requested to complete an ANP Education Needs Analysis annually.

ANPs in primary care provide a high quality, responsive service within the MDT context, whilst encouraging career development within the nursing profession. Many of the Primary Care Transformation Fund projects have developed the role of ANPs; an evaluation report from the PCTF will be published later in 2018 setting out key learning from the programme.

The Scottish Government has commitment to investing £3 million to train an additional 500 advanced nurse practitioners across primary and secondary care. This will equip nurses across Scotland to maximise their leading role in integrated health care of the future.

We are also improving data on the availability on the size and profile of the ANP workforce. Statistics on the number of ANPs employed by NHS Boards were published by NHS National Services Scotland for the first time in September 2017[89].

[87] Scottish Government (2017), *Details for the Transforming nursing, midwifery and health professionals roles: advanced nurse practitioner roles*: https://beta.gov.scot/publications/transforming-nursing-midwifery-health-professions-roles-advance-nursing-practice/
[88] See: http://www.nes.scot.nhs.uk/media/4031459/final__anp_sna-ena_tool.docx
[89] Available at: http://www.isdscotland.org/Health-Topics/Workforce/Publications/data-tables2017.asp

These data will be published annually, providing a more comprehensive picture of this crucial workforce.

Case Study: Primary Care Advanced Nurse Practitioners

East Ayrshire HSCP is testing a process of development and implementation of Primary Care ANPs in four GP practices. All have completed a post graduate certificate in advanced clinical practice and are working towards completion of a Masters' degree. They have received positive feedback from GP partners and service users. Running in parallel, NHS Ayrshire and Arran have identified and supported a cohort of primary care practice nurses to develop their knowledge and skill set to advanced clinical practitioner, through academic study, supervision, competence frameworks and clinical practice.

ANPs will be developed with generic primary care expertise similar to that of a GP so that they can provide clinical sessions responding to undifferentiated conditions, make referrals, house calls and visit those in care homes, undertake reviews and care for those with long term conditions. Mentoring is provided by GPs in a similar way to that provided to trainee doctors. Competency frameworks and the processes for support and mentoring have been implemented for Primary Care ANPs in conjunction with The West of Scotland Advanced Practice Academy and in line with national guidance.

Children and Early Years

Health Visitors

As part of the *Transforming Roles* programme, work has been completed to refocus the role and visiting pathway for Health Visitors. Focusing on family and child health, prevention, early identification and intervention, Health Visitors play a central role within early years services. They particularly focus on families with children under five years of age and offer universal services to all families whilst offering more targeted support to those families and children in greatest need.

To support and maximise the role and impact of Health Visitors within early years the Scottish Government has made a significant investment of £40 million (including over £3.4 million in health visitor training) over four years since 2014 to enable the number of Health Visitors in Scotland to increase by 500 by the end of 2018. When delivered, this will represent an unprecedented 50% increase in the number of Health Visitors. The Scottish Government will continue to support, develop and invest in career pathways for community nursing.

School Nurses

With a similar focus on prevention, early intervention and support for the most vulnerable, work has just completed to refocus the role of school nurses, increasing their capacity and competency and maximising their contribution as part of multiagency/multidisciplinary teams supporting health and wellbeing and raising

attainment of the school age population. This future facing role centres around children, young people and families with additional needs, alongside a number of priority areas (looked after children, mental health and well-being, substance misuse, domestic abuse, youth justice, young carers, homeless families and children, transition periods and child protection).

The Transforming nursing, midwifery and health professionals roles paper on the refocused school nurse role is available at: https://beta.gov.scot/publications/school-nursing-role-integrated-community-nursing-teams/

Supporting the best start in life

The *Best Start* review[90] was published in January 2017 and sets out a vision for the future planning, design and safe delivery of high quality maternity and neonatal services in Scotland. It puts the family at the centre of decisions so that all women, babies and their families get the highest quality of care according to their needs. It signals a shift towards relationship based care, with a move towards a continuity of carer model and local delivery of care within community hubs. This will have implications for the midwifery workforce that we will consider carefully.

Conclusion

The role of the nursing and midwifery workforce in supporting and driving the reform of primary care in Scotland is vital. Through significant investment in expanding the workforce and enhanced support for education and training, we will support integrated community nursing teams address the needs of people across a range of community settings.

We are clear that shifting the balance of care will require growth and additional investment in district nurses as key members of integrated community nursing teams. The Scottish Government will lead work alongside partners to understand the on-going requirements and investment necessary to deliver the required expansion of this workforce. There is a need for robust evidence and reliable data on supply needs to support both current delivery and emerging models of care to ensure effective targeting of investment.

[90] Scottish Government (2017), *The Best Start: A Five Year Forward Plan For Maternity And Neonatal Care in Scotland*, http://www.gov.scot/Publications/2017/01/7728

CHAPTER FIVE: PLANNING AND DEVELOPING THE MULTIDISCIPLINARY WORKFORCE – GENERAL PRACTITIONERS

- The new GP contract will deliver an enhanced role for the GP focused on complex care, undifferentiated illness and clinical leadership.
- There will be a reduction in GP workload pressures and responsibilities through service redesign.
- At least 800 (headcount) additional GPs will be added to the workforce over the next 10 years to meet increasing patient demand.
- A comprehensive package of retention measures will be put in place to support GPs, including during the first five years and towards the end of their careers.
- There will be enhanced support for GPs working in remote and rural areas.
- There will be enhanced support and encouragement for GPs working in the OoHs period
- On-going expansion of medical school and training places will help grow the GP workforce.
- The establishment of an *Increasing Undergraduate Education in Primary Care Working Group* to consider ways of increasing undergraduate education in primary care settings, which will help facilitate future careers in general practice.
- A marketing and recruitment campaign will promote Scotland as a great place to work as a GP.

Introduction

The GP has been at the heart of the health care system since the establishment of the NHS in 1948. Working within MDTs and wider community services, GPs manage the widest range of health problems, addressing multimorbidity, coordinating long-term care and addressing the physical, social and psychological aspects of patients' wellbeing.

The context under which GPs operate has changed significantly in recent years, with an ever more important role as clinical leaders in deciding how health services should be organised to deliver safe, effective and accessible care to patients in their communities within an increasingly integrated health and care system.

This evolving role formed the basis of the recent negotiation of the new GP contract between the Scottish Government and the BMA. The negotiations were guided by Barbara Starfield's "four Cs" of primary care[91], namely that GPs are uniquely able to deliver:

[91] Starfield, B. (1992) *Primary Care: Concept Evaluation and Policy.* OUP, New York

- Contact – accessible care for individuals and communities;
- Comprehensiveness – holistic care of people – physical and mental health;
- Continuity – long term continuity of care enabling an effective therapeutic relationship;
- Co-ordination – overseeing care from a range of service providers.

These four pillars of primary care are also evident in the landmark Royal College of General Practitioners (RCGP) report on *Medical Generalism*[92]. The ethos of generalism described in this report includes comprehensiveness, co-ordination and continuity. Generalism, by definition, is a form of care that is person - not disease - centred. It is precisely the type of medicine needed to meet the challenge of shifting the balance of care, realising *Realistic Medicine*[93], and enabling people to remain at or near home wherever possible.

The new GMS Contract articulates a refocused role for GPs as Expert Medical Generalists (EMGs). This recognises the GP as the senior clinical decision maker in the community, who will focus on:

- undifferentiated presentations;
- complex care in the community;
- whole system quality improvement and clinical leadership.

Expert Medical Generalists will ensure strong connections to, and coordination with, the enhanced primary care team, health and social care community based services and with acute services where required. Better coordination of patient care, including greater access to the right professional at the right time, will deliver improved patient outcomes and a more proportionate use of resources.

The role of the GP as an EMG can only be achieved if they have the capacity to develop this leadership role. We have set out in Chapters three and four how we will deliver enhanced MDTs to support comprehensive service reconfiguration in primary care. This chapter describes how we will support and retain our current GP workforce through a comprehensive package of support measures, while expanding the number of GPs working in Scotland by at least 800 (headcount) over the next decade.

Supporting and retaining the existing workforce

We recognise the pressures GPs are under due to changing demographics and the expectations of patients. The Cabinet Secretary for Health and Sport announced in December 2017 a comprehensive package of measures to retain and support the GP workforce:

- **Mentoring** – embarking on any career can be challenging and stressful and we know that young GPs want more portfolio type careers and a better work/life balance. GPs within their first five years will be offered mentoring

[92] Royal College of General Practitioners (2012) *Medical Generalism: Why expertise in whole person medicine matters*
[93] Scottish Government (2016), *Realistic Medicine* http://www.gov.scot/Resource/0049/00492520.pdf

support from experienced GPs as growing evidence suggests this may be an effective component to retaining GPs in workforce[94].

- **Continued Professional Development (CPD)** – heavy workloads can mean opportunities for CPD are limited. The new GMS Contract recognises this and will provide practices with resources to support 1 session per month for Professional Time Activities. Further support is being offered to GPs in first five years of their career.

- **Coaching** – Research demonstrated that professional coaching can be successful in turning around intention to leave the profession.

Table 6: Pre- and post- coaching 'likelihood of leaving the profession' ratings[95]

	Pre-coaching (base 51)	Post-coaching (base 28)
Average 'leave' rating	7.2	4.9
7 or above	74.5%	32%
4 to 6	23.5%	21%
3 or below	2%	46%

Note: where 1 = highly unlikely to 10 = highly likely

The aim of the coaching programme is to help GPs develop their resilience and develop ways of self-management to combat burnout. Such a scheme is already operating successfully in NHS Lanarkshire. We intend to build on this success and offer a national coaching service across Scotland with an initial aim of providing four sessions of professional coaching to 100 self-identified GPs.

- **Staying in practice scheme (SIPS**) – we are revising and extending the current retainer scheme (which is currently limited to those with caring responsibilities). The aim is to widen access to scheme to those who are considering leaving general practice early due to workload pressures.

- **Support for GP appraisal** – GPs undertake appraisal annually, and this is an important part of staying up to date, ensuring high quality patient care and is a route to GMC revalidation. However, some GPs report that they find the preparatory work for appraisal burdensome and bureaucratic. Working with NES, we will provide funding for tailored appraisal support to GPs who wish it through a series of workshops. The workshops will support the individual needs of the GP, for example, the challenges some GPs experience navigating the appraisal website or the articulating reflective component of CPD and Quality Improvement activities.

[94] For a description of mentoring, including the benefits, see: https://www.bma.org.uk/advice/career/progress-your-career/mentoring

[95] Faculty of Medical Leadership and Management (2017), *NHS England GP Coaching Pilot: Evaluation Report* https://www.fmlm.ac.uk/news-opinion/nhs-england-gp-coaching-pilot-evaluation-report

Support for rural GPs

We recognise that there are particular challenges in attracting and retaining GPs and other health professionals to Scotland's remote and rural communities. Along with the BMA we have committed to setting up a *Rural Short Life Working Group* which will support the implementation of the new GP Contract in rural areas. This will support the sustainability of remote and rural practices in particular for very small practices in remote areas.

An additional package of measures to support rural GPs includes:

- **Scottish Rural Medical Collaborative** – we will build on the current work of the collaborative to help target and tailor support to primary care services in remote and rural areas. It is anticipated that this may include a mentoring scheme for rural GPs, recruitment policies tailored for rural and remote areas, development of an overarching recruitment strategy, rural deprivation preference bursary to coach rural students prior to medical school application, including work experience.

- **GP for GP** – many very remote and rural GPs and their families have difficulty accessing routine general medical services, due to geography, remoteness or distance from registered GP. The NHS Highland GPs for GPs scheme, which has been running since 2003, provides a confidential service to rural GPs and their families at times of stress or illness, when they may have difficulty going to their own GP. In the past it has supported Highland GP's with problems such as stress, depression, inability to cope, and bereavement. We will extend this scheme to provide support for a greater number of remote and rural GPs across Scotland. This service is provided in addition to the GP Occupational Health Service which is available to all GPs and practice staff. The GP for GP scheme may refer or suggest self-referrals to the GP Occupational Health Service.

- **Relocation package** – we will encourage GPs to come and work in rural practices by offering an enhanced relocation package. The current scheme will be extended from a maximum of £2,000 to £5,000 to cover expenses such as removal costs, rent, etc. and we will widen the eligibility criteria from 44 Island practices to 160 remote and rural practices across Scotland.

- **Golden Hello** – to reflect the need to support sustainable rural services we will substantially expand the existing Golden Hello scheme from 44 to 160 practices in rural and remote areas, offering £10,000 for GPs taking up post in their first eligible rural practice.

Expanding the GP workforce

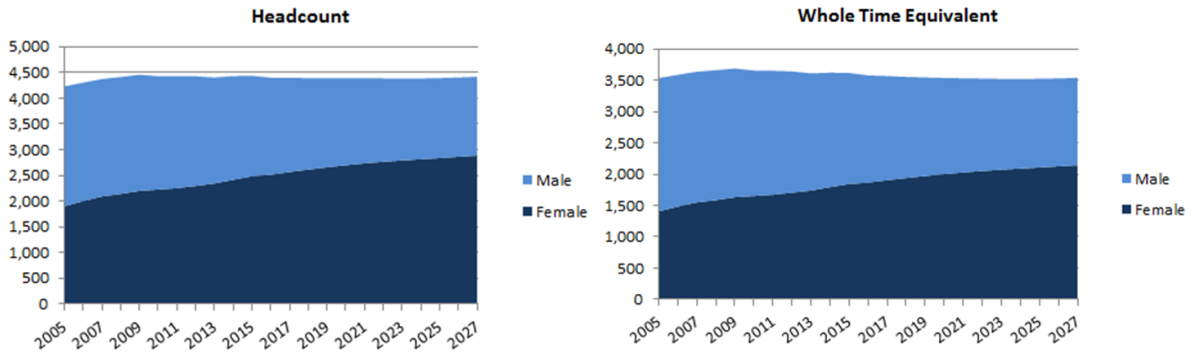
We know demand on primary care services will inevitably rise given increasing levels of multimorbidity from an ageing population and our strategic goal of shifting care from hospitals to community and home or homely settings. This requires a GP workforce that is both sufficient to meet demand but also flexible enough to address changing needs. As set out above, the new GMS contract is an important step in beginning to address workload issues by eliminating unnecessary bureaucracy,

reducing and streamlining the number of services that GP practices provide, and expanding and reconfiguring the primary care MDT.

But we recognise the need to go much further. We are able to estimate the number of GPs likely to be in the workforce over the next 10 years by modelling the age and gender of the current workforce, the number that typically leave and join the profession on an annual basis (whether new GPs completing training, flows in and out of Scotland, retirement, etc.) and taking account of increased part-time working.

Using data from the past five years we estimate that the number of GPs will remain broadly stable up to 2027. There is currently limited evidence that the GP workforce will contract significantly in the next decade, although this is difficult to assess with any degree of certainty and is based on a number of assumptions (e.g. that current rates of part-time working will remain uncharged). What does appear clear however is that the current workload issues are being driven by ever increasing demand of an ageing population rather than a significant reduction in GP capacity.

Figure 14: Forecast GP numbers to 2027[96]



The anticipated stability in the size of the GP workforce is not sufficient to meet increasing demand, estimated to increase at around 1% annually. We are therefore committed to a package of measures to ease the pressure on GPs, both in terms of support to retain those that may be considering leaving the profession and in promoting general practice as an excellent career choice, both for those considering a career in medicine and those currently training to be a doctor.

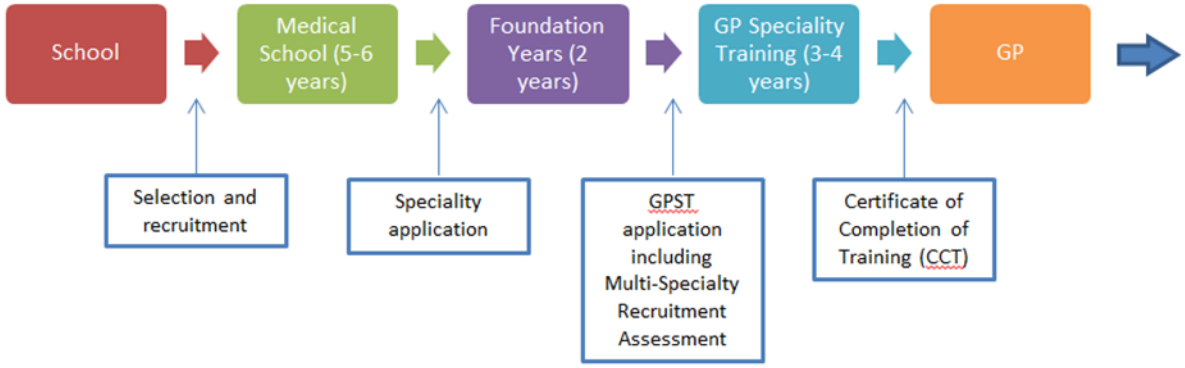
In December 2017 the Cabinet Secretary for Health and Sport committed to expanding the GP workforce by at least 800 GPs (headcount) over the next 10 years. We recognise the need for both short and longer-term initiatives to address current GP shortages and that there are no simple solutions to expanding the workforce. We need to be realistic on what can be achieved, and by when, but our commitment to increase GP capacity within primary care is clear. This commitment will require constant monitoring and review, based on better quality data (see Chapter seven).

[96] Analysis undertaken by Scottish Government. The WTE analysis was undertaken prior to the publication of the *Primary care Workforce Survey* that provides updated WTE data. The analysis will be re-run prior to the publication of the integrated workforce plan later this year.

Medical education and training

The Scottish Government is implementing and developing a range of medical education and training initiatives to increase the sustainability of the current and future workforce in Scotland. A number of strands of work are being taken forward and will address each stage of the GP career pathway set out below.

Figure 15: Medical education and training pipeline



(i) The Medical Education Package

The medical education package is a £23 million investment in undergraduate medical education. As part of that investment the Scottish Government increased the number of medical undergraduate places by 50 in 2016, and this increase was sustained for 2017 and will be again for 2018.

In addition, Scotland's first Graduate Entry Medical programme (ScotGEM) will commence in autumn 2018 adding a further 55 medical school places. The programme will be delivered by the medical schools in Dundee and St. Andrews in collaboration with the University of Highlands and Islands. This exciting new course focuses on primary care and remote and rural working offering immersive experience and aiming to attract students into these career paths.

The Scottish Government will pay the tuition fees of Scots domiciled and EU students who are accepted onto ScotGEM in order to offer as attractive a financial package as possible. Through ScotGEM we are also testing innovative retention methods. The Programme will also offer a 'return of service' bursary to all ScotGEM students. The scheme, to be administered by NHS Education for Scotland, will offer ScotGEM students a bursary of £4,000 per student per annum in return for a year of service up to a maximum of four bursaries and four equivalent years of service. We will evaluate ScotGEM over the short and long term, paying particular attention to the effectiveness of the return of service bursary and the numbers of ScotGEM graduates choosing a GP career.

(ii) Widening Access

As well as increasing capacity within medical schools, we are widening participation in medicine by promoting applications from talented young people from socially and

geographically disadvantaged situations. The 50 places added in 2016, for instance, are targeted at students from the most deprived 20% of Scotland's, as measured by the Scottish Index of Multiple Deprivation (SIMD).

The Scottish Government funded two new pre-medical entry courses at Glasgow and Aberdeen Universities, which commenced in autumn 2017. These courses support 40 places for pupils from less socially advantaged backgrounds to better prepare to undertake undergraduate medicine. This initiative supports key recommendations set out in the Report of *The Commission for Widening Access*, including a target that by 2030 students from the 20% most deprived backgrounds should represent 20% of entrants to higher education in Scotland. The programmes are also identifying school pupils from rural backgrounds who because of the size of their schools may experience disadvantage; this is an important part of the rural pipeline.

(iii) Proposed further action on medical school places

Part 1 of the National Workforce Plan committed to adding a further 50-100 undergraduate medical school places over the course of this Parliamentary term. These places will be awarded on a commissioning basis in line with strategic objectives which include significantly increasing the GP workforce. In order to attract as many young doctors into general practice as possible the Scottish Government has asked in particular for proposals which increase the percentage of clinical teaching that takes place in general practice to at least 25% of the clinical curriculum. It has also asked for proposals which ensure that all students are regularly selected, taught and/or assessed by GPs from the beginning of first year. The successful bids will be announced shortly.

Wider measures to increase exposure to primary care at undergraduate level

There is a clear need to address negative perceptions of careers in general practice. The RCGP's *Destination GP* report found a majority of students (91%) believe their peers hold negative views about general practice, and that they are most likely to associate the profession with being "boring", "lower status than other medical professions" and "less intellectually challenging"[97]. Research from the UK and abroad shows that exposure to general practice has a positive influence on students considering general practice as a career[98]. The RCGP has also found clinical placements in other specialities are particularly likely to expose students to negative views of general practice[99]. Equally, evidence demonstrates that medical students' perception of their GP teachers' job satisfaction positively affects their wish to become GPs[100].

[97] Royal College of General Practitioners (2017), *Destination GP: Medical students' experiences and perceptions of general practice* http://www.rcgp.org.uk/-/media/Files/Policy/A-Z-policy/2017/RCGP-destination-GP-nov-2017.ashx?la=en

[98] Howe A., and Ives, G. (2001) *Does community-based experience alter career preference? New evidence from a prospective longitudinal cohort study of undergraduate medical students*. Med Educ 35(4):391–397

[99] Royal College of General Practitioners (2017), *Destination GP: Medical students' experiences and perceptions of general practice*

[100] Harding A, McKinley R, Rosenthal J, Al–Seaidy M (2015) *Funding the teaching of medical students in general practice: a formula for the future? Educ Prim Care 26(4):215–219*

Currently some Scottish Universities teach as little as approximately a tenth of their clinical curriculum in primary care. Despite GPs comprising around 27% of the medical workforce, the UK's academic GPs account for only about 6% of all clinical academics[101]. We recognise that increasing clinical teaching in primary care and by primary care practitioners brings with it a number of complex challenges for medical schools and the Service and we do not underestimate these. As noted, these include the need to increase the number of GP educators and issues around competing demands on GP practice's time and around ACT funding and infrastructure. Under the joint auspices of the Scottish Government and the Board for Academic Medicine, we have establishment an *Increasing Undergraduate Education in Primary Care Working Group*, chaired by Professor John Gillies. It will consider ways of increasing undergraduate education in primary care settings, within a challenging but realistic timescale.

Post Graduate Medical Training

In 2016, as part of our programme to grow the numbers of graduates entering General Practice Specialist Training (GPST), 100 additional posts were introduced in Scotland, coupled with a further round of recruitment to maximise the number of posts filled. In recognition of yearly recruitment data and trainee feedback indicating persistent problems in filling unpopular four-year GPST posts where the 4th year of training is spent in hospital based posts, the Scottish Government asked NHS Education Scotland to reconfigure the balance of 3 and 4 year training programmes to prioritise 3 year rotations which maximised educational quality and ensured these posts met the curricular requirements. These measures will contribute towards making unpopular GPST posts more attractive options for potential trainees and help improve overall fill rates. Work to phase out educationally poor posts in favour of high quality 3 year rotations will continue in 2018 and 2019.

In tandem, to promote General Practice as an attractive career choice, a one-off bursary of £20,000 is available to trainees in posts that historically have found it more difficult to recruit including the Scottish National Rural Track Programme posts. The bursary payment is made to trainees as a lump sum on taking up the post and in return they agree to complete the three year placement in that location. If the trainees leave before completing three years they then have to repay the bursary.

Preliminary assessment of this initiative has shown there is a more even distribution of trainees, away from central areas and towards some harder to fill posts in rural areas.

To assist with increasing the number of doctors choosing a career in general practice we intend to offer additional support to foundation level doctors keen to undertake GPST. Where candidates have been unsuccessful in the GPST selection process, we would like to offer a 1 year development post with tailored support to equip individuals for re-application for subsequent GPST recruitment. A financial incentive would be offered to GP Trainers for supporting these candidates during their

[101] Centre for Workforce Intelligence (2014) *In-depth review of the general practitioner workforce: Final report,* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/507493/CfWI_GP_in-depth_review.pdf

development post. We are in the process of gauging interest from previously unsuccessful GPST candidates in such a scheme.

Shape of Training

The Scottish Government is also committed to implementation of recommendations arising from Professor Sir David Greenaway's *Shape of Training: Securing the future of Excellent Patient Care review*[102] as outlined within the report of the UK-wide Shape of Training Review Steering Group published in August 2017. Many of these recommendations align with the transformational plans already set out by the Scottish Government. In relation to GP training, the commitment is to develop an enhanced training model in which qualified GPs are offered a further year of training to furnish them with additional skills. It is clear that the development of additional skills must be responsive to local provider and patient needs and complement the Expert Medical Generalist role, particularly the increasing delivery of complex care in the community. It is also evident that there is a clear desire by many GPs to enhance their skills and experience complementary to their Expert Medical Generalist role, which facilitates a portfolio career. Against that background there are a number of formats which a further optional year of post CCT training or development could take and in conjunction with key stakeholders, including the BMA and RCGP, we will continue to develop and test a variety of options.

Additional measures to increase GP numbers

(i) Marketing and recruitment campaign

Scotland has a lot to offer its GPs – no bureaucratic Quality Outcomes Framework (QOF), no clinical commissioning and a new GMS Contract that refines and focuses the role of the GP as an Expert Medical Generalist and clinical leader of an expanded MDT. Patient satisfaction is consistently high with 87% rating the overall care provided by their GP practice as good or excellent in 2015-6[103]. Scotland is also blessed with natural beauty and a vibrant and tolerant culture, and is an excellent place to bring up a family.

We must do more to make the best use of these assets and promote Scotland as a great destination for GPs to relocate. We will therefore launch a GP marketing and recruitment campaign during 2018 to increase the number of GPs who wish to work in Scotland from the rest of UK and overseas. The aim of the campaign will be to improve the way we market abroad the opportunities to work in NHS Scotland, improved the use of SHOW website, and to build better targeted and more effective advertisement of Scottish jobs in England and elsewhere.

We will look at opportunities to employ a recruitment agency to work run alongside the marketing campaign. Scottish recruitment agencies are already working with individual health boards to attract GPs to Scotland; working at scale will offer additional advantages and better value for money. This could include access to databases, recruitment events, headhunting, support and pastoral care during and

[102] https://www.shapeoftraining.co.uk/reviewsofar/1788.asp
[103] Scottish Government (2016), *Health and Care Experience Survey 2015/16 - National Results* http://www.gov.scot/Publications/2016/05/9045

after recruitment. We will ensure consistency and coordination with the planned marketing campaign to attract nurses to work in NHS Scotland.

(ii) Exploring ways to enable doctors to switch specialities

At present most registrars / consultants who wish to become GPs are required to undertake the full three year GP training. This is perceived as a barrier to moving into general practice. We propose working with NES and others to consider ways in which this route to general practice could be better supported. This can be achieved but needs a substantial amount of work to be put in place by 2019.

Conclusion

We recognise the workload challenges currently facing our GPs and the need to expand both GP numbers and the wider MDT that will help deliver the aspirations set out in the new GMS Contract. Our intention to increase GP numbers by at least 800 (headcount) over ten years is ambitious, but our assessment is that it is achievable through a range of measures targeted at every stage from medical school through to late career. It is an essential component of building a strong and sustainable primary care system which will continue to serve as the bedrock of the NHS in the years ahead.

CHAPTER SIX: PLANNING AND DEVELOPING THE MULTIDISCIPLINARY WORKFORCE - WIDER CLINICAL AND NON-CLINICAL WORKFORCE

- We will build a sustainable pharmacotherapy service in Scotland that includes access to pharmacist and pharmacy technician support for every GP practice.
- Faster and more efficient whole system pathways will support patients with musculoskeletal conditions, led by physiotherapists.
- There will be a significantly enhanced paramedic provision in all Integration Authorities, aligned to clusters, based on local service design, and delivered via the commitment to train an additional 1,000 paramedics to work in the community.
- We will see a developed and enhanced role for allied health professionals in supporting patients' needs, including promoting prevention and self-management with improved access.
- We are committed to increasing the mental health workforce in A&Es, GP practices, police station custody suites and prisons by 800. Supported by investment of £12 million in 2018-19, with annual investment rising to £35 million by 2021-22.
- There will be 250 community links workers in place by 2021, reducing practice workload and supporting patients' holistic needs.
- We will support enhanced training and support for practice managers and practice receptionists to develop their roles, supported by continued investment.
- There will be increasing use of community pharmacy for improving population health, managing self-limiting illnesses and supporting self-management of stable long term conditions in- and out-of-hours, and an expanded workforce.
- We will work with stakeholders to consider the need for a proposed marketing campaign to attract individuals into allied health professions to ensure a sustainable workforce is available to meet Scotland's future requirements.

Introduction

The previous two chapters set out our approaches to enhancing and expanding the nursing and GP workforces. In this chapter we focus on how we will develop the wider clinical and non-clinical workforce to ensure enhanced MDT models of care will provide patients with the most appropriate treatment, as quickly as possible, by the most appropriate practitioner in the most appropriate setting. This includes models being developed for pharmacy, musculoskeletal physiotherapists, mental health workers, community links workers and paramedics as first point of contact. To ensure effective MDT working that delivers high quality person-centred care, local planners will need to give consideration to the collective mix of generalist and

specialist skills within each team and service. This will be facilitated by the development of more comprehensive workforce data, as set out in the final chapter.

Physiotherapists

Neck and lower back pain generates the second highest burden of disease in Scotland[104]. Early intervention and self-management can have a significant impact in preventing chronicity of these conditions. Musculoskeletal (MSK) health issues are a common cause of GP appointments but the majority of a GP's MSK caseload can be seen safely and effectively by a physiotherapist without a GP referral. However the existing patient pathway often includes an unnecessary delay while initial non-physiotherapeutic solutions are attempted prior to access to an MSK Physiotherapy service. While there is no waiting time to access advice via the Musculoskeletal Assessment and Treatment Service (MATS), there are variable waiting times across the country for access to face to face physiotherapy. Under a new model, physiotherapist's could provide first point of contact appointments providing assessment, diagnosis (including access to diagnostics), advice and onward referral to secondary care services if appropriate. Where they have appropriate training and skill mix, MSK physiotherapists should carry out prescribing as well as treatments such as injections. This will enable a faster and more efficient whole system pathway for patients with MSK conditions.

A sustainable Physiotherapy / Advanced Practice Physiotherapy provision should be considered by all Integration Authorities in developing their Primary Care Improvement Plans, potentially aligned to GP clusters. A significant proportion of the current workforce either already has the skills required, or could be quickly up-skilled to take on these roles. However, the training of new physiotherapists will take time, with undergraduate training currently lasting two to four years, therefore a transitional phase would be required to enable a sustainable model to be achieved.

New models of MSK physiotherapy provision have been tested across Scotland as part of the Primary Care Transformation Fund. The Scottish School of Primary Care is evaluating selected models on behalf of the Scottish Government. The study will help us understand the context in which the new models of MSK physiotherapy were tested, and examine the barriers and facilitators to deployment and uptake that were met by the test sites. It will also consider how well, in early sites, the changes have been embedded as part of routine practice, and consider sustainability issues. A report setting out key findings will be published by the end of 2018.

Future AHP workforce

NHS Boards across Scotland have indicated challenges around recruitment across all of the AHP workforce, but particularly affecting physiotherapy. The numbers entering the Allied Health Professions are not currently controlled, and are largely determined by supply and demand factors. The potential for a more managed approach to workforce planning for those training to become AHPs is being explored.

[104] Scottish Public Health Observatory (2017), *The Scottish Burden of Disease Study, 2015* http://www.scotpho.org.uk/media/1474/sbod2015-overview-report-july17.pdf

Consideration is also being given to the potential for other, faster, routes into the professions such as return to practice and post graduate training.

In addition, we will work with a range of stakeholders to consider how best to attract and retain people into AHP careers – particularly for those professions where it is already difficult to recruit to such as physiotherapy. As part of this wider work, we will consider the potential need for a marketing and recruitment campaign.

Pharmacists and pharmacy technicians

A three-tiered pharmacotherapy service is to be implemented in a phased approach with the aim of introducing a sustainable service that includes access to pharmacist and pharmacy technician support in every GP practice by 2021 as set out in the Memorandum of Understanding. Level one is a core service that will be made available to all GP practices, with activities at a generalist level of pharmacy practice focused on acute, repeat and serial prescribing, medication management and prescribing efficiencies (technical and basic clinical roles). Levels two (intermediate) and level three (advanced) are additional services and describe a progressively evolving stage of clinical pharmacy practice and experience which includes medication and polypharmacy reviews. The levels of support will take into account the needs of individual practices and practice clusters by planners at local level.

The Inverclyde *New Ways of Working* pilot provided an average of 0.5 WTE pharmacist per practice alongside some pharmacy technician involvement. Another model, which better accommodates the needs of remote and rural practices is 1 pharmacist per 10,000 list size.

The pharmacotherapy service will be led by the Directors of Pharmacy for the three year trajectory period to allow workforce planning to be supported, appropriate governance arrangements embedded and the successful initial momentum to be maintained. This will also allow the service to reach a level of maturity before being reviewed with the view to a handover to Integrated Authorities. A national implementation group has been established to support the delivery of the service.

Approximately one third of GP practices currently have pharmacy input supported by Primary Care Funding. Boards have adopted a number of different delivery models, including sessional input from hospital and community pharmacists, and split posts between practices and locality approaches. We will continue to work closely with NHS Boards to monitor progress against the Programme for Government commitment and to ensure that recruitment to the new pharmacotherapy service is delivered in a sustainable way so as to minimise any risk of destabilising other parts of the system. That is why a phased approach to the recruitment of pharmacists and pharmacy technicians into general practice has been essential.

The commitment that every GP practice will receive pharmacist and pharmacy technician support by 2021, through the Pharmacotherapy Service, is being supported through the Primary Care Fund. The funding available in 2017-18 for general practice pharmacy support was increased by a further £4.2 million. Based on this additional funding over and above the original three year figure of £16.2 million, by the end of March 2018, NHS Boards planned to have appointed over 200 whole

time equivalent pharmacists and over 50 whole time equivalent pharmacy technicians working with or within GP practices. Outturn figures up to the end of March 2018 are currently being gathered.

As part of their Primary Care Improvement Plans (PCIPs) Integration Authorities and Health Boards will be updating their plans for 2018-19 up to the end of 2021 and this will be reflected in future iterations of the workforce plan.

An evaluation of the workforce aspects of the GP practice-based pharmacists and pharmacy technicians should be available by the end of 2018 and the early findings, alongside the Inverclyde evaluation, will be used to inform detailed workforce planning work to identify how many additional pharmacists will be required to deliver full roll-out of the pharmacotherapy service.

Developing the future pharmacist workforce

Community Pharmacy

Community pharmacy already plays an important role in the provision of NHS pharmaceutical care, providing highly accessible services for people both in-hours and out-of-hours. We want more people to use their community pharmacy as a first port of call, not only for the treatment of self-limiting illnesses and medicine-related matters, but for the on-going self-management support for people with long term conditions. Enhancing these services also expands the clinical role of community pharmacists.

Achieving Excellence in Pharmaceutical Care[105] committed to working in collaboration with NHS Education for Scotland and other key stakeholders to understand and address future pharmacy workforce requirements. It describes the need to further build the clinical capacity within community pharmacy and our commitment to target resources to expand the number of community pharmacists undertaking independent prescribing and advanced clinical skills training. This includes exploring how resources to cover back-fill for the residential training and period of learning in practice can be provided in order to build clinical capacity to deliver an extended Minor Ailment Service and enhanced Chronic Medication Service.

Given the importance of community pharmacy in helping transform our primary care services, in Chapter 7 we describe how for the first time we have undertaken a national community pharmacy workforce survey to provide the necessary insights into staff numbers and skill mix to meet the challenges of delivering new models of primary care. Crucially this will inform national workforce planning and the educational needs of the profession in this sector.

[105] Scottish Government (2017), *Achieving Excellence in Pharmaceutical Care: A Strategy for Scotland* http://www.gov.scot/Publications/2017/08/4589

The Pharmacotherapy Service

With regard to the pharmacotherapy service in GP practices, there are a number of additional implementation factors that need to be considered alongside the number of pharmacists and pharmacy technicians required to deliver it. This includes their education and development and importantly securing the pipeline of new pharmacists.

Depending on the experience of the pharmacists and pharmacy technicians working in GP practices there can be a need for additional training, this includes advanced clinical and independent prescribing skills. This will also require appropriate levels of clinical mentorship. Resources have been identified and allocated to Boards to support this. Additionally, the new NES vocational training programme for pharmacists in primary care and community pharmacy will contribute towards ensuring early career pharmacists build skills and capability. A *General Practice Clinical Pharmacist Competency and Capability Framework*[106] has been developed to underpin the education and training needs of pharmacists supporting GPs going forward.

As a first step, and in order to increase the pool of qualified pharmacists available to provide the pharmacotherapy service, additional funding has been secured to increase the number of NES pre-registration pharmacist training posts from 170 to 200 per year from 2018/19 onwards.

Paramedics

A number of tests of change in Scotland over the last two years have focused on the role of paramedics in primary care. Evidence from pilots in Inverclyde, Hawick and Kelso shows that support (such as responding to urgent call out to patients) allows GPs to provide more appropriate patient care. The Inverclyde Pilot, for example, found that in the first three months following paramedic support to practices being put in place, the percentages of home visits carried out by GPs reduced by over 60%[107]. Paramedics are equipped to consult with unscheduled urgent care presentations, making them an ideal fit to work with primary care colleagues. This model will free up GPs' time to focus on their EMG role by reducing appointments and home visit requests for unscheduled and urgent care presentations.

This model also supports paramedics to practice their skills at the highest level of their professional competence, consolidate their learning, gain exposure to and experience of patients with acute illness and injury and develop closer relationships with primary care colleagues, becoming part of a wider multi-disciplinary team. It helps support the *Memorandum of Understanding*, which specifies that advanced practitioners, such as paramedics, should be used to respond to urgent care appointments, such as home visits, in place of the GP. These practitioners will be aligned to clusters as appropriate and be based on local service design and working

[106] The Framework is available to the Pharmacists funded via the Primary Care Fund, who access an electronic version via Portfolio on the NES TURAS platform. Additional information is available at: http://www.nes.scot.nhs.uk/education-and-training/by-discipline/pharmacy/pharmacists/prescribing-and-clinical-skills/pharmacists-working-in-gp-practices.aspx

[107] http://www.gov.scot/Resource/0052/00527530.pdf

during core general practice hours, as well as out of hours. These paramedics will assess and treat patients in a range of settings, including urgent and emergency care presentations, home visits and Heath Centre attendees.

As autonomous practitioners, paramedics will not require regular supervision by the GP within a cluster, but will need access to support when issues outwith their scope of practice arise. While this will be provided by a clinician, this may not necessarily be the GP. Supervision for paramedics working within a practice will always be agreed under the GPs clinical oversight. Peer supervision with clinical oversight and leadership from the GP will be encouraged under this new model.

Paramedics and advanced paramedics will continue to be employed by the Scottish Ambulance Service (SAS). As part of the Primary Care Improvement Plans, we expect the SAS to work with Integration Authorities to set out what support is required at a local level, using evidence gathered from current tests of change, such as in Inverclyde. This will include developing robust clinical governance frameworks and evaluating practice data.

SAS will integrate all existing pilot activity, such as the work being carried out in Inverclyde, into a single national programme of work to transform primary care in a 'Once for Scotland' approach. This will include developing robust clinical governance frameworks and evaluating practice data. As part of the Primary Care Improvement Plans, we expect the Scottish Ambulance Service to work with local Health and Social Care Partnerships to set out what support is required at a local level.

Patient safety will be fundamental in delivering this workforce at scale. At all stages of the roll-out, we will ensure the available workforce is appropriate to ensure the safety of patients requiring urgent unscheduled care is assured, and core ambulance services are not negatively impacted. This will require consistent and reliable provision of paramedic staff working in primary care teams, appropriate training and education, supervision and support arrangements, and, crucially, positive relationships between colleagues in the MDT.

Future paramedics workforce

There will be an increase in paramedics and advanced paramedics in the coming years. The Scottish Government has committed to training 1,000 additional paramedics during this Parliament to work in Scotland's communities to deliver more care at home. This is also in alignment with the Scottish Ambulance Service's strategy *Towards 2020: Taking Care to the Patient*[108] – focusing on increasing the Service's capacity for care at home or in the community. This role could be further enhanced as plans are now underway to allow paramedics to become independent prescribers.

Current paramedic training is carried out through a two year diploma in higher education and Scotland's first undergraduate BSc in Paramedic Science commenced in September 2017. Following publication of the *Paramedic Evidence*

[108] Scottish Ambulance Service *Towards 2020: Taking Care to the Patient*

Based Education Report (PEEP)[109] in 2013, a consultation is now underway to explore changing the training to be undertaken as a degree. This may impact on the availability of workforce due to longer training times and we will work with SAS and other stakeholders to ensure suitable transitional arrangements are in place.

Mental health workers

Mental health issues are a common feature of primary care consultations. For instance, Scottish research in primary care showed that depression is associated with a wide range of physical health conditions and is a significant burden on primary care[110]. Across a range of conditions, each patient with co-morbid depression costs health services between 30% and 140% more than equivalent patients without depression[111].

Appropriately skilling our primary care workforce to ensure they are confident in dealing with mental health problems is crucial. Mental health expertise therefore needs to be embedded in multi-disciplinary primary care teams through a mixture of specialist mental health workers and by ensuring that other professionals are mental health trained / aware.

A £10 million Primary Care Mental Health Fund (PCMHF) has allowed different services to try different approaches to improving mental health provision. The Scottish School of Primary Care is undertaking an evaluation of a range of projects funded by the Primary Care Transformation Fund and the PCMHF. The evaluation will comprise case studies with a geographic and thematic focus and will be published in Autumn 2018.

Future mental health workforce

The *Mental Health Strategy for 2017-2027*[112] recognises the importance of primary care transformation and sees it as an opportunity to improve services for people with mental health problems with parity of esteem between physical and mental health. This includes Action 23 which is a commitment to test and evaluate the most effective and sustainable models of supporting mental health in primary care, by 2019.

In addition, Action 15 states that we will increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. It commits to increasing additional investment to £35 million per annum by 2021-22 (including £12 million in 2018-19) for 800 additional mental health workers in those key settings.

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[109] https://www.collegeofparamedics.co.uk/downloads/PEEP-Report.pdf
[110] Smith, D. et al (2014) *Depression and multimorbidity: a cross-sectional study of 1,751,841 patients in primary care*, J Clin Psychiatry. 2014 Nov;75(11):1202-8
[111] Melek S. Norris D. (2008), *Chronic Conditions and Comorbid Psychological Disorders*. Seattle: Milliman Research Report
[112] Scottish Government (2017), *Mental Health Strategy 2017-2027* http://www.gov.scot/Publications/2017/03/1750

There are a number of implementation factors which need to be considered in respect of the delivery of this commitment. These include the commissioning arrangements of each Integration Authority and how to align the roles of services from both a national and local perspective in order to balance the skills and capacity for this additional workforce.

The Scottish Government has asked the Health and Justice Collaboration Improvement Board (which includes senior public sector leaders who, amongst other responsibilities, identify and address organisational and systemic barriers to working collaboratively) to develop recommendations on how to achieve Action 15 from 2018-19.

Wider Clinical Roles

There are a range of other roles as part of the MDT that can offer high quality care as part of a comprehensive and person-centred service.

Healthcare Scientists are the fourth largest clinical group, who collectively are responsible for over 80% of all clinical diagnoses[113]. This workforce covers over 50 different scientific specialities and is the specialist workforce in the health system that responds directly and uniquely to advancing scientific and technological changes.

A more holistic approach to treatment pathways could see scientists integrated into patient pathways, and working in multi-disciplinary teams as part of a whole systems approach. The ability to support patients with complex needs at home will increasingly rely on the use of networked medical technology supported by Medical Physics and Clinical Engineering services in collaboration with eHealth. Clinical Engineering services are already experienced in supporting equipment, such as portable ventilators and assistive technology, in the community and this expertise can be utilised to allow the roll out of other medical equipment for use in the non-hospital settings in a safe, controlled manner.

Healthcare Scientists can contribute to reducing out-patient attendance such as for Audiology, Cardiac Physiology and Respiratory Physiology where what are typically “routine” out-patient attendances for investigations and rehabilitation can be delivered in local setting e.g. community hospital type setting. Pharmacists and healthcare scientists are working together to develop models of point of care testing in community treatment centres.

Dieticians can now train as supplementary prescribers and have the skills and knowledge to help manage conditions such as irritable bowel syndrome, reducing referral to secondary care and improving symptoms for 70% of people, type 2 diabetes and food intolerance conditions[114].

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113 http://www.nhsemployers.org/~/media/Employers/Publications/Healthcare%20scientists%20in%20the%20NHS%2013%20April%20final.pdf

114 Williams M. (2013), *The importance and practical implementation of the LOW FODMAP Diet.* Complete Nutrition Focus; 5(1): 9-11

Mental health problems and presentations of distress are common in primary care. Early intervention can prevent later mental ill health and improves outcomes for the person. The prevalence of mental illness also has a profound effect upon our success in treating physical illness. Mental health presentations can be seen in the first instance by a primary care mental health practitioner (PCMHP). Occupational Therapists (OTs), working as a first point of contact practitioners in general practice, are providing quick access to early assessment and intervention for people with emerging mental health problems. When required the therapist can signpost and refer to third sector and other healthcare professionals as appropriate.

OTs have particular expertise in helping people who are frail or have long term conditions. The benefits of this role include enabling independence and social inclusion; preventing deterioration; and minimising crisis situations, thus reducing demand on GP practices and acute admissions.

A fully integrated primary care podiatry service can safely diagnose, manage, rehabilitate and prevent disease related complications of the feet, ankles and lower limbs, particularly around MSK, diabetes, rheumatoid conditions and peripheral arterial disease. They also have a significant role in the public health and prevention agenda specifically around falls prevention, cardiovascular risk reduction, medicines management and reconciliation, antibiotic stewardship and keeping people mobile and active.

Podiatrists have the ability to utilise advanced diagnostic techniques including imaging and can prescribe independently, for a range of lower limb conditions. As the experts in lower limb health and disease, podiatrists have the requisite knowledge, skills and training to work as first point of contact practitioners in primary care

Speech and language therapists have the specialist knowledge and skills to diagnose, directly assess and support problems in relation to communication, safe eating, drinking and swallowing. The assessment and management of eating, drinking and swallowing problems has an important role in to prevent malnutrition and dehydration, reduction the risk of repeated chest infections, urinary tract infections and falls.

Dentists

The 2016 dental workforce report[115] is the latest in a series of biennial dental workforce reports that aim to inform workforce planning for dental services in Scotland. The report examines supply and demand for services based on several contributory factors including uptake of services, population projections, changes in demography, country of qualification of the dentists and the years spent in the service post qualification.

On the current trajectory our dentist workforce will exceed the needs of the projected Scottish population by 2026. To help counter this potential future over-supply of

[115] NHS Education for Scotland (2016), *The Dental Workforce in Scotland 2016* http://www.nes.scot.nhs.uk/dental-workforce1.html

dentists we have reduced the dental school in-take of Scottish, Rest of the UK and EU dental students to 135 per year. The impact of this reduction will begin from June 2018 onwards.

However, when planning the dentist workforce it is necessary to consider the make-up of the workforce going forward, in particular the number of EU dentists and the possible impact Brexit may have. Primary Care dental services in remote and rural area have a higher non-UK dentist workforce, made up of EU and international dentists, and would potentially feel the effects of any Brexit impact more acutely than other parts of the country.

Dentists wishing to provide NHS General Dental Services in Scotland, unless otherwise exempt, have to complete a vocational training (VT) period of one year duration. Three-quarters of dentists who started working in Scotland after finishing VT in the UK were still in NHS Scotland six years later. If, however, they entered NHS Scotland from the EEA only 46% remained after six years. After 10 years more than half of vocational dental practitioners stayed in NHS Scotland. Currently approximately 10% of GDPs in Scotland qualified in the EEA but in recent years there is the beginning of a trend of these numbers reducing. Since the distribution of EEA dentists is skewed towards remote and rural areas, this is a concern for the future. We will continue to monitor trends in the profile of dentists via the biennial workforce plans.

Dental Care Professionals

The role of dental care professionals (DCPs), also has to be taken into account when planning the dental workforce. Approximately 40 new dental therapists qualify every year. As the emphasis on care moves towards prevention and there is an increasing need to consider the on-going care of older people the more potential there is for greater involvement of DCPs particularly therapists. Direct Access to DCPs (instead of patients visiting a dentist first) may enable them to contribute significantly more than at present but legal challenges to introduce this arrangement will first have to be overcome.

Optometry

Optometry plays a key role in the provision of community care. This has developed since the introduction of free NHS funded eye examinations in 2006, to the service being the first port of call for people with eye problems, helping to detect eye diseases early. More integrated care is being provided in local practices, with community optometry supporting pharmacy, GP, nursing, social care and third sector colleagues to help patients remain within primary care. The development of General Ophthalmic Services (GOS) to support community eye care has reduced the burden on GPs and has allowed more patients to be discharged from the hospital eye service. Age is the greatest risk factor for developing eye conditions, and training is being developed to enable safe and high quality community care for patients with long-term ophthalmic conditions.

The *Community Eyecare Services Review*[116] was commissioned by the Cabinet Secretary for Health and Sport in 2016 to consider and evaluate community eyecare services currently provided across Scotland, and identify examples of good practice that could be replicated on a national basis. The Review also forms part of the *Health and Social Care Delivery Plan*. The Review made a number of recommendations, including schemes to reduce geographical differences in services, more tailored arrangements for patients with specific complex needs to support care closer to home, and suggested that some eye services traditionally offered in hospitals (such as post-cataract surgery appointments and managing stable glaucoma patients) should be made available locally. The Scottish Government is in the process of implementing the recommendations of the Review, including the development of new GOS regulations, and is engaging with a range of stakeholders, including health professionals and patients.

Non-clinical staff

Community Links Workers (CLW)

Community links workers (CLW) have a specialist or generic non-clinical role in the primary care workforce. Their purpose is to improve patient health and well-being, reduce pressure on general practice and tackle health inequalities. To be most effective a CLW should be integrated or embedded in general practice, provide a non-clinical intervention which meets the needs and demands of the practice and practice population and is employed by a local authority or third sector organisation.

They provide an essential role in tackling deprivation, and the needs of those who have complex conditions, are socially isolated, or live far from other support. Following successful piloting in areas of high socio-economic deprivation, there are now CLWs in place in several areas. There are also numerous staff fulfilling comparable roles across the country with a range of job titles. Many CLWs are generalists, but staff providing specialist non-clinical support specifically with, for example, welfare issues or supporting mental health are providing equally valid services to patients who need it, and form part of our overall approach to CLWs.

CLWs are one of the six key services that, in future, will be provided to patients in GP practices or clusters of GP practices by Health Boards under the new GP contract. Their roles will be designed, commissioned and planned by Health and Social Care Partnerships, based on assessment of local need, working hand in hand with local GPs, patients and the third sector. This will be a locally-determined and delivered service, built up across the country to deliver our overall national commitment to at least 250 staff as per the Scottish Government's commitment. The new GMS contract National Oversight Group will ensure that the service is being rolled out at pace nationwide over the next three years.

[116] Scottish Government (2017), *Community Eyecare Services Review* http://www.gov.scot/Resource/0051/00516810.pdf

Practice manager and receptionists

Primary care transformation presents an opportunity to consider how non-clinical staff (practice managers and receptionists) can be up-skilled to help coordinate care as part of a wider MDT.

Practice Managers have a key role in ensuring the smooth and efficient day to day running of General Practices and the long term strategic management and co-ordination of primary care, including supporting the development of the multi-disciplinary team as set out in the new 2018 GP Contract.

With the introduction of the 2018 contract the need for Practice Managers with wide ranging, adaptable and versatile skills is going to increase as General Practice and Primary Care becomes a more complex landscape. In addition to continuing to manage the practice employed practice team and dealing with other practice based issues, their role working with external stakeholders including GP Clusters, Health Boards and HSCPs is going to develop and expand. Working closely with the developing services such as Vaccinations and Community Care and Treatment Services and other members of the multi-disciplinary teams that will be working in the practice or with the practice team will be vital. Coordination and communication with these new services will be crucially important across a range of issues including access to IT systems and supporting patients to access services.

Practice Managers therefore require a wide range of skills including financial management, IT management, HR management, contract management, leadership and facilitation, Quality Improvement skills, change management, communication and patient engagement skills. Following the announcement in May 2017 of £500,000 investment in the development of Practice Managers and Practice Receptionists, work is on-going with NES to work with Practice Managers to identify their training needs for the future, and make sure those needs are met over the next few years. Career development and succession planning is also going to be important for the profession going forward and is also being considered.

Alongside the changing role of Practice Managers, the role of receptionists and other non-clinical staff in the practice has also changed and developed and will continue to do so.

Practice Receptionists have a challenging role, managing patients' requests and expectations, often in difficult circumstances. They play a vital role both now and in the future which needs to be recognised, valued, supported and developed. In some practices the title of Practice Receptionist is now considered to be outdated and does not fully reflect their role and there should be consideration of a revised job title in future. Opportunities such as developing and up skilling practice receptionists to carry out care navigation of patients in this increasingly complex primary care landscape or to increase their role in the management of practice documentation , is currently being developed with NHS Healthcare Improvement Scotland who will be working with GP Clusters to develop training and resources to support this group of staff.

There is also a wide range of other practice administrative staff who carry out a variety of tasks depending on the needs of the practice from prescription management, medical secretarial skills, IT management including call and recall, documentation management, health and safety, finance management, and healthcare assistant roles. These staff are a highly skilled and adaptable workforce, who will continue to have an important role in the delivery of care by general practices. Strong leadership by Practice Managers supported by their teams and by the practice GPs is vital.

NHS 24

NHS 24's 111 service is at the forefront of delivering safe and effective urgent care and support to the public when GP practices are closed. As a national organisation NHS 24 has a unique opportunity through its infrastructure to align itself more closely with primary care, social care, and voluntary and independent sectors, in response to key drivers including Health and Social Care Integration, Primary Care Transformation, and national strategies such as the National Clinical Strategy. It is anticipated that over the next five years, to support the programme of development, an additional 371 WTE staff will require to be recruited. This represents an increase of approximately 40% of NHS 24's existing workforce. The majority of the resource requirements, approximately 65%, are for non-clinical staff, call handlers in particular, however, there will also be a requirement for NHS 24 to grow its requirement for clinical staff, including more nurse practitioners, advanced nurse practitioners, mental health nurses, general practitioners, and allied health professionals. With these additional staff in place, we would expect NHS 24 to work with Health and Social Care Partnerships to set out what support NHS 24 can offer at a local level, including the triage of patients to general practice or to self-management pathways as part of the Primary Care Improvement Plans

Conclusion

This chapter set out new models of care that will ensure quality service provision and build MDT capacity in local communities. To service these models we are re-configuring services both at a national and local level with associated investment. Nationally we are beginning to ensure through better workforce planning across all primary care professions the education and supply pipeline is adequately resourced and planned to ensure a sustainable workforce that takes account of changing trends.

CHAPTER SEVEN: A DATA AND INTELLIGENCE LED PRIMARY CARE

- Enhanced workforce data across 3 broad GMS contract areas: workforce, GP income and expenses, and quality improvement and sustainability/clinical activity.
- Improvements underway in collection of AHP, pharmacy and optometry workforce and activity data.
- Roll out of the Scottish Primary Care Information Resource (SPIRE), enabling health professionals and GP clusters to work more effectively together to improve the quality of care.
- Expansion of the successful Local Intelligence Support Team (LIST) programme into primary care to support GP Clusters deliver quality improvement.
- Development of the NES workforce data platform and supply modelling.
- The Primary Care Digital Services Development Fund, 2016-2018 delivering a wide range of systems enhancements, infrastructure improvements and innovative trials of new tools and technologies.
- Development of a 10 year Primary Care Monitoring and Evaluation Strategy to understand and share learning, including progress in delivering the commitments set out in this plan.

Introduction

The importance of good quality and timely data and the capacity to use it to drive the reform of primary care and quality improvement cannot be under-estimated. We are aware of the need to strengthen the primary care data we collect, and ensure the right healthcare professional has the right access to the right data at the right time to improve patient outcomes. We are currently rolling out a significant programme of work and investment to enable consistent, high quality and reliable data to be sourced, managed and utilised appropriately.

Workforce data

The *Primary Care Workforce Survey* is designed to capture aggregate workforce information from Scottish general practices and NHS Board-run GP Out of Hours services. The survey provides information on GPs, registered nurses (including nurse practitioners) and other clinical staff employed by Scottish general practices. It also collates data on vacancies, temporary cover for sessions / hours and out of hours commitments. The 2017 workforce survey was published in March 2018[117].

In recognition of the importance of reliable workforce data we have agreed with the BMA as part of the new GMS contract that, from 2018-2019, practices will return

[117] NHS National Services Scotland (2018), *National Primary Care Workforce Survey 2017* http://www.isdscotland.org/Health-Topics/General-Practice/Publications/2018-03-06/2018-03-06-PCWS2017-Report.pdf

data to NHS National Services Scotland. This will create a richer set of data to support local and national workforce planning and service improvement. Data is required across three broad areas:

- Workforce data for workforce planning and assessing practice sustainability. This is likely to be broadly in line with the information collected via the existing workforce survey but we will explore the potential of collecting these data on a quarterly basis;
- In order to prepare for Phase 2 of the GMS Contract we need to fully understand the current expenses of running a GP practice, the income of salaried GPs and the income of GP partners as well as the hours worked by individual GPs. The Scottish Government and the BMA have agreed that all GP practices will be required to provide this data (earnings, expenses, working hours/sessions) in a similar way to the data already provided for pension purposes;
- Clinical quality and activity data to support GP cluster quality improvement, planning and service re-design.

The need for robust data for ensuring continuity in high quality patient care applies equally to primary care services provided out-of-hours. This was acknowledged as one of the main recommendations in Sir Lewis Ritchie's *National Review of Out-of-Hours Services* report published in November 2015[118]. Since the Review's publication, work has been underway across all NHS Boards to improve the data collected and used within out-of-hours service, by upgrading the Adastra IT system. Once fully in place, this will ensure standardised use of the system across Scotland, allowing for consistent meaningful data to be collected.

The benefits of the system changes and the improved data collection are already being seen. NHS National Services Scotland is now reporting on primary care out-of-hours services data[119]. This data shows patient and workforce data for out-of-hours services, so allows Boards to plan and monitor how their service is delivered to ensure it is high quality and safe.

We are aware of the need to improve data on the AHP workforce. There is no national approach to the collection of all AHP activity data, or detailed information on where and how AHP services are delivered across all health and social care sectors (including in primary care). The *AHP Operational Measures*[120] project aims to address the activity data gap; paramedic data is collated separately. While ISD publish quarterly AHP workforce data[121], more detail is needed to fully understand how AHP services are delivered across all health and social care sectors. The AHP Directors of Scotland Group (ADSG) recognise the importance of understanding more about the AHP workforce and have begun a process of reviewing existing

[118] Scottish Government (2015), *National Review of Primary Care Out of Hours Services* http://www.gov.scot/Publications/2015/11/9014
[119] http://www.isdscotland.org/Health-Topics/Emergency-Care/GP-Out-of-Hours-Services/
[120] http://www.isdscotland.org/Products-and-Services/Data-Definitions-and-References/Allied-Health-Professionals-National-Dataset/Operational-Measures.asp
[121] http://www.isdscotland.org/Health-Topics/Workforce/Allied-Health-Professions/

workforce and workload tools. This work is in its early stages but a report including recommendations will be produced in due course.

For optometry, the national listing of optometrists and dispensing opticians (a key recommendation of the *Community Eyecare Services Review* published in April 2017)[122] on a single system will deliver improvements in the provision of optometry workforce data and in workforce planning.

In recognition of the gap in robust baseline data on the number of pharmacists and pharmacy technicians working in our network of community pharmacies, in February 2018 NES Pharmacy undertook the first national community pharmacy workforce survey to gain a better understanding of staff numbers and skill mix within community pharmacy in Scotland. The survey was carried out in partnership with Community Pharmacy Scotland, Community Pharmacy Champions and health board staff, and the Company Chemists' Association.

The survey was designed to capture a snapshot[123] of the community pharmacy workforce including pharmacists, pre-registration trainee pharmacists, pharmacy technicians including trainees, and pharmacy support staff. The information obtained is being analysed and will help to inform future iterations of workforce planning, to help ensure we have the right workforce in place and to take action to meet future service models and demands.

NES Data Platform and supply modelling

As set out in the *National Health and Social Care Workforce Plan: Part 1*, NES is working with stakeholders to bring together and align relevant workforce data under a data platform to better inform workforce planning. As an initial step NES has led a process to develop a minimum standardised data set with potential to use across different sectors. NES is currently engaging with regional and national planners with the aim of finalising the minimum dataset shortly. These engagement sessions will help inform further development of the platform over the course of this year.

The platform will assist the development of more sophisticated workforce modelling, including the design of a 'pipeline' approach demonstrating how supply via training and recruitment numbers will meet estimated demand. This work will be progressed during 2018 with full implementation expected in 2019. These are significant development that will lead to more informed and better integrated workforce planning decisions at local and national level.

Scottish Primary Care Information Resource (SPIRE)

SPIRE is an integral part of the reform of primary care and is a crucial tool in enabling the emerging model of more collaborative multi-disciplinary primary care[124]. By improving the management and usability of existing data within general practice

[122] Scottish Government (2017), *Community Eyecare Services Review* http://www.gov.scot/Publications/2017/04/7983
[123] Survey was undertaken during the period Monday 19th to Sunday 25th February 2018
[124] More information on SPIRE can be found at: http://spire.scot.

records the introduction of SPIRE is an essential component of making GP clusters effective.

SPIRE is currently being rolled out across Scotland and will help practices provide patients with better care and services and help with the following:

- Analysing and streamlining practice workload, getting information on patient encounters, and analysing practice demographics;
- Analysing the number of patients that have certain illnesses or looking at the medicines they are prescribed;
- Monitoring and improving data quality;
- Enabling GP clusters to work together to improve the quality of care;
- Improve the provision of health and care to vulnerable or disadvantaged groups.

Local Intelligence Support Team (LIST)

LIST analysts have been successfully working locally with Health and Social Care Partnerships and others, to help drive forward integration. The Scottish Government has provided additional funding from 2017-18, to expand the LIST service to work with primary care. This will support GP Clusters and their focus on improvement, following *Improving Together: A National Framework for Quality and GP Clusters in Scotland*[125].

LIST, part of NHS National Services Scotland, mainly comprises information analysts with the aim of adding capacity and capability to local expertise. The increasingly multi-disciplinary nature of the LIST team, with its connection to the national level resources in ISD and the ability to use national and local data, will help deliver an intelligence-led service which is joined up across health and social care, including GP Clusters. As of April 2018, LIST has grown to around 65 whole time equivalent staff. The team supports cluster and partnership working across Scotland[126].

Information Systems

We recognise the need to improve IT to help enable efficient and effective working. NHS Boards have commissioned a procurement competition to provide the next generation of GP clinical IT systems in Scotland. This is being undertaken by NHS National Services Scotland. The new systems will be more intuitive and user friendly. They will be quicker and more efficient, with increased functionality. They will be underpinned by strong service levels and performance management, with clear lines of responsibility and accountability, providing, overall, a more professional GP IT Service. All GP practices will transition to the new systems by 2020.

[125] http://www.gov.scot/Publications/2017/01/7911.
[126] More information on LIST is available at: http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Local-Intelligence-Support-Team/

Increasing Digital Capacity

The *Primary Care Digital Services Development Fund, 2016-2018* has enabled general practices to benefit from a wide range of systems enhancements, infrastructure improvements and innovative trials of new tools and technologies.

A number of the opportunities selected serve to increase the availability of, and access to, timely data. For example, the practical benefits of remote working tools to enable real time access out with the practice, dual monitors in consulting rooms to facilitate ease of working between information systems in real time and ultimately to support shared decision making with patients. A range of infrastructure improvements, including server replacements to increase speed of backups and connectivity and practice wi-fi to support multidisciplinary team working. Trials of new technologies include online consultations, decision support, mobile working software solutions and devices.

The impact of the fund is being measured using an outcomes framework developed with stakeholders which is aligned to the wider Primary Care Outcomes Framework (see below). A specific study on the use, spread and experiences of Mobile Working is being undertaken which encompasses the wider community and primary care workforce.

Monitoring and Evaluation

The continuing reform of primary care is challenging and will take time. We need to be realistic about what changes we expect to see and when, and be responsive to changing circumstances. The Scottish Government will publish a 10 year national monitoring and evaluating strategy for primary care, which has been developed in partnership with NHS Health Scotland, by summer 2018. We are also working with partners to develop a set of national indicators to track progress.

A Primary Care Evidence Collaborative (PCEC) involving national organisations[127] has also been established to champion evidence-based practice and service delivery across the primary care sector and to identify and help to fill gaps in evidence through research. The collaborative helped to develop Primary Care Outcomes Framework which describes, at a high level, how the vision for primary care will be achieved[128]. The outcomes pathway for workforce (see Annex A) sets out the short to longer term outcomes the actions set out in this plan, and as part of the wider reform of primary care, are expected to deliver. We will work with our partners to further develop this pathway and to ensure robust monitoring of these workforce outcomes is established.

[127] Primary Care Evidence Collaborative members: NHS Health Scotland, Scottish School of Primary Care, Healthcare Improvement Scotland, NHS Education for Scotland, National Services Scotland, The Alliance for Health and Social Care Scotland, Scottish Government (Primary Care Policy and Health and Social Care Analysis).

[128] http://www.gov.scot/Topics/Health/Services/Primary-Care

Conclusion

Local and national workforce planning needs to be informed by good quality and timely data on both the shape of the current workforce and intelligence on how the workforce needs to develop and expand to address a growing and increasing elderly population. We recognise that we are still some way off realising that ambition, but significant progress is now being made. Through the NES data platform and the enhanced general practice data that will be delivered via the GMS contract, supported by expanded local analytical support, we are moving towards our goal of evidence-led workforce planning. Further iterations of the National Health and Social Care Workforce Plan will set out how this work is developing.

CONCLUSION AND NEXT STEPS

We are rightly proud of the many achievements our primary and community workforce have delivered to improve Scotland's health, which is recognised in the continuing high levels of patient satisfaction with the care they receive. Whilst the workforce has continued to respond to increasing demand for services, we recognise that change is needed to ensure continued sustainability.

Getting primary and community care right is an essential element of ensuring the whole healthcare system delivers the highest quality care for its patients and promotes health and wellbeing among its staff. This plan therefore focuses on developing, building and expanding multidisciplinary teams, made up of professionals each contributing their unique skills to managing care and improving outcomes. The key principle underpinning the reform of primary care is that patients receive the most appropriate treatment in the most appropriate setting, when they need it.

To deliver this vision we have set out a series of ambitious commitments to significantly increase the primary care workforce, backed by a historic increase in investment in primary care. This is supported by the reshaping of roles and responsibilities as set out in our historic *Memorandum of Understanding* with Integration Authorities, the British Medical Association, NHS Boards and the Scottish Government. This plan begins to outline how we intend to deliver these pledges. What is clear however, is that we are already seeing considerable benefits from enhanced MDT working and new models of care across Scotland. This will gather pace in the coming years through the initiatives we and our partners are taking forward. Table 7 below summaries the commitments we have set out in this plan.

Leadership capability and capacity is fundamental to the effective organisation and nature of MDTs and the wider reshaping of primary care in Scotland. The re-focused role of the GPs as an Expert Medical Generalists will ensure strong connections to, and coordination with, the enhanced primary care team, health and social care community based services and with acute services where required.

We recognise the continuing need to improve the quality and breadth of data available to local and national planners. Going forward, the NES data platform will be crucial in supporting more integrated local, regional and national workforce planning in health and social care. This plan sets out a number of specific additional actions that will improve the data we have on the primary care workforce.

Integrated and collaborative workforce planning will become increasingly important in the period ahead. An integrated workforce plan will be developed later in 2018, bringing together progress on workforce planning, and allowing us to move towards a better articulated, holistic vision for the totality of the health and social care workforce. The establishment of the National Workforce Planning Group, involving representatives of health and social care workforce staff, employers and policy development, will provide a strategic focus for workforce planning. Ministers are clear that the Group has an important role in contributing to promoting change in workforce planning to ensure that the NHS and social care sectors in Scotland can continue to meet the needs of service users and provide rewarding careers for staff.

Table 7: Key recommendation and actions in reforming primary care services

	Recommendations	Supporting Actions
Facilitating primary care reform	1. Reform of primary care is driven by developing multidisciplinary capacity across Scotland. Workforce planners including NHS Boards, Integration Authorities and General Practices will need to consider the configuration of local multidisciplinary teams that offer high quality, person-centred care. 2. In recognition of an ageing workforce, local planners have responsibility for workforce planning and managing anticipated levels of staff turnover. 3. The implementation of the new GP contract will require services to be reconfigured to maximise workforce competencies and capabilities, and ensure people see the right person, at the right time and in the right place. 4. The National Workforce Planning Group will play a strategic role in implementing the recommendations of part three of the plan, and strengthen the development of approaches for the primary care workforce. 5. An integrated workforce plan to be published later in 2018 will move towards a better articulated joint vision for health and social care workforce planning	• Increasing in funding in primary care by £500 million by the end of 2021-2, including £250 million direct support of general practice. This investment will see at least half of frontline NHS spending going to community health services. • Implementing the terms of the MoU over the next three years through the development of local Primary Care Improvement Plans. • Establishing a National Oversight Group to support service change over the next three years to ensure that patients receive the right service at the right time from the right profession. First meeting of Group in Spring 2018. • Three year Primary Care Improvement Plans to be submitted by Health and Social Care Partnerships (HSCPs) by July 2018 setting out proposals to transform and improve local services. • Working with partners to support the health and wellbeing of the workforce. • Continuing to help local partners test new ways of delivering primary care services through the Primary Care Transformation Fund. Publication of evaluation report by end 2018.

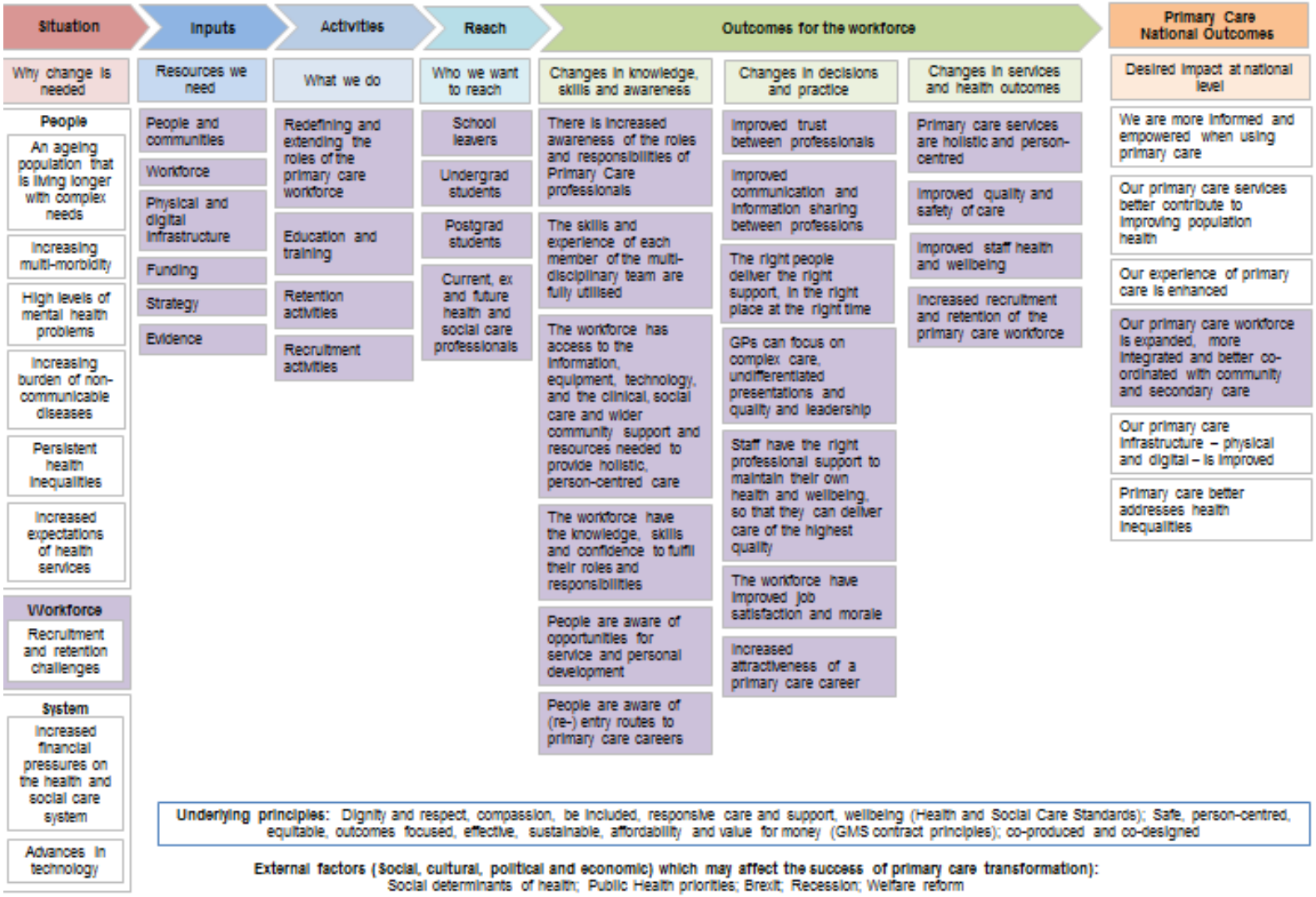
		• Publishing an integrated workforce plan later in 2018 bringing together progress on Parts 1-3, allowing us to move towards a better articulated, holistic vision for the health and social care workforce.
Building primary care workforce capacity	6. Significant investment will be made available over the next 3-5 years, as part of the First Minister's commitment to an additional £500 million for community health services, to plan for, recruit and support a workforce in general practice, primary care and wider community health, including community nursing. 7. Scotland's multidisciplinary primary care workforce will become more fully developed and equipped, building capacity and extending roles for a range of professionals, enabling those professionals to address communities' primary healthcare needs. 8. As part of national, regional and local activity to support leadership and talent management development, planners will need to continuously consider staff training needs in their workforce planning exercises; invest appropriately so that leaders in primary care are fully equipped to drive change; and enhance opportunities for the primary care workforce to further develop rewarding and attractive careers.	• Delivering an additional 2,600 nurse and midwife training places over the life of this Parliament, including a 10.8% increase in places for 2018/19, to ensure we can recruit and train the next generation of staff. • Investing £3 million to train an additional 500 advanced nurse practitioners by 2021. • An investment of £3 million over three years into training and education needs of general practice nursing. • An additional £3.9 million over three years into training and education needs of the wider community nursing team, including district nurses. • By September 2018, we will work alongside partners, including the Royal College of Nursing, to better understand the requirements and investment necessary to grow the District Nursing workforce. • Increasing the number of health visitors by 500, supported by funding which has increased over four years to £20 million annually, recurring.

		• Working with our partners to deliver our commitment to expand medical school and training places, helping deliver a commitment to recruit at least 800 (headcount) additional GPs over the next 10 years. • Investing in the Scottish Graduate Entry Medicine (ScotGEM) programme, a new four year course in medicine focused on general practice and remote and rural working commencing Autumn 2018. • Recognising the unique recruitment and retention challenges, offering a package of enhanced support for GPs working in remote and rural areas. • The establishment in Spring 2018 of an *Increasing Undergraduate Education in Primary Care Working Group* to consider ways of increasing undergraduate education in primary care settings. • Delivering a marketing and recruitment campaign in 2018-9 to promote Scotland as a great place to work as a GP, and to attract individuals into nursing and midwifery careers. • A marketing campaign to attract individuals into nursing and midwifery, allied health professional and other health and social care careers. • Delivering on our commitment that all GP practices to have access to pharmacist support

		by the end of 2021. • Increasing the mental health workforce in A&Es, GP practices, police station custody suites by 800 by iinvesting £12 million in 2018-19, with annual investment thereafter rising to £35 million by 2021-22. • Developing an enhanced role for allied health professionals in supporting patients' needs, including promoting prevention and self-management with improved access. • Recruiting 250 Community Links Workers by 2021 to help address patients' holistic needs. • Training 1,000 paramedics to work in the community, helping to reduce pressure on A&E services. • Enhanced training and support for practice managers and practice receptionist to develop their roles, supported by continued investment.
Improving data, intelligence and infrastructure in primary care	9. More integrated workforce data for primary care is required, in the context of the workforce data platform being developed by NHS Education for Scotland. 10. Local planners should consider workforce planning tools (such as the six step methodology) in developing their workforce strategies to address local population needs. 11. Planning for future staffing in primary care	• Enhancing workforce data across three broad GMS contract areas: workforce, GP income and expenses, and quality improvement. Submission of enhanced data to commence by end of 2018. • Improvements underway in collection of AHP, pharmacy and optometry workforce and activity data. • Developing the NES workforce data platform and

	should identify and make use of available guidance and intelligence on local recruitment and retention issues, and of wider developments in workforce data and scenario planning. 12. The Scottish Government will publish the Primary Care Monitoring and Evaluation Strategy 2018-2028 by June 2018.	supply modelling during 2018 to drive more integrated workforce planning. • Delivering the next generation of GP clinical IT systems in Scotland by 2020 to help enable facilitate efficient and effective working. • The Primary Care Digital Services Development Fund, 2016-2018 delivering a wide range of systems enhancements, infrastructure improvements and innovative trials of new tools and technologies. • Investing in local analytical (LIST) capacity to inform and drive service design; 65 analysts (WTE) in place by April 2018. • Continuing to support the roll out of the Scottish Primary Care Information Resource, with 85% of GP practices able to use SPIRE by the end of June 2018 with the remainder able to use it by December 2018. • Publishing a monitoring and evaluation strategy to capture and share learning from the reform of primary care in by summer 2018.

ANNEX A: OUTCOMES FRAMEWORK FOR WORKFORCE



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NHS Education for Scotland

Board Paper Summary

1. Title of Paper

Training and Development Opportunities for Board Members

2. Author(s) of Paper

David Ferguson, Board Services Manager

3. Purpose of Paper

To provide details of any upcoming training and development opportunities for Board members

4. Key Issues

- Papers detailing any upcoming training, conferences and seminars that may be of interest to Board members have become standing items for noting on Board agendas.

- We also continue to draw training and development opportunities to Board members' attention as they arise.

- The items below have been notified to Board members previously by e-mail:

(i) 'On Board Scotland' training

19th June 2018 – Stirling
11th September 2018 – Edinburgh
10th December 2018 – Stirling
19th March 2019 - Glasgow

(ii) The Effective Audit and Risk Committee training

27th June 2018 – Edinburgh
16th October 2018 – Glasgow
13th December 2018 – Stirling
21st March 2019 - Edinburgh

(iii) NHS Board Members National Masterclass

3rd September 2018 – Edinburgh

- A list of confirmed and pending national conferences (provided by the NES Conference Team) is attached to this paper.

- Members may also find it helpful to have this link to the details on the NES website of forthcoming events organised by the NES Conference Team: http://events.nes.scot.nhs.uk/

5. Educational Implications

None.

6. Financial Implications

The events at (i) above cost £395.00 plus VAT per place.

The events at (ii) above cost £225.00 plus VAT per place

There is no charge for the event at (iii) above

7. Recommendation(s) for Decision

None. This paper is for information only.

NES
May 2018
DJF

National Conference Dates 2018

Month	Date	Meeting/Workshop	Location	NES Contact	Conference Team Confirmed
June	18 & 19	NHSScotland Event	Scottish event Campus, Glasgow	John MacEachen	Y
	26	Healthcare Science	Murrayfield	Rob Farley	Y
October	7	Optometry Conference	The Hilton Hotel, Glasgow	Emily McGarva	Y
November	9	Academy for Healthcare Science/NES Event	The Studio, Glasgow	Rob Farley	Y
	21	NES Staff Conference	Perth Concert Hall (TBC)	Karen Howe	Y
Nov / Dec	TBC	Health Protection Symposium	TBC	Lesley Armstrong	Y